GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2023

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

RE: License #: AL410246443
Investigation #: 2023A0357013
Byron Center Manor IV

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 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 #:	AL410246443
Investigation #:	2023A0357013
Complaint Receipt Date:	02/17/2023
Investigation Initiation Date:	02/17/2023
Report Due Date:	04/18/2023
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 IV
Facility Address:	2115 84th Street, SW Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	06/06/2003
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 had sores on her heels & ankles from not being cared for properly.	No
Resident B's morphine was stored in his bedroom and his family members were allowed to dispense it.	Yes

III. METHODOLOGY

02/17/2023	Special Investigation Intake 2023A0357013
02/17/2023	Special Investigation Initiated - Telephone with Licensee Designee/Administrator.
03/21/2023	Inspection Completed On-site
03/21/2023	Contact - Face to Face With Bryan Cramer, Licensee Designee/Administrator and Kaie Wieringa, Clinical Coordinator.
03/21/2023	Contact - Face to Face Face-to-face with Katie Wieringa, Clinical Coordinator
03/21/2023	Contact - Document Received Katie Wieringa provided Documents on Resident A and B
04/04/2023	Contact - Telephone call made, Telephone with Resident A's Family Member 1 and Family Member 2.
04/05/2023	Contact - Telephone call received. From Family Member 2.
04/06/2023	Contact - Telephone call made, With Manager Irene Fuglseth
04/07/2023	Contact - Telephone call made With Kim Chambers, Mary Free Bed at Home
04/07/2023	Contact - Telephone call made, With Resident B's Family Member 1. Joi Larson-Miller, Med Tech. Interview with Sandra Hahn, RN for Hospice of Holland
04/10/2023	Contact - Telephone call received,

	With Manager Irene Fuglseth
04/07/2023	Contact -telephone -message left for Katie Wieringa.
04/09/2023	Text message received from Katie Wieringa
04/13/2023	I conducted a telephone with Bryan Cramer, Licensee Designee/Administrator.

ALLEGATION: Resident A had sores on her heels & ankles from not being cared for properly.

INVESTIGATION: On 03/21/2023 I conducted a face-to-face interview with Katie Wieringa, Clinical Coordinator. We discussed Resident A who is an 88 year old female. She was admitted to the facility on 09/19/2022. Ms. Wieringa reported that she had chronic issues with wounds. We reviewed her Health Care Appraisal dated 09/19/2022. Her diagnosis was Alzheimer's Dementia, Polymyalgia rheumatic, CKD Stage 3, and Bilateral leg enema. Ms. Wieringa reported that she had been receiving wound care from a nurse. Ms. Wieringa stated that they have a new Manager in the facility, Irene Fuglseth who on 01/10/2023 was notified and received a photograph showing that Resident A's heels were beginning to look worse. Ms. Fuglseth immediately elevated her heels and contacted a wound nurse. She reported that later on Resident A choose to receive care from Faith Hospice.

On 03/21/2023, Ms. Wieringa provided the documents form Mary Free Bed at Home which were from the wound nurse and PT and OT. The wound nurse Judy Allen RN had seen Resident A on 12/09/2022. She had dressed the wounds and left orders to, *'Change dressings to legs 2x a week,'* and she had written how to care for them. She stated she would return on Tuesday 12/13/2022. I reviewed Ms. Allen's written notes on 12/13/2022 that read to please change the dressings to Resident A's right knee and left ankle and left heal once a week on Friday or Saturday. She wrote that staff were to apply foam dressings to Resident A's left heel and change weekly for deep tissue and avoid pressure to left heel. The next note was on 12/21/2022. She wrote in part "*the wounds to right leg are completely healed. Left knee and left ankle change dressings on Saturday.'* She left other orders how to care for Resident A. On 12/28/2022 Ms. Allen's notes directed staff to change Resident A's dressing to her left leg once a week and she would change the dressings on Wednesday. Ms. Allen saw Resident A on 01/04/2023 and wrote that staff should, *'float heels when ever patients in bed'*. She again provided instructions how to care of Resident A's wounds. She saw Resident A on 01/12/2023 with more wound care and more instructions. Ms. Allen wrote, '*leave right and left knees and right ankle open to the air that these wounds are healed.'* Ms. Allen saw Resident A again on 02/02/2023 when she wrote a referral, for Faith Hospice and the family agreed. She wrote to continue with the current wound treatment for Resident A's skin tears on her legs.

The next notes are from Faith Hospice as they took over Resident A's wound care and ordered antibiotic ointment for Resident A's right pinky toe.

On 04/04/2023, I telephoned Family Member 1 (FM1). After discussing Resident A, FM1 asked me to contact his daughter who is a Registered Nurse, Family Member 2 (FM2). FM1 did report that Resident A fell in the bathroom at Byron Center Manor, and he believes that it was in November 2022, when she broke her hip and went to the hospital and then to a Rehab Center. Then she returned to Byron Center Manor. He was unsure when her heels developed sores, but he thought it has been since January 2023.

On 04/04/2023, I telephoned FM2. She reported that Resident A fell on a Friday night (date unknown) in the bathroom, and they found her in the morning on the floor. They did not realize that she had broken her hip or her leg. On that Sunday (date unknown) the staff called the family to report that Resident A was "screaming in pain" when they touched her, and she was shaking all over. She had developed a temp/fever and maybe her leg was broken. The facility staff were sending Resident A to the hospital. FM2 reported that later on she learned that Resident A'a hip was broken, and she required surgery to repair her broken hip. FM2 reported that Resident A was in the hospital for about 10 days and then transferred, to a Rehabilitation Center and then returned to the facility at Byron Center Manor. FM2 stated that Resident A is "*very thin skinned and prone to skin break down".* She reported that Ms. Fuglseth, Manager, called her to let her know that Resident A was developing ulcers on her heels and that Mr. Fuglseth had called Mary Free Bed for the wound nurse to come soon. FM2 stated that Resident A was now on Hospice, and they are caring for the wounds. She stated that the wound care nurse from Mary Free Bed came to dress the wounds two days a week. FM2 stated that she has not observed Resident A's heels when the bandages are being changed but she understands that they are getting better. FM1 is there every day and he reports to FM2 that they are getting better.

On 04/06/2023, I interviewed Ms. Irene Fuglseth by telephone, and she said she started working at the facility on 11/28/2022. She learned that Mary Free Bed wound nurse had worked with Resident A in the past and as far as she knows the wounds were properly cared for. She reported that the wound nurse put in her notes that some wounds were healed.

On 04/04/2023 I telephoned Ms. Allen. She explained that Resident A had fallen and had been in the hospital and then to a rehab center and back to the facility. She was unsure when the wounds on Resident A had started but expressed her opinion that Resident A's wounds were improving. She reported that the wound nurse from Faith Hospice was caring for Resident A.

On 04/10/2023, I spoke by telephone with Ms. Fuglseth and reported that a staff from an agency had sent her pictures on 01/10/2023 of Resident A's heels and they looked like wounds. The staff had changed the bandages and she had redressed

them. Ms. Fuglseth reported that the wound nurse from Mary Free Bed, Ms. Judy Allen, RN, had last see Resident A on 01/04/2023 so she called her immediately to report the changes and the wound nurse came out on 01/12/2023 to see Resident A and asses the wounds and she wrote orders on how to care for the wounds.

On 04/13/2023 I conducted a telephone conference with Bryan Cramer, the Licensee Designee/ Administrator and he agreed with my findings.

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.
	It was alleged that Resident A had sores on her heels/ankles from not being properly cared for. Resident A had been seen by the wound care nurse from Mary Free Bed at Home for a substantial amount of time. Notes from the wound care nurse started on 12/09/2022 and continued through 02/02/2023. It was noted that some of Resident A's wounds had healed. Faith Hospice is now providing wound care. = Ms. Fuglseth was notified of a change of condition for Resident A's heels on 01/10/2023 and she immediately contacted the wound nurse who came to see Resident A on 01/12/2023. During this investigation there was no evidence found that would indicate Resident A's personal needs, protection and safety were not met. The facility took immediate action and sought help for Resident A. Therefore, there is no rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B's morphine was stored in his bedroom and his family members were allowed to dispense it.

INVESTIGATION: On 03/21/2023 I conducted a face-to-face interview with Katie Wieringa, Clinical Coordinator. Resident B is an 87-year-old male who was admitted to the facility on 03/08/2022. We reviewed his Health Care Appraisal dated 03/08/2022. His diagnosis included Stroke, CAD, HTN, OA and dementia. We reviewed his Assessment Plan for AFC Residents which was signed on 03/08/2022. Ms. Wieringa reported that he was receiving care from Hospice of Holland. On

02/21/2023 Ms. Wieringa provided Resident B's Charting Notes, which I reviewed. On 12/23/2022 Med Tech, Joi Larson-Miller typed the following note. *'Resident very agitated and restless throughout the shift. Wanting to get up and walk to the bathroom but was too weak. Med Tech and family members tried to administer Morphine and Lorazepam around 4pm and again around 6pm but was unsuccessful as resident was very agitated by this. Resident finally took his 8pm Scheduled dose of Lorazepam with Haldol as requested by family and approved by Hospice. Resident is currently resting at time of writing (9:00 PM).'*

On 04/07/2023 I conducted a telephone interview with Family Member 1 (FM1). FM1 explained that she and Resident B have always been very close, and she usually stays with him in his room and provides care to him around the clock. She said he wanted her to care for him. She stated that Resident A's hospice nurse is Danielle (no last name provided) from Hospice of Holland. She explained that Resident B does not like to accept medications from the staff (med tech) but he would accept it from her. FM1 reported that Resident B was NPO (nothing by mouth). They also had ordered for him to not get out of his bed. She reported that the nurse Danielle RN had given permission to FM1 to administer his morphine medication to him because he would accept it from her. She said she thought she had a written note from Danielle, but she could not find it. She said they tried to get a hold of Katie Wieringa to see if she would approve of FM1 administering his morphine to him, but they could not reach her. I asked her if she had some type of a med sheet and she thought she had one where she could write down the dosage, but she did not know where it was.

On 04/07/2023 I conducted a telephone interview with the med tech Joi Larson-Miller. She reported that she works on second shift. When she found out that FM1 wanted to administer Resident B's morphine she asked the med tech from the first shift and that unnamed staff said Ms. Wieringa had said it was ok to do it. Ms. Larson-Miller stated that Resident B was very agitated, and he had refused his medications. She said she had the morphine drawn up in the syringe. She said she signed off that she, with FM1 were going to administer Resident B his medications. She said that was all she remembered about the situation.

On 04/07/2023 I telephoned the supervisor of Hospice of Holland and spoke with Sandra Hahn. We talked at length, and she told me that she did not have a physician's written order allowing FM1 to administer Resident B's morphine to him.

On 04/07/2023 I reviewed Resident B's Administration History for Morphine Sulfate SOL 100MG/5ML (20MG/ML). On the date of 12/23/2022 at 3:08PM Joi Larson-Miller wrote that, '*Resident Refused*.' The same was noted on 12/23/2022 at 11:00 PM. by Caregiver I'esha Crawford-Debose. On 12/24/2022 at 3:11 PM. Joi Larson-Miller wrote the following: *'Not given due to problem with order notified mgmt. for clarification*. *Family administers medication now.'* On 12/25/2022 at 7:39 AM Caregiver Danelle Hibler wrote the following: *'Physically unable to take. Resident passed away 5:15am Christmas day.'*

On 04/07/2023, I left a message for Katie Wieringa. On Saturday 04/09/2023 she sent me a text message and wrote the following: *'I became aware of the morphine being kept in the resident's room when I was rounding that on coming Monday. I spoke with Joi I believe. He had already passed. It happened over the weekend I believe I was aware staff were bringing the medication to the room and family would help give when was he was agitated. Which he was at times. There was no order for family to keep in room and dispense. That was one of the first things I checked when I found out.'*

On 04/13/2023 I conducted a telephone exit conference with Bryan Cramer, the Licensee Designee/Administrator and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1)Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be for the specified resident in accordance with the requirements, Of Act No, 368, of the Public Acts of 1978, as amended, being S333.1101 et. Seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. **(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.**
ANALYSIS:	It was alleged that Resident B's morphine was stored in his bedroom and his family members were allowed to dispense it. Katie Wieringa stated that she could not find an order to allow FM1 to administer morphine to Resident B. Ms. Wieringa acknowledged on 04/12/2023 that Resident B's morphine was kept unlocked in his room. Hospice reported they did not provide a written order for FM1 to administer morphine to Resident B. FM1 verified that she administered morphine to Resident B. During this investigation there was evidence that FM1 administered morphine to Resident B and that Resident B's

	morphine supply was stored in Resident B's bedroom. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the licensee provide an acceptable plan of correction and the license remain the same.

Arlene B. Smith 04/13/2023

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 04/14/2023

Jerry Hendrick Date
Area Manager