GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2026

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

RE: License #: AL410418572
Investigation #: 2026A0357008
Byron Manor #5

Dear Mrs. 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, 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 #:	2026A0357008
Complaint Receipt Date:	12/03/2025
Investigation Initiation Date:	12/04/2025
Report Due Date:	02/01/2026
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 Woziak
Name of Facility:	Byron Manor #5
Facility Address:	Suite 5, 2115 84th Street SW, Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	09/20/2024
License Status:	REGULAR
Effective Date:	03/20/2025
Expiration Date:	03/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed multiple doses of medications Torsemide and Buspirone, due to facility's failure to refill them. The absence of her medications contributed to her Emergency Department visit and ongoing breathing issues.	Yes

III. METHODOLOGY

12/03/2025	Special Investigation Intake 2026A0357008
12/04/2025	Special Investigation Initiated - Telephone Called the facility to find where the resident was located.
12/04/2025	Contact - Telephone call received Amy Kruithoff called back.
01/09/2026	Inspection completed on site. Interview with Crystal Lamkin House Manager, Bryan Cramer Administrator.
01/23/2026	Contact - Document Received Received by email from Bryan Cramer, Administrator, Resident A's document from University of Michigan Health-West.
01/23/2026	Inspection Completed On-site Unannounced inspection.
01/23/2026	Contact - Face to Face Interviews with Krystal Lamkin, Home Supervisor and Bryan Cramer, Administrator.
01/23/2026	Contact - Face to Face Face-to-face interview with Med Technician: Erika Velthouse and Tiffany Ridley.
01/23/2026	Contact - Face to Face With Resident A and Family Member/daughter # 1.
01/23/2026	Contact - Document Received Received and reviewed two Sheets of Resident A's Medication Administration Record, Medication List Report and three Incident Report.

02/18/2026	Telephone-call-made to daughter FM#2.. Discussed Resident A’s missing meds.
02/19/2026	Telephone exit conference with the Licensee Designee.

ALLEGATION: Resident A missed multiple doses of medications Torsemide and Buspirone, due to facility’s failure to refill them. The absence of her medications contributed to her Emergency Department visit and ongoing breathing issues.

INVESTIGATION: On 12/03/2025, we received the complaint that read*: “(Resident A’s) daughter’s reported lapse in her medications (Buspirone and Torsemide) due to the medications not being filled on time by residential facility. (Resident A) missed three doses of Buspirone on 11/21/2025, (medications resumed on 11/22/2025). Residential facility stated cause of the lapse was that the pharmacy received an outdated med list. (Resident A) also ran out of Torsemide on 11/23/2025. (Resident A) went to ER (Emergency Room) on11/24/2025 due to COPD (Chronic Obstructive Pulmonary Disease) w/acute exacerbation. (Resident A’s) daughter FM2 (Family Member 2) called cardiologist on 11/28/2025 as (Resident A) was still experiencing SOB (Shortness of Breath) and difficulty breathing. She found out (Resident A’s) Torsemide ran out on 11/23/2025 and she has been without the medication since. She (FM2) requested refill and stated she would bring Torsemide to residential facility on 11/28/2025 to ensure (Resident A) resumed medication as soon as possible…”*

On 12/05/2026, I spoke with Amy Kruithoff, Social Worker Supports Coordinator, for Area Agency on Aging. She verified that Resident A is receiving AAA services. She stated that she was aware of Resident A not receiving her prescribed medications. She understood that the medication list that the facility had received was old and inaccurate and therefore there was a “mix up”. She explained that Resident A ran out of her Torsemide on 11/23/2025, which caused her to go to the Emergency Department on 12/03/2025 for breathing issues. She also stated that Resident A had missed three doses of her medication Buspirone as well.

On 01/09/2026, I made an unannounced inspection at the facility. I met and interviewed Krystal Lamkin, House Manager and Bryan Cramer, Administrator. Ms. Lamkin stated that somehow Resident A’s medication list that went to their pharmacy was incomplete and therefore they did not receive the medications that had been prescribed. I asked Ms. Lamkin if Resident A had not received her prescribed Buspirone and Torsemide and she acknowledged that Resident A had not received these medications correctly. She provided me with two pages of Resident A’s MAR (Medication Administration Record) for the month of November 2025. One page had recorded her Buspirone 10MG, take 1 tablet by mouth three times daily (for Major Depressive Disorder). Ms. Lamkin had highlighted the doses that were missing. On 11/22/2025, no administration at the times 0800, 1400, 2000

and on 11/23/2025, no administration at 0800 and1400. Therefore, five Buspirone, a total of 50MG, were not administered to Resident A.

On 01/09/2026, I reviewed Resident A's November 2025 MAR. Listed was Torsemide 20 MG tablet, take "2" tablets by mouth once daily. Ms. Lamkin had highlighted the days that the medication was not administered. Starting on 11/11/2025 through 11/28/2025. There were 16 days that Resident A did not receive 32 doses of her prescribed Torsemide 20MG at 0800. The MAR Shows that Resident A was in the hospital on 11/29 and 11/30/2025.

On 01/23/2026, I met with Resident A and Family Member #1. Due to Resident A diagnosis, she was unable to contribute to the investigation. She did not remember what had happened to her. Family Member #1 reported that Resident A did not receive her medications as prescribed from the facility.

On 01/23/2026, I interviewed Erika Velthouse, Med Tech and she confirmed she works full time on 1st shift. She stated that she had to call their pharmacy (Hometown Pharmacy) to ask for Resident A's medications to be sent to the facility. She stated that she called every day, and they told her that they would send Resident A's medication, but the next day the medication was not brought to the facility. She stated that she called Resident A's physician but for the most part she could only leave a message. She said one time she was able to speak to someone, and they told her they would send the refill order for her medications. But the medications still did not come. She said one of Resident A's daughters had spoken to her to tell her that Resident A needed her medication. She said the daughter told her she would call the physician and request a five-day script. Ms. Velthouse stated that Resident A's medications came after Resident A was in the hospital. I asked her if she had documented any of her calls to the pharmacy or the physician's office and she said she had not. I asked her if she had told her Supervisor, Ms. Lamkin, and she reported she had not told her that Resident A's medications were not available.

I asked Ms. Velthouse if she had called Resident A's physician to let him know that Resident A did not have her prescribed Buspirone and Torsemide. She stated that she did not, except when she had called and left messages. I asked her how Resident A was doing without her medication, and she said her legs were more swollen and she had requested her inhaler more often. She also reported Resident A was more anxious and came to the nursing station more often.

On 02/18/2026, I was able to speak to Resident A's daughter Family Member #2 (FM#2). She reported that she found Resident A's ankles swollen so she took her to the hospital (not date provided). She stated that she called Resident A's Cardiologist and told him about it. She stated that the doctor said he may have to increase her dosage, but FM#2 found out that Resident A had not been receiving her "water pill" for a week. She reported that Resident A had trouble breathing. She said she asked the doctor for a 14-day supply of the Torsemide to get Resident A through until the new prescription was received by the pharmacy. She said she went to Walgreens

and secured the medication and brought them to the facility. She also reported that Resident A's blood pressure had dropped very low and that this happened several times. She also stated that the staff at the facility had not told her or other family members that the facility's pharmacy had not delivered Resident A's medications Torsemide or that she did not have her Buspirone which was for her depression and had missed several doses. She said Resident A had a "difficult time for about three weeks". She stated that Resident A went to the hospital three times. She reported that after Resident A had received her water pills, she then had dehydration. Her blood pressure had dropped, and she had fallen several times. She said as a family they were very concerned about this situation. She expressed concern that facility staff had not told them about not having Resident A's medications because if they had, they would have intervened by securing her medications.

On 12/19/2026, I conducted a telephone exit conference with the Licensee Designee, Kimberly Woziak. We discussed the findings of this investigation. She agreed with my findings.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	It was alleged that Resident A missed multiple doses of two prescribed medications (Torsemide and Buspirone) due to facility's failure to refill them. The absence of her medications contributed to her Emergency Department visit and ongoing breathing issues. Resident A was prescribed Buspirone HCL 5MG tablet, take 1 tablet by mouth once daily at 0800. On 11/20 & 21/2025 at 0800, it was not administrated. Therefore, two Buspirone for a total of 10MG were not administered as prescribed. Resident A was prescribed Torsemide 20 MG tablet, take "2" tablets by mouth once daily. Starting on 11/11/2025 through 11/28/2025, Resident A did not receive 32 of her prescribed Torsemide at 20MG at 0800. Erika Velthouse, Med Tech acknowledged that Resident A did not receive her prescribed medications of Buspirone HCL at two different doses, and her Torsemide at the facility. This investigation found evidence that Resident A did not receive her prescribed medications of Buspirone and Torsemide

	as printed on her November MAR. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Erika Velthouse, Med Tech confirmed that Resident A was not doing well without her medication, and she said her legs were more swollen and she had requested her inhaler more often. She also reported Resident A was more anxious and came to the nursing station more often. Family Member #2 stated she found Resident A's ankles swollen and took her to the hospital. She stated that Resident A's blood pressure had dropped very low and that this happened several times. She stated Resident A had a really difficult time for about three weeks. She stated that Resident A went to the hospital three times. She reported that after Resident A had received her water pills, she then had dehydration. Her blood pressure had dropped, and she had fallen several times. During this investigation evidence found that Resident A was not protected and safe because she had not received her prescribed medications Buspirone for her depression and Torsemide for her blood pressure and retaining water. Family Member #2 confirmed Resident A had a really difficult time for about three weeks. She stated that Resident A went to the hospital three times. She reported that after Resident A had received her water pills, she then had dehydration and she had fallen several times. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/19/2026

Arlene B. Smith Date
Licensing Consultant

Approved By:

02/19/2026

Jerry Hendrick Date
Area Manager