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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 14, 2022

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

RE: License #: AL370264709
Investigation #: 2022A1029023
Margaret's Meadows

Dear Mr. Ramade:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2022A1029023
Complaint Receipt Date:	01/18/2022
Investigation Initiation Date:	01/18/2022
Report Due Date:	03/19/2022
Licensee Name:	Margaret's Meadows, LLC
Licensee Address:	5257 Coldwater Rd., Remus, MI 49340
Licensee Telephone #:	(989) 561-5009
Administrator:	Satish Ramade
Licensee Designee:	Satish Ramade
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:	10/23/2021
Expiration Date:	10/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Resident C had unexplained bruising and was left sitting in soiled clothing.	No
Resident C was not fed regularly at Margaret's Meadows leading to a 40 pound weight loss.	No
The couch cushions are stained and the facility smells like urine.	No

II. METHODOLOGY

01/18/2022	Special Investigation Intake 2022A1029023
01/18/2022	Special Investigation Initiated – Telephone with complainant
01/18/2022	Contact - Document Sent - Emailed Skyler Fike Careline Physicians group
01/19/2022	Contact - Telephone call made to Careline Physicians Group Lindy Hilding
01/21/2022	Contact - Telephone call made to NP Hilding Careline
01/21/2022	Contact - Face to Face with Staff 1, 2, Resident A, G, and J
01/21/2022	Contact - Telephone call made to new facility where Resident C moved to. Left a message.
02/04/2022	Contact - Telephone call made to Staff 3 and 4
02/04/2022	Contact - Telephone call made to Brittany Riskovich at the new facility where Resident C resides, Left a message for her.
02/08/2022	Contact - Telephone call made to McKenzie McCann
02/08/2022	Contact - Telephone call received to Careline Administrator Patti Rohn; message left
02/14/2022	Contact - Telephone call made to Careline Patti Rohn
02/14/2022	Contact - Telephone call made to Staff 8 wireless customer unavailable, Staff 12, wrong number, Staff 7 (mailbox full), Staff 6 (left a message), call from Staff 5, Staff 8

02/14/2022	Contact - Telephone call made to Satish Ramade licensee designee
02/23/2022	Contact - Face to Face completed by Licensing consultant, Rodney Gill and Area Manager, Dawn Timm at Margaret's Meadows
03/08/2022	Contact - Document Sent - Email to Satish Ramade
03/08/2022	Contact - Document Received - Document from Satish Ramade
03/10/2022	Exit conference with licensee designee, Satish Ramade
03/14/2022	Contact – Called Centralized Intake to make APS referral.

ALLEGATION:

Resident C had unexplained bruising and was left sitting in soiled clothing.

INVESTIGATION:

On January 18, 2022 a complaint was received from BCHS online complaint system alleging that Resident C had unexplained bruising on her and was left sitting in soiled clothing at Margaret's Meadows. Resident C moved from Margaret's Meadows to another facility in December 2021. Attempts were made on January 21, 2022 and on February 4, 2022, to contact the new facility to further discuss any bruising and Resident C's condition at the time Resident C moved into the new facility.

On January 18, 2022, I received pictures from Relative C1 of a bruise on Resident C's chest area. There was no explanation from Relative C1 how Resident C received these bruises. There was also no date stamp on the pictures to determine when the picture was taken or where Resident C was located at the time the picture was taken.

On February 4, 2022, I interviewed Staff 3 and Staff 4. Neither of them knew of any instances that Resident C was not provided timely personal care and was left sitting in soiled briefs. Neither staff reported noticing bruising on Resident C before she moved to her new facility. Staff 3 stated she never observed any bruising on her. Staff 3 stated Resident C did not fall often because Resident C transferred from her bed to the wheelchair and then back to her bed. Staff 3 stated Resident C also used a shower chair for showers. Staff 3 clarified Resident C only used her wheelchair to ambulate before she moved from the facility. Staff 3 did notice Resident C's nails were dirty because she ate with her hands and got upset when direct care staff members tried to cut her nails or clean them.

On February 14, 2022, I interviewed Patty Rohn, administrator from Saginaw Careline Hospice. She said that due to staffing concerns, there were times that Virginia, the aide from Hospice, arrived to find a resident in a wet or soiled brief but she did not know how long the resident's brief had been in that condition. Ms. Rohn stated hospice has increased their visits to three times per week so many residents are showered by hospice aides. Closer to the end of life, Ms. Rohn stated Hospice Services are out to see the resident every day. Ms. Rohn stated she was not notified of any bruising on Resident C's body when she resided at Margaret's Meadows but stated there could have been falls. Ms. Rohn stated Resident C is at a new facility now and her condition has not improved and she does not believe that moving from Margaret's Meadows caused great improvement in her condition.

On February 14, 2022, I interviewed licensee designee, Satish Ramade who stated there is a task list now for each shift that will show what items are being done and not being done. Mr. Ramade stated he is working with direct care staff members to fix the issue at the time rather than telling him after the fact. He thinks there are direct care staff members that are quick to blame other staff when something is not getting done. He is not sure that he will get rid of "drama between staff" but wants to minimize it and ensure it's not affecting personal care to the residents.

On February 14, 2022, I interviewed direct care staff member, Staff 8. She was not familiar with Resident C but stated they now have a document in each resident bedroom to complete to document resident personal care with their initials and the time. Staff 8 stated that resident care is the top priority for the residents. She has gone into work and there are dirty sheets however she does not know how long the sheets were like this and she promptly changed them.

On February 23, 2022, licensing consultant, Rodney Gill and area manager, Dawn Timm made an unannounced onsite investigation at Margaret's Meadows. All residents' needs appeared to be met and he did not observe anyone to be in soiled briefs or have visible bruising. Mr. Ramade informed Mr. Gill that he implemented a checklist system for resident care needs and it is placed in each resident room to document the personal care that is provided.

Mr. Ramade sent Resident C's resident record for review. According to her *Assessment Plan for AFC Residents*, Resident C required assistance from one direct care staff member for toileting, grooming, and dressing. There was also documentation that she required the use of a walker and needs assistance due to being a fall risk and having physical limitations. Her *Health Care Appraisal,* completed by Nurse Practitioner Hilding on November 4, 2021, indicated that she has a gait abnormality and weakness and uses a wheelchair for an assistance device.

Mr. Ramade also has a form called the *Margaret's Meadows Fall Assessment Form* which was filled out when a resident has a fall. According to these documents, all of the falls included documentation that a relative / guardian was contacted after the incident. This was included in the resident record for Resident C for falls on the following dates:

- July 9, 2021 – Resident C fell in her bedroom and was assisted during the fall. She fell onto her bed and staff caught her before completely falling because she tripped over the wheel on her wheelchair.

- August 4, 2021 – Fall was not observed. Fall resulted in a physical injury of bruising. She fell in her bedroom. Staff heard the alarm and went to check on her and she was found on the floor.

- August 7, 2021 – Fell in her bedroom unassisted and did not appear to have an injury.

- September 6, 2021 – Fell in her bedroom while being assisted by direct care staff member on the way to the bathroom. No injuries.

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:	There is no indication that Resident C's personal care needs were not attended to at Margaret's Meadows. According to her *Assessment Plan for AFC Residents*, Resident C requires assistance from direct care staff members for toileting, grooming, and dressing. There is also documentation that she requires the use of a walker as an assistive device and she needs assistance due to being a fall risk and having physical limitations. Resident C had some falls at Margaret's Meadows which could be a plausible explanation for the bruising. There was no indication any direct care staff member injured Resident C or did not attend to her personal care needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C was not fed regularly at Margaret's Meadows leading to a 40 pound weight loss.

INVESTIGATION:

On January 18, 2022 a complaint was received from BCHS online complaint system alleging that Resident C was not being fed regularly at Margaret's Meadows leading to a forty pound weight loss.

Resident C moved out of Margaret's Meadows in December 2021, so I was unable to interview her. During the onsite investigation, I reviewed the menus at Margaret's Meadows and was able to ensure there were three regularly scheduled meals. I interviewed Resident G and Resident J who did not report any concerns of the meals not being adequate at Margaret's Meadows. Both residents stated they received enough to eat on a regular basis.

I reviewed the *Resident Weight Record* for Resident C for 2021. On January 26, 2021, Resident C weighed 116 pounds and on December 4, 2021, she weighed 109 pounds. Her weight at admission was 117.5 pounds so she did not have a weight loss of almost forty pounds while residing at Margaret's Meadows. Resident C had a weight loss of 8.5 pounds.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my review of the menus, interviews with Resident G and Resident J, and Resident C's *Weight Record*, there is no indication that she was not being fed regularly at Margaret's Meadows. She did not have a weight loss of forty pounds while she was living at Margaret's Meadows.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The couch cushions are stained and the facility smells like urine.

INVESTIGATION:

On January 19, 2022, additional concerns were received via the BCHS online complaints system regarding the smell in the facility and that there was a smell of urine and feces in the facility. There were concerns that the couch cushions were stained from not being cleaned properly.

On January 21, 2022, I spoke with Nurse Practitioner Lindy Hilding who is the current nurse practitioner through Careline Hospice for several residents at Margaret's Meadows. She stated that two weeks before at the beginning of January 2022, she was at the facility interviewing a resident who was sitting on the couch. She had her get up and complete the interview in her resident bedroom because there was feces on the couch cushions.

On January 21, 2022, I interviewed Staff 2 at Margaret's Meadows. Staff 2 stated she worked third shift recently and went through and washed all the covers and steam cleaned all the furniture because the cushions needed to be cleaned. Staff 2 stated she placed the covers on the couches and chairs on January 19, 2022 and has decided the chuck pads will now stay on the couches and chairs to assist them in staying clean.

During the unannounced onsite inspection on January 21, 2022, I did not observe any stains, feces, or odors on the couches. There were blue chuck pads that were lifted off the couches and chairs to inspect for stains. None of the couches or chairs had stains on them during the onsite inspection. The facility was free from any odors of feces or urine. There was one spot on the carpet in Resident A's bedroom because she had recently been sick and vomited on the carpet. During the time of the onsite inspection, Resident A was transported to the hospital and the direct care staff members stated they would go in and clean the area on the carpet. Before that, Resident A was adamant she did not want anyone in her bedroom area. I attempted to interview her and she promptly requested that I leave her bedroom.

On January 21, 2022, I also interviewed Resident G and Resident J who both stated the facility appears to be "pretty clean" and they did not notice any feces on the couches.

On February 4, 2022, I interviewed direct care staff member Staff 3 who stated she has never noticed that there was feces on the couch cushions or the floor. She stated the facility was recently deep cleaned and the cushions were steam cleaned. Staff 3 stated this process will be repeated soon. Staff 3 stated the resident bedrooms are cleaned each day. Staff 3 stated if the resident bedrooms need to be vacuumed or swept, they will be done on day shift along with all resident toilets being cleaned during the day. The community bathrooms, used by staff, residents, and visitors, located in the back hall are cleaned on a regular basis.

On February 14, 2022, I interviewed Patty Rohn, administrator from Saginaw Careline Hospice who has been to the facility and did not notice any feces or stains on the couch or odors in the facility. Ms. Rohn stated that the facility appeared to be lived in but she never had concerns regarding cleanliness or odors.

On February 23, 2022, licensing consultant, Rodney Gill and area manager, Dawn Timm made an unannounced onsite investigation at Margaret's Meadows. Mr. Gill stated that the facility was clean and maintained well, there were no stains on the couch cushions, and the bathrooms were also clean.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During my onsite inspection on January 21, 2022, all the couches and chairs were observed to be clean and free from any stains and odors. All couches were steam cleaned by Staff 2 during third shift and covered with blue chucks pads. There was no odor present at Margaret's Meadows during the onsite inspection on January 21, 2022 or when Mr. Gill was at the facility on February 23, 2022.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

I recommend no change in the license status.

Jennifer Browning 3/10/2022_____
Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 03/14/2022
_____
Dawn N. Timm Date
Area Manager