GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2022

Bryan Cramer
Byron Center Manor Inc
2115 - 84th Street SW
Byron Center, MI 49315

RE: License #: AL410247136
Investigation #: 2022A0357018
Byron Center Manor V

Dear Mr. Cramer:

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 #:	AL410247136
Investigation #:	2022A0357018
Complaint Receipt Date:	05/11/2022
Investigation Initiation Date:	05/15/2022
Report Due Date:	06/10/2022
Licensee Name:	Byron Center Manor Inc
Licensee Address:	2115 - 84th Street SW Byron Center, MI 49315
Licensee Telephone #:	(616) 878-3300
Administrator:	Bryan Cramer
Licensee Designee:	Bryan Cramer
Name of Facility:	Byron Center Manor V
Facility Address:	2115 84th Street Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	05/23/2003
License Status:	REGULAR
Effective Date:	01/24/2022
Expiration Date:	01/23/2024
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has fallen numerous times, resulting in injury and she fell on 05/07/2022 resulting in a black eye and a bruise on the forehead.	Yes
There was no Incident report filed, the family was not notified of her fall and resulting injuries and they did not receive a copy of the Incident/Accident Report.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/11/2022	Special Investigation Intake 2022A0357018
05/11/2022	Contact - Face to Face Face-to-face with, former Clinical Director. Melissa Guritz and Katie Wieringa were also present.
05/11/2022	APS Referral Family Member 1 made the referral to Centralized Intake and she received a denial from APS.
05/11/2022	Contact – Telephone Call made t To Family Member 1.
05/12/2022	Special Investigation Initiated - On Site I observed the resident at lunch time.
05/12/2022	Contact Document Received Incident/Accident Report on Resident A’s injury
05/15/2022	Contact - Document Received Family Member 1 sent me a picture of the bruise on Resident A's neck.
05/15/2022	Contact - Telephone call received Telephone from Family Member 1 concerning the bruise on Resident A's neck.
05/16/2022	Contact - Document Received Received Incident/Accident Report concerning "large bruise on the left side of her neck."
05/17/2022	Contact - Document Received

	Received four Incident Reports via text message from Family Member 1 concerning Resident A.
06/03/2022	Contact - Face to Face Conducted face-to-face with Direct Care Staff, Faith Guritz, direct care staff, Augustin Muhizi, Med Passer Tiffany Ridley, and Direct Care Staff, Francisco Nsengiyumva.
06/07/2022	Contact - Telephone call made To Family Member 1.
06/07/2022	Contact - Document Received Ms. Wieringa sent me her response after speaking to the Hospice nurse.
06/08/2022	Contact - Document Received Received Resident A's Service Plan, ADL's, assessment plan, Health Care Appraisal, and other related documents.
06/09/2022	Contact – Telephone call Received From Casey Nichols, RN, Clinical Manager.
06/09/2022	Contact - Telephone call made Interview by telephone with direct care staff, Chelesa Fuller and Melissa Guritz.
06/10/2022	Contact - Telephone call made I conducted a telephone interview with direct care staff, Aminata Monjolo.
06/10/2022	Contact – Telephone call made To Family Member 1.
06/14/2022	I conducted an exit conference by telephone with the Licensee Designee, Bryan Cramer.

ALLEGATION: Resident A has fallen numerous times, resulting in injury and she fell on 05/07/2022 resulting in a black eye and a bruise on the forehead.

INVESTIGATION: On 05/11/2022, I spoke by telephone the Resident A's Family Member 1 (FM1). She stated that Resident A is receiving Hospice care and on Monday morning 05/09/2022 she received a telephone call from a nurse from Hospice asking her if anyone from the facility had contacted her about the injury found on Resident A. FM1 stated she told the nurse that she had not received any telephone calls from Byron Center Manor. FM1 reported that the nurse told her that when she went to see Resident A this AM she found her with a large black eye and

bump on her forehead. She said the nurse told her that their agency Kindred Hospice had not been notified of any injury to Resident A. FM1 reported that the Hospice nurse did not want her to be “shocked” when she and other family members came to visit Resident A without prior knowledge of Resident A’s injuries. FM1 reported she went on Monday May 9, 2022, to see Resident A and she was “shocked” because her eye was red all the way around it and there was a bruise on her head. She stated she asked the staff on duty what had happened, and they told her they did not have any information of what had happened to Resident A. She said she requested to see an Incident Report and the staff told her there was not any incident report about Resident A’s injuries. FM1 stated no one completed an Incident Report on how the injuries had occurred and no one had notified her, nor had they notified Resident A’s Hospice. FM1 stated she thought Resident A had been abused. I explained that she may call Centralized Intake which connects to Adult Protective Services, and she volunteered to call. I provided her with the telephone number, and she stated she would make the call.

On 05/11/2022, I was at the facility, and observed Resident A siting at the table for lunch. I spoke with Resident A and asked how she had received her eye injury. Resident A said she had fallen yesterday on her back and then she said she had fallen today. I observed her eye to be red in color all around her eye. She also had a red bruise on her forehead.

On 05/11/2022 I interviewed the Clinical Manager, Katie Wieringa. She stated that “med passer”, Tiffany Ridley, had called her early on Sunday morning May 8, 2022, and explained to her that Resident A had a black eye, but she did not know how she received the black eye. She said she told Ms. Ridley to complete an incident report. Ms. Wieringa stated that it is the responsibility of the med passer to call Hospice, Resident A’s physician, and the family about the injuries. Ms. Wieringa had reported to me that their policy is for the staff who discovered Resident A with injuries are required to call Hospice if they are on Hospice and call the resident’s physician and call the family to report the incident and the injuries.

On 05/12/2022, when I was at the facility, I received the Incident/Accident Report regarding Resident A’s eye and head injury. This report was dated 05/08/2022 at 1:40 AM. Tiffany Ridley was the staff on duty and her name was at the bottom of the report. Under the section of what happened the following was typed in: *‘While doing rounds staff observed resident sleeping in her chair with heavy bruising around her eye. Resident unsure what happened.’* Under the section of Action taken by staff the report read as follows: ‘*Staff assessed range of motion to look for further injuries, completed with no signs or symptoms of pain. BP 171/86 P 76.’* Under the section of corrected measures, it read as follows: *‘Staff will continue to monitor resident.’* The report was signed by Kathleen Wieringa, Manager on 05/09/2022. The report read that Resident A’s FM1 was contacted on 05/09/2022 at 2:00 p.m., and Kindred Hospice was contacted on 05/09/22 9:00 a.m.

On 06/03/2022, I was at the facility and conducted a face-to-face interview with direct care staff Faith Guritz. Ms. Guritz stated she did not work the weekend that Resident A was injured. She said she saw the bruised eye on Monday 05/09/2022, when she returned to work. She reported that Taylor Huntington, second shift manager had said that Ms. Ridley was on second shift on Saturday, and she knew that Resident A had fallen because what was written in the Communication Log.

On 06/03/2022, I conducted a face-to-face with direct care staff, Augustin Muhizi. Mr. Muhizi reported he worked second shift in the facility they refer to as “Navy,” on 05/07/2022. He reported that after supper he was getting residents ready for bed. He reported that Ms. Ridley was passing Medications in the facility known as “Red” and she came over to pass meds in Navy and she told him he had to go and help staff get residents ready for bed in the Red unit. He thought the time was around 8:00 PM and he went to the Red side to work. He stated that direct care staff, Francois Nseniyumva was working alone on the Red side because staff Kassandra (no last name provided) had come with Ms. Ridley to the Navy side. He reported that he and Mr. Nsengiyumva helped different residents get ready for bed and then they went to see Resident A. He said that Ms. Ridley had returned to the Red Unit. Then he heard “Help, Help!” He reported that he and Mr. Nsengiyumva went to Resident A’s room and found her on the floor and stated it appeared she had slipped out of her chair. He said he immediately went to find Ms. Ridley because she was the med passer to come and assess Resident A. He reported that they asked Resident A if she was okay, and she said she was okay. He stated that Ms. Ridley came and took Resident A's blood pressure, pulse and felt her head and reported to him and Mr. Nsengiyumva that she was okay. He said he did not touch Resident A. All the time Ms. Ridley was checking Resident A who was still on the floor, Resident A kept saying, “I’m okay, I’m okay.” He stated that after Ms. Ridley left, they got her up into her bed, changed her and put a new brief on her and her night clothes and put her to bed. He reported that staff Marlene (no last name) had written in the communication log that Resident A had fallen. I asked if he had completed an Incident/Accident report (I&R) and he said he had not because this was not the unit he was assigned to work in and he assumed that the Med Passer, Ms. Ridley, would complete the I&R since she evaluated Resident A. I asked Mr. Muhizi if Resident A required a one or two person assist and he reported that she required a one person assist but he said after this incident they changed this to a two person assist. I reminded Mr. Muhizi that since he was the one who found Resident A on the floor that he should have completed an IR.

On 06/03/2022, I conducted a face-to-face interview with direct care staff, Francisco Nsengiyumva. He stated that he worked second shift on 05/07/2022 and Ms. Ridley was the med passer for the shift. He stated there is much work to be done to get all the residents ready for bed. He reported that Mr. Muhizi came from the Navy unit to help him put residents to bed (time unknown). He said that when he took Resident A to her room as she was sitting in her Broda chair, Resident A told him she wanted to be the last one put to bed. He stated that he took care of one resident while Mr. Muhizi took care of another resident. He said when each of them had finished they

entered Resident A's room and saw her on the floor. He said they called for Ms. Ridley and she came and took Resident A's blood pressure, pulse, temperature, and assessed her movement. I asked him if he knew what time this was, and he said "maybe 7:30 PM." After Ms. Ridley had completed her assessment of Resident A, she reportedly told them that Resident A was good and "had no problems". He said they got Resident A up and onto her bed. He said she did not have any skin tears that they could observe but her skin on her face started bruising around her eye and on her neck below her chin. He reported they changed her clothes, did a clean brief (adult protection) change, and cleaned her up and then put her into her bed. I asked him if he had any idea how she might have fallen out of her chair, and he said Resident A likes to watch TV and maybe she reached for the remote to change a channel and then she fell. He said she was comfortable in her Broda chair the first time he left her. I asked if there were any restraints holding her in her Broda chair like a belt and he said there were none. He stated he did not complete an Incident/Accident report because he assumed Ms. Ridley would complete one since she took Resident A's vitals.

On 06/03/2022, I conducted a face-to-face with Ms. Tiffany Ridley. She confirmed that she is not a nurse, but she is a **"**med passer**"**. She reported that she worked for a staffing agency called QCI and she confirmed that she was working for Byron Center Manor on 05/07/2022 and that she worked the second and third shift. Third shift stared on 05/07/22, then turned to 05/08/2022 at midnight. She reported that staff Marleen (no last name provided) came to do her insulins with residents around 8:30 PM. Then a little later Mr. Muhizi came and reported to her that Resident A had slipped out of her chair. She stated that she went to check Resident A's vitals. She said the two male staff had picked Resident A up off the floor and had put her in her Broda chair before she got there because when she entered Resident A's room, she was sitting in her Broda chair. She stated that she took Resident A's vitals. Later on third shift she reported that when she did her rounds checking on residents, at 1:40 AM she found Resident A still sitting/sleeping in her Broda Chair and not in her bed. She said she had to wake her up and change her clothes and she was wet with urine, and she had had a BM. She said she saw that Resident A's eye was turning colors, so she called Ms. Wieringa, Clinical Manager who told her to administer one or two Tylenol 325mg. She reported that Ms. Wieringa told her it was late and not to call Hospice, or the family and that she would do this in the AM herself. Ms. Ridley stated the two male staff did not know how to complete an Incident/Accident report. She verified that she had completed the IR on 05/08/2022 where she had written that there was heavy bruising around Resident A's left eye. I asked Ms. Ridley to respond to the information I had gathered that two other staff (un-named) reported they did not put Resident A into her Broda Chair and they had cleaned her up and put her to bed. She said she knew what she did, what she saw and what they did.

On 06/03/2022, I conducted an interview with Ms. Taylor Huntington. She provided me with a copy of the page out of the Communication Log. The page stated, *'2nd shift. Augustin, Francisco and Tiffany. All residents went to bed around 7 pm.'* There were no initials written next to this sentence. Then it read, *'(Resident A) fell down in*

her room.' There were no staff's initials next to this statement. Ms. Huntington provided me with another sheet from the Communication Log. It stated, *'5/7/22 3rd shift report Aminata (M) Tiffany (F) … (Resident A) was in her chair w/a black eye when 3rd. shift did toileting Rounds! ----TR.(Tiffany Ridley)'.* None of the other entries were initialed.

On 06/09/2022, I received a telephone call from Casey Nicholas RN, Clinical Manager for Kindred hospice. He explained to me that Resident A reportedly fell out of her Broda chair on 05/07/2022, and they were not notified of the fall until 05/09/2022. He stated that they were concerned not only about Resident A's injuries and the fact that it was a head injury, but the fact they had not been notified right away so they could come in to assess her. He said sometimes information "falls through the cracks" like at change of shift and a staff thinks another staff has contacted them when in fact they have not. He said it would be better if they received extra calls regarding an incident rather than not receive any calls. He stated that he is aware that Resident A had rolled out of her bed in the past but falling out of the Broda chair is much different.

On 06/08/2022, I received by email Resident A's assessment plan which I reviewed. This document stated that Resident A required assistance with eating/feeding, toileting, bathing, grooming, bathing, personal hygiene and that staff are to push Resident A's wheelchair. This was signed by Melissa Guritz, Manager on 01/20/22. Resident A has a Service Plan which has all of her ADL's recorded for each staff member to see and provide for her. She is to be checked every two hours, toileted every three hours when awake and every four hours when she is sleeping. It also notes that Resident A needs assistance of two staff for all transfers. I received and reviewed her Health Care Appraisal dated 01/19/2022. This document included some of her diagnoses', of Alzheimer's, Dementia, depression, and Type 2 DM. This report also stated she is frail, has memory loss and has weakness and loss of muscle control. In her documents it stated under diagnosis that she has a history of falls. I reviewed her Resident Care Agreement and Family Member 1 is her designated representative.

On 06/10/2022, I conducted a telephone interview with med passer Aminata Monjolo. She confirmed that she worked the third shift starting on 05/07/2022 and ending 05/08/2022. She reported that she was required to pass medications in both Red and in Navy. She stated that she asked Ms. Ridley how the second shift went, and Ms. Ridley said it was all fine with no problems. She said she went to the Navy to pass medications. She said she was cleaning up the nurse's station when Ms. Ridley called and said, "I need you." She said she came to the Red side and Ms. Ridley asked her to observe Resident A. She said she observed Resident A sitting in her chair with a black eye. She said that Ms. Ridley did not tell her at the beginning of the shift that Resident A had fallen during second shift. She reported that Ms. Ridley was taking Resident A's vitals while Resident A was sitting up in her Broda chair. She reported that Resident A seemed comfortable. She thought this was around 2:00 AM. She did not remember if Resident A was in her bed clothes.

She reported that it was then that she found out from Ms. Ridley that Resident A had fallen out of her wheelchair onto the floor around 9:00 PM on 05/07/2022, and now she had a black eye. She thought an IR had been completed but was not certain. She stated that Ms. Ridley had explained that she was passing medications on the Navy side when she was notified that Resident A had fallen. She said the staff came to get her to help get Resident A back into her Broda Chair. Ms. Ridley stated that she went on working and she did not see Resident A until she did rounds at 2:00 AM when she saw the back eye. Ms. Monjolo stated that she was certain that Ms. Ridley did not call Resident A's family or the manager. She stated she helped Ms. Ridley put Resident A into her bed. Ms. Monjolo explained that Resident A leans forward in her chairs and she has slid out before. She stated that is why Hospice had secured her with a new chair called the Broda chair, which is on wheels. She said it has the mechanisms to sit Resident A straight up or to gently sit her farther back, depending on her comfort level.

On 06/10/2022, I telephoned FM1 and asked her what she knew about Resident A's injuries, and she said to this date the staff at Byron Center Manor had not talked to her to explain what actually had happened to Resident A.

On 06/10/2022, I conducted an interview with med passer, Melissa Gurtiz, I asked her if she had any knowledge of what had happened to Resident A when she was discovered with a black eye and a bruise on her forehead. Ms. Gurtiz stated she did not have any direct knowledge of Resident A falling.

On 05/15/2022, I received a text message from FM1 with pictures of a bruise on the side of Resident A's neck. This is an injury that was not previously noted. FM1 called me and we discussed the bruise. She reported that she and her sister came to visit Resident A and they discovered a bruise on left side of Resident A's neck. FM1 again stated to me that she believes Resident A is being abused at Byron Center Manor. She stated they saw Resident A last Friday and there was no bruising on her neck. She stated that she did not think this was related to the black eye and bruise on her forehead that occurred on 05/07/2022.

On Monday 05/16/2022, I spoke by telephone with Ms. Wieringa about the bruising on Resident A's neck. She reported that no staff had any knowledge about the bruising of Resident A's neck. She reported that med passer Melissa Guritz had completed an IR dated 05/15/2022 when she observed the bruise. Ms. Wieringa sent me the IR. The IR stated that FM 1 was notified on 05/15/2022 at 2:50 AM and that Kindred Hospice was notified on 05/15/2022, at 3:00 PM. Ms. Wieringa signed the IR on 05/16/2022. I asked Ms. Wieringa if she had any idea about cause of the bruising. She stated that she had learned that an aid with Kindred Hospice who had cared for Resident A had secured a half-circled neck pillow for Resident A to use. She said she would follow-up with Resident A's nurse from Hospice.

On 05/16/2022, Ms. Wieringa sent me an email which read: "*The neck pillow for Resident A was something that was ordered by Kindred Hospice recently."*

On 05/17/2022, FM1 sent four pictures of Incident/Accident Reports. The first IR was the report completed by Tiffany Ridley dated 05/08/2022, which read, *'While doing rounds staff observed resident sleeping in her chair with heavy bruising around her left eye. Resident unsure what happened.'* FM1 typed a message, *'I now have received this report & does not say what happened.'* The second IR was dated 05/15/2022 and it read, *'While staff was going to toilet resident, they observed a large bruise on the left side of her neck. No pain noted.'* FM 1 sent three of the same IR's.

On 06/03/2022, Ms. Huntington provided me with copies of the two IR's related to injures to Resident A. I reviewed the one dated 05/15/2022, at 10:30 AM, completed by staff med passer Melissa Guritz. The other staff name on the report was Chelsea Fuller. This IR has to do with the discovered bruise on Resident A's neck. The IR read in the section of 'explain what happed', *'While staff was going to toilet resident, they observed a large bruise on the left side of her neck.*' Under the section of Action taken by staff it read, *'Family and management notified. No wound care needed.'* Under the section of Corrective Measures Taken to Remedy and/or Prevent Recurrence read, *'Staff will continue to monitor for any abnormal signs or symptoms.'*

On 06/07/2022, I received an email from Ms. Wieringa. She wrote that Resident A had the neck pillow before she was promoted to her new position of Clinical Manager. She wrote that she had first talked to Tammy, (no last name provided) who was a new nurse for Resident A from Kindred hospice. She reported Tammy started shortly after Resident A's fall. She wrote that then when they talked Tammy said it was a possibility that the pillow did the bruising, but it seemed unlikely, but with Resident A's leaning to the side it could be the pillow. She also said that Tammy stated there were no hand marks or bruising that was of concern. Ms. Wieringa stated that Tammy the nurse had assessed the bruise a day or two after the bruise on her neck was discovered.

On 06/09/2022, I received a telephone call from Casey Nicholas RN, Clinical Manager for Kindred hospice. He stated he was returning my call to their nurse because she is fairly new. He stated he was familiar with Resident A and her care needs but acknowledged that he had not personally observed the bruise on Resident A's neck. He said the nurse aid possibly ordered the neck pillow or she may have made the suggestion, but they did not recall that there had been any orders for Resident A to have a neck pillow. He explained that their volunteers make the neck pillows and they have them in the office. He said the aid may have brought one to the facility for Resident A to use. He said they do not provide orders for their neck pillows. He said they are very soft and he did not think the neck pillow caused the bruising on Resident A's neck.

On 06/10/2022, I conducted a telephone interview with med passer Melissa Guritz. She confirmed that she had witnessed the bruise on Resident A's neck, and had completed the IR. She stated that she did not make the call to the family or to

Hospice. She said maybe Ms. Wieringa made the calls. She stated the bruise was about two inches long and was “reddish purplish” in color. She stated that Resident A did not complain of any pain. She said there were no fingermarks on the bruise. She said it was more like a car seat belt that had rubbed against her neck, but Resident A had not traveled outside of the facility. She said she asked Resident A about the bruise on her neck and Resident A had no idea how she received the bruise. Ms. Guritz stated that she knew Resident A had a neck pillow. She said that other staff said she lays her head on the neck pillow and goes to sleep. She stated that Resident A does bruise very easily, and also has bruising on her arms.

On 06/14/2022, I conducted a telephone exit conference with the Licensee Designee, Bryan Cramer. Mr. Cramer agreed with my findings although he stated it was very hard to prevent resident falls.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was left alone in her bedroom while seated in her Broda chair for an undetermined amount of time. It is believed that she fell from her chair onto the floor resulting in injuries. Melissa Gurtiz reported that Resident A has tried to get out of her Broda chair by herself before, but her legs are too weak to hold her. Aminata Monjolo reported that Resident A leans forward in her chairs and has slid out before and that is why Hospice had obtained a new chair for her called the Broda chair. On 05/15/2022, Resident A was found with an unexplained bruise on her neck which was not explained other than she was using a neck pillow. During this investigation Resident A’s personal needs, safety and protection were not adequately provided for when she fell out of her Broda chair onto the floor resulting in a black eye and a bump on her forehead. This occurred when she was left alone in her bedroom for an undetermined amount of time. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Direct care staff, Augustin Muhizi and Francisco Nsengiyumva both acknowledged that they found Resident A on the floor of her bedroom, and they reported she had fallen out of her Broda chair on 05/07/2022, on second shift and had hit her head on the floor. Mr. Nsengiyumva acknowledged when they were getting her ready for bed, he observed her face started bruising around her eye and maybe on her neck side below her chin. Both staff told Ms. Taylor Huntington that Resident A had fallen on the floor in front of her chair when they found her. Neither of the staff called Hospice or a medical professional or Resident A's family. Tiffany Ridley, acknowledged that she was aware Resident A had fallen to the floor and that she took Resident A's vitals. She said that when she entered Resident A's room, she was sitting in her Broda chair. Later during third shift she reported that when she did her rounds checking on residents, she found Resident A still sitting/sleeping in her Broda Chair, and she was not in her bed. She said she saw that Resident A's eye was turning colors, so she called Ms. Wieringa, Clinical Manager. She acknowledged that she did not call Hospice, the family or any health care professional Casey Nicholas RN, Clinical Manager for Kindred hospice stated Resident A reportedly fell out of her Broday chair on 05/07/2022, and they were not notified of the fall until 05/09/2022. During this investigation I found evidence that the two staff who knew Resident A had fallen out of her Broda chair and hit the floor did not seek care immediately. Ms. Ridley had been told that Resident A had fallen onto the floor from her Broda chair and she took vitals but acknowledged she did not seek needed care immediately. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There was no Incident report filed, the family was not notified of her fall and resulting injuries and they did not receive a copy of the Incident/Accident Report.

INVESTIGATION: On 05/11/2022, I spoke by telephone with FM1. She complained that Resident A had fallen on 05/07/2022 and sustained injuries including a black eye and a bump on her forehead. She explained that on Monday morning, 05/09/2022 the Hospice nurse had called her and asked if she had been notified of Resident A's injuries. The nurse told her that Resident A had a black eye and a bump on her forehead. FM1 stated that she is the designated representative for Resident A, and she had not been notified of Resident A's injuries. She explained that she went to the facility, and she asked the staff to see the Incident /Accident report and was told by staff (no name provided) that there was not one. FM1 wanted to know what had happened to Resident A to have this type of injury.

On 05/11/2022, I met with Kathleen Wieringa and I explained I had a complaint concerning Resident A. I requested the Incident/Accident Report and she provided one, dated 05/08/2022 completed by med passer Tiffany Ridley. This report read as follows, *'While doing rounds staff observed resident sleeping in her chair with heavy bruising around her left eye. Resident is unsure what happened.'* Action taken by staff read, *'Staff assessed range of motion to look for further injuries, completed with no signs or symptoms of pain. BP 171/76, P 76. Management notified.'* Corrective Measures Taken to Remedy and/or Prevent Recurrence read as follows, *'Staff will continue to monitor resident.'* On the Incident/Accident Report it read Designated Representative with the name of FM1, with notification on 05/09/22 at 2:00 PM. On the same form was Kindred Hospice notified on 05/09/22 at 9:00 AM. This document was signed by Kathleen Wieringa on 05/09/2022. This report did not provide information related to the accident to Resident A or explain the cause of the accident. It only addressed the bruising on Resident A's left eye, not the bruise on Resident A's forehead. This document did not explain the effect of the accident on Resident A, nor did it provide the care given to Resident A. This report did not provide a statement regarding the extent of the injuries, the treatment ordered and the disposition of the Resident A. The form did not contain the corrective measures that were taken to prevent the accident or from happening again.

On 05/17/2022, FM1 sent me a picture of a bruise on Resident A's neck. She also sent me copies of the Incident/Accident Report from Resident A's accident on 05/07/2022 and from the accident from 05/17/2022. She wrote, *'I now have received this report & it does not say what happened.'* Upon meeting with Taylor Huntington, manager, Kathleen Wieringa, the Clinical Manager and interviewing staff fact-to-face and interviews over the phone there was no cause identified for the bruise on her neck, unless it was from the neck pillow which was not identified by the two nurses from Hospice. The form did not meet all of the required criteria.

On 06/09/2022, I received a telephone call from Casey Nicholas RN, Clinical Manager for Kindred hospice. He stated that they were not notified of what had

happened to Resident A including a head injury until 05/09/2022 when Resident A was found injured on 05/07/2022.

On 06/14/2022, I conducted a telephone exit conference with the Licensee Designee, Bryan Cramer and he agreed with my findings. Mr. Cramer acknowledged that the first Incident/Accident Report was incomplete, but his managers have completed a new incident report with the correct information.

APPLICABLE RULE	
R 400. 14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavioral episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved, and the care given. (d) The name of the individuals who were notified and the time of the notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person involved. (f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	Resident A suffered a fall from her Broda Chair resulting in a back eye and raised bruise on her forehead. Because Resident A did not meet the criteria for providing the written report to the Designated Representative the Licensee was not required to provide the written report to FM1. The Incident/Accident Report completed for Resident A's accident with resulting injuries, did not meet the requirements of the above-cited rule. This report did not provide information related to the accident to Resident A, and it did not explain the cause of the accident. It only addressed the bruising on Resident A's left eye. It did not address the bruise on Resident A's forehead. This document did not explain the effect of the accident on Resident A, nor did it provide the care given to Resident A. This report did not provide a statement regarding the extent of the injuries, the treatment ordered and the

	disposition of the Resident A. The form did not contain the corrective measures that were taken to prevent the accident from happening again. During this investigation I found that the Licensee failed to meet the requirements of rule. Therefore, there is a rule violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 05/07/2022, Resident A was found by two staff to have fallen out of her Broda Chair directly into the floor. Resident A was injured and had a black eye and a bruise on her forehead.

On 05/11/2022 FM1 stated that she was not notified by the staff of the facility that Resident A had been injured on 05/07/2022. She stated that the Hospice nurse had contacted her on 07/09/2022 about Resident A's injuries including a black eye and a bruise on her forehead. FM1 stated that she asked the staff of the facility what had happened to Resident A, and no one was able to explain what had happened to Resident A to cause these injuries. Ms. Huntington had explained to me that she had spoken to the family about Resident A. On the IR Ms. Wieringa identified that she had contacted FM1 on 05/09/2022 at 2:00 PM.

On 06/09/2022, I received a telephone call from Casey Nicholas RN, Clinical Manager for Kindred Hospice. He stated that Resident A was injured when she fell from her Broda chair on 05/07/2022. Mr. Nicholas stated that they as the responsible agency were not notified until 05/09/2022.

On 06/10/2022, I spoke by telephone with FM1. She stated that she still does not know what happened to Resident A and why she has injuries. She said they have not told her what happened, and she is the designated representative. She feels that they are not cooperating fully with her.

On 06/14/2022, I conducted a telephone exit conference with the Licensee Designee, Bryan Cramer and he did not agree with my findings. He acknowledged that the staff did not contact Resident A's family member or hospice at the time of the incident, but since 05/9/2022, the two managers have made a concerted effort to be open and transparent with what they know about the incident by telephone, in writing and in person with the family. He stated they have communicated openly and honestly with them and shared what they know about what happened.

APPLICABLE RULE	
R 40.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(11) a license, direct are staff, and an administrator shall be wiling to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.
ANALYSIS:	Resident A was found on the floor after falling from her Broda Chair on 05/07/2022. Resident A's Designated Representative confirmed she had not been contacted by the facility staff concerning what had happened to Resident A. She also confirmed that she asked staff what had happened, and they told her they did not know. As of 06/10/2022, FM1 verified that she still has not been told what has happened to Resident A to cause such injuries. Casey Nicholas RN, Clinical Manager for Kindred Hospice verified that Resident A was injured when she fell on 05/07/2022 and they were not notified until 05/09/2022. He did not feel that the facility staff had fully cooperated with Hospice in the care needs of Resident A after her injuries. During this investigation I learned that the facility staff have not told FM1, Designated Representative, what had happened to Resident A related to her injuries. In addition, Kindred Hospice Clinical Manager, Casey Nicolas had not been notified of Resident A's injuries that occurred on 05/07/2022 until 05/09/2022. Therefore, there is rule violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

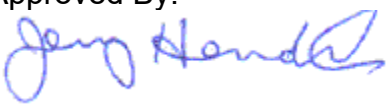
IV. RECOMMENDATION

I recommend the Licensee submit an acceptable plan of correction and the license will remain the same.

Arlene B. Smith 06/15/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:



06/15/2022

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Jerry Hendrick Date
Area Manager