GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 7, 2025

Kimberly Anne Wozniak, Licensee Designee
Byron Center Care Operations, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AL410418572
Investigation #: 2025A0357011
Byron Manor #5

Dear Ms. Wozniak:

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 #:	AL410418572
Investigation #:	2025A0357011
Complaint Receipt Date:	12/10/2024
Investigation Initiation Date:	12/10/2024
Report Due Date:	02/08/2025
Licensee Name:	Byron Center Care Operations, LLC
Licensee Address:	1435 Coit Ave NE, Grand Rapids, MI 49505
Licensee Telephone #:	(616) 878-3300
Administrator:	Bryan Cramer
Licensee Designee:	Kimberly Anne Wozniak
Name of Facility:	Byron Manor #5
Facility Address:	Suite 5, 2115 84th St. SW, Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	09/20/2024
License Status:	TEMPORARY
Effective Date:	09/20/2024
Expiration Date:	03/19/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving her supplemental drink.	No
Resident A has not been showering.	Yes
Resident A wore the same nightgown four days in a row without being washed.	No
Resident A's toenails were so overgrown, curled and digging into her skin.	Yes

III. METHODOLOGY

12/10/2024	Special Investigation Intake 2025A0357011
12/10/2024	Special Investigation Initiated - Telephone To the Administrator and Home Manager.
12/10/2024	Contact – Telephone Call From Supports Coordinator, Amy Kruithoff, from Area Agency on Aging (AAA), to discuss the compliant.
12/11/2024	Contact - Telephone call made to Bryan Cramer, Administrator and the Home Manager, Crystal Lamkin.
01/17/2025	Contact - Telephone call received From Amy Kruithoff, Supports Coordinator, from AAA.
01/28/2025	Contact - Telephone call made with Administrator, Bryan Cramer about the investigation.
01/31/2025	Inspection Completed On-site
01/31/2025	Contact - Face to Face I met Face to Face with Bryan Cramer, and Administrator, Home Supervisor, Krystal Lamkin. I met and interviewed Resident A.
01/31/2025	Contact - Document Received Received and reviewed Resident A's Assessment Plan, her face sheet, Health Care Appraisal and her medication orders.
01/31/2025	Contact - Telephone call received From Resident A's Family Member 1.
01/31/2025	Contact - Telephone call made To Resident A's Family Member 2. Left message to call me.

02/03/2025	Contact - Telephone call received From Administrator, Bryan Cramer to discuss the compliant.
02/03/2025	Contact - Telephone call made To Family Member 2, left message to return my call.
02/05/2025	Contact - Telephone call received Amy Kruithoff, Supports Coordinator, AAA.
O2/06/2025	I conduced a telephone exit conference with the Licensee Designee.

ALLEGATION: Resident A is not receiving her supplemental drink.

INVESTIGATION: On 12/10/2024, I spoke with Amy Kruithoff, Supports Coordinator, from Area Agency on Aging (AAA). She stated that Resident A's family member had informed her that family members do not believe that Resident A is receiving her prescribed supplemental drink.

On 01/31/2025, I met with Home Manager, Krystal Lamkin. I asked her to provide me with Resident A's physician's order and their documentation when she had received her supplemental drink. Ms. Lamkin provide me with a copy of Resident A's, "Order Summary Report," and physician orders. This document read "Dietary Supplements Ensure three times a day, ordered on 08/07/2024," by Physician Andrea Sylvester. Ms. Lamkin provided me with Resident A's, Medication Administration Record starting on 11/01/2024 through 01/31/2025 which read "Ensure three times a day at 1200, 1600, 2100." There were staff's initials on three times per day at the required times for three months. I asked Ms. Lamkin if she was certain that the staff were administrating the Ensure and she reported she has worked as a direct care staff member on all three shifts many times and has witnessed the staff she has worked with administer the Ensure and she has administered it herself. She stated that Resident A likes the Ensure and she accepts it and drinks all of it.

On 01/31/2025, I conducted a telephone interview with Family Member 1 (FM1). She explained that she thought Resident A was receiving the Ensure but said they had never found any used Ensure containers in the waste basked when she and her sister visit Resident A. She went on to explain that recently they changed the delivery of the Ensure to her sister's Family Member 2 (FM 2), home. She said they will bring in the Ensure and fill Resident A's refrigerator in her room at the facility. She said that way that can observe if the Ensure is going down in numbers. She reported that they have given Resident A an extra Ensure when they have been with her so therefore, she has had four a day, occasionally, and she said Resident A always drink it.

On 01/31/2025 I interviewed Resident A. I asked her if she had been receiving her Ensure and she said, “Yes.”

On 01/31/2025 and on 02/03/2025 I telephoned FM 2 and left her my telephone number and I asked her to call me back. As of the date of this report I have not received a telephone call back.

On 02/06/2025 I conducted a telephone exit conference with the Licensee Designee, and she agreed with my findings.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**
ANALYSIS:	It was alleged that Resident A is not receiving her supplemental drink. According to Resident A’s Medication Administration Record (MAR) her physician prescribed Ensure three times a day starting on 08/07/2024. Resident A’s MAR indicates she has received the Ensure as prescribed. Ms. Krystal Lamkin stated that she has worked as direct care staff and has seen staff administer the Ensure. She stated that when she has worked as direct care staff, she has administered the Ensure. During this investigation I did not find any evidence that Resident A did not receive her Ensure three times a day. Therefore, there is no violation to this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A has not been showering.

INVESTIGATION: I On 12/10/2024, I spoke with Amy Kruithoff, Supports Coordinator, from Area Agency on Aging (AAA). She stated that Resident A’s FM 2 told her that Resident A has not been showering.

On 01/31/2025, I conducted an interview with Krystal Lamkin, Home Manager. I asked her if Resident A was showering. She explained that Resident A has a diagnosis of Alzheimer's Disease, and she does sometimes refuse her showers. Ms. Lamkin stated that they cannot make her take a shower and they have not found any incentives that work for her. She also stated that Resident A can shower independently but when they say it is time for her to take her shower she will refuse. I asked Ms. Lakin if she had documentation of Resident A's showers, and she provided me with "Activities of Daily Living" forms. She provided me a sheet for October 2024, November 2024 and December 2024. I reviewed October 2024 and found that there were four refusals: 10/04, 10/08 10/22, and 10/25/2024. She showered five times on: 10/01, 10/11, 10/15, 10/18 and 10/29/2024. Her shower was on 10/01 and the next was on 10/11, which was ten days between showers. From 10/11 to 10/15 was 4 days. From 10/15 to 10/18 was three days. The rule requires that a resident bathes at least weekly and more often if necessary. Ten and 11 days between showers is more than one week. She did not receive her minimum of one shower a week for two weeks in October 2024.

I reviewed November 2024, and there were three refusals: 11/08, 11/19, 11/26/2924. She showered five times on: 11/05, 11/12, 11/15, 11/22 and 11/29/2024. Since her last shower in October was on 10/29, her next shower was on 11/05, which was seven days. From 11/05 to 11/12, was seven days. From 11/12 to 11/15 was three days. From 11/15 to 11/22 was seven days. From 11/22 to 11/29 was seven days. Therefore, she had one shower per week for November 2024. Four weeks were seven days between showers, the minimum amount.

I reviewed December 2024, and she refused six times on: 12/03, 12/06, 12/13, 12/19, 12/21, and 12/24/2024. She accepted showers five times on: 12/04, 12/10, 12/17, 12/28 and 12/31/2024. Resident A's last shower in November was on 11/29. her next shower was on 12/04 which is six days. From 12/04, to 12/10, was six days. From 12/10 to 12/17 was seven days. From 12/17 to 12/28, was 11 days. From 12/28 to 12/31 was three days. Therefore, she did not receive her shower weekly and went 11 days between her showers in December 2024**.**

On 01//31/2025, I interviewed Resident A, and I asked her about taking her shower and her response was immediately by saying "I can do my own shower." She denied that she has refused her showers.

Since Ms. Kruithoff reported to me that FM 2 had reported that Resident A was not being showered. I attempted to speak to her on 1/31/2025 and on 02/03/2025 but as of the date of this report she has not returned my telephone calls.

On 02/06/2025, I conducted a telephone exit conference with the Licensee Designee, and she agreed with my findings.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	It was alleged that Resident A has not been showering. Ms. Lamkin reported that Resident A refuses her showers, and they can't make her take one. Resident A reported that she takes her showers. I reviewed Resident A's recorded showers for October 2024, November 2024, and December 2024. She did not receive her minimum of one shower a week for two weeks in October 2024. For the month of November 2024, Resident A had one shower per week seven days between showers. For December 2024, Resident A had a shower on 12/17, and her next shower was on 12/28/2024, which was 11 days between showers. During this investigation there was evidence the licensee did not ensure that Resident A received a shower at least weekly. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A wore her same nightgown four days in a row without being washed.

INVESTIGATION: On 12/10/2024, I spoke with Amy Kruithoff, Supports Coordinator, from Area Agency on Aging (AAA). She stated that Resident A's family member (FM 2), had seen Resident A on last week Monday 11/04/2024, and again on Thursday 11/07/2024 and she was wearing the same night gown "4 days prior." FM 2 stated that the night gown has not been washed.

On 01/31/2025, I conducted a face-to-face interview with the Home Manager, Krystal Lamkin. She reported that although Resident A has been diagnosed with Alzheimer's Disease, she is very capable of choosing her own clothes and nightwear. She said that Resident A can be very stubborn about what she wears

including being insistent on her own choices and if you try to dissuade her, she can become very upset. She stated that Resident A's family members want facility staff to allow Resident A to make her own choices and to keep her as independent as possible. Ms. Lamkin stated that Resident A has always been able to dress herself since her admission date of 02/02/2024 and they do not have to assist her unless they think she needs some help but that has not happened. Ms. Lamkin stated that Resident A takes pride in her abilities. Ms. Lamkin could not explain why Resident A had the same nightgown on for four days except to say that Resident A dresses and undress's herself and she must have chosen to wear the night gown and not to put it in the dirty laundry. She said they can't make her do things that she does not want to do. She reported that they do her laundry for her and she always has clean clothes. She explained she just completed Resident A's annual assessment and is planning to meet with Resident A's family members to discuss Resident A's needs and how those needs would be met, but she told me the plan was that Resident A could dress herself.

On 01/31/2025, I interviewed Resident A, and I asked her about her clothes and nightwear. She said she can dress herself and can pick out what she chooses to wear. I asked her if she had ever worn her nightwear when it has been soiled and she immediately responded with "never, my clothes are aways clean and I do not wear dirty clothes." Resident A told me numerous times during our interview that she has been a "night person", all of her life and that she worked 15 years in the hospital from 7PM to 7AM. I interviewed her close to 5:00 PM and she was just waking up. She stated she stays up late at night and sleeps during the day. She stated that all of her clothes in her closet are clean.

On 01/31/2025, I conducted a telephone interview with FM 1. I asked her if she had any concerns regarding Resident A wearing a dirty night gown and she said she had no concerns.

Since Ms. Amy Kruithoff had informed me that FM 2 had told her about the dirty night gown, I attempted to interview FM 2. On 01/31/2025 and on 02/03/2025 I telephoned FM 2 and left her my telephone number and I asked her to call me back. As of the date of this report I have not received a telephone call back.

On 02/06/2025/ I conducted a telephone exit conference with the License Designee and agreed with my findings.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(5) A licensee shall afford a resident who is capable with opportunities, and instructions, when necessary, to routinely launder clothing. Clean clothing shall be available at all times.

ANALYSIS:	It was alleged that Resident A wore the same nightgown for four days in a row without being washed. Resident A spoke very clearly when I interviewed her that she only wears clean clothes. She also said she can dress herself and make her own choices as to what she wears. FM 1 did not express any concerns as to what Resident A has chosen to wear. Ms. Lamkin confirmed that Resident A can dress and undress herself and that she does not require help with dressing, and she chooses what she wants to wear. During this investigation I did not find evidence that Resident A did not have clean clothes to wear. It appeared she only had one time of wearing her nightgown more than once. Therefore, there is not a violation to the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's toenails were overgrown, curled and digging into her skin.

INVESTIGATION: On 12/10/2024, I spoke with Amy Kruithoff, Supports Coordinator, from Area Agency on Aging (AAA). She stated that Resident A's family member (FM 2) had spoken to her and explained that Resident A's, FM 1 had previously taken Resident A to her home for a "spa day," where she took a warm shower. FM 2 stated that FM1 had assisted Resident A in removing her socks and found her toenails so overgrown that they were curled and digging into her skin. It looked like they had not been trimmed since she had been at the facility.

On 12/11/2024, I telephoned Bryan Cramer, Administrator and the Home Manager, Crystal Lamkin and we discussed the complaint. I asked Ms. Lamkin to look immediately at Resident A's toenails. She did and reported that they been trimmed. She did not know who had trimmed Resident A's toenails. She reported she asked her staff if they had cut them, but they denied cutting them.

On 01/17/2025, I received a telephone call from Amy Kruithoff, Supports Coordinator, from AAA. She reported that she had spoken to the Resident A's family members, and they told her that they had cut Resident A's toenails.

On 01/31/2025, I made an announced inspection to the facility. I met with Mr. Cramer and Ms. Lamkin to discuss the compliant. Ms. Lamkin reported that Resident A is "fiercely independent". She can dress and undress herself and take her own showers. Therefore, the staff would not have observed her toes nails. I

explained that the assessment plan under Self Care Skill Assessment clearly states that a part of Resident A's care is grooming and cutting her nails. I asked to see Resident A's assessment plan and Ms. Lamkin provided it. Under Section D "Grooming (hair care, teeth, nails etc) "needs help" was checked "No." "Independent with grooming needs." Ms. Lamkin acknowledged that another staff member had completed the assessment plan. Now that Resident A has been in the facility for almost a year (02/02/2024) Ms. Lamkin reported that she is working on a new assessment plan, and she now is aware that Resident A cannot trim her own toenails, so she has changed this in the plan. She said she needs to meet with the family to review what the new assessment plan will be for Resident A. I asked Ms. Lamkin for Resident A's Health Care Appraisal, which she provided and I reviewed it. This document listed Resident A's Diagnoses as: CAD, Alzheimer's Disease, PAF, COPD/Ashma, OSA, Gerd, and Dyslipidemia. This document stated that Resident A has memory issues and memory decline and is easily confused. Ms. Lamkin reported that Resident A will say I have been here four days it is time for me to leave. Ms. Lamkin reported that she has added Resident A to her list, and she will cut Resident A's nails every two weeks.

On 01/31/2025, I interviewed Resident A. I was able to observe her feet and her toe nails were trimmed. I asked her who trimmed her toenails, and she said: "I do." She reported that she showers herself, gets dressed and does all of her personal care.

On 01/31/ 2025, I conducted a telephone interview with FM 1. She reported that Resident A had complained that her toes were hurting so she said she looked at them and found her nails totally overgrown, turned under and digging into her skin. She was unable to provide a date of this discovery. FM 1 stated that she did not know who was responsible for cutting Resident A's toenails. She said she cut them herself. She stated that FM 2 also saw Resident A's toenails. I asked her if she had any concern regarding Resident A and she said the care is "wonderful" and she was very thankful for her being in this facility.

On 02/05/2025, Ms. Kruithoff telephoned me and said she had spoken with FM 2 and that she was so pleased with the care of Resident A and that she had no complaints. She also reported that FM 2 had told her she had seen Resident A's overgrown toenails. She volunteered to ask FM 2 to return my call. She also stated that the facility has secured a Pediatrist to cut Resident A's toenails going forward.

On 02/06/2025, I conducted a telephone exit conference with the Licensee Designee and she agreed with my findings.

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 Resident A's toenails were overgrown, curled and digging into her skin. FM 1 stated that she had found Resident A's toenails overgrown, curled and digging into the skin. She stated that FM2 had seen the toenails also. FM 1 confirmed that she cut Resident A's toenails upon discovery. Ms. Amy Kruithoff reported that FM2 had called her after seeing Resident A's toenails overgrown, curled and digging into skin. During this investigation evidence was found that Resident A's toenails had not been cut for an extended period and that they were overgrown, curled and digging into her skin. Therefore, there is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommendation that the Licensee provide an acceptable plan of correction, and the license remain the same.

Arlene B. Smith 02/06/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

02/07/2025

Jerry Hendrick Date
Area Manager