GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2025

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

RE: License #: AL410418570
Investigation #: 2025A0357035
Byron Manor #3

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, 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 #:	AL410418570
Investigation #:	2025A0357035
Complaint Receipt Date:	04/22/2025
Investigation Initiation Date:	04/22/2025
Report Due Date:	06/21/2025
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 Anne Wozniak
Name of Facility:	Byron Manor #3
Facility Address:	Suite 3 2115 84th Street SW Byron Center, MI 49315
Facility Telephone #:	(616) 878-3300
Original Issuance Date:	09/18/2024
License Status:	REGULAR
Effective Date:	03/18/2025
Expiration Date:	03/17/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Teresa Moyer (Home Supervisor) did not treat Resident A with dignity and respect.	Yes

III. METHODOLOGY

04/22/2025	Special Investigation Intake 2025A0357035
04/22/2025	Special Investigation Initiated - Telephone
05/23/2025	Contact - Telephone call made Telephone call to Bryan Cramer, Administrator.
06/18/2025	Contact - Telephone call made Resident A's son/Family Member 1. Telephone interview.
06/18/2025	Contact - Telephone call made Telephone interview with Resident A.
07/23/2025	Contact - Telephone call made To Bryan Cramer, Administrator.
08/01/2025	Inspection Completed On-site Inspection completed on site with Bryan Cramer and Krystal Lamkin, House Supervisor
08/01/2025	Contact - Document Received Received Resident A's face sheet, Health Care Appraisal, General Durable Power of Attorney papers, Level of Care, Assessment Plan and med sheets.
08/28/2025	Contact - Telephone call made Interview with Witness 1.
09/02/2025	Telephone exit conference with Licensee Designee.

ALLEGATION: Teresa Moyer (Home Supervisor) did not treat Resident A with dignity or respect.

INVESTIGATION: On 05/23/2025, I telephoned Bryan Cramer, the Administrator. He explained that Resident A had chosen to discharge from the facility and move in

with Family Member 1 (FM 1) which is in another county. He said that FM1 reported to him that he did not want to give details, but Resident A felt disrespected when her friend, who is a nurse, (RN), tried to ask Ms. Moyer questions and her answer was disrespectful. Ms. Moyer would not answer her questions, and she belittled Resident A, and was rude to her friend. Ms. Moyer said that Resident A has a DPOA (Durable Power of Attorney) and that is who she has to speak with, which was FM 1. Ms. Moyer would not answer the questions Resident A and her friend had asked her. Mr. Cramer stated that the DPOA had not been activated so Resident A could speak for herself, and she could give her consent for Ms. Moyer to speak to her friend. He also stated that Resident A is FM 1's mother.

On 06/18/2025, I telephoned FM 1. He said that Resident A was upset because she wanted to know more about her medications. He said her friend was a registered nurse and Resident A trusted her, and she has helped her health for a long time. He said that I should speak with his mother (Resident A) because she can tell me what happened. He confirmed Resident A had left the Byron Manor and now lives with him and his wife, and he provided me with her telephone number.

On 06/18/2025, I conducted a telephone interview with Resident A. Resident A said that she could not remember the date, but the med tech had brought her morning medications to her in a little cup. She said she counted the pills and was uncertain what several of the pills were called and what they were for, so she asked the med tech (whose name she could not remember) what the pills were and what they were for. She said the med tech just told her that they were her pills. She said she tried to explain that she wanted to know the names of her pills. The med tech told her that she was refusing her medications. She said she was not refusing her medications. She said the med tech took her pills away and told her they would be destroyed because she refused them. The med tech told her if she wanted to know more about her pills she should talk with Teresa Moyer, House Manager. Resident A found this to be very distressing. She said now I can't have any of my pills and I know I need my pills especially her blood pressure pills because she was recovering from a recent stroke. She went on to explain that her friend, who is an RN, came to see her that morning so she told her what had happened. After they discussed the incident, they thought they should speak with Ms. Moyer, so they went to her office. Ms. Moyer was on the phone. She reported that they waited until she finished. Then they went into her office, and she started to explain what had happened to her AM medications. She reported that Ms. Moyer started to yell at her and she said she could not talk to her without her Power of Attorney (her son/FM 1) with her. Resident A said she knew that the DPOA had not been activated, and it was not needed because she could make her own decisions. She tried to introduce her friend, and she gave permission to her friend to help her understand her medications and Ms. Moyer **c**ould talk with her. Resident A said that Ms. Moyer would not answer any of her questions. Resident A said Ms. Moyer was rude to her and she did not treat her with any dignity because she would not listen to her. Resident A told me that she would like me to interview her friend because she always takes notes and she would

be able to provide more information about what happened including dates and specifics. She provided her telephone number for me.

On 08/01/2025, I met with Mr. Cramer, Administrator, and Krystal Lamkin, House Manager for the Memory Unit at the facility, where Resident A was first admitted. Mr. Cramer explained that Resident A had suffered a stroke, and came to their facility, referred to as the Red Unit/Memory Care Unit on 01/23/2024, and she did well. She showed significant progress, so they offered for her to move to Byron Manor # 3, and she moved there on 05/03/2024. Mr. Cramer said Resident A was receiving the Medicaid Waiver Program. He also stated that Resident A had a DPOA document, but it was not activated because Resident A recovered so well. He said that he understood that Resident A was leaving their facility because of Ms. Moyer. He said Resident A did not like their food. He reported she was discharged on 05/10/2025. Mr. Cramer stated that Ms. Moyer is no longer employed with them. I asked Mr. Cramer if Ms. Moyer had called him on 04/16/2025 to clarify if the DPOA had been activated for Resident A and he said "No." Ms. Lamkin also stated that the DPOA had not been activated.

Ms. Lamkin provided me with a copy of Resident A's Health Care Appraisal, which I reviewed. Her diagnoses were listed as "History of stroke, hypertension, heart disease, cardiomyopathy, Afib, and slight weakness on right side." Ms. Lampkin also provided Resident A's Assessment Plan completed by Ms. Teresa Moyer. This plan stated that Resident A was able to make her needs known, understands verbal communication, she is aware of current surroundings, was able to read and write, aware of time of day, understands verbal instructions, no displays of aggressive behaviors, gets along well with others and is very pleasant, and she could feed herself, she had some weakness and staff would assist with needs PRN.

On 08/28/2025, I conducted a telephone interview with Resident A's friend (Witness 1). She reported that when she visited Resident A on 04/16/2025 Resident A told her she had not received her AM medications that morning at 8:00AM because she questioned the number of the pills that she was getting. Resident A told her she had been getting 5 pills but one had been discontinued so she should only have been given 4. At this AM she was given 5 meds in a cup, so she questioned it. She said the medications were handed to her in a cup by a "med nurse." She was told by the med nurse she would have to talk with Teresa Moyer, House Manager, about it but she was in a meeting so she would have to wait. Witness 1 stated they decided to wait to take her medications until after she had talked with Ms. Moyer. They were expecting that Ms. Moyer would be able to identify each pill and find out what the five pills were. Resident A was unable to see Ms. Moyer so consequently she never took her 8:00 AM meds. After breakfast she was told by the med nurse, she could not have her pills because she didn't take them on time, and they had now been thrown away. Around 10:40AM Resident A and Witness 1 asked if they could come into Ms. Moyer's office to ask about her medications. Witness 1 said Ms. Moyer immediately stated in a "punitive tone" that she could talk to Resident A, but undesirable behavior had happened before because she had refused her

medications one time. Ms. Moyer said it had been discussed with Resident A and she was aware of the policies. Ms. Moyer said she could not talk to Resident A about her medications, because Witness 1 was in the room and she could only talk to Resident A and her DPOA. Witness 1 said she was not allowed to say anything about her medications or hear what they discussed because Ms. Moyer said it was a HIPPA violation. Ms. Moyer stated that FM 1, Resident A's DPOA, would have to be in the room for any discussion to take place. Resident A reported to Ms. Moyer that her DPOA had not been activated, and she was able to make her own decisions, and she was giving Ms. Moyer her permission to let Witness 1 ask questions about her medications and that she was a nurse. Witness 1 said Ms. Moyer had a brief talk with Resident A and Witness 1 and they were able to clarify some things about her medications. Witness 1 said Resident A was just trying to find out the answers to her questions about her medications. Resident A did not want to take medications that weren't ordered or should have been stopped several days earlier. Witness 1 said that this AM in Ms. Moyer's office, Resident A asked several times for clarification of the medications that were in her med cup and each of her requests were dismissed or ignored. Resident A stated she would take them at the present time (about 11 AM) if she knew what they were but was told that they had been thrown out as she didn't take them at the 8AM time when they were offered to her. No attempt was made by Ms. Moyer to look at any med book or other official chart forms to determine what the medications were, and she made no attempt to call Resident A's physician to see if she could take them late. She simply stated that the med time was over, and Resident A had refused to take her meds, it was dully noted, and she would have to wait for tomorrow. Witness 1 stated that Resident A had said 'I want my meds,' and Ms. Moyer said, "I can't talk to you, you're mentally incompetent."

On 09/02/2025, I conducted a telephone exit conference with the Licensee Designee and she agreed with my findings.

APPLICABLE RULE	
R 400.15305	**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:	It was alleged that Teresa Moyer (Home Supervisor) did not treat Resident A with dignity or respect. FM 1 reported to Bryan Cramer, Administrator, that Resident A felt disrespected when her friend, who is a nurse, tried to ask Teresa Moyer, House Manager, questions and her answer was disrespectful. Ms. Moyer would not answer her questions and belittled Resident A, and she was rude to Resident A and her

	friend. Mr. Cramer stated that the DPOA had not been activated so Resident A could speak for herself, and she could give her consent for Ms. Moyer to speak to her friend. Resident A stated she had concerns about her pills and what they were at the 8:00 AM med pass and was told because of her questions that she had refused her medication. She spoke with Ms. Moyer who refused to talk with her without her DPOA and Resident A said the DPOA was not activated. She asked Ms. Moyer about her medications and Ms. Moyer yelled at her and never answered her concerns or recognized her friend. Resident A said Ms. Moyer was rude to her and did not treat her with dignity. Witness 1 stated that Ms. Moyer would not recognize her or provide information regarding Resident A's medications. Each time she made her requests Ms. Moyer dismissed or ignored Resident A. Ms. Moyer reportedly told Resident A she was uncooperative and that she had refused to take her medications. During this investigation I found evidence that Ms. Moyer verbally abused Resident A and refused to answer her questions about her medications. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction.

Arlene B. Smith 09/02/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 09/02/2025

Jerry Hendrick Date
Area Manager