



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 11, 2024

Satish Ramade  
Margarets Meadows, LLC  
5257 Coldwater Rd.  
Remus, MI 49340

RE: License #: AL370264709  
Investigation #: 2024A1029056  
Margarets Meadows

Dear Mr. Ramade:

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 licensee designee 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.

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.

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,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid.

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**

<b>License #:</b>	AL370264709
<b>Investigation #:</b>	2024A1029056
<b>Complaint Receipt Date:</b>	07/19/2024
<b>Investigation Initiation Date:</b>	07/19/2024
<b>Report Due Date:</b>	09/17/2024
<b>Licensee Name:</b>	Margarets Meadows, LLC
<b>Licensee Address:</b>	5257 Coldwater Rd., Remus, MI 49340
<b>Licensee Telephone #:</b>	(248) 470-4862
<b>Administrator:</b>	Satish Ramade
<b>Licensee Designee:</b>	Satish Ramade
<b>Name of Facility:</b>	Margarets Meadows
<b>Facility Address:</b>	5257 Coldwater Road, Remus, MI 49340
<b>Facility Telephone #:</b>	(989) 561-5009
<b>Original Issuance Date:</b>	10/11/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/23/2023
<b>Expiration Date:</b>	10/22/2025
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
The residents at Margarets Meadows are not provided personal care when needed which results in residents left in soiled clothing.	No
The residents are not receiving adequate meals at Margarets Meadows causing them to lose weight.	No
Additional Findings	Yes

## III. METHODOLOGY

07/19/2024	Special Investigation Intake 2024A1029056
07/19/2024	Contact - Telephone call made to nurse practitioner, Lindy Hilding NP Careline Health Group.
07/19/2024	Special Investigation Initiated – Telephone call to Careline Health Group Sylvania
08/01/2024	Inspection Completed On-site – face to face with Pam Pardee, direct care staff members Georgia Royce, Jordan Wilson, Resident A, Resident B, Resident C, and Resident D at Margaret's Meadows
08/02/2024	APS Referral made to Centralized Intake
08/09/2024	Contact – Telephone call to licensee designee Satish Ramade, left message, direct care staff member Alyssa Boyd, email to Mr. Ramade and Ms. Pardee
08/14/2024	Contact – Telephone call to licensee designee Satish Ramade, sent email to Kimberly Henney - Careline Health Group, email to Pam Pardee
08/15/2024	Contact – Telephone call received from Vice President of Careline Health Group, Jennifer Gabbard
08/27/2024	Contact – Telephone call to Hospice Aide Caylee Robinette, Left message.
09/05/2024	Contact – Telephone call to Hospice Aide CNA Caylee Robinette, direct care staff members Jordan Wilson Left message, Stormie

	Bussell-Gilby (number unavailable), Makayla Snider, NP Amelia Albachten, Left message for Bonnie, clinical coordinator
09/06/2024	Contact – Telephone call made to direct care staff member Jordan Wilson
09/06/2024	Exit conference with licensee designee Satish Ramade

**ALLEGATION:**

**The residents at Margarets Meadows are not provided personal care when needed which results in residents being left in soiled clothing.**

**INVESTIGATION:**

On July 19, 2024 a complaint was received via the Bureau of Community and Health Systems online complaint system alleging that residents at Margarets Meadows are not provided personal care as needed which results in them being left in soiled clothing. In the complaint allegations, there were no resident names listed or other details of the concerns.

On August 1, 2024, I completed an unannounced on-site investigation at Margarets Meadows and met with administrative assistant Pam Pardee. Ms. Pardee stated she has never observed any of the residents to be soaked with urine because they did not receive personal care as needed. Ms. Pardee stated most of the residents require toileting assistance at Margarets Meadows. Ms. Pardee stated the residents are changed every two hours and if it is a resident who remains in bed, that resident is checked more often. Ms. Pardee stated all the residents except for Resident P require an incontinence brief at this time. Ms. Pardee stated there are some residents who refuse at times to have personal care provided to them such as Resident I, Resident J, and Resident G.

I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E at Margarets Meadows. All residents interviewed stated direct care staff members provide personal care on a regular basis and denied ever being left to sit in urine or feces at any time. Resident B stated she has been sick lately requiring more frequent toileting assistance and direct care staff members are doing “a great job with her.” Resident C stated there is a resident bedroom which smells like urine at the end of the hallway but direct care staff members are still attentive and do what they can to clean this space. Resident D stated the direct care staff members provide care every two hours to him and more if he rings his button. Resident D stated when the button is pushed, they are typically there within 15 minutes to assist.

I reviewed the following documents:

- I reviewed the staffing schedule for the time frame of June 30, 2024-July 27, 2024 and confirmed there were always at least two direct care staff members working during each shift.
- I also reviewed the *ADL Care Logs* which are placed in each resident room documenting when resident was checked whether they required personal care assistance, if they were “wet or dry”, and if they were changed. Each direct care staff member signed off on this and I was able to confirm of the residents appeared to be receiving regular checks several times a day.
- I reviewed the *Assessment Plan for AFC Residents* for Resident A, Resident C, Resident E, Resident F, Resident G, Resident I, Resident L, Resident O, Resident S, Resident N, Resident T, Resident Q, Resident K and according to their *Assessment Plan for AFC Residents*, they all need assistance with bathing and toileting, however, there are no details documented regarding the specific needs except for Resident G which stated sometimes she only needs prompting with bathing and Resident I only needs assistance with transferring and cleaning.

On August 1, 2024, I interviewed direct care staff members Jordan Wilson and Georgia Royce. Ms. Wilson stated direct care staff check residents every two hours and if the resident is dry during the check, the briefs are automatically changed after the next check. Ms. Wilson and Ms. Royce both stated they document these checks on the *ADL Care Logs*.

On August 9, 2024, I interviewed direct care staff member Alyssa Boyd. Ms. Boyd stated she works primarily third shift and checks on the residents every two hours and if needed she will need to assist them with walking to the toilet, changing their brief, and helping them back into bed. Ms. Boyd stated there are some residents will urinate more at night, some she gets up every two hours and some will let her know if they must use the bathroom. Ms. Boyd stated Resident G and Resident O both require brief changes to be completed in their bed because they are unable to walk to the bathroom assisted. Ms. Boyd stated Resident O is paralyzed and he has a Hoyer lift to get out of bed and Resident G receives hospice services and very weak.

Ms. Boyd stated there is an additional direct care staff member who works a few hours during day shift to assist with cooking, showers, and changing residents. Ms. Boyd stated a third direct care staff member has been added during the day for the last four months. Ms. Boyd stated there is an *ADL Care Log* for each resident which hangs in their room and is marked off when personal care has been provided. Ms. Boyd stated every two hours direct care staff mark on the log and check to see if the residents' charts are marked dry and/or if personal care was provided. Ms. Boyd stated she has

had concerns residents are not being changed during the day shift as they should because she stated there are sometimes she comes in at night shift and the resident is completely soaked even though it says dry on their *ADL Care Log*.

On August 14, 2024, I interviewed licensee designee Satish Ramade. Mr. Ramade stated he has not had any concerns that residents were not receiving regular personal care. Mr. Ramade stated Careline Hospice and The Care Team are at Margarets Meadows often and they have not expressed concerns to him. Mr. Ramade stated the *ADL Care Log* are working out well for direct care staff members to track personal care provided. Mr. Ramade stated he has also started having direct care staff members entering more details in the progress notes than they did in the past. Mr. Ramade stated the room at the end of the hallway sometimes smells like urine despite cleaning it each day. Mr. Ramade stated it's hard to get the smell out. Mr. Ramade stated Resident K will urinate on the floor and then will tell the direct care staff members "this is your job" to clean it up. Mr. Ramade stated Resident K does this because he can. Mr. Ramade stated there are also residents who refuse to be changed by the direct care staff members. Mr. Ramade stated Resident I does not like certain direct care staff members and decides who she would like to receive personal care assistance from depending on whether she likes that direct care staff member.

On August 15, 2024, I interviewed Vice President of Careline Health Group, Jennifer Gabbard. Ms. Gabbard stated they are currently providing services to Resident F, Resident G, and Resident M. Ms. Gabbard stated she spoke to her team who provides care at Margarets Meadows and they did report some concerns in the past however, since Ms. Pardee started there, it has improved because she is trying to assist with any concerns.

Ms. Gabbard stated Hospice Aide, CNA Caylee Robinette informed her Resident F had vomited on herself on an unknown date at least a month ago and the vomit was dried on her. Ms. Gabbard stated direct care staff did not clean this because they knew Ms. Robinette was coming to give Resident F a shower the following day.

On September 5, 2024, I interviewed Careline Hospice Aide, Caylee Robinette. CNA Ms. Robinette stated Resident F and Resident G have both thrown up on themselves in the past. Ms. Robinette stated in late May/early June 2024, Resident G's bedroom smelled like vomit and it was on her shirt so she informed Resident G she was going to get her washed up. Ms. Robinette stated she went to talk to the staff member Ms. Wilson to ask how Resident G was feeling and Ms. Wilson stated, "yeah, she puked on herself during 2<sup>nd</sup> shift yesterday but she refused to be cleaned up and I knew Hospice was coming today so we left her." Ms. Robinette stated another incident occurred with Resident G when Ms. Robinette found Resident G soiled from head to toe. Ms. Robinette stated when she looked at the *ADL Care Log* it had been at least five hours

since she had been checked. Ms. Robinette stated she does not recall the date of this incident but stated it was about a week after the first incident.

Ms. Robinette stated there was an incident with Resident F when she had dried feces all over her face due to throwing up feces because it was on her sheets, pillowcase, and clothing because of a possible bowel obstruction. Ms. Robinette stated she was informed by an unknown direct care staff member that it was more than 24 hours since she had a brief change. Ms. Robinette stated she was informed by direct care staff that Resident F refused assistance. Ms. Robinette stated Resident F did not normally refuse personal care assistance especially after Ms. Robinette explains to Resident F the reasons she needs to be changed. Ms. Robinette stated she has never spoken with licensee designee Mr. Ramade about these concerns but she did talk to Ms. Wilson and Ms. Pardee. Ms. Robinette stated Ms. Pardee told her she would take care of the issue.

Ms. Robinette stated she believes this situation has gotten better since May / June 2024 because she has never found any of the residents soaking or needing to be changed recently. Ms. Robinette stated she did walk by and see one of the residents urinating on the floor but when she informed the direct care staff members they quickly went in to assist him.

On September 5, 2024, I interviewed direct care staff member Makayla Snider. Ms. Snider stated she does not have any concerns regarding residents not receiving personal care as needed. Ms. Snider stated most of the residents require briefs and help with toileting. Ms. Snider stated there are a few residents who can shower themselves, some they assist, and a few have aides who come in. Ms. Snider stated she doesn't know anything about a resident not being assisted after vomiting. Ms. Snider stated if they have feces on them or anything she will make sure they were cleaned even though they were going to be bathed by Hospice because they usually come in 3-4 times per week. Ms. Snider stated she keeps track regarding personal care by using the progress notes and also the *ADL Care Log* to document who receives personal care. Ms. Snider stated she checks on the residents every two hours or if they need to be checked sooner.

On September 6, 2024, I interviewed direct care staff member Ms. Wilson who stated Hospice comes days per week to shower residents and if residents need showers or bed baths in between hospice visits, direct care staff bath residents. Ms. Wilson stated she does not recall a time where Resident F or Resident G had dried vomit on them, needed to be changed and were not cleaned up by direct care staff members. Ms. Wilson stated they do not have any residents with dried vomit or feces on them. Ms. Wilson stated direct care staff members would take them directly into the shower or change their clothes. Ms. Wilson stated sometimes residents refuse to be cleaned up or changed at the time of the accident but direct care staff make attempts throughout the

day. Ms. Wilson stated she has not had any concerns regarding any residents not being changed as needed.

<b>APPLICABLE RULE</b>	
<b>R 400.15303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on the interviews completed with Mr. Ramade, Ms. Pardee, Ms. Wilson, Ms. Boyd, and Ms. Snider there does not appear to be instances where the residents are not being cared for as defined in their <i>Assessment Plan for AFC Residents</i> . I also reviewed the <i>ADL Care Logs</i> Each and I was able to confirm each resident was documented as having received regular checks several times throughout the 24 hour cycle. Although there were two incidents reported by Ms. Robinette regarding Resident F and Resident G there are no dates of this incident or supporting evidence to determine this occurred since. Ms. Wilson and Ms. Snider both reported a resident would be cleaned up immediately, rather than waiting for hospice, if found with feces or vomit on them.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**The residents are not receiving adequate meals at Margarets Meadows causing them to lose weight.**

**INVESTIGATION:**

On July 19, 2024 a complaint was received via the Bureau of Community and Health Systems online complaint system with allegations residents at Margarets Meadows are not provided with adequate meals which was causing them to lose weight. According to the allegations, the residents are given lettuce with dressing on it which is not an adequate meal.

On August 1, 2024, I completed an unannounced on-site investigation at Margarets Meadows and met with administrative assistant Pam Pardee. Ms. Pardee stated she is the one who complete the grocery shopping at least twice per week at Margarets Meadows. Ms. Pardee stated each shopping trip she spends around \$700 on food. Ms. Pardee stated she has never had concerns regarding the residents not getting enough

food and denied they ever received lettuce and dressing. Ms. Pardee stated there is a smaller meal for lunch and a larger meal for dinner because this is what the resident prefer. Ms. Pardee stated she has never heard complaints regarding the food from relatives, and if anything, she has been told their relative has gained weight living there. Ms. Pardee stated Resident F and Resident G are on Hospice at this time and they do not have a large appetite for meals.

Ms. Pardee was able to show menus for Margarets Meadows which showed a variety of foods being served to the residents. Ms. Pardee stated she did have issues with a scale in the past and had to purchase a new one so some of the residents weights look like they had a drop but when she purchased another scale, the weight went back up.

I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E at Margarets Meadows. All residents interviewed stated they like the food served at Margarets Meadows and they always get enough. They all denied they have ever had a meal with just lettuce and dressing.

On August 1, 2024, I interviewed direct care staff members Jordan Wilson and Georgia Royce while they were washing dishes in the kitchen after lunch. Ms. Wilson stated the residents have never been served lettuce and dressing. Ms. Wilson stated they do serve salads but they always have a meat, croutons, bacon bits and it's a large chef salad which is filling for them. Ms. Wilson stated Ms. Pardee completes the shopping and she shops at least weekly on Wednesday or Thursday and typically goes to three stores to make sure she gets everything they need. Ms. Royce stated she believes the residents have a good variety of foods to eat.

I was able to observe the food supply at Margarets Meadows and confirmed they had enough food for at least two weeks. Margarets Meadows has two large refrigerators, a regular size refrigerator, and a large pantry area that was fully stocked.

During the on-site investigation, I reviewed all resident records as well as weight records for each resident. The resident weights were pulled for the last few months for each of the residents between the dates of March 1, 2024 – July 31, 2024. Out of the 20 residents, there were 5 residents who lost weight however only two (Resident F and Resident H) had a significant weight loss of 31 and 31.4 pounds. Resident F and Resident H are both on Hospice at this time.

On August 9, 2024, I interviewed direct care staff member Alyssa Boyd. Ms. Boyd stated she does not have concerns about the residents getting enough food however she does think they could buy more food for them. Ms. Boyd stated the residents seem to be satisfied with what they eat but sometimes they will refuse to eat because they eat a lot of the same meals. Ms. Boyd stated each week at least once a week they have pizza or sandwiches and they get tired of eating the same items. Ms. Boyd stated she

has never observed them to have a salad that was only lettuce or dressing and stated when they have chef salad for lunch, they have several toppings on it.

On August 14, 2024, I interviewed licensee designee Satish Ramade. Mr. Ramade stated he stated it is surprising there is not enough food there because there is always a lot of food. Mr. Ramade stated food is never a problem and this is the least concerning area because it just needs to be purchased and cooked. Mr. Ramade stated they buy a lot and he has never had concerns the meals were not balanced. Mr. Ramade stated having an extra person on during the mealtimes has really helped to make the mealtimes go smoother.

On August 15, 2024, I interviewed Vice President of Careline Health Group, Jennifer Gabbard. Ms. Gabbard stated she did not have concerns there was not enough food but possibly they were not making enough of an effort to feed the residents receiving Hospice services. d. Ms. Gabbard stated she was informed by her team the meals look better than most facilities where they provide services.

On September 5, 2024, I interviewed Careline Hospice Aide, CNA Caylee Robinette. CNA Ms. Robinette stated she has never had any concerns Hospice patients do not have decent meals however, many of them do not have an appetite any longer. Ms. Robinette stated Resident G just eats mostly Saltine crackers because she doesn't have any appetite for regular meals anymore. Ms. Robinette stated she will get regular meals because they offer it and she will take a few bites but she does not want it and will ask for crackers. Ms. Robinette stated the meals look decent when she is there. Ms. Robinette stated Resident F did have a weight loss but she stated it was a mixture of her not having an appetite for food and there were times when they would not try to feed her. Ms. Robinette stated Ms. Wilson told her once she did not try to feed her because she was coming there anyway so Ms. Robinette assisted her with eating, however, that was not on her task list for the day and they typically do not assist residents with mealtime.

On September 5, 2024, I interviewed direct care staff member Makayla Snider. Ms. Snider stated there have been no concerns regarding lack of food or quality of meals. Ms. Snider stated there is a good variety of foods served at the facility and denied she has ever observed a meal of only lettuce with dressing.

<b>APPLICABLE RULE</b>	
<b>R 400.15313</b>	<b>Resident nutrition.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	Based on the interviews with Ms. Pardee, Ms. Wilson, Ms. Boyd, and Ms. Royce there is no indication the residents at Margarets Meadows are receiving inadequate food. I interviewed five residents during the onsite inspection and none of them had any concerns regarding the food provided to them. The resident weights were pulled for the last few months for each of the residents between the dates of March 1, 2024 – July 31, 2024. Out of the 20 residents, there were 5 residents who lost weight only two (Resident F and Resident H) had a significant weight loss of 31 and 31.4 pounds however Resident F and Resident H are both on Hospice at this time.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During the on-site investigation, I reviewed all resident weight records between the dates of March 1, 2024 – July 31, 2024 due to the concerns the residents were losing weight due to not having enough food available at Margarets Meadows. Although there were no significant changes in weight due to inadequate food supply, the following weights were missing from their records.

1. Resident C - Missing June 2024
2. Resident D - Missing May -July 2024. Ms. Pardee stated he is a PACE client and he does not get weighed because he cannot support his weight.
3. Resident F - Missing March, April, and June 2024. There was a note on the Resident Weight Record which states "Hospice gave Okay not to weigh as it causes her too much pain."
4. Resident H - Missing April and May 2024
5. Resident I - Missing June 2024.
6. Resident J - Missing April 2024
7. Resident K - Missing June 2024
8. Resident N - Missing June 2024

<b>APPLICABLE RULE</b>	
<b>R 400.15310</b>	<b>Resident health care.</b>
	<b>(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.</b>

<b>ANALYSIS:</b>	While reviewing the Resident Weight Records, Resident C, Resident D, Resident F, Resident H, Resident I, Resident J, Resident K, and Resident N all had missing weights in their Resident Weight Record.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Jennifer Browning*

Jennifer Browning  
Licensing Consultant

09/06/2024

Date

Approved By:

*Dawn Timm*

09/11/2024

Dawn N. Timm  
Area Manager

Date