GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 17, 2025

Agnes Kamanzi
Horminy Family LLC
2091 Palm Dale Dr Sw
Wyoming, MI 49519

RE: License #: AS410418239
Investigation #: 2025A0583024
Horminy Family LLC

Dear Ms. Kamanzi:

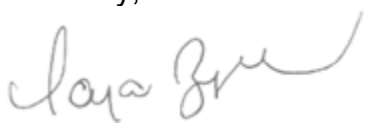
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418239
Investigation #:	2025A0583024
Complaint Receipt Date:	02/21/2025
Investigation Initiation Date:	02/24/2025
Report Due Date:	03/23/2025
Licensee Name:	Horminy Family LLC
Licensee Address:	2091 Palm Dale Dr Sw Wyoming, MI 49519
Licensee Telephone #:	(720) 416-6298
Administrator:	Agnes Kamanzi
Licensee Designee:	Agnes Kamanzi
Name of Facility:	Horminy Family LLC
Facility Address:	2091 Palm Dale Dr Sw Wyoming, MI 49519
Facility Telephone #:	(720) 416-6298
Original Issuance Date:	04/23/2024
License Status:	REGULAR
Effective Date:	10/23/2024
Expiration Date:	10/22/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS, DEV. DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Licensee Designee Agnes Kamanzi evicted Resident A without proper notice.	Yes
Residents of the facility provide Resident B's personal care.	Yes
Resident B sexually assaulted Resident A.	No
Staff do not administer Resident A's Lithium as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/21/2025	Special Investigation Intake 2025A0583024
02/24/2025	Special Investigation Initiated - Telephone Relative 1
02/24/2025	APS Referral
02/24/2025	Inspection Completed On-site
03/14/2025	Exit Conference Licensee Designee Agnes Kamanzi

ALLEGATION: Licensee Designee Agnes Kamanzi evicted Resident A without proper notice.

INVESTIGATION: On 02/21/2025 at 6:00 PM I received a voicemail message from Relative 1. Relative 1 stated that Licensee Designee Agnes Kamanzi had given Resident A an immediate discharge notice and Relative 1 requested an investigation into the appropriateness of that discharge. In response to Relative 1's request, a Special Investigation was immediately opened.

On 02/24/2025 I interviewed Relative 1 via telephone. Relative 1 stated that Resident A resides at the facility and has a guardian named Tory Kamerling. Relative 1 stated that on 02/21/2025 Resident A sent Relative 1 a text indicating that Resident A had been sexually assaulted by Resident B. Relative 1 stated that Resident A's text further reported that Resident B had sat on Resident A's head while Resident B had no clothing on. Relative 1 stated that Resident A reported that this has occurred on multiple occasions. Relative 1 stated that she contacted the Wyoming Police Department and met an officer at the facility at approximately 1:30 PM that same day. Relative 1 stated that Licensee Designee Agnes Kamanzi was not cooperative with law enforcement and threatened to "kick (Resident A)" out of the facility. Relative 1 stated that she and law enforcement did leave the facility and Resident A stayed at the facility until 02/23/2025 at which time Mr. Kamerling sent

Resident A to the emergency department for a medication evaluation. Relative 1 stated that while at the emergency department, it was found that Resident A's Lithium level was below the therapeutic level. Relative 1 stated that Resident A was not admitted to the hospital for an inpatient stay and is currently at Degage Ministries homeless shelter. Relative 1 stated that Ms. Kamanzi refused to allow Resident A to return to the facility after her emergency department discharge.

On 02/24/2025 I interviewed Adult Protective Services (APS) staff Sheena McBride. Ms. McBride confirmed that she is assigned to investigate the complaint allegations. Ms. McBride stated that she interviewed Resident A today at Degage Ministries homeless shelter and interviewed licensee designee Agnes Kamanzi at the facility. Ms. McBride stated that Resident A said she was given a 24-hour discharge notice from Ms. Kamanzi over the weekend. Ms. McBride stated that Ms. Kamanzi confirmed that she had given Resident A a 24-hour discharge notice over the weekend due to allegations that Resident A was slamming doors and yelling at the facility staff over the past weekend. Ms. McBride stated that due to Resident A's behaviors, guardian Tory Kamerling had Resident A evaluated at the local emergency department. Ms. McBride stated that Resident A was discharged that same day and then went to stay at the Degage Ministries homeless shelter.

On 02/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Agnes Kamanzi. Ms. Kamanzi stated that on 02/20/2025 she did not work at the facility, but Ms. Kamanzi received text communication from her staff Renee Partee that Resident A had returned from an Alcoholics Anonymous meeting intoxicated. Ms. Partee stated that Resident A pulled her bed mattress out of her bedroom and placed it in the living area and continued to yell and exhibit belligerent behaviors. Ms. Kamanzi stated that she went to the facility to work on 02/21/2025 and observed that Resident A continued to display belligerent behaviors such as yelling and slamming doors. Ms. Kamanzi stated that she spoke with Resident A's guardian Tory Kamerling over the telephone and sent Mr. Kamerling an emergency discharge notice on 02/22/2025. Ms. Kamanzi stated that on 02/23/2025, Mr. Kamerling transported Resident A to the local emergency department for a mental health evaluation and Resident A was discharged that same day to Degage Ministries homeless shelter. Ms. Kamanzi acknowledged that she did not follow the steps for issuing a less than 30-day discharge per licensing rule R 400.14302 (5). Ms. Kamanzi acknowledged that she did not notify Resident A's case manager Joshua May of the discharge. Ms. Kamanzi also acknowledged that she did not provide alternatives to discharge that had been attempted or the location to which Resident A was being discharged, if known, on the discharge notice supplied to Mr. Kamerling. Ms. Kamanzi stated that she would allow Resident A to return to the facility if this is what Mr. Kamerling and Resident A desire.

While onsite I observed the "Emergency 24 hour Evacuation Notice" dated 02/22/2025 drafted by Ms. Kamanzi. Ms. Kamanzi stated that the document was emailed to my attention on 02/23/2025 and I did verify this to be accurate. The

document was addressed to Tory Kamerling and stated that Resident A must "immediately vacate the premises by 3:30 PM tomorrow". The document stated that Resident A "had been displaying increasing threatening behavior, including slamming doors, disturbing other residents, and making threats" towards staff and residents. The document does not identify any alternatives to discharge and the location to which Resident A would be discharged.

On 03/10/2025 I left Resident A a voicemail message requesting a phone call back. That same day I also sent Resident A a text message requesting a phone call back.

On 03/12/2025 I interviewed Tory Kamerling via telephone. Mr. Kamerling stated that he is Resident A's public guardian. Mr. Kamerling stated that on 02/22/2025 he received a discharge notice via email from licensee designee Agnes Kamanzi. Mr. Kamerling stated that the discharge notice required that Resident A vacate the facility by 02/23/2025 due to Resident A exhibiting verbally confrontational behaviors and creating instability inside the home. He stated that the discharge notice did not include alternatives to discharge that had been attempted or the possible locations to which Resident A could be discharged to. Mr. Kamerling stated that he removed Resident A from the facility on 02/23/2025 and she is currently at Forest View Hospital. Mr. Kamerling stated that Ms. Kamanzi informed him that Resident A could return to the facility however Resident A has refused to do so.

On 03/13/2025 I attempted to speak with Resident A via telephone at Resident A's current placement of Forest View Hospital. I left a message requesting a telephone call back.

On 03/14/2025 I completed an Exit Conference with Licensee Designee Agnes Kamanzi via telephone. Ms. Kamanzi stated that she did not dispute that a violation had occurred and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:**

	(i) The reason for the proposed discharge, including the specific nature of the substantial risk. **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency** **or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Licensee Designee Agnes Kamanzi stated that Resident A presented as a substantial risk to staff and residents due to the slamming of doors and yelling. Ms. Kamanzi stated that she spoke with Resident A's guardian, Tory Kamerling over the telephone and sent Mr. Kamerling an emergency discharge notice on 02/22/2025. Ms. Kamanzi stated that she emailed a copy of the same discharge notice to the attention of Licensing Consultant Toya Zylstra. Ms. Kamanzi acknowledged that she did not follow the appropriate steps for issuing a less than 30-day discharge per licensing rule R 400.14302 (5). Ms. Kamanzi acknowledged she did not notify Resident A's case manager Joshua May of the discharge. Ms. Kamanzi also acknowledged that she did not provide the alternatives to discharge that had been attempted or the location to which Resident A would be discharged, if known, on the discharge notice supplied to Mr. Kamerling.

	A preponderance of evidence supports that a violation of the appliable rule occurred. Licensee Designee Agnes Kamanzi discharged Resident A with less than 30-day notice and failed to notify Resident A's case manager Joshua May. She also failed to provide alternatives to discharge that had been attempted or the location to which Resident A would be discharged to Resident A's guardian Tory Kamerling and Adult Foster Care Licensing Consultant Toya Zylstra.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents of the facility provide Resident B's personal care.

INVESTIGATION: On 02/24/2025 I interviewed Relative 1 via telephone. Relative 1 stated that residents of the facility provide personal care in the form of adult brief changes to Resident B.

On 02/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Agnes Kamanzi. Ms. Kamanzi stated that Resident A requires assistance from staff with all activities of daily living. Ms. Kamanzi stated that Resident B is developmentally disabled and non-verbal. Ms. Kamanzi stated that Resident B has been diagnosed with a pervasive developmental disability that limits Resident B's cognitive and verbal abilities. Ms. Kamanzi stated that Resident B utilizes an adult brief. Ms. Kamanzi stated that staff have never asked any resident to assist with Resident B's personal care. Ms. Kamanzi stated that Resident C had previously assisted Resident B with changing his adult brief after Resident C observed Resident B walking in the lower level of the facility with his adult brief falling off. Ms. Kamanzi stated that she informed Resident C not to change Resident B's adult brief because it was facility staff's responsibility to do so. Ms. Kamanzi stated that she asked Resident C to notify staff if Resident B was observed to be in need of personal assistance.

I visually observed the wellbeing of Resident B who was appropriately dressed and groomed. Resident B is unable to speak and operates in an infantile manner. Resident B is pervasively developmentally disabled and communicates in babbles and screeches. He is mobile and utilizes adult briefs.

Resident C explained that Resident B's bedroom was in the lower level of the facility and Resident B often wakes up and walks around the lower level before going upstairs. Resident C stated that she has changed Resident B's adult brief multiple times when she has observed it to be wet from urine in the mornings. Resident C stated that she has also assisted Resident C in the mornings with getting dressed from urine-soaked clothing into new clothing. Resident C stated that no staff has requested for her to assist Resident B with his brief changes or personal care.

Resident D stated that she has never changed Resident B's adult brief and has never been asked by facility staff to assist Resident B with his personal care. Resident D stated that she has observed Resident B with his "diaper on one leg" because it was falling off his body. Resident D stated that she has requested staff assist Resident B with his detached diaper and staff immediately provide adequate care.

Resident E stated that she has never changed Resident B's adult brief but stated that it is common for him to walk around the facility with his adult brief falling off in the morning until staff observe him. Resident E stated that after facility staff observe Resident B with a wet adult brief, staff immediately change Resident B's adult brief.

On 03/14/2025 I completed an Exit Conference with Licensee Designee Agnes Kamanzi via telephone. Ms. Kamanzi stated that she did not dispute that a violation had occurred and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14305	**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:	Licensee Designee Agnes Kamanzi stated that Resident B utilizes an adult brief. Ms. Kamanzi stated that staff have never asked any resident to assist with Resident B's personal care. Ms. Kamanzi stated that Resident C had previously assisted Resident B with changing his adult brief after she observed Resident B walking with his brief falling off. Ms. Kamanzi stated that she informed Resident C not to change Resident B's adult brief because it was facility staff's responsibility to do so. I visually observed Resident B who was appropriately dressed and groomed. Resident B is unable to speak and is pervasively developmentally disabled and communicates in babbles and screeches. He is mobile and utilizes adult briefs. Resident C stated that she has changed Resident B's adult brief multiple times when she has observed it to be wet from urine. Resident C stated that she has also assisted Resident B in the mornings with getting dressed from urine-soaked clothing into new clothing. Resident C stated that no staff has requested for her to assist Resident B with his brief changes.

	Resident D stated that she has never changed Resident B's adult brief and has never been asked by facility staff to assist Resident B with his personal care. Resident D stated that she has observed Resident B with his "diaper on one leg" falling off his body. Resident D stated that she has requested staff assist Resident B with his detached diaper and staff immediately provide adequate care. Resident E stated that she has never changed Resident B's adult brief but it is common for him to walk around the facility with his brief falling off until staff observe him. Resident E stated that after facility staff observe Resident B with a wet adult brief, staff immediately change Resident B's brief. A preponderance of evidence supports that a violation of the appliable rule occurred. Resident B's personal needs have not been adequately met as evidenced by Resident B being observed on multiple occasions walking throughout the facility with his adult brief wet and hanging off his body. Resident C has changed Resident B's clothing and wet brief due to Resident B being observed in urine-soaked briefs with his adult brief hanging off his body.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B sexually assaulted Resident A.

INVESTIGATION: On 02/24/2025 I interviewed Relative 1 via telephone. Relative 1 stated that on 02/21/2025 Resident A informed Relative 1 that Resident B had sexually assaulted Resident A by placing his naked genitals on Resident A's head. Relative 1 stated that she contacted law enforcement who visited the facility on 02/21/2025 and took a police report.

On 02/24/2025 I interviewed APS staff Sheena McBride. Ms. McBride stated that she had interviewed Resident A today at Degage Ministries homeless shelter. Ms. McBride stated that Resident A reported that on the morning of 02/21/2025, Resident A was sleeping in the lower-level living room of the facility when Resident B placed his naked genitals on Resident A's head and bounced on Resident A's head. Resident A reported that Resident B has sat on Resident A's head with and without clothing four times since residing at the facility.

On 02/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Agnes Kamanzi. Ms. Kamanzi stated that on 02/20/2025 Resident A attended an AA meeting and returned to the facility under the influence of some type of substance as exhibited by agitation and irritability. Ms.

Kamanzi stated that on 02/20/2025 Resident A pulled her bed mattress into the lower-level living room and slept on her bed mattress overnight. Ms. Kamanzi stated that on 02/21/2025 Resident A texted Relative 1 and Tory Kamerling and stated that Resident B had placed his naked genitals on Resident A's head while Resident A had been in the living room on her mattress. Ms. Kamanzi stated that Resident A never told Ms. Kamanzi of the incident and Ms. Kamanzi only became aware after law enforcement arrived at her facility on 02/21/2025. Ms. Kamanzi stated that Resident B operates in an infantile manner and lacks the ability to verbally communicate. Ms. Kamanzi stated that no other residents have reported Resident B has touched them inappropriately. Ms. Kamanzi did acknowledge that Resident B will occasionally take his urine-soaked adult briefs off and walk through the facility naked until staff observe him and immediately change his clothing. Ms. Kamanzi stated that she spoke to Resident E who observed the 02/21/2025 incident. Ms. Kamanzi stated that Resident E said Resident B walked over to Resident A who was lying on her mattress in the lower-level living room and proceeded to give Resident A hug. Ms. Kamanzi stated that Resident E said Resident B did not have pants on but never sat on Resident A and Resident A did not appear distressed. Ms. Kamanzi stated that after she was informed of the incident on 02/21/2025, she moved Resident B's bedroom from the lower level to the main level for additional supervision. Ms. Kamanzi stated that Resident B does not have a history of inappropriate sexual behaviors.

I observed Resident B who was appropriately dressed and groomed. Resident B is unable to speak and operates in an infantile manner. Resident B is pervasively developmentally disabled and communicates in babbles and screeches. He is mobile and utilizes adult briefs.

Resident C stated that she has observed Resident B walk through the facility without his clothing on. Resident C stated that staff do assist him with getting dressed and changing his adult brief once they observe him unclothed. Resident C stated that she has never observed Resident C display sexually inappropriate behaviors.

Resident D stated that she has observed Resident B walk through the facility unclothed and when staff observe this, they immediately clothe him. Resident D stated that she has never observed Resident B display sexually inappropriate behaviors.

Resident E stated that she observed the 02/21/2025 incident involving Resident A and Resident B. Resident E stated that she was in the lower level of the facility and observed that Resident A was laying on her bed mattress located in the lower-level living area. Resident E stated that Resident B walked over to Resident A and gave Resident A a "hug". Resident E stated that Resident B's pants and adult brief were "off" during the incident. Resident E stated that the incident occurred in the morning before staff had observed Resident B and at no time did Resident B place his genitals on Resident A's head. Resident E stated that the incident did not involve any sexual behaviors and after staff observed Resident B without his pants on, he

was changed immediately. Resident E stated that Resident A did not appear upset or distressed during or directly after the 02/21/2025 incident.

On 03/12/2025 I interviewed Tory Kamerling. Mr. Kamerling stated that on 02/21/2025, he received a text from Resident A and subsequently spoke to her. Mr. Kamerling stated that Resident A reported that she had pulled her bed mattress into the lower-level living area and slept there the night of 02/20/2025. Mr. Kamerling stated that Resident A reported that Resident B woke up on the morning of 02/21/2025 with a wet diaper that had fallen off. Mr. Kamerling stated that Resident A said Resident B approached Resident A and put his genitals on Resident A's head. Mr. Kamerling stated that Resident A said she then assisted Resident B with placing his diaper back on. Mr. Kamerling stated that Resident A did not immediately inform staff of the incident but instead texted Relative 1 and Mr. Kamerling to inform them of the incident. Mr. Kamerling stated that Relative 1 then proceeded to contact law enforcement. Mr. Kamerling stated that Relative 1 and law enforcement visited the facility and completed a police report.

On 03/14/2025 I completed an Exit Conference with Licensee Designee Agnes Kamanzi via telephone. Ms. Kamanzi stated that she agreed with the Special Investigation Findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	APS staff Sheena McBride stated that Resident A reported that on the morning of 02/21/2025, Resident A was sleeping in the lower-level living room of the facility when Resident B placed his naked genitals on Resident A's head and bounced on Resident A's head. Resident A reported that Resident B has sat on Resident A's head with and without clothing four times. Resident E stated that she observed the 02/21/2025 incident involving Resident A and Resident B. Resident E stated that Resident B walked over to Resident A and gave Resident A a "hug". Resident E stated that Resident B's pants and adult brief were "off" during the incident. Resident E stated that at no time

	did Resident B place his genitals on Resident A's head. Resident E stated that the incident did not involve any sexual behaviors and after staff observed Resident B without his pants on, he was changed immediately. A preponderance of evidence does not support that violation of the appliable rule occurred. Resident E stated that on the morning of 02/21/2025 she observed Resident B give Resident A hug while Resident B did not have pants on. Resident E stated that she did not observe Resident B place his genitals on Resident A's head. Resident C, Resident D, and Resident E each reported that they have not observed Resident B to act out sexually at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff do not administer Resident A's Lithium as prescribed.

INVESTIGATION: On 02/24/2025 I interviewed Relative 1 via telephone. Relative 1 stated that Resident A was seen by St. Mary's hospital staff on 02/23/2025 due to behavioral issues and it discovered that Resident A's Lithium level was not within the therapeutic range.

On 02/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Agnes Kamanzi. Ms. Kamanzi stated Resident A moved to the facility on 01/06/2025. Ms. Kamanzi stated that Resident A arrived with two bottles of Lithium. Ms. Kamanzi stated the Resident A took both bottles with her when she moved out of the facility on 02/23/2025. Ms. Kamanzi stated that one of Resident A's bottles stated that she was prescribed two tablets of Lithium once daily and the other bottle stated that she was prescribed three tablets of Lithium once daily. Ms. Kamanzi acknowledged that she did not remember the dosage of the Lithium contained in Resident A's pill bottles. Ms. Kamanzi acknowledged that she did not observe a prescription script to verify the required dosage and administration.

While onsite I observed Resident A's Medication Administration Record from 01/07/2025 until 01/31/2025. The document was handwritten and stated that Resident A is prescribed "Lithium carb tab 300 mg ER". The document indicated that Resident A received the medication once daily at 8:00 AM by licensee designee Agnes Kamanzi.

On 03/12/2025 I interviewed Tory Kamerling via telephone. Mr. Kamerling stated that he transported Resident A to St. Mary's Emergency Department due to Resident A displaying erratic behaviors on 02/23/2025. Mr. Kamerling stated that it was determined by medical personal that Resident A's Lithium level was not within

therapeutic levels of .8 to 1.2. mEq/L. Mr. Kamerling stated that on 02/23/2025, Resident A's Lithium measured .4 mEq/L. Mr. Kamerling stated that he spoke to licensee designee Agnes Kamanzi who reported that Resident A's Medication Administration Record stated that Resident A is prescribed three 300 MG tablets of Lithium once daily, however Resident A's Lithium bottle stated that she was prescribed one 450 MG tablet of Lithium twice daily. Mr. Kamerling stated that Ms. Kamanzi admitted to administering Resident A one 450 MG tablet once daily by mistake.

On 03/14/2025 I completed an Exit Conference with Licensee Designee Agnes Kamanzi via telephone. Ms. Kamanzi stated that she did not dispute that a violation had occurred and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Licensee Designee Agnes Kamanzi stated Resident A moved to the facility on 01/06/2025. Ms. Kamanzi stated that Resident A arrived with two bottles of Lithium. Ms. Kamanzi stated the Resident A took both bottles with her when she moved out of the facility on 02/23/2025. Ms. Kamanzi stated that one of Resident A's bottles stated that she was prescribed two tablets of Lithium once daily and the other bottle stated that she was prescribed three tablets of Lithium once daily. Ms. Kamanzi acknowledged that she did not remember the dosage of the Lithium contained in Resident A's pill bottles. Ms. Kamanzi acknowledged that she did not observe a prescription script to verify the required dosage and administration. Guardian Tory Kamerling stated that he transported Resident A to St. Mary's Emergency Department due to Resident A displaying erratic behaviors. Mr. Kamerling stated that it was determined that Resident A's Lithium level was not within therapeutic levels of .8 to 1.2. mEq/L. Mr. Kamerling stated that Resident A's Lithium measured .4 mEq/L. Mr. Kamerling stated that he spoke to licensee designee Agnes Kamanzi who reported that Resident A's Medication Administration Record stated that Resident A is prescribed three 300 MG tablets of Lithium once daily, however Resident A's Lithium bottle stated that she was prescribed one 450 MG tablet of Lithium twice daily. Mr. Kamerling stated that Ms. Kamanzi admitted to administering Resident A one 450 MG tablet once daily by mistake.

	A preponderance of evidence supports that a violation of the appliable rule occurred. Licensee Designee acknowledged that she did not administer Resident A's Lithium pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The facility was operating over their licensed capacity.

INVESTIGATION: On 02/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Agnes Kamanzi. Ms. Kamanzi stated that for the past two weeks, the facility had been operating above their approved licensing capacity of six residents. Ms. Kamanzi stated that Resident A, Resident B, Resident C, Resident D, Resident E, Resident F and Resident G were all residing at the facility and receiving adult foster care services for the past two weeks concurrently.

On 03/14/2025 I completed an Exit Conference with Licensee Designee Agnes Kamanzi via telephone. Ms. Kamanzi stated that she did not dispute that a violation had occurred and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	Licensee designee Agnes Kamanzi acknowledged that for the past two weeks the facility had been operating above their approved licensing capacity of six residents. Ms. Kamanzi stated that Resident A, Resident B, Resident C, Resident D, Resident E, Resident F and Resident G were all residing at the facility and receiving adult foster care services for the past two weeks concurrently. A preponderance of evidence supports that a violation of the appliable rule occurred. Licensee Designee Agnes Kamanzi acknowledged that the facility operated above their authorized capacity.
CONCLUSION:	**VIOLATION ESTABLISHED**

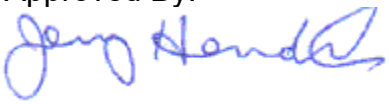
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

03/17/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



03/17/2025

Jerry Hendrick Date
Area Manager