GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 27, 2023

Steven Gerdeman
3109 Lawton Drive NE
Grand Rapids, MI 49525

RE: License #: AL410007158
Investigation #: 2024A0350003
Ramsdell AFC

Dear Steven Gerdeman:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410007158
Investigation #:	2024A0350003
Complaint Receipt Date:	10/17/2023
Investigation Initiation Date:	10/17/2023
Report Due Date:	11/16/2023
Licensee Name:	Ramsdell Extended Care
Licensee Address:	3109 Lawton Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	(419) 494-4008
Administrator:	Steven Gerdeman
Licensee Designee:	Steven Gerdeman
Name of Facility:	Ramsdell AFC
Facility Address:	12471 Ramsdell Drive NE Rockford, MI 49341
Facility Telephone #:	(616) 696-4885
Original Issuance Date:	12/02/1991
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
It is unclear whether staff acted in a timely manner during Resident A's health emergency on 10/14/2023.	No
Additional Finding	Yes

III. METHODOLOGY

10/17/2023	Special Investigation Intake 2024A0350003
10/17/2023	Special Investigation Initiated - Telephone I spoke with Misti Graham, Home Manager, and Samuel Whitehead, DCW
10/17/2023	Contact - Telephone call made I spoke with Steve Robinson, DCW
10/17/2023	Contact - Document Received I received an email from Ms. Graham with the documents I requested attached
10/18/2023	Contact - Document Sent I sent Ms. Graham an email requesting further information
10/18/2023	Contact - Document Received I received an email from Ms. Graham
10/19/2023	Contact - Document Sent I sent Ms. Graham an email requesting further information
10/19/2023	Contact – Telephone call made I spoke with Samuel Whitehead
10/26/2023	Exit conference – Held with Steven Gerdeman, Licensee Designee

ALLEGATION: It is unclear whether staff acted in a timely manner during Resident A's health emergency on 10/14/2023.

INVESTIGATION: On 10/17/2023, I called and spoke with Misti Graham, Home Manager. I informed Ms. Graham that I was calling to gather information regarding what happened the morning of 10/14 when Resident A was experiencing a health emergency. I asked Ms. Graham which staff member responded first to this emergency, and she said it was Samuel Whitehead, Direct Care Worker (DCW). Ms. Graham stated that Resident A came to Mr. Whitehead's door, and after Mr. Whitehead opened it, Resident A fell and Mr. Whitehead called 9-1-1. Ms. Graham reported that the Courtland Township Fire Chief, Steve Mojzuk arrived, but told Resident A he was "faking", and called off the ambulance. Ms. Graham told me that Resident A did not have a history of falling or of having heart attacks.

Ms. Graham said that after they arrived, one of the Emergency Medical Team members said that it appeared Resident A had an "organ rupture" which prevented his heart from pumping blood. Ms. Graham informed me that neither Fire Chief Mojzuk nor the EMT team left a report about this incident. I requested that Ms. Graham send me verification of Mr. Whitehead's Cardio-Pulmonary Resuscitation (CPR) and First Aid training, Resident A's Health Care Appraisal, and the phone number of Steve Robinson, DCW, who assisted Mr. Whitehead in this emergency. Ms. Graham told me that Mr. Whitehead was currently at the home and asked if I wanted to speak with him. I told her I did, and she gave the phone to him.

On 10/17/2023, I spoke with Samuel Whitehead, DCW. I asked him to describe what happened with Resident A the morning of 10/14/2023. Mr. Whitehead stated that at around 7:00 a.m., Resident A knocked on the door to his living quarters. When he opened the door, he saw Resident A fall to the floor. Mr. Whitehead said he went to pick Resident A up but Resident A informed him that he wanted to lay there for a few minutes, which he did for "about five to ten minutes." Mr. Whitehead stated that at that point, Resident A "seemed fine," and was talking normally. After Mr. Whitehead checked on Resident A to make sure he was alright, he called 9-1-1, and Fire Chief Mojzuk came to the home and checked Resident A's Blood Pressure. Mr. Whitehead reported that at this point Resident A "seemed out of breath," and he asked Mr. Robinson, who had just arrived for work, to get Resident A's inhaler. Mr. Robinson got the inhaler, they assisted Resident A in using it, and after "one to two minutes" his breathing became "normal." Mr. Whitehead stated that Fire Chief Mojzuk told Resident A he was faking and called the ambulance service, telling them not to come to the home. Mr. Whitehead reported that Fire Chief Mojzuk and Mr. Robinson got into an argument in which Mr. Robinson told Fire Chief Mojzuk to leave, but he didn't. Mr. Whitehead told me he called 9-1-1 again, and the EMT arrived. By this time, Resident A had vomited blood and stopped breathing. The EMTs performed CPR on Resident A for 30 minutes to an hour but were unable to resuscitate him. Mr. Whitehead informed me that there was no special protocol as far as checking on Resident A. He said that Resident A had had surgery on his head before moving into Ramsdell. He told me that Resident A had dementia and had been experiencing pain in his knees and lower back, but that was it. He added that Resident A was last in the hospital a week ago for having "gas build-up" but had been home for the past week without any signs of physical distress.

On 10/17/2023, I spoke briefly with Ms. Graham again on the phone. She reported that Fire Chief Steve Mojzuk, had refused to provide assistance to some of the residents at Ramsdell before.

On 10/17/2023, I called and spoke with Steve Robinson, DCW, who told me when he arrived for work on 10/14 at about 8:00 a.m., he saw that Resident A was lying on the floor, but he was talking just fine. He said that Mr. Whitehead told him he called 9-1-1. Mr. Robinson stated that Fire Chief Mojzuk arrived and "was very rude to (Resident A)," telling him he was lying about having a medical emergency. Mr. Robinson said while Fire Chief Mojzuk was still at the home, Resident A "aspirated blood" and 9-1-1 was called again. He reported that the EMTs arrived in less than five minutes. Mr. Robinson told me that Fire Chief Mojzuk used suction on Resident A, and then the EMTs performed CPR on Resident A for 45 minutes to an hour, but he did not respond and passed away. Mr. Robinson stated that Fire Chief Mojzuk has refused to provide medical assistance to residents of Ramsdell before and told one resident he was going to "blacklist" him, meaning if they received a call regarding this resident, he would refuse to come out.

On 10/17/2023, I received an email from Ms. Graham with the documents I requested attached. One was a certificate showing that Mr. Whitehead completed CPR/First Aid/AED training on 10/17/2023. Resident A's Health Care Appraisal lists the following medical conditions: COPD (Chronic Obstructive Pulmonary Disease) OA spine (osteoarthritis), Vitamin D and B12 Deficiency, Dementia, TBI (Traumatic Brain Injury), and Schizoaffective Disorder. It also shows that Resident A had an "unsteady gait." His date of birth was 04/29/1951.

On 10/18/2023, I called and spoke with Ms. Graham. I asked her if Mr. Whitehead had previously been trained in CPR and First Aid because the document she sent me showed he had completed these trainings on 10/17/2023, three days after this incident. Ms. Graham told me that Mr. Whitehead did complete these trainings before, and that she would try to find a document showing this. I also inquired as to the location of Mr. Whitehead's live-in staff apartment, and she said it was located on the second floor. I asked her how residents get ahold of Mr. Whitehead if they need him while he is in his apartment. She told me that they either knock on his door or call him if they have their own cell phone. Ms. Graham informed me that Resident A did not have his own cell phone. I requested that Ms. Graham send me Resident A's Assessment Plan, and she said she would.

On 10/18/2023, I received an email from Ms. Graham with Resident A's Assessment Plan attached. I observed that Resident A's Assessment Plan indicated he was unable to climb stairs, with no additional information pertaining to that issue included.

On 10/26/2023, I called and held an exit conference with Steven Gerdeman, Licensee Designee. I informed Mr. Gerdeman that I was not citing violation of this rule. He thanked me and had no further comment.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A knocked on live-in staff Samuel Whitehead's door at approximately 7:00 a.m. on 10/14/2023. When Mr. Whitehead opened the door, he saw Resident A fall. Mr. Whitehead observed that Resident A was breathing and talking, then he called 9-1-1 immediately afterward. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: On 10/17/2023, I received an email from Ms. Graham with the documents I requested attached. One was a certificate showing that Mr. Whitehead completed CPR/First Aid/AED training on 10/17/2023.

On 10/18/2023, I called and spoke with Ms. Graham. I asked her if Mr. Whitehead had previously been trained in CPR and First Aid because the document she sent me showed he had completed these trainings on 10/17/2023, three days after this incident. Ms. Graham told me that Mr. Whitehead did complete these trainings before, and that she would try to find a document verifying this.

On 10/19/2023, I received an email from Ms. Graham which stated, "He (Samuel Whitehead) said he did in 2018 when he worked at Mission Point in Cedar Springs, but he doesn't have the card anymore."

On 10/19/2023, I called and spoke with Mr. Whitehead. I asked him if he ever completed CPR and First Aid training, and he said he did, when he worked for the company before working at Ramsdell. Mr. Whitehead said that he never received a certificate for those trainings, however. Mr. Whitehead reported that he started working at Ramsdell AFC in May of 2023, and confirmed that he completed the CPR and First Aid training again on 10/17/2023.

On 10/26/2023, I called and held an exit conference with Steven Gerdeman, Licensee Designee. I informed Mr. Gerdeman that I was citing violation of this rule. Mr. Gerdeman told me that he had terminated Mr. Whitehead because he said he had completed CPR/1st Aid training, but that turned out not to be true. Mr. Gerdeman said that due to this situation, he had all the employees' files checked to make sure they each had all of the required documents. He reported that everyone's did. Mr.

Gerdeman further stated that he also gave Ms. Graham a written reprimand and will have another regional manager provide oversite for a while to make sure things run more smoothly.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.** **(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:** **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.**
	The Home Manager, Misti Graham, did not have proof that Samuel Whitehead, DCW, had completed CPR/First Aid training before 10/17/2023. Mr. Whitehead has worked at this home from May of 2023 without proof that he completed CPR and First Aid training. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

October 26, 2023

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Ian Tschirhart Date
Licensing Consultant

Approved By:

October 27, 2023

Jerry Hendrick
Area Manager

Date