GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 11, 2024

Marcia Curtiss
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398969
Investigation #: 2025A0583009
Willow Creek - West

Dear Mrs. Curtiss:

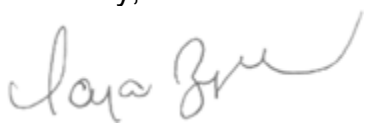
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2025A0583009
Complaint Receipt Date:	12/02/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	01/01/2025
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St., Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Willow Creek - West
Facility Address:	1011 28th St. SE, Grand Rapids, MI 49507
Facility Telephone #:	(616) 432-3074
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A presented to the hospital “covered in diarrhea”.	No
Additional Findings	Yes

III. METHODOLOGY

12/02/2024	Special Investigation Intake 2025A0583009
12/02/2024	Special Investigation Initiated - Letter APS Stephen Conrad
12/04/2024	Inspection Completed On-site
12/11/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Resident A presented to the hospital “covered in diarrhea”.

INVESTIGATION: On 12/02/2024 complaint allegations were received from Adult Protective Services via the LARA-BCHS-Complaints system. The complaint stated that “(Resident A) is an elder adult that is diagnosed with dementia and has loss of hearing and sight” and that “on October 29, 2024, (Resident A) sustained a fall while at the AFC that was not witnessed by staff.” The complaint alleged that “it is unknown how long (Resident A) was on the floor, but he was covered in diarrhea” and admitted to Corewell health hospital.

On 12/02/2024 I received an email from Adult Protective Services staff Stephen Conrad. Mr. Conrad confirmed that he was assigned to investigate the complaint. Mr. Conrad stated that Resident A was admitted to Corewell Health Hospital Intensive Care Unit for severe dehydration. Mr. Conrad stated that Resident A was discharged back to the facility where Mr. Conrad observed Resident A in person. Mr. Conrad stated that Resident A appeared “confused”.

On 12/04/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Executive Director Miranda Cockrell, staff Nita Hewlett, and Resident B.

Ms. Cockrell stated that Resident A was sent to Corewell Health on 10/29/2024 after a fall and a diagnosis of virus causing dehydration and diarrhea. Ms. Cockrell stated that Resident A was admitted to the hospital and stabilized before being sent back to the facility on 11/04/2024. Ms. Cockrell stated that during the 10/29/2024 incident, Resident A was provided adequate care by facility staff. Ms. Cockrell stated that

due to a viral illness, Resident A was severely dehydrated and experiencing severe and uncontrollable diarrhea. Ms. Cockrell stated that on 11/26/2024 Resident A was sent back to the hospital and admitted due to a urinary tract infection. Ms. Cockrell stated that Resident A is currently at a rehabilitation facility and will return to the facility after he fully recovers.

Ms. Hewlett stated that Resident A is independent and does not require staff assistance with toileting. Ms. Hewlett stated that she worked at the facility on 10/29/2024 with staff Tiffany Day and staff Aimee Nelson. Ms. Hewlett stated that on 10/29/2024 Resident A became rapidly ill due to a stomach virus. Ms. Hewlett stated that early on the day of 10/29/2024, Resident A was observed to be operating at his baseline. Ms. Hewlett stated that on the afternoon of 10/29/2024, Resident A was observed to have fallen in his bedroom and was experiencing uncontrollable diarrhea. Ms. Hewlett stated that she and other staff cleaned Resident A and proceeded to contact emergency medical personnel to transport Resident A to the hospital. Ms. Hewlett stated that Resident A's diarrhea was constant, and each time staff cleaned his adult brief, Resident A defecated again. Ms. Hewlett stated that emergency medical responders exhibited a difficult time getting Resident A loaded into the ambulance because Resident A continued to defecate on himself multiple times. Ms. Hewlett stated that Resident A did not appear to have sustained any obvious injuries related to his fall but given his advanced age; Resident A required medical attention for symptoms of a virus. Ms. Hewlett stated that staff provided Resident A with appropriate care.

Resident B stated that he is Resident A's roommate. Resident B stated that on 10/29/2024 he observed Resident A fall in their bedroom and staff quickly attended to Resident A who was sick with a virus. Resident B stated that Resident A was suffering from severe diarrhea and staff did change Resident A's clothing before sending him to the hospital for treatment. Resident B stated that staff are helpful and provide adequate care to Resident A and other residents.

While onsite I observed an incident report signed by staff Aimee Nelson on 10/29/2024. The document stated that Resident A had fallen on his bedroom floor and was sent via ambulance to the hospital due to "not responding appropriately".

On 12/06/2024 I interviewed Resident A in person at the SKLD Wyoming facility. I observed that Resident A was lying in a hospital bed eating lunch. Resident A presented with appropriate hygiene. Resident A was not oriented to time and place and was unable to complete an interview. Resident A did state that he believed he would be returning to the Willow Creek West facility and enjoyed residing there.

On 12/09/2024 I received an email from licensee designee Marcia Curtiss. The email contained Resident A's Assessment Plan. The document was signed on 12/01/2023 and stated that Resident A did not require assistance with toileting.

On 12/09/2024 I received and reviewed an email from licensee designee Marcia Curtiss. The email stated that Resident A was admitted to the facility on 10/25/2024 and the Assessment Plan signed on 12/01/2023 was completed at his previous facility. Ms. Curtiss acknowledged that a new Assessment Plan was not completed since his admittance to the facility on 10/25/2024.

On 12/11/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she agreed with the findings and declined to add any additional information.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Staff Nita Hewlett stated that Resident A is independent and does not require staff assistance with toileting. Ms. Hewlett stated that on 10/29/2024 Resident A became rapidly ill due to a stomach virus. Ms. Hewlett stated that on the afternoon of 10/29/2024, Resident A was observed to have fallen in his bedroom and was experiencing uncontrollable diarrhea. Ms. Hewlett stated that she and other staff cleaned Resident A and proceeded to contact emergency medical personnel to transport Resident A to the hospital. Ms. Hewlett stated that Resident A's diarrhea was constant, and each time staff cleaned his adult brief, Resident A defecated again. Ms. Hewlett stated that emergency medical responders exhibited a difficult time getting Resident A loaded into the ambulance because Resident A continued to defecate on himself multiple times. Ms. Hewlett stated that staff provided Resident A with appropriate care. Resident B stated that on 10/29/2024 he observed Resident A fall in their bedroom and staff quickly attended to Resident A who was sick with a virus. Resident B stated that Resident A was suffering from severe diarrhea and staff did change Resident A's clothing before sending him to the hospital for treatment. Resident A's Assessment Plan stated that Resident A did not require assistance with toileting. On 10/29/2024 Resident A presented to the emergency department with uncontrollable diarrhea. Prior to his

	transportation to the hospital, staff responded to Resident A's personal care needs appropriately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A's Assessment Plan was not completed at the time of his admission.

INVESTIGATION: On 12/09/2024 I received an email from licensee designee Marcia Curtiss. The email contained Resident A's Assessment Plan, which was signed on 12/01/2023.

On 12/09/2024 I received and reviewed an email from licensee designee Marcia Curtiss. The email stated that Resident A was admitted to the facility on 10/25/2024 and that the Assessment Plan signed on 12/01/2023 was completed for his previous facility. Ms. Curtiss acknowledged that a new Assessment Plan had not been completed since his admission to the facility on 10/25/2024.

On 12/11/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss via telephone. Ms. Curtiss declined to add any additional information and stated that she would submit a Corrective Action Plan after reading the Special Investigation Report.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Licensee designee Marcia Curtiss acknowledged, via email, that Resident A was admitted to the facility on 10/25/2024 and that a new Assessment Plan has not been completed. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A's Assessment Plan for AFC Residents was not completed at the time of admission.

CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: Resident A's Resident Care Agreement was not completed at the time of admission.

INVESTIGATION: On 12/09/2024 I received an email from licensee designee Marcia Curtiss. The email contained Resident A's Resident Care Agreement, which was not signed by any of the required parties.

On 12/09/2024 I received and reviewed an email from licensee designee Marcia Curtiss. The email stated that Resident A was admitted to the facility on 10/25/2024. Ms. Curtiss acknowledged that the Resident Care Agreement had not been signed by any of the required parties since his admission to the facility on 10/25/2024.

On 12/11/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss via telephone. Ms. Curtiss declined to add any additional information and stated that she would submit a Corrective Action Plan after reading the Special Investigation Report.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal. (b) A description of services to be provided and the fee for the service. (c) A description of additional costs in addition to the basic fee that is charged. (d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. (e) An agreement by the resident or the resident's designated representative or responsible agency to provide

	necessary intake information to the licensee, including health-related information at the time of admission. (f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule. (g) An agreement by the resident to follow the house rules that are provided to him or her. (h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident. (i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315. (k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. (l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.
ANALYSIS:	Licensee designee Marcia Curtiss acknowledged, via email, that Resident A was admitted to the facility on 10/25/2024 and that the Resident Care Agreement has not been signed by any of the required parties. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A's Resident Care Agreement was not completed at the time of admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend that the license remain unchanged.

12/11/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

12/11/2024

Jerry Hendrick Date
Area Manager