

GRETCHEN WHITMER GOVERNOR

# STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

June 8, 2021

Mr. Ramade Margaret's Meadows, LLC 5257 Coldwater Rd. Remus, MI 49340

> RE: License #: AL370264709 Investigation #: 2021A1029008

> > Margaret's Meadows

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 feel free to 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 (231) 922-5309.

Sincerely,

gennifer Browning

Jennifer Browning, Licensing Consultant Bureau of Community and Health Systems 1919 Parkland Drive Mt. Pleasant, MI 48858-8010

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

#### I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2021A1029008
Completed Descript Deter	0.4/00/0004
Complaint Receipt Date:	04/20/2021
Investigation Initiation Date:	04/20/2021
Report Due Date:	06/19/2021
Licensee Name:	Margaret's Meadows, LLC
Licensee Address:	5257 Coldwater Rd., Remus, MI 49340
Licensee Telephone #:	(989) 561-5009
Administrator:	Satish Ramade, Designee
Licensee Designee:	Satish Ramade, Designee
Name of Facility:	Margaret's Meadows
Facility Address:	5257 Coldwater Road, Remus, MI 49340
Facility Telephone #:	(989) 561-5009
Original Issuance Date:	10/11/2004
License Status:	REGULAR
Effective Date:	10/23/2019
Expiration Date:	10/22/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

## II. ALLEGATION(S)

# Violation Established?

There are not enough direct care staff members to care for the	No
residents' needs.	
Additional Findings	Yes

## III. METHODOLOGY

04/20/2021	Special Investigation Intake 2021A1029008	
04/20/2021	Special Investigation Initiated – Telephone call to Relative R1	
04/20/2021	Contact - Telephone call made to AFC licensing consultant, Leslie Herrguth	
04/29/2021	Contact - Face to Face with Ashlynn Isanhart, Nicole Turner, Haley Ervin at Margaret's Meadows.	
04/29/2021	Inspection Completed On-site	
05/04/2021	Contact - Document Sent - Email sent to Ashlynn requesting the schedules for January - March 2021.	
05/10/2021	Contact - Telephone call made to Ashlynn Isanhart	
05/10/2021	Contact - Telephone call made to direct care staff member, Shyann Daniels	
05/10/2021	Contact - Telephone call made to Onnalee Recker, direct care staff member	
05/24/2021	Contact - Telephone call made to Sierra Caron, direct care staff member	
05/24/2021	Contact - Telephone call made to Fay Haney, direct care staff member.	
05/24/2021	Contact - Telephone call made to Ashlynn Isanhart. Left message for her.	
05/24/2021	Contact - Telephone call made to Ashlynn Isanhart	

05/25/2021	Contact - Document Received - Email from Ashlynn with schedules.
05/28/2021	Exit Conference conducted with Satish Ramade.
06/02/2021	Contact – Telephone call to Resident I and Resident K.
06/07/2021	Contact – Telephone call to Relative R1

#### **ALLEGATION:**

There are not enough direct care staff members to care for the residents' needs.

#### **INVESTIGATION:**

On April 20, 2021, a complaint was received via centralized intake alleging that the staffing level was not adequate for the high level of care needed for the residents at Margaret's Meadows. Complainant stated the residents all have high care needs and the staffing level is not adequate with two direct care staff members working on each shift. Complainant stated given most of the residents who reside at the facility have extensive personal care needs and have mobility constraints, two direct care staff members cannot adequately care for the residents.

On April 20, 2021, I interviewed Relative R1 who stated there was concerned with the staffing levels at the home. He was informed by one of the staff members, whose name he could not recall, that Margaret's Meadows staff were only required to have one direct care staff member on for every twelve residents and they have eighteen residents all with high personal care needs.

On April 29, 2021, I conducted an unannounced on-site investigation and interviewed Ashlynn Isanhart, home manager at Margaret's Meadows. The physical layout of the facility is set up with a kitchen, dining and living room areas in the middle of the facility as one walk in the front door, with three long hallways coming off each side of the dining room.

Ms. Isanhart has been employed there for six years and has been a home manager since August 2020. She stated at that time there were seventeen residents living at the facility since Resident R passed away on April 11, 2021. All residents in the home currently have some level of cognitive impairment due to memory loss. Ms. Isanhart stated that there were struggles with staffing and they only had two people working during day shift on some days.

When preparing the schedule, she always pairs an experienced direct care staff member with a more inexperienced direct care staff member. She never puts two newer staff on together. The staffing levels for that day were two people on first shift and three people on second shift.

I was able to review the direct care staff member schedule for January 2021 to May 2021.

- January and February 2021: First and second shift had four direct care staff members scheduled during the day and three direct care staff members on the weekends. Third shift had two or three direct care staff members scheduled.
- March 2021: Two workers on first shift for 19 days. Many of the days, there were
  three or four workers scheduled and then they are crossed off due to call ins.
  Even with these changes, there was always at least two direct care staff
  members scheduled. The second and third shift schedule always has at least
  two or three direct care staff members scheduled.
- April and May 2021: First shift always had between two and three direct care staff members on at a time. Second shift typically had three people assigned each day, and third had two staff members. Occasionally there was an extra person with a notation that they were training that day.

Ms. Isanhart stated she was also working during first and part of second shift in the office, but she was able to assist on the floor if needed. They currently have fourteen employees that rotate on the schedule. There are currently eight residents in the non-secured section and nine in the secured section of the facility.

During this meeting, I was able to review the resident records for each resident and discuss each of their personal care needs with Ms. Isanhart. According to the Resident *Health Care Appraisals* (BCAL-3947) and *Assessment Plan for AFC Residents* (BCAL-3265), and additional information received during the interview with staff members, the current residents had the following care needs.

- Residents who are fully ambulatory without an assistive device: Two
- Residents who are fully able to ambulate independently with an assistive device such as a walker or cane: Fourteen
- Residents who needed someone to assist them at their side while using their assistive device: Two
- Residents who are wheelchair users: Five
- Residents who need assistance with grooming and dressing: Fifteen
- Resident who needs assistance with eating: Three
- · Residents who are a two person assist: Four
- Residents who require the use a hover lift: Two
- Residents who have a catheter: Two
- Residents who need assistance with a shower: Sixteen

On April 29, 2021, I interviewed direct care staff member, Nicole Turner. She has been employed at Margaret's Meadows since 2015. She stated they have struggled finding enough staff to work there but they just hired five new staff so that should help. Typically, she works with Haley Ervin on the weekends. There has never been a time that they had only one direct care staff member working. There is typically two people working at a time but ideally, they should have three direct care staff members on first and second shift.

On April 29, 2021, I interviewed direct care staff member, Haley Ervin. She started working there January 25, 2021 on first shift. She stated there was recently several new direct care staff members hired which will help with the staffing levels since most days there are two direct care staff members working during her shift. Ms. Ervin stated it was hard to assist the residents that needed one-on-one personal care when there is only two direct care staff member working. The staffing used to be better but became worse in mid-February. She was unable to give any examples of residents that have gone without personal care but stated some of the other tasks such as cleaning were harder to get done.

Ms. Ervin stated part of her position is to assists with the fire drills and keeping record of them. She was able to produce the more recent fire drills for Margaret's Meadows. I reviewed the Fire Drill Records from September 2019-March 2021. On the fire drill log, there were nineteen fire drills at various times of the day. The two longest evacuation time was 8 minutes and 37 seconds at 5:00 a.m. on February 28, 2021 and 9 minutes and 20 seconds on September 15, 2020 at 4:10 a.m. The other times all ranged between 3 minutes and 8 minutes.

On May 10, 2021, I interviewed direct care staff member, Shyann Daniels. She stated she believed there was enough staff to provide care to the residents, but they were very busy. She said that when she arrives to work, there are three to four direct care staff members working. She did not have any examples of the residents not receiving necessary personal care due to the staffing levels.

On May 10, 2021, I interviewed second shift home supervisor, Onnalee Recker. She stated they went through a "rough spot with staffing" between January - March 2021 where all employees had to work several hours of overtime to ensure that staffing levels were met. During this time, it was common to only have two direct care staff members per shift. She typically has three direct care staff members on second shift with her now. They have several high needs residents and some of them have declining health currently. Even with the staffing shortage, she felt the residents' needs are being met but small tasks such as sweeping the floor may end up left for the next shift but resident's personal care needs are being met.

On May 24,2021, I interviewed direct care staff member, Sierra Caron. She has not worked at Margaret's Meadows since February because she was in quarantine due of COVID and then gave birth to her daughter. She typically worked third shift and has

been employed at Margaret's Meadows since June 2020. She had two - three direct care staff members on the schedule for third shift. Some days there was five direct care staff members working at a time on first and second shift. Some of them worked for several weeks without a day off and she wishes that the other direct care staff members were more reliable and came to work without calling in sick. She was asked if residents are going without care due to the staffing levels and she stated that some residents did not get their dentures cleaned out or their nails cut.

On May 24, 2021, I interviewed direct care staff member, Fay Haney. She has been employed there for three years and works first shift as a supervisor. Ms. Haney has also recently been covering third shift. She stated there used to be four direct care staff members all the time on first shift and she is hoping with the new hires, they will be back at that number. In the past they used to have a medication passer, kitchen staff, and two direct care staff members working to provide personal care to residents. She feels that Ms. Isanhart and the licensee designee, Mr. Ramade are doing their best to get adequate staffing by interviewing and hiring new direct care staff members.

Ms. Haney stated that staffing issues have been a concern since before the COVID-19 pandemic, but it was more noticeable once the pandemic started. One of the concerns is that the new direct care staff members do not stay very long so they will finish their training requirements and then leave shortly after.

When asked if residents were going without personal care due to the staffing levels, Ms. Haney stated sometimes they are not getting all their showers on their schedule and the residents' bedrooms are not getting always cleaned on second shift. She has been there for a fire drill lately and knows these are being completed on a regular basis. During the most recent fire drill, there was three people working.

On May 24, 2021, I interviewed home manager, Ashlynn Isanhart. Ms. Isanhart stated the staffing levels were improving because there were three direct care staff members working on first and second shift most days. On third shift, they seem to do well with two direct care staff members. She said there are two direct care staff members for each shift and a third that is responsible for the meals and medications. She does have interviews scheduled to hire additional direct care staff members this week.

On June 2, 2021, I interviewed Resident I who has lived there since October 2020. He stated that he enjoys living at Margaret's Meadows and feels that everyone is "very nice" there. He is not supposed to get up and move around without assistance. He has multiple sclerosis which is progressing. He does not walk without the assistance of wheelchair or walker. He feels the staff that are there are responsive to his needs. They help him get out of bed, get to the toilet, and take care of his care personal care needs. He does have a call button that he can use if he needs help. Sometimes he may have to wait for assistance because there is a lot of residents there, but he never has to wait long. He can rest well there and likes that he can watch the squirrels from his window.

On June 2, 2021, I interviewed Resident K who has lived there for two months. She stated she uses a walker most of the time. She can move independently with the walker. She primarily needs assistance with bathing and dressing. She feels the care provided there is "pretty good." If she has any questions or needs anything, they will assist and help her. She was not sure if there is a call button but she is checked on often so she has never needed to use one. She feels that there is enough staff working that everyone can get the care need.

APPLICABLE RULE		
R 400.15206	Staffing requirements.	
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.	
ANALYSIS:	Based on a review of direct care staff schedules from January 2021 through May 2021 along with a review of each resident's Assessment Plan for AFC Residents, I found there to be sufficient staff scheduled to work to meet the needs of residents currently residing in the facility. There has been at least two direct care staff members working per shift which is adequate to meet the needs of residents along with being within the required ratio of residents to direct care staff members.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

#### **INVESTIGATION:**

On April 20, 2021, Relative R1 indicated that there was over \$300 that was given to Resident R for her weekly hair appointments. Relative R1 was concerned where the money was after Resident R passed away on April 11, 2021. He has not had contact with Margaret's Meadows indicating that the money was found or would be returned. Resident R1 stated the money was initially given to Resident R to get her hair done weekly. There were also hearing aids that were not returned when she passed away. Relative R1 inquired if another resident was wearing her hearing aids since they were not returned to him.

On April 29, 2021, I reviewed the resident record for Resident R at Margaret's Meadows. There was a Resident Funds Part II (*BCAL-2319*) form documenting her rent payments of \$1900 per month for the months of July 2020-November 2020. There was not a BCAL-2319 form documenting the \$300 spending money that was given for her weekly hair appointments.

Ms. Isanhart stated that she was unaware of funds remaining for Resident R and that the "wallet with just under \$200" was returned to the family after she passed away. She could not find the hearing aids at that time the family picked up her belongings, however, staff later found them, and they were in her office. Ms. Isanhart stated she would a plan to return them to Resident R's family.

On April 29, 2021, I interviewed direct care staff member, Nicole Turner. She has been employed at Margaret's Meadows since 2015. She stated the residents there should not have money kept on them due to their memory loss. She knows that Resident R was given \$300 for her haircuts when she first moved into Margaret's Meadows. She knows that she was able to get her hair done weekly on Tuesdays for about 1.5 years but did not know how much it cost for her hair appointments. She knows the money was kept in the office for her but does not know if the money was locked or if there was any documentation for it.

On April 29, 2021, I interviewed direct care staff member, Haley Ervin. She was not aware that Resident R had any money and did not know where it was kept.

On May 10, 2021, I interviewed second shift home supervisor, Onnalee Recker. She stated she has never observed Resident R with any funds. The procedure if any money is given to a resident would be to give it to Ms. Isanhart. Since most residents have some level of memory loss, she did not feel they should be responsible for safeguarding their funds. Ms. Recker stated the safest place would likely be in the locked safe where the extra narcotics are because it was not open to everyone and is in a locked room.

On May 24,2021, I interviewed direct care staff member, Sierra Caron. When asked about Resident R's funds, she was not aware of any money or valuables that was locked up. Typically, they do not have money that they hold on to. She thinks there is usually a payee or guardian that holds the money for the residents. She was unaware of any money given to Resident R for hair appointments.

On May 24, 2021, I interviewed home manager, Ashlynn Isanhart again. Ms. Isanhart stated that she found the remainder of Resident R's \$300 in a drawer where her wallet was found. She does not know why the money was not given to the family when the wallet was returned when the family picked up her belongings. In the future, she is going to make sure the families or guardians hold the funds in the future for the residents. If there is a situation where the home manager has the funds, it will be documented on a Resident Funds Part II form and locked securely in the desk. In the future, Ms. Isanhart stated she will have the families or guardians hold the funds for the residents. Ms. Isanhart had not called the Resident R's family notifying them she will return the money. She also still has Resident R's hearing aids that were left at the facility after she passed away on April 11, 2021. Ms. Isanhart stated she will mail the money order with \$167 and the hearing aids to the family.

On June 7, 2021, I contacted Relative R1 and left a voicemail to confirm if the funds and hearing aids were returned.

APPLICABLE RULE		
R 400.15315	Handling of resident funds and valuables.	
	(15) Personal property and belongings that are left at the home after the death of a resident shall be inventoried and stored by the licensee. A licensee shall notify the resident's designated representative, by registered mail, of the existence of the property and belongings and request disposition. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the designated representative.	
ANALYSIS:	Resident R passed away on April 11, 2021 and she had a wallet with \$167 and hearing aids at the facility. When the family came to pick up her property and belongings, they could not find the hearing aids. Almost a month after the wallet was given to the family, \$167 was found in the desk where the wallet was. This is believed to be the balance of the \$300 however there is no documentation on Resident R's Resident Funds Part II form to document this money. More than 30 days had passed at that point and the licensee did not notify the designated representative by registered mail the existence of the property and request disposition.	
CONCLUSION:	VIOLATION ESTABLISHED	

#### **INVESTIGATION:**

On April 20, 2021, Relative R1 indicated that there was over \$300 that was given to Resident R to get her hair done.

On April 29, 2021, I reviewed the resident record for Resident R. There was a Resident Funds Part II (*BCAL-2319*) form documenting her rent payments of \$1900 per month for the months of July 2020-November 2020. During this on-site inspection, there was no Resident Funds Part II form (*BCAL-2319*) documenting her \$300 that was given for her hair appointments. Ms. Isanhart stated that there was "just under \$200" in a wallet and that was locked up. However, she did not know the exact amount since there was no documentation of the funds.

On May 24, 2021, I interviewed home manager, Ashlynn Isanhart again. Ms. Isanhart stated that she found \$167 in the drawer which she believes is the remainder of the \$300 given to Resident R for her hair appointments. She does not know why the money was not given to the family when the wallet was returned previously. It is unclear why the money was not given in the wallet to the family or if this is the correct balance since there is no documentation of the funds. In the future, she is going to make sure the families or guardians hold the residents' funds. Ms. Isanhart said future monies given to her from families will be locked securely in the desk and documented on a Resident Funds Part II form.

APPLICABLE RULE		
R 400.15315	Handling of resident funds and valuables.	
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.	
ANALYSIS:	On April 29, 2021, I reviewed the resident record for Resident R. There was a Resident Funds Part II (BCAL-2319) form documenting her rent payments of \$1900 per month for the months of July 2020-November 2020. There was not a Resident Funds Part II form documenting her money that was given for hair appointments. Therefore, there is no documentation that the \$167 found in the drawer is the remainder from the \$300 that Resident R had for her hair appointments.	
CONCLUSION:	VIOLATION ESTABLISHED	

### IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Genrifer Browning		6/8/21
Jennifer Browning Licensing Consultant		Date
Approved By:		
Suure Omm	06/09/2021	
Dawn N. Timm Area Manager		Date