GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2025

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

RE: License #: AL410418572
Investigation #: 2025A0357022
Byron Manor #5

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,

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 #:	AL410418572
Investigation #:	2025A0357022
Complaint Receipt Date:	02/05/2025
Investigation Initiation Date:	02/07/2025
Report Due Date:	04/06/2025
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 #5
Facility Address:	Suite 5, 2115 84th Street SW, Byron Center, 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 DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was transferred to the hospital with a bedsore, a chip on this right hip, three broken ribs, a brain bleed, and a Urinary Tract Infection. There was no record of Resident A falling and no record of him being fed in the last 24 hours.	No
Additional Findings	Yes

III. METHODOLOGY

02/05/2025	Special Investigation Intake 2025A0357022 The resident was in the hospital and then transferred to a Hospice facility where he passed away.
02/07/2025	Special Investigation Initiated - Telephone To Administrator, Bryan Cramer
02/26/2025	Contact- with Administrator, Bryan Cramer and Krystal Lamkin, Home Manager to discuss the complaint.
02/26/2025	Contact Document Received Ms. Lamkin provided a copy of Resident A's Health Care Appraisal and his History and Physical along with his medication list were attached and his "Move in Record."
02/26/2025	Contact - Telephone call made, to Resident A's wife, left a message to return my call.
O3/06/2025	Contact - Telephone call made to Family Member # 2 and left a message to return my call.
03/11/2025	Contact - Telephone call received Telephone interview with Family Member # 2.
03/19/2025	Contact - Document Received From Krystal Lamkin, Home Manager provided me with Assessment Plan, Health Care Appraisal, Medication list, face sheet, three incident/accident reports, and notes from Resident A's hospital stay.
04/01/2025	Contact - Face to Face Interview face-to-face Med leads, Joi Miller, and Santana Garza.

04/02/2025	Contact - Document Received Received an email from Administrator, Bryan Cramer
04/03/2025	Contact - Document Received Krystal Lamkin, Home manager sent me the staff schedule
04/03/2025	Contact - Document Received Mr. Cramer send me the Medication Administration Records
04/18/2025	Contact - Face to Face Interviews face-to-face with staff: Lauren Scribbner, Hannah Ratliff, Athanase Kapiriga, and Ayda Jazlin. Also spoke with Bryan Cramer, Administrator and Crystal Lamkin, Home Manager.
06/11/2025	Contact with APS worker Ashleigh Wassenaara.
06/10/2025	Telephone exit with Licensee Designee, Kimberly Wozaniak.

ALLEGATION: Resident A was transferred to the hospital with a bedsore, a chip on this right hip, three broken ribs a brain bleed, a Urinary Tract Infection. There was no record of Resident A falling and no record of him being fed in the last 24 hours.

Note: Before we received this complaint Mr. Cramer, Administrator had sent me an email that Resident A was sent the hospital on 01/28/2025, requested by family because he was not a baseline. He also reported that Hospice staff were present.

INVESTIGATION: The complaint was originally received in our Lansing office on 02/6/2025. The complaint read as follows: *'(Resident A) has a horrendous bed sore, chip out of this right hip, three broken ribs, (unknown which side) a brain bleed, a UTI, and influenza. (Resident A) was taken to the ICU of Trinity Health Hospital….There is nothing in (Resident A's) record that he had fallen at Byron Center Memory Care. (Resident A) has not eaten in 24 hours. Two female residents were seen lifting (Resident A) up from the floor and putting (Resident A) into a chair on Sunday, 01/26/2025. It is unknow if that is how (Resident A) sustained these injuries.'*

On 02/07/2025, I telephoned the Administrator, Bryan Cramer and he reported that an Adult Protective Services worker had come to the facility and had told him they would probably close the case because Resident A no longer resides in the facility. He stated that Resident A was admitted to the facility on 01/24/2025 after being in the hospital for approximately three- and-a-half weeks. He stated that Resident A had "a caretaker," with him 24 hours a day while he was in the hospital.

On 02/26/2025, I met with Mr. Cramer and Krystal Lamkin Home Manager. Mr. Cramer stated he had received an inquiry from Resident A's family member for a placement into their memory care unit on 01/04/2025. Mr. Cramer reported that Resident A's wife and daughter came to the facility on 01/08/2025, for a tour which he provided for them. He said they had decided that Resident A could be admitted to their facility. Mr. Cramer stated that he and Ms. Lamkin evaluated Resident A for admission to their facility on 01/23/2025 at the hospital. He was in the hospital at that time, and he had fallen the day before. They both learned that Resident A and his wife were living in an independent living facility, and he was wandering and asking at the desk where his wife was. They learned that Resident A had some agitation, and his wife had difficulty redirecting his behaviors. He was in the hospital for help with adjusting his medications to address his behaviors. It was their understanding that the hospital personnel had asked the family members to not visit Resident A while he was in the hospital. Mr. Cramer stated that Resident A's wife signed their Resident Care Agreement, and they were told that she was the decision-making person for Resident A. He stated that she was the DPOA. He also stated since his wife signed the paperwork and reported that she was the DPOA that they spoke to her about the falls he had had in the facility. He stated that Resident A had been admitted to Trinity Health Hospital on 12/29/2024 and they worked on adjusting his medications to help with his worsening behaviors. He stated that a daughter (name unknown) had at some point mentioned the nurses would help Resident A at their facility. He said at that time he explained that they are an Adult Foster Care Facility and are not required to have any licensed personnel, and they do not have licensed personnel working in the facility.

On 02/26/2025, Ms. Lamkin, Home Manager provided me with a copy of Resident A's Health Care Appraisal with his attached History and Physical plus his medication list which I reviewed. In the History and Physical it read that their Chief Complaint (per family) was agitation. It was noted that he lives in an independent living facility with his wife and has been making verbal and physical threats towards his wife and family members. He had been wandering inappropriately, peeing in the sink, blaming his wife for everything, and pacing. He is difficult to verbally reorient at times and in triage. It was reported that he has made no attempts to harm himself, has Alzheimer's and is disoriented at baseline. The documentation noted that Resident A's wife feels unsafe at home and the family has been trying to get Resident A into memory care. This document also read that Resident A has late onset of Alzheimer's dementia with behavioral disturbance. It is noted that Resident A's daughter reported they have not been doing well since the move and his wife has had trouble redirecting his behaviors, taking care of him at home and trouble remembering when to give his Risperdal dosing. He has been having agitation, paranoia, exit seeking/wandering and belief that his spouse is his girlfriend. According to this documentation he was admitted to the hospital on 12/29/2024.

On 02/26/2025, Ms. Lamkin provided me with Resident A,'s "Move in Record," dated 01/24/2025. I reviewed this document, and it contained his "Diagnosis Information." "Alzheimer's Disease with late onset, Unspecified Dementia, Unspecified Severity,

With Agitation. Other Specified Forms of Tremor." Also listed was "Abnormal Weight Loss and Hyperglycemia Unspecified." There were 11 other diagnoses listed.

On 03/11/2025, I conducted a telephone call with Resident A's daughter (Family Member # 2). She reported that when Resident A was admitted to Trinity Health Hospital on 01/28/2025, they told her that he had a "horrendous" bed sore, chip out of this right hip, three broken ribs, (unknown which side) a brain bleed, a UTI, and influenza. She said he went into ICU. She said that some of the nurses told her that they thought he had been abused and neglected, and they would be reporting this. (APS staff had been at Byron Manor #5 after Resident A had been discharged and they told Mr. Cramer that since the Resident was not there, they would probably close the case. I was never contacted by APS.)

Family Member # 2 stated that her mother told her Resident A was hitting his head into the glass door and she requested the staff give him something like Zyprexa. She went on to say the staff had told her mother that they cannot do that without a physician's order. They also stated that his primary care physician had not prescribed a PRN (as needed) medication for agitation. Later on in our conversation I asked her about Hospice, and she reported that the family had called them, and they came to do his assessment on 01/28/2025 and they suggested that he was not at baseline and that he should go to the hospital. That is when they asked the staff of the facility to send him to the hospital. She also stated that no one from the facility informed Resident A's family members when Resident A fell. She said, "A lot of information was withheld from us." She stated that Mr. Cramer had spoken with her brother-in law, (no name provided) and he informed Mr. Cramer about their dissatisfaction with the care. She said Mr. Cramer returned their money they had paid to the facility for Resident A's care. I explained to her that I had called her mother and left a message. Mr. Cramer stated that he had spoken to the son-in-law and he had stated that Resident A's wife was 82 years old and had dementia. Family Member # 2 stated that Resident A was transferred to a Hospice facility, and he later died there. No date of his death was provided.

On 03/19/2025, I reviewed Resident A's assessment plan, which Resident A's wife had signed. Under the section of the Social Behavioral Assessment under I Controls Aggressive Behavior the following was written: "Resident has a history of aggression. Staff to offer and attempt cares. If he becomes aggressive ensure safety and give space." Under L. Exhibits Self Injurious Behavior and the following was written: "Staff will continuously monitor for any changes and report any changes to management." There was no help needed for eating/feeing. Under the section of the Assessment Plan called "Self Care Skill Assessment" under this were sections entitled with "toileting, grooming, bathing, dressing, and personal hygiene" and the plan read that the staff would assist with all of these cares related to his dementia. The plan stated they would administer his medications.

On 03/19/2025, I reviewed the documents provided by Ms. Lamkin that she had obtained from the hospital concerning Resident A's hospital stay. This document was

a “Transfer Summary,” which reported “Wound 12/31/2024 Back Medial; Right.” His wound bed tissue was “dry.” Wound Bed Tissue was “pink.” It also read “Peri-Wound Assessment Moist, Dressing Status Clean: Dry; Int.” In addition, this document read “Wound Skin Tear 01/14/2025, Pretibial Left, not present on admission, Wound Location, Left, Dressing Status Dry, Dressing Status Clean; Intact.” This information would indicate that he had wound issues while he was in the hospital. I asked Ms. Lamkin and Mr. Cramer if they had completed a skin assessment upon his admission to the home and they both reported they had not completed a skin assessment.

On 03/19/2025, Ms. Lamkin provided me with three Incident/Accident Reports, which were all dated 01/26/2025. Each of these had the staff listed as Santana Garza and Resident A as the resident. The first one was dated 01/26/2025 at 3:41PM in the common area. The written explanation as to what had happened read as follows: “Staff observed resident on the floor under a table. It appeared that he was attempting to fix the table. Wife asked staff to assist him up.” The next section of the report was Action Taken by Staff: “Staff assist of two off the floor from under the table. No injury observed.” The next section is “Corrective Measures Taken to Remedy and/or Prevent Recurrence: “Staff will continue to monitor resident and offer reminders to say on his feet.” During this meeting Bryan Cramer the Administrator stated that they gave Resident A’s wife the Incident/Accident Reports since she was the designated representative and the DPOA for Resident A.

The second Incident/Accident Report dated 01/26/2025 at 4:16PM in the dining room. Explain what happened: “Staff observed resident and his wife on their hands and knees in the dining area while they were setting up dinner. Saff asked how they fell and the wife state that the resident had tripped on his own feet and they both went down. Action Taken by Staff: Staff did range of motion on resident, and it was within normal limits. Staff assist of 2 to get resident to his feet. Staff offered wife assistance to stand as well and wife declined.” Corrective Measures Taken to Remedy and/or Prevent Recurrence: “Staff will continue to monitor resident.”

The third Incident/Accident Report was dated 01/26/2025, at 4:45PM in the common area. Explain what happened: “Resident was banging his head up against a glass window and also waked into it thinking it was a sliding door.” Action Taken by Staff: Staff: “Staff attempted to redirect Resident multiple times with no success. When attempting to redirect resident grabbed staff wrist and attempted to bed it. Wife was yelling at staff to give him medications but no PRN’s were prescribed by hospital or PCP.” Corrective Measures Taken to Remedy and/or Prevent Recurrence: “Staff will redirect resident and have management react to PCP (Primary Care Physician) for PRN orders.”

According to the documentation on Resident A’s Progress Notes, 01/27/2025, Krystal Lamkin, Home Manger had called Resident A’s PCP, to inform them of behaviors that had occurred over the weekend. MA will be giving DO a note

explaining what occurred and see what they would like to do about changing his medications.

On 04/01/2925, Ms. Lamkin verified she had called Resident A's physician, and they never got back to her.

On 04/01/2025, I conducted an interview with Joi Miller who said she was a Med Lead and has worked there for three years. She reported that Sanatana Garza, Med Lead had worked on second shift on 01/24/2025 when Resident A was admitted, and she worked first shift on 01/25/2025. She reported that when Resident A was admitted he wanted to shovel snow because he has always shoveled snow, so he did some shoveling in the courtyard and the staff said he was happy. She explained that she learned from staff that Resident A started moving the furniture in the small living room, picking up chairs, and taking sheets off the linen cart to place over the furniture like he was building forts. She said the staff reported that he would not take redirection, and he did not sleep much at all that first night. She said she understood he was very busy. She said on her shift he became very aggressive and wanted to do this own thing, and they had difficulty in redirecting him and he was all over the place. She said you cannot have a conversation with him. She reported she worked first shit on 01/26/2025. She said she was in his room several times and that he was lying on the floor with a type of blanket under him like he had put it down and then laid on top of it. She said she did not hear any yelling or any falling. She said she found no injuries on him when she helped him up. She said this happened twice in the same day. She said he got up for lunch but was all over the unit. She said he was sound asleep for the bedtime med pass and could not wake up to take his medications. She was aware of his two falls and the head banging on 02/26/2025, but she did not hear of any injury. She reported that she was off Monday and back on Tuesday 01/28/2025. She said she saw him eating while he was standing, and staff was feeding him. She said he refused fluids and she and others tried to get him to drink but he refused. She stated she worked on 01/28/2025. She reported that he was very resistant with cares, as she was attempting to change him, and she saw a skin tear in the middle of his right buttock. She said that she checked with third shift, and they knew nothing about it. She said she alerted Bryan Camer, immediately. She also stated that Resident A would refuse his medications. She asked Santana Garza how she would get him to take his medications, and she reported that Ms. Garza told her that she crushed his medications and then he took them. Ms. Santana stated immediately they did not have a physician's order to crush his medications. She reported that the family had requested Hospice. She said she told the Hospice nurse when she was there doing his assessment about the skin tear. She reported that she did not write an Incident/Accident Report but wrote what had happened in his Progress Notes. She said she told Bryan Cramer of the skin tear.

On 04/01/2025, I reviewed Resident A's Progress Notes and the following note read as: "Upon changing resident today, it was observed for the first time that resident had a large shin teat on buttocks. Resident is very combative and resistive to cares so staff was unable to see it before. Family had mentioned it to staff before brief

change today and during brief change today and blood was noticed in brief. Management has been informed of this." Signed by Ms. Miller.

On 04/18/2025, I conducted a face-to-face interview with Sanatana Garza, she reported she was a Med Lead. She confirmed that she did work on 01/26/2025 and she worked a double shift (1st and 2nd) that day as she had the day before. I asked her about the Incident Report dated 01/26/2025 at 3:41 PM. She said she had observed Resident A on the floor under a table appearing that he was trying to fix something. She stated that she sought a male staff, Athanase Kapiriga, to help pick Resident A up and she did not observe any injuries. She stated he seemed fine and went on walking with his wife. I asked her about the second incident on 01/26/2025, 4:16PM and she saw both Resident A and his wife were on their hands and knees in the dining area. She asked his wife how they fell, and his wife said Resident A tripped on his own feet and they both fell down. Ms. Garza stated that she did ROM (Range of Motion) with Resident A, and they were within normal limits. I asked her about the third incident on 01/26/2025 at 4:45 PM and she explained that Resident A was hitting his head on the glass window, nonstop and his wife was yelling to give Resident A some medication. She reported that she tried to redirect him many times and he would not stop hitting himself. Then he grabbed her wrist and tried to bend it. She stated they had no prescribed PRN's (As needed medications) to administer to him. She said he finally settled down. I asked Ms. Garza if she saw Resident A exhibiting any pain, holding his head or holding his rib area and she said no. She stated that Resident A acted happy and not hurt in any way. I asked her who had helped her pick Resident A up from the fall on the floor. She reported that one time it was Direct care Staff, Anhanase Kapiriga. She did not remember who had helped the second time.

On 04/18/2025, I telephoned Direct care Staff, Anhanase Kapiriga and I asked him if he had helped Ms. Garza to help Resident A off the floor and he stated he did not remember helping with Resident A. He did not remember changing his brief. Ms. Krystal Lamin the Home Manager also stated she called him, and he told her he had no memory of picking Resident A up from the floor.

On 04/18/2025, I conducted an interview with Lauren Scribbner. She acknowledged that she worked 3rd, shift (01/27-28/2025, and she worked a 2nd shift on 01/27/2025. She said she was a Med Lead. She said that Resident A was aggressive toward her, and he did not want to be touched. He did not want to get out of the recliner, and he was "dead weight" and half asleep when she took him to the bathroom. She stated that he was really wet when she change him. She said she had trouble with his clothes because they were tight on him. She said she did not see any bed sore on his buttocks, and he did not act as though he was in pain.

On 04/18/2025, I conducted an interview with Direct Care Staff, Hannah Ratliff. We reviewed her work schedule. She worked 3rd shift on 01/24-25/2025, and 2nd shift on Monday 01/27/2025. She said she did not remember picking him up after a fall and she did not remember changing his brief. She said she did not see him in pain.

On 04/18/2025, I conducted an interview with Jazlin Bultsma, Direct Care Staff, and she stated she worked 3rd shift on 01/25-26/2025, 3rd shift 01/26-27/2025. She explained that Resident A was very tall and heavy, and he would stiffen up when they would get him up and he kept his eyes closed. She explained that she cleaned him up and he went back to his recliner chair. She stated she checked him every two hours. She stated he was unstable upon standing and when he was wet, she washed him and changed his clothes. She said she did not notice that he was in pain, and she denied seeing a bed sore on his buttocks.

On 04/18/2025, I conducted an interview with Ayda Gusman, Direct Care Staff. She confirmed that she worked 3rd shift 01/24-25/2025, and 3rd shift 01/25-26/2025 and 3rd shift 01/27-28/2025. She reported the first time she had met Resident A, he was half asleep and half awake. He was walking and pushing furniture around. She said he was very agitated and very confused, and they had no PRN medication to give to him. She stated that he stayed in the living room area sleeping on the couch. all night and refused to go to his room. In the AM he required a two person assist, was very combative, and was very stiff and he walked with a limp. She said he was soaked and they changed him and cleaned him up and dressed and he sat in his recliner in his room. She said she saw no bruising or skin tear or any signs of pain. The next third shift she worked with him she provided the same cares, of going to the bathroom and checking on him every 1 to 2 hours. She said he was up around 6:00AM and they took him to the bathroom and cleaned him up and helped him dress. She said he did not exhibit any pain or complain of anything, and she denied seeing any skin break down on his buttocks. She said on the 3rd shift on 01/27-28/2025 he still required two staff to take him to the bathroom. He went from his bed to the bathroom to his recliner. He remained stiff and refused food and drink, but she said they tried. She said she used cotton swabs to wipe out his mouth because he was so dry. Again, no signs of pain and she denied seeing any skin breakdown on his buttocks. She stated he did not have any falls.

As of the date of this investigation Resident A's Family Member 2 has not provided any documents concerning Resident A's injuries that she had spoken about with his admission to the hospital.

On 06/10/2024 I conducted a telephone exit conference with the Licensee Designee, Kimberly Wozniak. She 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 reported that Resident A was transferred to the hospital, and they found he had a bedsore, a chip on this right hip, three broken ribs, a brain bleed, a Urinary Tract Infection. There was no record of Resident A falling and no record of him being fed in the last 24 hours. Bryan Cramer, Administrator stated that Resident A' s wife was the DPOA, and she had signed all the admission papers. He reported they gave the incident/Accidents Reports related to Resident A's two falls and his head banging on the glass to his wife (DPOA). His wife was with him for all three of the incidents. He stated that Resident A was only in the facility for 96 hours I reviewed Resident A's assessment plan, and it stated that Resident A required no assistance with eating/feeing. The plan stated the staff would help him with toileting, grooming, bathing, dressing, and personal hygiene and the plan read that the staff would assist with all of these cares related to his dementia. If Resident A exhibits Self Injurious the staff will continuously monitor for any changes and report any changes to management. The incident of his head bagging into the glass was reported to management. Resident A's Transfer Summary from the hospital indicated Resident A had a Wound on 12/31/2025, Back Medal; Right. Resident A had a Wound Skin Tear on 01/14/2025, Pretibial Left and this was not present on admission. Med Lead Santana Garza worked with Resident A on 01/26/2025 and found him on the floor two times and with his head banging into the glass. She stated that on the second fall at 4:16PM she did Range of Motion on Resident A and it was within normal limits. She reported Resident A did not show any pain of any kind. She also did not see any skin breakdown on his buttocks when she changed him. She tried to get him to drink, and he refused. Med Lead Joi Miller stated Resident A was resistive to cares. She found him on the floor in his room two times but denied hearing any falls, or any yelling and when she helped him up, he exhibited no pain symptoms. She tried to get him to drink, and he refused. She said other staff tired the same and he continued to refuse. Direct care staff Lauren Scribbner, Hannah Ratliff, Ayda Guzman, Jazlin Bultsma and Med Lead Santana Garza all

	stated they knew nothing about Resident A's bed sore. They also reported they did not see him exhibit or complain of pain. Ms. Lamkin had contacted Athanase Kaporiga and he did not remember helping Resident A up from the floor, I did the same and he did not remember. Med Lead Joi Miller stated that she found a skin tear on Resident A's right buttock on 01/28/2025, which she reported to Mr. Cramer. After Resident A's two falls and head banging into the glass, Ms. Krystal Lamkin contacted Resident A's physician and explained what had occurred and to see what they would like to do about changing his medications. During this investigation I did not find any evidence that staff, including the Home Manager and the Administrator had ignored Resident A's protection, supervision, or his personal care needs written about in Resident A's assessment plan. They all spoke of caring for him, changing his brief, cleaning him up and checking on him. Ms. Joi Miller reported she found a skin tear the same day and within a few hours that he was discharged to the hospital and notified the Administrator and the nurse from Hospice. Ms. Lamkin had notified Resident A's physician after his two falls and his head banging into the glass. There was no other evidence provided to licensing from the last hospitalization of the alleged injuries. Therefore, there is not a violation of this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: ADDITIONAL FINDINGS:

INVESTIGATION: On 04/01/2025, I conducted an interview with Med Lead Joi Miller. She stated that Resident A had refused his medications. She said she had asked Santana Garza how she would get him to take his medications, and she reported that Ms. Garza told her that she crushed his medications and then he took them. Ms. Santana stated immediately they did not have a physician's order to crush his medications. I reported this finding immediately to Mr. Bryan Cramer the Administrator. He stated that he would follow-up.

On 04/18/2025, I conducted an interview with Ms. Lamkin and Mr. Cramer. They both reported that they had checked their records and there were no instructions given by Resident A's physician or his pharmacist to crush any of his prescribed

medications. They reported that Med Lead Santana Garza had taken upon herself to crush Resident A's medications. They took disciplinary action against her related to their personnel policies.

On 06/10/2025 I conducted a telephone exit conference with the Licensee Designee, Kimberly Wozniak. She agrees with my findings,

APPLICABLE RULE	
R 400.15312 (4) (e)	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	On 4/01/2025, Ms. Joi Miller reported that Resident A refused his medications. She reported that she had asked Santana Garza how she had administered Resident A's medications, and she reported that Ms. Garza told her she had crushed his medications. Ms. Miller stated they did not have crush order for Resident A's medications. Upon learning of this information, I immediately contacted Bryan Cramer, Administrator and he contacted Krystal Lamkin. Both Mr. Cramer and Ms. Lamkin reported that they did not have a crush order for his medications. They followed their disciplinary policies with Ms. Garza. During this investigation I learned that Ms. Santana Garza has crushed Resident A's medications without a physician or pharmacist's order. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

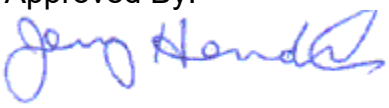
I recommend the licensee provide a written acceptable plan of correction to the rule violation and the license remain the same.

Arlene B. Smith 06/11/2025

_____

Arlene B. Smith Date
Licensing Consultant

Approved By:



06/12/2025

Jerry Hendrick Date
Area Manager