GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2023

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

RE: License #: AL410247136
Investigation #: 2023A0357014
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 #:	2023A0357014
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 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's medication ran out for about a week but was charted as given.	Yes
Resident B pushed Resident C which caused her to fall and fracture her hip.	No
Resident D was found by her family on the floor in the morning and she had laid there all night.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/17/2023	Special Investigation Intake 2023A0357014
02/17/2023	Special Investigation Initiated - Telephone with telephone to Licensee Designee/Administrator.
03/21/2023	Inspection Completed On-site
03/21/2023	Contact - Face to Face interview with Bryan Cramer, Licensee Designee, and Administrator, and Katie Wieringa, Clinical Coordinator. Review file of Resident A, B, and C. Reviewed Resident A's MAR. Reviewed Document of Resident B and C.
03/21/2023	Contact - Document Received Received and reviewed documents of Resident A, B, and C and D.
04/05/2023	Contact – Telephone call made ot Family Member 1.
04/10/2023	Contact – Telephone call made to Irene Fuglseth, Manager**.**
04/13/2023	Conducted a telephone exit conference with Bryan Cramer, Licensee Designee/Administrator.

ALLEGATION: Resident A's medication ran out for about a week but was charted as given.

INVESTIGATION: On 03/21/2023, I conducted a face-to-face with Katie Wieringa, Clinical Coordinator. She reported that Resident A was 79 years of age, and he was admitted to the facility on 09/19/2022. She explained that he was receiving the

medication Mesalamine 400 MG and he was to take six capsules (2400MG) by mouth twice daily. She explained that he received the medication for Chron's disease. She acknowledged that the staff who were administering Resident A's medication did not notify her that Resident A's medications were running out. She stated that as soon as she was made aware she immediately contacted the physician and Resident A's family. She made copies of their electronic medication sheets, which we reviewed together. On 11/14/2022, AM, there was typed a "Recorded Exception," which read as follows: Not given due to problem with order, notified mgmt for clarification." It also read, "out." On 11/14/2022, PM, the "Recorded Exception" read as follows: "Not given due to problem with order notified mgmt for clarification. Out of med." On 11/15/2022. AM, "Recorded Exception" read as follows: Not given due to problem order notified mgmt for clarification. Needs new script sent." On 11/15/2022, PM, "Recorded Exception" read as follows: "Not given due to problem with order, notified mgmt for clarification. Out of med and Dc'd." Ms. Wieringa stated that this medication had not been discontinued. On 11/16/2022, AM, "Recorded Exception" read as follows: Not given due to problem with order, notified mgmt. for clarification. Not in cart."

Ms. Wieringa reported that Resident A was admitted to Kindred Hospice on 11/15/2022 and they took over the ordering of Resident A's medications. She showed me the "Renewal Response," Issued by Tuyen D Nguyen DO for Mesalamine 400 MG, written on 11/15/2022. She stated that they received the medication on 11/15/2022 but it was not administered until 11/16/2022 in the AM. We reviewed Resident A's Assessment Plan For AFC Residents that was signed on10/06/2022. This document stated that, "Staff will administer all medications." The allegation was that the medication of Mesalamine was charted as administered when the medication was out of stock. It was not charted as administered but we did find the medication was not re-ordered in a timely fashion and the resident was not administered the medication as prescribed on 11/14/2023, 11/15/2023, or 11/16/2022 in the AM.

On 04/13/2023, I conducted a telephone Exit Conference with the Licensee Designee/Administrator Bryan Cramer 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 labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled

	Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Medication for Resident A was not administered because the medication was not reordered in time for the required administration times. Ms. Katie Wieringa acknowledged that she was not made aware that Resident A's medication Mesalamine 400MG was not reordered. She acknowledged that Resident A was not administered this medication as prescribed on 11/14, 11/15 or 11/16/202 in the AM. During this investigation it was verified that Resident A's medication Mesalamine 400MG, six capsules twice a day was not administered for two and ½ days. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B pushed Resident C which caused her to fall and fracture her hip.

INVESTIGATION: On 03/21/2023 I interviewed Katie Wieringa about the allegation. She reported that Resident B is an 82-year-old female admitted to the facility on 10/27/2022. She stated that Resident B is followed by a neurologist and Corso Care. They maintain Behavior Logs. She explained that Resident B has been diagnosed with "Major Neurocognitive Disorder" and she has memory impairment. She also has Osteoporosis, senile, anxiety, and agitation due to dementia. She stated that Resident B does steal food from other resident's plates, but they replace the food. The staff redirect her in these situations which usually works. Ms. Wieringa stated that Resident C was admitted on 06/12/2019. We reviewed her Health Care Appraisal dated 05/10/2022. She has been diagnosed with Alzheimer's Dementia, and Osteoarthritis. She is also a fall risk. She was on Hospice but there was no date when this occurred. I asked Ms. Wieringa about the allegation that Resident B had pushed Resident C which resulted in Resident C breaking her hip. She stated she was aware of the incident, but that Resident C was not injured and there was no Incident/Accident report completed. She stated that Resident C did not fracture her hip from Resident B pushing her. She stated that Resident C fell at another time, (date not provided) and at that time she did fracture her hip and she passed on 12/04/2022 while on Faith Hospice.

On 04/10/2023, I conducted a telephone interview with Irene Fuglseth, Manager. She stated that she has documentation dated 11/01/2022 that an agency staff had written that Resident B had pushed Resident C into a chair. She stated that no

injuries were noted for Resident C. Ms. Fuglseth stated that she also found in the notes that on 11/23/2022 Resident C had fallen on the floor by her bed, and they learned from Hospice that she had a right hip fracture. They were instructed by Hospice to immobilize and support her hip to prevent discomfort. She confirmed that Resident C passed on 12/04/2022.

On 04/13/2023 I conducted a telephone exit conference with Bryan Cramer, 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.
ANALYSIS:	It was alleged that Resident B physically abuses other residents, and she pushed Resident C which caused her to fall and fracture her hip. Ms. Wieringa acknowledged that Resident B had pushed Resident C but this did not result in a fractured hip or injury. Manager Ms. Fuglseth also acknowledged that Resident B had pushed Resident C into a chair resulting in no injuries to Resident C on 11/01/2022. During this investigation there was no evidence found that Resident B had caused a fractured hip or injury to Resident C. Therefore, there is no violation of the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident D was found by her family on the floor in the morning and she had laid there all night.

INVESTIGATION: No date was provided for this allegation. On 03/21/2023, I conducted a face-to-face interview with Katie Wieringa, and we discussed the complaint concerning Resident D who is a 79 years old female admitted on 09/19/2022. We looked at the documents attached to her Health Care Appraisal dated 09/19/2022. She was diagnosed with Lewy Body Dementia which affects her balance and instability, unsteady gait, progressive on-going anxiety, Generalized anxiety disorder, worsening concentration, memory, and occasional word finding. She has Orthostatic hypotension and Essential hypertension and other fatigue. She

also has chronic right shoulder pain, unsteady gait and uses a rolling walker. Ms. Wieringa stated that Resident D fell a lot and she tended not use her walker. I asked about Resident D being found lying on the floor. She explained that they do rounds and observe each resident every two hours during the nighttime (10:00pm., 12:00am., 2:00am., 4:00am., and 6:00am.). She stated that staff found her at 6:00 AM on the floor and no one was sure how long she had been lying there. Ms. Wieringa stated that the family did not find her on the floor, but the staff of the facility found her. She stated the family member came in and she was taken by ambulance to the hospital. She said Resident D did not come back to the facility after being in the hospital but was taken to another licensed facility and she was discharged from Byron Center Manor on 11/10/2022. Ms. Wieringa provide a copy of the AFC Licensing Division – Incident / Accident Report, dated 11/07/2022 at 2:00pm. This document explained what had happened: "*Resident had a fall earlier in the day no current injuries or wounds seen. Resident reporting some pain on left side/hip."* Action taken by Staff/ Treatment Given: "*ROM within normal limits for resident. Some pain in right hip. Blood pressure taken 134/68. PCP notified and sent out nurse to assess. Recommended to go to ER due to fall, pain in hip and being COVID positive symptoms."* This was written by Direct Care Staff, Melissa Guritz. Dr. Bates is Resident D's physician and the report indicated he was contacted on 11/07/2022. There was no I/R regarding Resident D's fall. We reviewed her Assessment Plan which was signed on 09/22/2022. This plan indicated that for her toileting, "Staff to assist as needed." Under Walking/Mobility it also stated: "Staff to assist as needed." She had a wheeled walker, cane, and grab bars. Ms. Wieringa provided me with Resident D's for "Rounds." According to the documentation Resident D was checked on 11/06/2022 at 1:48pm. after lunch. The next check was noted on 11/07/2022 at 8:00am and the next check noted on 11/07/2022 was at 6:00am, which should have been reversed because 6:00am comes before 8:00am. According to this documentation of rounds there were no checks after 1:48am on 11/06/2022. So, the staff did not document rounds/check on Resident D for approximately 16 hours. There were no noted rounds/checks on 11/07/2022 at the required rounds of 10:00pm., 12:00am., 2:00am., and 4:00am. According to Ms. Wieringa Resident D was found at 6:00am on the floor in her bedroom. The direct care staff was recorded as Imair Haskins.

On 04/05/2023, I called Family Member 1 (FM1). She stated that the staff knew that Resident D needed help going to the bathroom. She stated that due to dementia she was up a lot in the nighttime. She stated that she was taking children to school on 11/07/2022 and an (unknow staff) called her at 7:30 or 8:00am. and reported that they found Resident D on the floor and that she was very cold. The staff reported that they got her into bed because she was not dressed and got her warmed up. FM1 stated she came to the facility immediately. She said she found Resident D in her bed. FM1 said she asked Resident D if she was hurt, and Resident D said, 'I don't think so.' FM1 reported that she found urine on the floor, and she went to tell the staff about the urine on the floor and she said she told them it needed to be cleaned up. She wondered how they could find Resident D on the floor, put her back to bed and not see the urine on the floor. She stated that she called FM2 and told

him about the fall and she called Resident A's Doctor's office and asked for someone to come and check Resident D. She reported that no one from the office could come out right away. She reported that Resident D was asleep. She reported that FM3 came and checked on Resident D and she found that she had pain in her back. She reported that staff checked Resident D's blood pressure and checked her over.

FM1 stated said no one knows how long Resident D was on the floor. She reported that the doctor's office was finally able to send someone out to check on Resident D. FM1 stated that after they assessed Resident D, they determined that she needed to go to the hospital. FM1 reported that Resident D was admitted to the hospital, and she ended up staying there for a week. She stated they did an MRI and there was not a sign of a stroke. She stated as Resident D's family decided that she would not return to Byron Center Manor, and they found another licensed facility.

On 04/13/2023 I conducted a telephone exit conference with Bryan Cramer, Licensee Designee/Administrator and he 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 D was found by her family on the floor in the morning and she had laid there all night. FM1 stated that Resident D's family did not find Resident D on the floor, but staff found her. FM1 believes she was on the floor all night because she was so tired and unable to stay wake. Ms. Wieringa confirmed that a direct care staff did find Resident D on the floor at 6:00 am. She also reported that the staff are required to do "Rounds," every two hours. Starting at 10:00pm. 12:00am., 2:00am., 4:00am, and 6:00am and then at 8:00am. Upon review of the documentation for "Rounds," there was no documentation of rounds throughout the nighttime. There was no documentation for 16 hours. The last documented rounds were on 11/06/2022 at 1:48pm (after lunch) and the next documented time was at 6:00am., on 11/07/2022. During this investigation it was found that the direct care staff failed to do the required two-hour rounds/check on Resident D. They failed to do personal care and help her to the bathroom

	and failed to provide Resident D with her needed protection because she fell on the floor and laid for an undetermined amount of time. Staff found her at 6:00am on 11/07/2022. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/21/2023, I conducted a face-to-face interview with Katie Wieringa. She acknowledged that Resident A had not received his prescribed medications of Mesalamine 400 MG Capsule, take 6 capsules (2400MG) by mouth twice daily. She acknowledged that Resident A missed 30 doses of his prescribed medication on 11/14-15/2022 on 11/16/202 in the AM. I asked her if the staff had contacted a health professional to report they were out of the medication. She acknowledged that the staff did not contact a health care professional.

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

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Ms. Wieringa acknowledged that Resident A missed 30 doses of his prescribed medication on 11/14-15/2022 on 11/16/202 in the AM and staff did not contact a health care professional. During this investigation evidence was found that the staff failed to contact the health care professional when Resident A was without his prescribed medication for several days. Therefore, a violation of the rule was found.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee provide an acceptable plan of correction and the license will not change.

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