GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2025

Marica Curtis
CSM Serenity, LLC
61 Sheldon Ave., SE
Grand Rapids, MI 49503

RE: License #: AL030393311
Investigation #: 2025A0357025
Macatawa East

Dear Ms. Curtis:

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030393311
Investigation #:	2025A0357025
Complaint Receipt Date:	02/12/2025
Investigation Initiation Date:	02/12/2025
Report Due Date:	04/13/2025
Licensee Name:	CSM Serenity, LLC
Licensee Address:	61 Sheldon Ave., SE, Grand Rapids, MI 49503
Licensee Telephone #:	(616) 550-4653
Administrator:	Amanda Brenner
Licensee Designee:	Marcia Curtiss
Name of Facility:	Macatawa East
Facility Address:	1710 West 32nd St., Holland, MI 49423
Facility Telephone #:	(616) 550-4653
Original Issuance Date:	05/10/2018
License Status:	REGULAR
Effective Date:	11/07/2024
Expiration Date:	11/06/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 02/09/2025, Resident A and Family Member 1 found loose pills next to his chair.	Yes
On 02/09/2025, Resident A and his Family Member 1 found his colostomy bag unattached.	No

III. METHODOLOGY

02/12/2025	Special Investigation Intake 2025A0357025
02/12/2025	Special Investigation Initiated - Telephone To Kristin Campbell, (Supports Coordinator). Area Agency on Aging.
04/03/2025	Inspection Completed On-site I made an announced inspection.
04/03/2025	Contact - Face to Face Face to face interview with Direct Care Staff, Josphine Delgado. Interview with Resident A.
04/03/2025	Contact - Telephone call made with Supervisor Amanda Bremmer. Discussed the complaint.
04/03/2025	Contact - Telephone call made With Resident A's Family Member 1.
04/03/2025	Contact Email received from Family Member 1 Sent me pictures of the found pills.
04/04/2025	Contact - Telephone call made interview with Direct Care Staff, Sabrina Cruz-Regan.
04/04/2025	Contact - Telephone call made Interview with Direct Care Staff, Connie Jones. Interview with Supervisor Amanda Brenner.
04/04/2025	Contact – Documents received by email Resident A Face sheet, Assessment Plan, HomeMD's reviews, Interim Health Care Notes and recommendations and ADL Logs.
04/07/2025	Referral to Centralized Intake/Adult Protective Services.

04/08/2025	Telephone exit conference with Licensee Designee.

ALLEGATION: On 02/09/2025, Resident A and Family Member 1 found loose pills next to his chair.

INVESTIGATION: On 02/12/2025, I conducted a telephone interview with Kristin Campbell, Supports Coordinator, (AAA) for Resident A. She explained that She received a telephone call from Resident A's family member on 02/20/2025 informing her that when the family member (FM 1) went to pick up Resident A to take him to church, she found loose pills next to his chair. Ms. Campbell reported that she called Ms. Amanda Brenner, Supervisor to report the incident. She said that Ms. Brenner reported that all resident medications are provided on the main level in the home in the medication room near the kitchen. She reported that Ms. Brenner suggested that the medications they found might have been from the move from the last facility Resident A was living at. Ms. Campbell reported that she spoke with Resident A, and he confirmed that his medications are provided on the main floor in the medication room. Resident A's bedroom is on the second floor of the facility.

On 04/03/2025, I made an unannounced inspection of the home. I met with Direct Care Staff, Josephine Delgato. She provided Ms. Brenner's telephone number to me and reported she did not work on 02/09/2025. She reported that she had no knowledge of the situation.

On 04/03/2025, Ms. Delgato took me upstairs to Resident A. He was lying on his bed and appeared to be resting. Resident A presented well and was dressed well. He remembered that he and FM1 found the pills by his big chair that he often sits in. I asked if he knew what the pills were, and he did not. He explained that he walks downstairs for his breakfast and the staff bring his pills to him. At night he reported they bring his pills to him at bedtime. I asked what they did with the pills they had found, and he did not remember. He said FM1 took care of them. He has a room to himself with no roommate.

On 04/03/2025, I telephoned the Supervisor, Amanda Brenner. She said she was aware of the situation, and she thought the pills had been in his chair because it was the same chair he brought from the facility he came from. She confirmed that staff pass resident medications from the medication room on the main floor and the residents come to the med room to receive their medications. She did not know how there were pills on Resident A's floor by his chair. She confirmed that Direct Care Staff, Sabrina Cruz-Regna worked on 02/09/2025 on the first shift and reported she would be working on 04/04/2025 so I could call back to speak to her then.

On 04/03/2025, I conducted an interview with Direct Care Staff, Josephine Delgado. She reported that she works second shift from 3:00 to 11:00PM. She reported that she administered Resident A's pills at 8:00 PM and she takes them upstairs to his room and she said she makes sure he takes all of them and then goes back to the

med cart to chart that he took his medications. She denied that she had seen any pills by Resident A's chair, and she was certain any medications she administered to him she made sure he had taken them all.

On 04/03/2025, I telephoned Family Member 1. She explained that Resident A had been in the home about two months when she went to pick him up for church and found the pills on 02/09/2025. She reported there were five to six pills under his chair and on the arm of his chair and some on the floor by his table. She went on to say she took the pills to the staff Sabrina Cruz-Regna who was in the medication room. She said Ms. Cruz-Regna said, "I can't give him the pills now." FM1 said she already knew that. I mentioned that some staff thought the pills came from his chair because he had it at the home he came from. FM1 said that she took his chair apart and scrubbed it with a steam cleaner and she did not find any pills. She reported that Resident A lived with her for a time, and his dexterity was poor. She said he could not take his pills from the little cup without spilling them or missing some. She stated that the staff should help him take his pills and watch him to make sure he takes them all. She was not able to identify any of the pills she had found but she was certain these were Resident A's pills that must have been dropped.

On 04/03/2025, FM 1 sent me pictures of the pills she had discovered. There were five pills different shapes and colors.

On 04/04/2025, I conducted a telephone interview with Direct Care Staff, Connie Jones. She explained she takes Resident A's pills to him, and she watches him to make sure he takes all of his pills, then she charts on the computer MAR (Medication Administration Record). She said he never refuses his pills. She said they take his blood pressure in the AM when he takes his pills, and they determine if he needs more medication according to what his orders are. She denied that he has dropped any pills when she administered them to him. She denied that she had seen any pills on the floor.

On 04/04/2025, I telephoned and was connected to Sabrina Cruz-Regan, direct care staff. She confirmed that she had worked on 02/09/2025 on the First Shift. She reported that she takes Resident A's pills to him at the breakfast table, and she said**,** "I make sure he takes all of them, and then I go back to the med cart and check that he has taken them." She also stated that if he is upstairs in his room she take**s** his 2:00 PM pills up to him and again she said she makes sure he takes them all. I asked her about the incident on 02/09/2025. She reported that she remember**s** that FM1 brought her pills and explained that she found them on the floor. She said she immediately called her boss, Ms. Brenner and told her and then she destroyed the pills. I asked her if she had recognized his pills, or if she had compared them to his pills to see if any matched and she said no. She said she knew she could not administer them because they had been on the floor. She denied ever dropping any of Resident A's pills and she reported she had not seen any of his pills on the floor by his chair.

On 04/08/2025, I conducted a telephone exit conference with the Licensee Designee, and she agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 02/09/2025, FM 1 found loose pills next to Resident A's chair. Amanda Brenner, Supervisor thought the pills were in his chair from his last placement. FM 1 stated she had taken the chair apart and steamed cleaned it before he moved into this home. She stated she found no pills in his chair during the cleaning. FM 1 provided a pictured of six different pills she had found on 02/09/2025, on the floor by Resident A's chair and under it, on the arm of the chair and on the table he uses. She took the pills to Sabrina Cruz-Regan, Direct Care Staff. Sabrina Cruz-Regan, Direct Care Staff, confirmed that FM 1 had brought pills to her on 02/09/2025 and told her she had found them in and around Resident A's chair. She called her supervisor and then destroyed the pills. Direct Care Staff, Josphine Delgado, Sabrina Cruz-Regan and Connie Jones all stated they administer Resident A's medications, and they all denied that any pills were dropped or not administered. During this investigation evidence was found that six medications in pill form, were found on 02/09/2025, by FM 1 in and around Resident A's chair. Resident A confirmed they found pills. FM 1 sent me the picture she had taken of the six pills. She took the pills to Direct Care Staff, Sabrina Cruz-Regan, who acknowledged FM 1 had brought her the pills that she described she found in and around Resident A's chair. Resident A does not have a roommate. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 02/09/2025, Resident A and Family Member 1 found his colostomy bag unattached.

INVESTIGATION: On 02/12/2025, I spoke by telephone to Kristin Campbell, (Supports Coordinator) from Area Agency on Aging. She stated FM 1 had telephoned her on 02/10/2025 to report when she picked up Resident A for Church on Sunday his colostomy bag was unattached. She stated that she spoke directly with Resident A, and he reported the colostomy bag was not unattached, but tape holding the colostomy bag at the top of the bag was loose. She also stated unless Resident A informs staff of additional problems outside of twice daily checks, staff will not be aware.

On 04/03/2025, I was introduced to Resident A, and I conducted an interview with him in his room. He told me his birthday and said he was 84 years old. He also stated that he had been in this home for three months. He explained that he had his stomach removed and now he has colostomy. He said he has had this for 14 years. He stated that FM 1 obtains all of the supplies to care for the colostomy and he showed me where they were in his closet. He also showed me a large picture attached to the door of his closet with each step to putting the bag onto the stoma that FM 1 put there for staff to see and reference. He said that he wanted to change his colostomy himself, but FM 1 said that is what they are paying staff to do for him. He reported the incident on 02/09/2025 and he said the tape was loose. He immediately stood up and showed me his colostomy. I could see that it was leaking, and his clothes were wet. I pointed it out to him, but he did not seem to be concerned about it. He said when the staff change the bag, they do not dry the area entirely before they put the adhesive on and then attach the bag and since it is not totally dry it does not stick. He seemed frustrated and kept repeating he could do it himself.

On 04/03/2025, I spoke with Amanda Brenner, the supervisor by telephone and we discussed the complaint. She said staff have had trouble with the colostomy since he was admitted. She said it leaks often. She said she has instructed staff to check on his colostomy every 2 hours and to make sure he is emptying his bag when it is full, because he knows how to do that. She said, “He messes with it and that is why it is not sticking.” She said he can report when it is leaking but he does not report it. She said she had arranged training from their nurse to teach the staff how to care for the colostomy. She also explained that she had a Home Health agency work with the staff to know how to apply the bag and they worked with Resident A. She stated they were only involved with him for two weeks when they discharged him from their care. I asked if the care of the colostomy was in his assessment plan and she reported it was, and she would send it to me the next day. She was certain all the direct care staff were fully trained, and they know how to care for the colostomy. She stated that FM1 obtains all of his supplies. FM 1 has changed the bag several times. She also reported that his skin gets red and inflamed when the bag leaks. She reported that they now have extra jelly to apply to make it stick better.

On 04/03/2025, I was able to speak with the Direct Care Staff, Josphine Delgado to

let her know that I had observed his bag leaking when I had interviewed Resident A. She assured me she would check on him. She said she takes his nighttime meds to him at 8:00PM and she always checks it then. I asked her about his colostomy care, and she stated that she often changes it after dinner. She said FM 1 has told her how to care for it and she washes the area and then she dries it with a dry washcloth and then the adhesive sticks. She said it has to be totally dry. I asked if she has seen him 'mess with it' and she said she has never seen Resident A mess with it.

On 04/03/2025, I conducted a telephone interview with FM 1. She said on 02/09/2025, she came to take Resident A to church, and she found the bag leaking so she had to clean him up and put on a new bag. She did not know how long it had been leaking. She said before this she had to take him to the Ostomy clinic (no date provided) because it was so bad with being opened along with redness, swelling and it took a long time to heal. She said now that it is healed it is doing much better. She said once you change the bag you have to change in every four days, unless it is leaking. She said she knows he thinks he can change it "but he can't do it." She had him in her home and cared for him for a time and he cannot do it himself. She said the staff are really trying to care for him and his colostomy, but she wished they would check on him more often because he does not tell them when it is leaking. She said she has taught different staff how to do it.

On 04/03/2025, I received a text message from FM 1. She stated that Ms. Delgado had telephoned her to report to her that Resident A's abdomen was very red, raw and painful. She had him take a shower and put a new bag on him.

On 04/04/2025, Ms. Brenner sent me information on Resident A and contained was a telehealth visit dated 04/04/2025. It read the "ostomy bag leaking and causing irritation at ostomy site." The staff had reached out to HomeMD.

On 04/04/2025, Ms. Brenner emailed me Resident A's assessment plan. The section of the assessment plan under 'Self Care Skill Assessment', under B "Toileting," "Yes" is checked and it read as follows: "Q 3-hour Reminders." Under C 'Bathing' "Yes" is checked and it read as follows: "Full assist and changing ostomy." Under D 'Grooming (hair care, teeth, nails etc.)' "Yes" is checked and it read as follows: "Check ostomy often, history of leaking."

Ms. Brenner also attached information from HomeMD. A review of his problems included "Impaired cognition, Arthritis of right knee, Hyperlipidemia, Major depressive disorder, Orthostatic hypotension, Impacted cerumen, ileostomy, Degenerative joint disease, chronic kidney disease stage 3, Celiac disease, Type 2 Diabetes mellitus and Leukocytosis.' He has a Pacemaker and creation of ileostomy. He has trouble hearing. Resident claims he has Dementia. This document reported Resident A at 5' 10" and 106 pounds.

Ms. Brenner attached the notes from the Interim Health Care dated 02/20/2025. They advised to look at patient throughout the day to monitor for leaks. Remind

Patient to empty bag often to prevent leaks. Please look at bag every few hours to make sure it is not leaking or if patient needs to empty.

Ms. Brenner attached Resident A's ADL (Activities of daily living) for the month of February 2025. "AM Care -Day Shift: Check Ostomy with AM care. 7:00AM to 11:00 AM." For every hour staring with hour 1 through the 24th. hour, staff's initials were recorded for every hour. "Dressing: Ensure Ostomy Bag isn't Leaking. 7:00 AM to 2:30 PM and 3:00 PM to 10:30 PM. Starting with every hour from hour 1 through 24 hours staffs initials were recorded for every hour.

On 04/08/2025, I conducted a telephone exit conference with the Licensee Designee, and she agreed with my finding.

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:	It was alleged that on 02/09/2025, Resident A and FM1 found his colostomy bag unattached. Kristin Campbell, Supports Coordinator, from AAA confirmed that she spoke to Resident A, and he reported the tape holding up the colostomy bag, at the top was loose. Resident A's assessment plan stated, "full assist and changing ostomy when he was bathed". It also stated, "check ostomy often, history of leaking". Interim Health Care wrote notes dated 02/20/2025 advising staff to look at Resident A throughout the day to monitor for leaks and remind Resident A to empty his bag often to prevent leaks. It was also noted that staff should look at the bag every few hours to make sure it is not leaking or if Resident A needs to empty it. FM 1 reported on 02/09/2025, she found the bag to be unattached and she had to wash him and change the bag. The ADL logs indicated that Resident A was checked every hour on 02/09/2025 noted by the staff's initials. During this investigation there was not sufficient evidence to determine that Resident A's ostomy was not checked often as

	the assessment plan stated. There is no way of knowing when Resident A's bag started leaking. Therefore, there is not a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction and then the complaint be closed and the license remain the same.

Arlene B. Smith 04/09/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 04/09/2025

Jerry Hendrick Date
Area Manager