



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2026

Katy Juarez
The Legacies ALC, LLC
8702 Orleans Ave
Fenwick, MI 48834

RE: License #: AL410393508
Investigation #: 2026A0469011
Legacies Assisted Living B1

Dear Ms. Juarez:

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. If 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 blue ink that reads "Natasha Grew". The signature is written in a cursive style with a large initial 'N' and 'G'.

Natasha Grew, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410393508
Investigation #:	2026A0469011
Complaint Receipt Date:	02/13/2026
Investigation Initiation Date:	02/13/2026
Report Due Date:	04/14/2026
Licensee Name:	The Legacies ALC, LLC
Licensee Address:	8702 Orleans Ave Fenwick, MI 48834
Licensee Telephone #:	(616) 325-4309
Administrator:	Carrie Danks
Licensee Designee:	Katy Juarez
Name of Facility:	Legacies Assisted Living B1
Facility Address:	9031 B1 N. Rogers Ct. SE Caledonia, MI 49316
Facility Telephone #:	(616) 275-4999
Original Issuance Date:	03/25/2019
License Status:	REGULAR
Effective Date:	09/25/2025
Expiration Date:	09/24/2027
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff are not entering medication orders, so residents are not getting their medications.	Yes
Nurse, Roy Juarez, is tampering with and stealing residents' medications and selling them.	No

III. METHODOLOGY

02/13/2026	Special Investigation Intake 2026A0469011
02/13/2026	Special Investigation Initiated - Telephone
02/13/2026	APS Referral Complaint is from APS
04/06/2026	Contact - Telephone call made Kent County Sheriff's Department Detective Jason Door
04/06/2026	Contact - Telephone call made APS Stephen Conrad
04/07/2026	Inspection Completed On-site
04/29/2026	Contact - Telephone call made Licensee- Katy Juarez
04/30/2026	Inspection Completed On-site
05/13/2026	Exit Conference Licensee Katy Juarez

ALLEGATION: Facility staff are not entering medication orders, so residents are not getting their medications.

INVESTIGATION: On 02/13/2026, LARA received a complaint from Adult Protective Services (APS) stating that Roy Juarez is a nurse at this facility and is responsible for ordering and managing the residents' medications. The complaint stated that medications are constantly running out because Mr. Juarez does not get orders entered. The complaint stated that Mr. Juarez is tampering with and stealing residents' morphine/narcotics and replacing them with unknown pills. It is unknown how Mr. Jaurez would achieve this since it is unknown how he would be able to reseal the bubble packs if he was taking medications out.

It should be noted that this complaint was initially assigned to Licensing Consultant Arlene Smith on 02/13/2026. However, it was reassigned to me on 04/02/2026.

On 04/06/2026, I talked with Detective Jason Door with Kent County Sheriff's Department. Detective Door confirmed he has an active investigation at this facility regarding the allegation that nurse Roy Juarez is stealing and selling resident medications.

On 04/06/2026, I interviewed Stephen Conrad from APS via telephone. Mr. Conrad confirmed he has an active investigation regarding a resident at this facility who is allegedly not getting morphine. Mr. Conrad stated the allegation was that the nurse, Roy Juarez, is taking the morphine out of the syringes and replacing it with an unknown substance. Mr. Conrad stated because there is an active law enforcement investigation, he is coordinating with the detective for interviews.

On 04/07/2026, I completed an unannounced onsite inspection. While onsite I interviewed administrator Carrie Danks, assistant administrator Grace Contreras, and direct care workers Mackenzie Brower, Chelsey Watson, and Debora Stora, all individually. I asked Ms. Danks if there were issues with residents not getting medications due to orders not getting entered. Ms. Danks stated no. I asked Ms. Danks who puts orders in for medications. Ms. Danks stated Ms. Contreras puts orders in for medications to get filled. Ms. Danks stated sometimes hospice personnel enter medication orders. Ms. Danks stated she has access to enter orders, as does Mr. Juarez and Ms. Juarez. Ms. Danks stated hospice nurses are also able to enter orders for medications. Ms. Danks stated Ms. Contreras does audits on medication carts frequently to put in orders for medications for residents when the medications are low, discontinued, or expired.

I asked Ms. Contreras if there have been incidents when residents have not received medication due to orders not being entered. Ms. Contreras stated no. Ms. Contreras stated she does most of the ordering for medications. Ms. Contreras stated she does audits on medication carts at least twice a week. Ms. Contreras stated she typically does these audits at the beginning and end of the week to ensure medications are correct and order more if medications are low. I asked Ms. Contreras if there were issues of residents "running out" of medications. Ms. Contreras stated no.

I asked Ms. Brower if there were issues with residents not getting medications due to orders not getting entered. Ms. Brower stated no. I asked Ms. Brower if she has ever gone to pass medication for a resident and it was not available. Ms. Brower stated no. Ms. Brower stated she has not had an issue with medication "running out" and has been able to pass medications as directed. Ms. Brower stated there are audits completed at least weekly on the medication carts. Ms. Brower stated these medication cart audits are to check for medications to be refilled. Ms. Brower stated these audits are completed by Ms. Contreras, Ms. Juarez, or Mr. Juarez. I asked Ms. Brower who puts orders in for medications. Ms. Brower stated Ms. Contreras typically enters the orders for medications to be filled. I asked Ms. Brower if there

were other staff who could assist with entering orders for medications. Ms. Brower stated hospice nurses, Ms. Danks, Mr. Juarez, or Ms. Juarez could also assist with putting orders in or correcting them.

I asked Ms. Watson if there were issues with residents not getting medications due to orders not getting entered. Ms. Watson stated no. I asked Ms. Watson if she has ever gone to pass medication for a resident and it was not available. Ms. Watson stated no. Ms. Watson stated she finished her medication administration training last week, so she has not passed as many medications as other staff. Ms. Watson stated Ms. Contreras does frequent medication cart audits to order medications that are running low and to dispose of medications that were discontinued.

I asked Ms. Stora if there were issues with residents not getting medications due to orders not getting entered. Ms. Stora stated yes. Ms. Stora stated it is typically on the weekends when resident medications run out. Ms. Stora stated Mr. Juarez is supposed to be the one putting orders in, but he does not always put orders in for medications to get filled. Ms. Stora stated Mr. Juarez is on-call when he is not at the facility to assist with medication issues. Ms. Stora stated there have been several times when she has attempted to contact Mr. Juarez during weekend shifts and had difficulty reaching him. Ms. Stora stated Ms. Contreras and Ms. Danks have helped with entering or correcting orders during the day, but also sometimes on weekends or after hours.

While onsite I was unable to interview the residents present due to diagnoses of dementia and Alzheimer's.

While onsite I requested the Medication Administration Records (MARs) for January 2026, February 2026, and March 2026 for all residents in this facility. These were printed for me.

On 04/24/2026 I reviewed the MARs for January 2026, February 2026, and March 2026 for Resident A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. While reviewing the MARs I observed there were several spots that noted "other" with no additional explanations.

On 04/29/2026 I contacted Licensee Katy Juarez via telephone. I requested additional information for the MARs that were provided as there were no explanations for when "other" was used. Ms. Juarez stated she could re-print the MARs when she is back in the office.

On 04/30/2026, I completed an unannounced onsite inspection for a new complaint received for this facility. Also present for this onsite inspection was Mr. Conrad from APS, Detective Door, and Licensing Consultant Gene Coulter. While onsite we interviewed nurse Roy Juarez and Ms. Contreras, individually.

We asked Mr. Juarez if he is aware of any issues with orders getting entered for

medications to be filled. Mr. Juarez stated no, this is not typically an issue. Mr. Juarez stated he used to be the primary person to do enter orders for medications. Mr. Juarez stated that due to a lawsuit between Ms. Juarez and Mr. Tetzlaff, he took a step back from some of his job responsibilities sometime in November 2025. Mr. Juarez stated the lawsuit was started last summer with allegations that he was stealing resident medications and selling them. Mr. Juarez stated Ms. Contreras has been the primary person entering orders since he took a step back with some of his job responsibilities. Mr. Juarez stated during the transition of this responsibility, there was an order for a resident for “comfort packs” from hospice that did not get entered into the system right away. Mr. Juarez explained that the order gets entered into the system for the pharmacy to get filled, and then the order gets filled. Mr. Juarez stated he gave the order to Ms. Contreras but she filed it without entering it into the system. Mr. Juarez stated the order did get put in the next day after it was discovered that the “comfort packs” were not ordered. Mr. Juarez stated the resident had been on hospice for about a year and already had “comfort packs” however they had expired which was why they had a new order for them. I asked who has access to putting orders in. Mr. Juarez stated Ms. Contreras, Ms. Juarez, Ms. Danks, hospice, and himself.

We asked Mr. Juarez if there were issues with medications “running out” and residents not getting medications because of orders not getting entered. Mr. Juarez stated “no, not typically”. Mr. Juarez stated that some residents have run out of over-the-counter medications because the family prefers to purchase these themselves and give them to the facility because it’s cheaper than the facility ordering these through the pharmacy. Mr. Juarez stated when the family is notified of the need for the medication, the family does not always bring the medication in timely and a resident may miss a dose.

We asked Ms. Contreras if there was an issue with an order not getting entered for “comfort packs” when she took over ordering medications from Mr. Juarez in November 2025. Ms. Contreras stated she did not think so. Ms. Contreras stated she did not think there were any missing orders that needed to be entered. Ms. Contreras stated when “comfort packs” were needed in November 2025, hospice had called in that order.

While onsite, I requested the MARs for January 2026, February 2026, and March 2026 to include the explanations for when “other” was documented from Mr. Juarez and Ms. Contreras. These were printed for all residents at the facility and provided to me.

On 05/05/2026 and 05/06/2026, I reviewed the MARs for Resident A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q.

Resident C’s MAR notes:

- On 01/11/2026 the 8:00pm dose for Oxybutynin 5mg is other with the explanation of “resident is out of, on call notified”.

- On 01/12/2026 the 8:00am dose for Oxybutynin 5mg is other with no explanation.
- On 02/26/2026 the 8:00pm dose for Oxycodone 5mg is other with the explanation of "waiting on pharmacy".

Resident D's MAR notes:

- On 01/07/2026 the 8:00am dose for Zituvio 25mg is other with no explanation.
- On 01/08/2026 the 8:00am dose for Zituvio 25 mg is other with the explanation "out of med".
- On 02/08/2026 the 8:00am dose for Zituvio 25mg is other with the explanation "waiting on orders from pharmacy".

Resident E's MAR notes:

- On 01/03/2026 and 01/04/2026 the 1:00pm dose for Acetaminophen 500mg is other with the explanation "resident does not have medication".
- On 01/14/2026 the 7:00am dose for Alendronate 70mg is other with no explanation.
- On 01/20/2026 the 8:00am dose for Probiotic is other with the explanation "out of medication".
- On 01/21/2026, 01/23/2026, 01/24/2026, 01/26/2026, 01/27/2026 the 8:00am dose for Probiotic was other with no explanation.
- On 01/25/2026, the 8:00am dose for Probiotic is other with the explanation "still waiting on meds".

Resident F's MAR notes:

- On 01/01/2026 the 8:00pm dose for Doxycycline Mono 100mg is other with the explanation of "out of medication".
- On 01/02/2026 the 8:00am dose for Doxycycline Mono 100mg is other with the explanation of "med is done".
- On 01/02/2026 the 8:00pm dose for Doxycycline Mono 100mg is other with the explanation of "not available".
- On 01/03/2026 the 8:00pm dose for Doxycycline Mono 100mg is other with the explanation of "med is done".
- On 01/03/2026 the 8:00am dose for Hydroxyzine 20mg is other with the explanation of "out of medication".

Resident G's MAR notes:

- On 01/27/2026 the 8:00pm dose for Eliquis 2.5mg, Senna-Docustate Tab, Buspirone 10mg, Ipratropium 0.03% nasal spray, and Cephalexin 250mg are blank.
- On 03/01/2026, 03/02/2026, 03/03/2026, and 03/04/2026 the 10:00pm dose for Diclofenac Sodium Gel is other with various explanations "out of Gel", "waiting on meds", "Resident out of medication", and "out of medication".
- On 03/05/2026 the 10:00pm dose for Diclofenac Sodium Gel is blank.
- On 03/12/2026 the 8:00am dose for Potassium CL ER 20meq is blank.
- On 03/23/2026 and 03/27/2026 the spots for the 9:00pm Would Care- Coccyx

are blank.

Resident H's MAR notes:

- On 02/05/2026 for the 8:00pm Catheter Bag change is other with an explanation "no bag present".
- On 03/05/2026 the 10:00pm Catheter Bag check is blank.
- On 03/06/2026 the 5:00am Catheter Bag check is blank.
- On 03/14/2026 the 9:00pm Catheter Bag check is blank.
- On 03/18/2026 the 5:00am Catheter Bag check is blank.

Resident I's MAR notes:

- On 03/29/2026 the 8:00pm Evencare G2 Glucose Strips for a blood sugar check is blank.
- On 03/31/2026 the 8:00am dose for Mounjaro 5mg is blank.

Resident K's MAR notes:

- On 03/05/2026 the 10:00pm time for Crush Meds is blank.
- On 03/14/2026 the 8:00pm dose for Cyclobenzaprine 5mg is blank.
- On 03/14/2026 and 03/30/2026 the 9:00pm dose for Acetaminophen 500mg are blank.

Resident M's MAR notes:

- On 02/24/2026 the 8:00am dose for Guaifenesin ER 600mg is other with the "out of medication".
- On 02/24/2026 the 8:00pm dose for Guaifenesin ER 600mg is other with the explanation "med is done".

Resident N's MAR notes:

- On 03/11/2026 the 8:00am dose for Deep Sea 0.65% Nose Spray is other with an explanation "waiting on meds".

Resident O's MAR notes:

- On 01/10/2026 the 8:00am dose for Thera M Plus is other with an explanation "waiting on meds from family".
- On 02/09/2026 the 8:00am and 8:00pm dose for Carvedilol 6.25mg is other with no explanation.
- On 02/17/2026 the 8:00pm dose for Guaifenesin ER 600mg is other with the explanation "not in stock yet".

Resident Q's MAR notes:

- On 03/09/2026 the 9:00pm dose for Magnesium Oxide 400mg, Potassium CL ER 10meq, Senna 8.6mg, Trazodone 50mg, Methocarbamol 500mg, and Montelukast 10mg are blank.
- On 03/12/2026 the 9:30pm Bedtime Check is blank.
- On 03/18/2026 and 03/25/2026 the Hourly Checks for 2:00am, 3:00am, 4:00am, and 5:00am are blank.

- On 03/30/2026 the Hourly Check for 11:00pm is blank.
- On 03/31/2026 the Hourly Checks for 12:00am, 1:00am, 2:00am, 3:00am, 4:00am, and 5:00am are blank.

On 05/13/2026, I completed an exit conference via telephone with Licensee Katy Juarez. I informed her of the findings and that a corrective action plan is due 15 days from receipt of this report. Ms. Juarez agreed to complete the corrective action plan.

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:	<p>The complaint alleged residents were not getting medications due to facility personnel not entering orders properly.</p> <p>While some staff did not have issues with medications “running out”, others did note issues with orders not getting entered for resident medications to get filled. Mr. Juarez acknowledged one order that was not entered during the transition of this role from himself to Ms. Contreras in November 2025. Ms. Contreras did not think there were any missed orders.</p> <p>In January 2026, the MAR for Resident C, D, E, F, G, and O had notes related to being out of medication. In February 2026, the MAR for Resident C, D, M, and O had notes related to being out of medication. On 02/05/2026, Resident H did not have a Catheter Bag change due to “no bag present”. On 03/11/2026, Resident N’s medication had an explanation “waiting on meds”. In March 2026, the MAR for Resident G, H, I, K, and Q, noted blank spots for medications, wound care, and other required checks.</p> <p>There are several residents not getting medications as prescribed as indicated by explanations related to the residents being out of medication or blank spots on the MAR. Therefore, this is a rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Nurse, Roy Juarez, is tampering with and stealing residents’ medications and selling them.

INVESTIGATION: During my interview with Ms. Danks on 04/07/2026, I asked her if she was aware of any concerns with staff tampering with and stealing resident medications and selling them. Ms. Danks stated yes, there was an investigation “last summer” regarding Mr. Juarez being accused of stealing resident medications and selling them. Ms. Danks stated that it was investigated then and there were no findings. Ms. Danks stated there is a lawsuit between the owners of this facility (Katy Juarez and John Tetzleff), which has caused hostility within the facility between staff and management. Ms. Danks stated that some staff were recently terminated and there could be retaliation for complaints getting called in because of this. Ms. Danks stated she has no concerns with any staff or Mr. Juarez tampering, stealing, or selling resident medications.

During my interview with Ms. Contreras on 04/07/2026, I asked her if she was aware of any concerns with staff tampering with or stealing resident medications and selling them. Ms. Contreras stated no. Ms. Contreras stated when she does audits on the medication carts, this includes narcotic counts. Ms. Contreras stated she has not observed any issues with the narcotic count being off. I asked Ms. Contreras if she has observed any packaging being tampered with during the audits for the medication carts. Ms. Contreras stated no.

During my interview with Ms. Brower on 04/07/2026, I asked Ms. Brower if she has observed any resident medication packaging opened or tamped with prior to passing the medication. Ms. Brower stated no. I asked Ms. Brower who disposes of medications. Ms. Brower stated that med techs can when there is a patient refusal. Ms. Brower stated disposing medications requires two staff, and typically Ms. Danks and Ms. Contreras assist with medication disposals. Ms. Brower stated when narcotics are to be disposed of these are not done by med techs and are done by management or hospice and another staff. Ms. Brower stated management does the disposal with two people as well, and management are Ms. Danks, Ms. Contreras, Mr. Juarez, or Ms. Juarez. I asked how medications are disposed of. Ms. Brower stated the medication is put into a “drug buster”.

During my interview with Ms. Watson on 04/07/2026, I asked her if she has observed any resident medication packaging opened prior to passing the medication. Ms. Watson stated no. I asked Ms. Watson how medications get disposed of. Ms. Watson stated medications get put into the drug buster to be disposed of. I asked Ms. Watson who disposes medications. Ms. Watson stated two staff or two people from management disposes medications. Ms. Watson stated if a patient refuses medications or a medication is discontinued; those medications are put into the drug buster.

I asked Ms. Stora if she observed any resident medication packaging opened prior to passing medication. Ms. Stora stated no. Ms. Stora expressed concern that it did not seem like some residents’ morphine was working as it should due to the resident being in significant pain after doses were given. Ms. Stora stated she had “speculation” that the morphine was not actually morphine. Ms. Stora stated a while

ago there was a discrepancy with Resident B's Eliquis medication. She stated the order was in the system as Eliquis 2.5 mg, however the medication in the medication cart was Eliquis 5 mg and 2.5 mg for Resident B. I asked Ms. Stora if she knew if the incorrect dose of Eliquis was given to Resident B. Ms. Stora stated no, but she was concerned that med techs were giving Resident B the Eliquis 5 mg instead of the Eliquis 2.5 mg. Ms. Stora stated when she discovered the issue, she notified Ms. Contreras and verified the Eliquis 2.5 mg dose was correct for Resident B.

Prior to leaving the facility on 04/07/2026, Mr. Tetzleff stopped me and stated he wanted to share concerns that he had about Mr. Juarez. Mr. Tetzleff stated he is a co-owner of the facility with Katy Juarez. Mr. Tetzleff stated there is a lawsuit between them. Mr. Tetzleff stated that Nick Stormzand came into the facility "a while ago" saying that he had purchased narcotic medication from Mr. Juarez and Mr. Juarez had "sheets of Norcos" in his truck. Mr. Tetzleff stated that law enforcement has an active investigation regarding these concerns. Mr. Tetzleff stated he shared this information with law enforcement.

During the interview with Mr. Juarez on 04/30/2026, Mr. Juarez stated that due to the lawsuit between Ms. Juarez and Mr. Tetzlaff, he took a step back from some of his job responsibilities sometime in November 2025. Mr. Juarez stated the lawsuit was started last summer with allegations that he was stealing resident medications and selling them. Mr. Juarez denied there was truth in these allegations. Mr. Juarez stated there was an investigation last summer with no findings. Mr. Juarez stated he has not had contact with Mr. Stormzand in several years and does not talk with him.

We asked Mr. Juarez what the process is for disposing of medications. Mr. Juarez stated the destruction process has changed over the last several months. Mr. Juarez stated there used to be a bin in the medication cart labeled for destruction. Mr. Juarez stated when medications needed to be disposed of, they would be put into the destruction bin and disposed of at least weekly. Mr. Juarez stated shortly after Resident B moved in, while cleaning Resident B's apartment a medication bottle of Eliquis 5 mg was found. Mr. Juarez stated Ms. Contreras put the Eliquis 5 mg into the destruction bin as it was no longer a current dose for Resident B. Mr. Juarez stated later that day staff found Resident B's medication of Eliquis 5 mg put into the medication cart. Mr. Juarez stated there was an incident report filled out for this. After this occurred, the destruction bin was removed from the medication cart and moved to a locked location where Ms. Contreras and Ms. Danks had access to it. We asked Mr. Juarez if Resident B had been given the 5 mg of Eliquis. Mr. Juarez stated he did not think so because there was also the correct dose of Eliquis 2.5 mg in the medication cart. Mr. Juarez stated due to the location of this bin and needing space, this bin was no longer used and now medications are disposed of as needed into the drug buster. Mr. Juarez stated there are always two staff required for disposing medications. Mr. Juarez stated Ms. Contreras and Ms. Danks primarily assist with disposing medications into the drug buster.

We asked Ms. Contreras if there was an issue with Resident B's Eliquis medication.

Ms. Contreras stated yes. Ms. Contreras stated she found a bottle of Eliquis 5 mg in Resident B's apartment. Ms. Contreras stated she put Resident B's Eliquis 5 mg in the destruction bin as Resident B's current order was for Eliquis 2.5 mg and that was in the medication cart. Ms. Contreras stated she was contacted about the Eliquis 5 mg being put into the medication cart. Ms. Contreras stated she took the Eliquis 5 mg out of the medication cart and back into the destruction bin. Ms. Contreras stated they would have this bin and destroy medications at the end of the week. Ms. Contreras said after this issue with the medication being taken out of the destruction bin and put into the medication cart, they moved the destruction bin. Ms. Contreras stated they have discontinued using the destruction bin completely and dispose of medications as needed with the drug buster.

While onsite, I reviewed the incident report (IR) for Resident B's Eliquis. The IR noted the date of the incident as 12/23/2025 and was completed by Ms. Contreras. The IR stated "On 12/18 (Ms. Contreras) put a bottle of 5mg Eliquis in facility destruction tote. On 12/22 (Ms. Stora) called admin to verify correct dose. Admin verified correct dose is 2.5mg." The action taken on the IR verified the 2.5 mg Eliquis was in the medication cart, and 5 mg Eliquis back in the destruction tote. Additionally, the destruction tote was removed from access to med techs.

On 05/13/2026, I completed an exit conference via telephone with Licensee Katy Juarez. I informed her there were no findings for a violation of this rule.

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	The complaint stated nurse Roy Juarez was tampering with, stealing, and selling residents' medications. Throughout interviews, staff had not observed packaging for residents' medications being tampered with. During medication cart audits, Ms. Contreras did not have issues with the narcotic count being off or observing packaging being tampered with. While there was an issue with Resident B's Eliquis 5mg being taken out of the destruction bin and put into the medication cart, it was taken out of the medication cart and an incident report

	completed. Following this incident the process for disposing medications changed. There is no evidence for a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



05/13/2026

Natasha Grew
Licensing Consultant

Date

Approved By:



05/13/2026

Jerry Hendrick
Area Manager

Date