GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

Ellen Byrne
Commonwealth Senior Living at North Byron
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2025A1028044
Commonwealth Senior Living at North Byron

Dear Ellen Byrne:

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 feel free to 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410402896
Investigation #:	2025A1028044
Complaint Receipt Date:	03/20/2025
Investigation Initiation Date:	03/20/2025
Report Due Date:	05/19/2025
Licensee Name:	MCAP Byron Center LLC
Licensee Address:	Suite 301, 915 E. High Street, Charlottesville, VA 22902
Licensee Telephone #:	(434) 220-1055
Administrator:	Rebecca Duncan
Authorized Representative:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at North Byron
Facility Address:	5812 Village Dr SW, Wyoming, MI 48519
Facility Telephone #:	(616) 421-2675
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	166
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medications in accordance with physician orders resulting in an inpatient psychiatric hospital admission.	Yes
Additional Findings	No

III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A1028044
03/20/2025	Special Investigation Initiated - Letter
03/20/2025	APS Referral
03/26/2025	Contact - Face to Face Interviewed facility administrator at the facility.
03/26/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
03/26/2025	Contact - Document Received Received requested documentation from facility administrator.
03/26/2025	Inspection Completed On-site Inspection completed onsite due to special investigation. Attempted to interview Resident A, but Resident A was out of the building for the day.

ALLEGATION:

Resident A did not receive medications in accordance with physician orders resulting in an inpatient psychiatric hospital admission.

INVESTIGATION:

On 3/20/2025, the Bureau received the allegations through the online complaint system.

On 3/26/2025, I interviewed the facility administrator at the facility who reported Resident A is independent to modified independent with most care, but the facility manages Resident A's medication administration. Resident A is currently receiving home health nursing for mental health services as well. The administrator reported it was brought to the facility's attention by the home health nurse that Resident A was missing medications Wellbutrin and Lexapro since February 2025. Facility administration and the home health nurse reviewed Resident A's physician orders and medication administration record (MAR) together. It was determined those medications, and no other medications were missing. The administrator reported a few of the medications were adjusted for titration levels or discharged but Resident A was provided medications in accordance with the physician orders. Resident A also refused medications a couple of times, but no medication was missing. There were no medication errors, and the facility reviews all resident MARs regularly to ensure correct medication administration and documentation. The administrator reported Resident A was sent to the hospital on 3/20/2025 due to complaints of not feeling well. The administrator reported Resident A's medications were being adjusted at that time to include titration of psych medications and this may have caused Resident A to not feel well. Resident A was assessed at the hospital and returned to the facility the same day. Resident A was not admitted to inpatient services. Resident A has adjusted to [their] medications and there have not been any complaints from Resident A since 3/20/2025. The administrator provided with the requested documentation for my review.

On 3/26/2025, I interviewed Employee 1 at the facility whose statement was consistent with the administrator's statement. Employee 1 confirmed [they] reviewed Resident A's MAR several times with the home health nurses to ensure physician orders and medication administration as prescribed. Employee 1 confirmed Resident A's medications were being adjusted and discharged to include titration as well. Employee 1 also confirmed Resident A refused medications intermittently and that no medication errors occurred. Resident A received medications in accordance with physician orders. Employee 1 confirmed Resident A went to the hospital for evaluation on 3/20/2025 due to not feeling well possibly due to [their] medications being adjusted at that time. Resident A returned to the facility the same day with no new physician orders and was not admitted to inpatient psych services. Employee 1 reported Resident A is adjusted to the most recent medication changes.

On 3/26/2025, I attempted to interview Resident A at the facility, but Resident A was out for the day with family.

On 4/2/2025, I reviewed the requested documentation which revealed the following:

- February 2025 MAR demonstrated medication was administered in accordance with the physician orders. Evidence Resident A refused medication intermittently, that medication was discharged, and that the facility communicated with the pharmacy about medication orders.

- March 2025 MAR demonstrated the facility communicated with the pharmacy about medication orders.
- On 3/23/2025 and 3/24/2025, Resident A was to take 1 tablet 100mg of Trazadone by mouth at bedtime (sleep/mood). The entries on the MAR are blank and there is no documentation demonstrating why Resident A did not receive this medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A did not receive medications in accordance with physician orders resulting in an inpatient psychiatric hospital admission. Interviews, onsite investigation, and review of documentation reveal the following: • During February 2025 and March 2025, Resident A had several medication adjustments to include medication titration and medication discharge. • Evidence Resident A refused medications. • Evidence the facility regularly communicated with the physician, home health nurses, and the pharmacy about medication orders. • Resident A was sent to the hospital on 3/20/2025 due to complaints of not feeling well. Resident A returned the same day with no new orders. Resident A was not admitted to inpatient psych services. However, the March 2025 MAR is blank on 3/23/2025 and 3/24/2025 for medication administration of one 100 mg tablet of Trazadone to be taken by mouth at bedtime for Resident A. There is no documentation in the record that demonstrates why Resident A did not receive this medication in accordance with physician orders. It cannot be determined if Resident A received this medication or not due to the blank entries. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved correction plan, I recommend the status of this license remain the same.

Julie Viviano

4/2/2025

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

04/29/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section