



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 8, 2026

Kimberly Wozniak
Byron Center Care Operations, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AL410418569
Investigation #: 2026A0583053
Byron Manor #2

Dear Ms. 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,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

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 #:	AL410418569
Investigation #:	2026A0583053
Complaint Receipt Date:	08/10/2026
Investigation Initiation Date:	08/11/2026
Report Due Date:	09/09/2026
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 Wozniak
Name of Facility:	Byron Manor #2
Facility Address:	Suite 2 2115 84th Street SW Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	09/19/2024
License Status:	REGULAR
Effective Date:	03/18/2025
Expiration Date:	03/17/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/10/2026	Special Investigation Intake 2026A0583053
08/11/2026	Special Investigation Initiated - On Site
08/11/2026	APS Referral
09/08/2026	Exit Conference Licensee Designee Maggie Rosser

ALLEGATION: The facility is insufficiently staffed.

INVESTIGATION: On 08/10/2026 allegations were received via LARA-BCHS- Complaints from an anonymous complaint source. The allegations were assigned for my investigation on 08/11/2026 and stated the following, "Management leaves Med Tech in unit of 20 Assisted Living with 3 hoyers and multiple two person assists, on their own without an aide or coming in to help".

On 08/11/2026 I completed an unannounced onsite investigation at the facility and interviewed administrator Bryan Cramer and wellness director Jessica Knott. Both stated that the facility provides care to nineteen residents, and three residents require the assistance of two staff members for safe transfers. Both stated that the facility is staffed with two staff members during waking hours and one staff member during "third shift". Both stated that "third shift" includes the hours of 11:00 PM until 7:00 AM.

On 08/11/2026 I referred complaint allegations to Adult Protective Services via the online portal.

On 08/12/2026 I received an email from Mr. Cramer. The email contained the facility's staffing schedule which indicated that the facility is staffed with two staff members from 11:00 PM until 7:00 AM. The email contained the Resident Assessment Plans for Resident A, Resident B, and Resident C. Resident A's Assessment Plan signed 01/23/2025 was completed on 09/18/2024 and does not indicate that Resident A requires the assistance of two staff members for safe transfers. Resident B's Assessment Plan signed 11/21/2024 states that Resident B utilizes an electric wheelchair, sit to stand lift, and does not indicate that Resident B

requires the assistance of two staff members for safe transfers. Resident C's Assessment Plan signed 07/13/2026 states that Resident C requires the assistance of two staff members for bathing and grooming. Resident C's Assessment Plan states that Resident C is "bed bound" and requires the assistance of a wheelchair and sit to stand lift.

On 08/12/2026 I interviewed Mr. Cramer via telephone. He stated that the staff schedule that he provided was inaccurate because it incorrectly indicates that two staff members work from 11:00 PM until 7:00 AM. He stated that the facility is staffed with one staff from 11:00 PM and 7:00 AM.

On 08/17/2026 I interviewed Mr. Cramer via telephone, and he stated that Resident A, Resident B and Resident C each require the assistance of two staff members for safe transfers. He reported that Resident A and Resident B's Assessment Plans are outdated and require updating to reflect their care needs.

On 09/08/2026 I completed an exit conference with licensee designee Maggie Rosser via telephone. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.671	Resident care.
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Administrator Bryan Cramer and wellness director Jessica Knott both stated that the facility provides care to nineteen residents, and three residents require the assistance of two staff members for safe transfers. Both stated that the facility is staffed with one staff member during "third shift" which includes the hours of 11:00 PM until 7:00 AM. Resident C's Assessment Plan states that Resident C requires the assistance of two staff members for bathing and grooming. Resident C's Assessment Plan states that Resident C is "bed bound" and requires the assistance of a wheelchair and sit to stand lift. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. The facility is insufficiently staffed with one staff member from 11:00 PM until 7:00 AM.

CONCLUSION:	VIOLATION ESTABLISHED
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ADDITIONAL FINDINGS: The staff schedule is inaccurate.

INVESTIGATION: On 08/12/2026 I received an email from Mr. Cramer. The email contained the facility's staff schedule which indicated the facility is staffed with two staff members from 11:00 PM until 7:00 AM.

On 08/12/2026 I interviewed Mr. Cramer via telephone. He stated that the staff schedule that he provided was inaccurate because it incorrectly indicates that two staff members work from 11:00 PM until 7:00 AM. He stated that the facility is staffed with one staff from 11:00 PM and 7:00 AM.

On 09/08/2026 I completed an exit conference with licensee designee Maggie Rosser via telephone. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.639	Staff records.
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: (a) Names of staff on duty. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Scheduling changes when made.
ANALYSIS:	I observed that the email contained the facility's staffing schedule which indicated the facility is staffed with two staff members from 11:00 PM until 7:00 AM. Mr. Cramer stated that the staffing schedule that he provided was inaccurate because it incorrectly indicates that two staff members work from 11:00 PM until 7:00 AM. He stated that the facility is staffed with one staff from 11:00 PM and 7:00 AM. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. The staff schedule does not accurately document each staff member's hours worked.

CONCLUSION:	VIOLATION ESTABLISHED
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ADDITIONAL FINDINGS: Resident Assessment Plans are not completed annually.

INVESTIGATION: On 08/12/2026 I received an email from Mr. Cramer. The email contained the Resident Assessment Plans for Resident A and Resident B. Resident A's Assessment Plan signed 01/23/2025 was completed on 09/18/2024 and does not indicate that Resident A requires the assistance of two staff members for safe transfers. Resident B's Assessment Plan signed 11/21/2024 states that Resident B utilizes an electric wheelchair, sit to stand lift, and does not indicate that Resident B requires the assistance of two staff members for safe transfers.

On 08/17/2026 I interviewed Mr. Cramer via telephone, and he stated that Resident A and Resident B's Assessment Plans are overdue and require updating to accurately reflect their care needs.

On 09/08/2026 I completed an exit conference with licensee designee Maggie Rosser via telephone. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's Assessment Plan, signed 01/23/2025, was completed on 09/18/2024. I observed that Resident B's Assessment Plan was signed on 11/21/2024. Mr. Cramer stated that Resident A and Resident B's Assessment Plans are overdue and require updating. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule.

	Resident A and Resident B's Assessment Plans were not completed annually.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



09/08/2026

Toya Zylstra
Licensing Consultant

Date

Approved By:



09/08/2026

Jerry Hendrick
Area Manager

Date