GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

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

RE: License #: AL370264709
Investigation #: 2024A0007042
Margarets Meadows

Dear Satish Ramade:

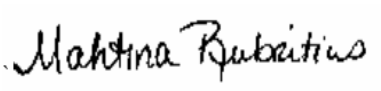
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (517) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2024A0007042
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	11/18/2024
Licensee Name:	Margarets Meadows, LLC
Licensee Address:	5257 Coldwater Rd. Remus, MI 49340
Licensee Telephone #:	(248) 470-4862
Administrator:	Satish Ramade
Licensee Designee:	Satish Ramade
Name of Facility:	Margarets 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:	10/23/2023
Expiration Date:	10/22/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are restricted to their daily activities. Residents are bullied by staff.	No
Once awake, dayshift staff do not feed residents right away, when they sleep through dinner.	No
Certain staff (names unknown) do not provide adequate wound care.	No
Staff have been required to work a 24-hour shift, due to staff shortages.	No
New staff are not properly trained to pass medications.	No
There is mold in the back bathroom and the toilet is wobbly. When the back bathrooms are out of order, residents are told to use staff bathroom. The toilets and shower drain back up when it rains or snows.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/19/2024	Special Investigation Intake - 2024A0007042
09/20/2024	Special Investigation Initiated – Letter APS Referral made.
09/20/2024	APS Referral made.
09/30/2024	Inspection Completed On-site- Unannounced - Face to face contact with Pam Pardee, DCW, Resident B, Resident C, and Resident D, two direct care staff, and three other residents.
10/31/2024	Contact - Telephone call made to Employee #2. Message left. I requested a returned phone call.
11/01/2024	Contact - Telephone call received from Employee #2. Interview.
11/04/2024	Contact - Telephone call made to Employee #4. Voicemail not set up.
11/04/2024	Contact - Telephone call made to Pam Pardee x2. Discussion.

11/05/2024	Contact - Telephone call made to Employee #5. Voicemail box is full.
11/05/2024	Contact - Document Received - Invoices for septic services.
11/13/2024	Contact - Telephone call made to Residential Home Health Care x3. Message left. I requested a returned phone call.
11/13/2024	Contact - Telephone call made to facility x 2. Message left.
11/13/2024	Contact - Telephone call made to Employee #4. No answer.
11/13/2024	Contact - Telephone call received from Pam Pardee. Discussion.
11/13/2024	Contact - Telephone call made to Employee #8. Interview.
11/13/2024	Contact - Telephone call made to Dr. Amilia E., Careline Physician Services- I requested and returned phone call.
11/13/2024	Contact - Telephone call made to Aaron Dupuis, RN, Residential Home Health Care. Message left. I requested a returned phone call.
11/13/2024	Contact - Telephone call received from Aaron Dupuis, RN, Residential Home Health Care. She left a message.
11/14/2024	Contact - Telephone call made to Aaron Dupuis, RN, Residential Home Health Care. Message left.
11/14/2024	Contact - Telephone call received from Aaron Dupuis, RN, Residential Home Health Care. Interview.
11/14/2024	Exit Conference conducted with Satish Ramade, Licensee Designee.

ALLEGATION: Residents are restricted to their daily activities. Residents are bullied by staff.

INVESTIGATION:
I reviewed the complaint, and the additional information was noted:

- Certain staff on dayshift are telling residents what they can and cannot do. If the resident wants to lay down for a while, certain staff will tell them “No they are not allowed to lay down.” If they lay down and want to get back up, when staff takes

them back out for smoke break, staff will tell them “No we can't be doing that” even management told staff not to get them back up.

- Certain staff will sit back and yell at the residents. Certain staff will tell the resident that they are not the boss of the staff and that they have to listen to the staff.

- If a resident rings their call button staff will sit there and complain and not get up to check on the residents, when they ring their light. The resident hit their button 10 different times and certain staff just sit there.

On September 30, 2024, I conducted an unannounced on-site investigation and made face to face contact with Pam Pardee, DCW, Resident B, Resident C, Resident D, two direct care staff, and three other residents.

Pam Pardee informed me that she has the role of Home Manager. Regarding staff telling residents what they can and cannot do, Pam Pardee stated that residents can lay down if they want. There is a resident who smokes, and because of their diagnosis, they must have staff assist them during their smoke break. Regarding staff yelling at the residents, Pam Pardee informed that one direct care staff, Employee #1, talks loud but she does not “holler” at the residents. Pam Pardee stated that she has not heard staff tell the residents that they are not the boss. If residents utilize their call button, it is expected that direct care staff will respond as soon as they can. Pam Pardee recalled that there is one resident, Resident E, that continues to press the call button and staff will stand outside of the bedroom to make sure she’s okay. I inquired if I could speak with Resident E and Pam Pardee stated that she was not home as she was out in the community.

While at the facility, I interviewed Resident B. She reported to be doing well and that it doesn’t take the staff too long to respond to the call button. Staff treat her well. Resident B did not confirm that staff yell or tell her that she’s not the boss. Resident B informed that she gets along with everyone and was enjoying her stay in the facility.

I interviewed Resident C stated that the staff were great. She informed that the staff did not yell at the residents. Resident C recalled that one resident (name not given) pushes her luck, but the staff don’t mistreat her. Resident C did not report any concerns regarding how she was treated by staff.

While at the facility, I attempted to interview Resident D; however, he did not appear to want to be interviewed. Therefore, the interview was ended.

On November 1, 2024, I interviewed Employee #2. She stated that she does not tell residents they have to listen to the staff, but she has heard Employee #1 tell the residents they have to listen. In addition, that Employee #1 yells at the residents. Regarding responding to the call button, Employee #2 stated that staff are supposed

to go and see what the residents need, and she has heard residents complain that Employee #1 does not respond. When asked if she has observed Employee #1 ignore residents when they pushed their call button, she stated at first Employee #1 did respond quickly but as Employee #1 got comfortable working with Employee #2, Employee #1 would wait to respond. Employee #2 stated that this was told to management, but they really don't do anything. Employee #2 expressed that she wanted to quit but worried about the residents if she no longer worked in the home.

On November 4, 2024, I interviewed Employee #1. She informed that there were usually three staff on duty. Employee #1 informed that if a resident requests to go lay down, and if direct care staff are assisting other residents, then direct care staff will ask the resident to give them a few moments. Some of the residents require staff supervision when they're outside smoking; therefore, other residents may have to wait a few minutes for assistance according to Employee #1. Employee #1 informed that staff are strategic, when assisting other residents who are smoking outside, as there are some residents who will go into behaviors if they're not quickly attended to.

Employee #1 informed that she has not heard staff say to residents that they (staff) are the boss. Employee #1 recalled that Resident H will say he's going to tell the boss lady and Employee #1 responds with "well I'm the boss lady today, so tell me." Employee #1 followed up by stating "we don't tell residents they are not our boss." Employee #1 denied yelling at the residents, but she stated that she talks loudly, as some of the residents are hard of hearing. Employee #1 stated "I'm a loud person." Employee #1 reported that her boss has spoken to her about how loudly she speaks. Regarding the call button, Employee #1 informed that staff are to finish what they're doing and assist residents as soon as possible; in the order that the call buttons are activated. Employee #1 recalled that there is one resident, Resident E, who "blows up the button." After Resident E utilizes the call button, direct care staff could be on their way, and she will press the button again. Resident E has been reminded that she only needs to press the button one time. Employee #1 denied sitting and not responding when residents hit the call buttons.

On November 13, 2024, I interviewed Employee #8. I inquired if she had observed anyone bullying the residents, and she confirmed that she had. While she could not provide a specific situation, she stated that Employee #1 can be rude, and it appeared to be a part of her personality. Employee #8 stated that Employee #1 will say that she's not hollering, and it's just the way she talks, but it's not. In addition, that Employee #1 has told the residents that they have to listen to her because she's in charge. Regarding the call button, Employee #8 stated that she thinks she does a good job responding when the call buttons are pressed. However, she had noticed quite a few times that a call button will go off, and she will finish up what she's doing and come out of the room; and observe staff just sitting there, and then they'll respond. Employee #8 recalled that Resident E rings her bell a lot, and when staff arrive at her room, she giggles.

On November 14, 2024, I conducted the exit conference with Satish Ramade, Licensee Designee. We discussed the investigation, the conclusion, and my recommendations. I recommended that he have a follow-up conversation with staff and remind them about their tone when speaking to the residents. He informed that he would speak to staff and reiterate the importance of these matters.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Pam Pardee stated that residents can lay down if they want. There is a resident who smokes, and because of their diagnosis, they must have staff assist them during their smoke break. Pam Pardee informed that one direct care staff, Employee #1, talks loud but she does not “holler” at the residents. Pam Pardee stated that she has not heard staff tell the residents that they are not the boss. If residents utilize their call button, it is expected that direct care staff will respond as soon as they can. Resident B reported to be doing well and that it doesn’t take the staff too long to respond to the call button. Staff treat her well. Resident B did not confirm that staff yell or tell her that she’s not the boss. Resident C stated that the staff were great and that the staff did not yell at the residents. Resident C did not report any concerns regarding how she was treated by staff. Employee #2 informed that she does not tell residents they have to listen to the staff, but she has heard Employee #1 tell the residents they have to listen. In addition, that Employee #1 yells at the residents. Regarding responding to the call button, Employee #2 stated that she has heard residents complain that Employee #1 does not respond. Employee #2 informed that at first Employee #1 did respond quickly, but as Employee #1 got comfortable working with Employee #2, Employee #1 would wait to respond. Employee #1 informed that residents may be asked to wait a few minutes if staff are assisting other residents. Employee #1 denied yelling at the residents. Employee #1 stated “I’m a loud person.” Employee #1 informed that staff are to finish what they’re doing and assist the residents as soon as possible. Resident E utilizes her call button a lot and staff have encouraged her to only push the button once. Employee #1 denied sitting and not responding when residents use the call buttons. According to Employee #8, Employee #1 can be rude, and Employee #1 will say that she’s not hollering, and it’s just the way she talks, but it’s not. In addition, that Employee #1 has told the residents that they have to listen to her because she’s in charge. Employee #8 stated that she had noticed quite a few times that a call button will go off, and she will finish up what she’s doing and come out of the room; and observe staff just sitting there, and then they’ll respond. Employee #8 recalled that Resident E rings her bell a lot, and when staff arrive at her room, she giggles.

	Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that resident's activities are restricted, they are yelled at or ignored by direct care staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Once awake, dayshift staff do not feed residents right away, when they sleep through dinner.

INVESTIGATION:
I reviewed the complaint, and the following additional information was noted: Dayshift staff will serve other residents' dinner, and some are still sleeping. When they get up, staff will tell them there is none left. If they want something else, staff do not feed them right away.

Pam Pardee informed me that if a resident is asleep during the mealtime, usually the direct care staff will save a plate for them. Some residents will say they don't want the food, and staff will offer them a different option in its place. Pam Pardee stated that staff are supposed to document if residents are asleep during mealtimes. Pam Pardee provided me with progress notes for Resident D, which staff documented when he did and did not eat.

I observed the menu posted that included chef salad, snack and mini cheesecake for lunch.

I interviewed Resident B who reported that she had a chef salad for lunch and "It was good." Resident B informed that she gets enough to eat, and she did not have any concerns regarding her meals.

Resident C reported to have a chef salad for lunch, which also had meat, and that she gets enough to eat; however, she would like more vegetables. I inquired if residents could have meals later, if they sleep through dinner, and she stated that staff usually lets them know that the meal is being served, so they have the option to have the meal at that time.

While at the facility, I attempted to interview Resident D; however, he did not appear to want to be interviewed. Therefore, the interview was ended.

On November 1, 2024, I interviewed Employee #2. She stated that she did not work during the shift when dinner was served but she heard from other staff that dayshift staff had made comments to the residents (about nothing being left from the meal served). In addition, that most of those staff were no longer employed except for

Employee #1. Employee #2 stated that she provided snacks to the residents when requested.

On November 4, 2024, I interviewed Employee #1, and she stated that they will attempt to wake the residents up for their meals. If they don't awaken, then a plate is put to the side for them and the other residents are fed. Direct care staff then go back and try to encourage the residents to eat the meals again. If they don't want the food that has been placed aside, the residents can have a sandwich, leftovers, or whatever they want. I inquired if it takes a long time for direct care staff to provide the alternative meals, and Employee #1 stated that it usually is served within fifteen to twenty minutes.

On November 13, 2024, I interviewed Employee #8. She informed that if residents are asleep during the mealtimes, that a plate is made and put away in the refrigerator until they wake up. In addition, that staff arriving for their shifts will be notified that the meal was put aside, to be given to the residents when they awake; however, she feels that sometimes this does not occur. When asked why, Employee #8 informed that the meal is still in the refrigerator on the following day. Regarding residents being provided alternative meals, Employee #8 informed that staff will give the residents a sandwich, leftovers, or they might make something easy for them, and that it usually takes about ten minutes or so to prepare another meal.

During the exit conference, Satish Ramade stated that he was surprised by these allegations, as it only takes a few minutes to make a different meal. He stated the job is busy and they meet with staff weekly to address matters like these.

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:	Pam Pardee informed me that if a resident is asleep during the mealtime, usually the direct care staff will save a plate for them. Some residents will say they don't want the food, and staff will offer them a different option in its place. Resident B reported to get enough to eat, and she did not have any concerns regarding her meals. Resident C also reported to get enough to eat but reported she would like more vegetables. She also stated that staff usually lets them know that a meal is being served, so they have the option to have a meal at that time. Employee #2 heard from other staff that dayshift staff had made comments to the residents (about nothing being left from the meal served). Employee #2 provided snacks when requested. Employee #1 stated that they will attempt to wake the residents up for their meals; and if they don't awaken, then a plate is put to the side for them. After feeding the other residents, the direct care staff then go back and try to encourage the residents to eat the meals again. If they don't want the food that has been placed aside, the residents can have a sandwich, leftovers, or whatever they want. Employee #1 informed that the alternative meal is usually served within fifteen to twenty minutes. Employee #8 reported that sometimes the meals that are placed aside remain in the refrigerator the following day. In addition, that it usually takes about ten minutes to prepare an alternative meal for the residents. Based on the information gathered during this investigation and provided above, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that residents are not provided with meals, in a timely manner, when they sleep through the mealtimes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Certain staff (names unknown) do not provide adequate wound care.

INVESTIGATION:
I reviewed the complaint, and the additional information was noted:
If a resident has a really bad wound on their butt or other places, certain staff will not treat it. Staff told management about it, but staff and management don't listen. So, the wound on the resident will get infected because it's not being taken care of properly.

During the on-site inspection, Pam Pardee informed me that Resident A was the only resident with a wound issue. Pam Pardee stated that Resident A received

wound care from Residential Home Health Care Hospice. Pam did not recall the workers name, but stated a representative from the agency visited the home each week. I inquired about staff documenting the condition, and Pam Pardee informed me that staff only document information in the progress notes if there was a problem. Pam Pardee reviewed staff progress notes and staff documented that Residential Home Health Care visited, they applied barrier cream and kept her tailbone area clean. I inquired about Resident A having an infected wound and Pam Pardee stated that she was not aware of an infected wound. That Resident A had a sore on her leg, it was red, the doctor prescribed antibiotics, as a precaution, and there were no issues with it being infected. Pam Pardee stated that no staff brought it to her attention about there being a concern with the care that Resident A was receiving. Pam Pardee reviewed Resident A's medication logs, and it was noted that on 9/16/24 she was prescribed Doxycycline Hyclate (10mlg, 1 capsule by mouth twice daily), and she ended the prescription on 9/27/2024. Pam Pardee also provided me with progress notes regarding Resident A.

The progress notes for Resident A were reviewed and the following was noted:

- On September 14, 2024, at 3:05 a.m., Employee #4 documented that Resident A was assisted to the bathroom and then to bed. Direct care staff noticed a cut or mark on her right leg and staff cleaned the wound. On this same date, around 10:34 p.m. direct care staff documented that day shift staff contacted the doctor's office about Resident A's leg, and they said to wrap and clean the wound twice a day. In addition, that they were sending an order for treatment. Resident A's son, Relative A1 was also contacted to keep him updated. Staff also documented that Resident A was struggling with anxiety that day.

- On September 27, 2024, at 6:07 a.m. staff documented that Resident A did not eat her snack, but she took her medications. Resident A was hallucinating, and she did not want to go to the toilet or to bed. Staff noted that her skin had a grey look to it.

- On September 27, 2024, Employee #1 documented that Resident A had not eaten her meals as staff could not awake her enough to eat any food that day. Residential Home Health Care visited her that day to examine and care for her wounds. Resident A did not awake while the wound care was provided, and she was slurring her words. Staff will continue to monitor Resident A closely and will let the provider know if there was no change in the behaviors or if it worsened.

On November 1, 2024, I interviewed Employee #2. She stated that Resident A had a wound on the bottom of her leg, around the calf area, that wasn't being cared for. Resident A's doctor (name not given) and her son (Relative A1) were contacted because staff had done nothing about the wound on her leg. The doctor prescribed and sent medications over and instructed staff as to how to care for the wound. Employee #2 stated that the wound was always "gross and smelled bad." In addition, that the doctor stated that the wound dressing was supposed to be changed twice a day. Eventually, she and Employee #4 ended up writing their initials

on the bandages, so they could track when other staff did not change the bandage as required. I inquired if staff documented in the progress notes when they changed the bandages, and Employee #2 stated that she could not recall.

I interviewed Employee #1 regarding the wound care Resident A received. Employee #1 stated that the physician's decide if the wound is infected and that the wounds are never left unassisted. I inquired where staff document when they change the bandages and Employee #1 stated that it's supposed to either be in the progress notes or on the MAR. According to Employee #1, staff should document this information, so that they don't change the bandages too often. Employee #1 recalled that Resident A had a wound on her buttocks, and they tried to treat it with a medicated skin patch; and the doctor instructed them to keep the area clean. They also had to rotate her so that she was not putting pressure on the area. Employee #1 informed that the wound on Resident A's buttocks was gone. Employee #1 stated that Resident A has a wound on her left leg, and they would like to see it heal properly. They changed the bandage every three days, and they included the date on the dressing, so they know when it was last changed. Employee #1 stated they don't document this information on the MAR because Resident A also has a wound care nurse, who provides the care most of the time. The staff assist between the nurse visits or if the bandage is dirty or there is pus, then staff will change the bandage.

During the interview with Employee #8, she informed that Resident A had a pressure sore just above the crack of her buttocks and one on her leg, that first looked like a scab. Employee #8 recalled that she would change the bandage on her leg and wrap it a certain way, and the following day, it would be wrapped the same way. She stated that she did not observe an odor or any pus from the wound, but the care was inadequate because the bandage was not changed properly.

On November 13, 2024, I spoke to Pam Pardee, and she provided an update regarding Resident A. She informed that Resident A went to the hospital on Friday, November 8, 2024, and her son, Relative A1, later informed that she would not be returning to the home. This was due to information they heard, which was not true. Pam Pardee has reached out to Resident A's son, Relative A1, but she has not heard back from him.

On November 14, 2024, I spoke with Aaron Dupuis, RN, from Residential Home Health Care. She informed that she and Tina Fernbach, LPN, shared case management responsibilities, and provided wound care to Resident A on a weekly basis. They also took photos of the wound. The staff were instructed to remove the old dressing, clean the area, pat skin dry, apply Triad cream, and cover with gauze, daily. I inquired if she had any concerns regarding the wound care that was provided and she stated that she did not, and there were no concerns brought to her attention. She last saw Resident A on October 28, 2024, and Aaron Dupuis reported that Resident A would be transitioning off their services as she was going to receive hospice care.

During the exit conference, I recommended that staff document when the bandages are changed on the MAR or another tracking system. Satish Ramade informed that they have a system with the ability to track this information and that he would look into ways to improve this process.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	According to Pam Pardee, Resident A received weekly wound care from Residential Home Health Care Hospice. Pam Pardee informed me that staff only document information in the progress notes if there was a problem. Pam Pardee stated that she was not aware of an infected wound. That Resident A had a sore on her leg, it was red, the doctor prescribed antibiotics, as a precaution, and there were no issues with it being infected. Pam Pardee stated that no staff brought it to her attention about there being a concern with the care that Resident A was receiving. Pam Pardee reviewed Resident A's medication logs, and it was noted that on 9/16/24 she was prescribed Doxycycline Hyclate (10mlg, 1 capsule by mouth twice daily), and she ended the prescription on 9/27/2024. Employee #2 stated that Resident A had a wound on the bottom of her leg, that wasn't being cared for. Employee #2 stated that the wound was always "gross and smelled bad." Employee #2 reported that the bandages were to be changed twice a day, and other staff did not change the bandages as required. Employee #1 stated that the physician's decide if the wound is infected and that the wounds are never left unassisted. Employee #8 observed that Resident A's bandage was not changed properly. While there were inconsistencies regarding when staff changed the bandages, Resident A was monitored by Aaron Dupuis and her colleague on a weekly basis and photos were taken. Aaron Dupuis reported to have no concerns regarding the wound care that direct care staff provided. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence at this time to support the allegations that the wound care that Resident A received was inadequate.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff have been required to work a 24-hour shift, due to staff shortages.

INVESTIGATION:
As a part of this investigation, I reviewed the written complaint and the following information was noted: If management can't find coverage, staff will have to work a 24-hour shift.

On September 30, 2024, during my interview with Pam Pardee, I inquired if any staff were required to work for 24 hours, and she stated that staff have worked 18 hours

in the past, but she did not think it's happened in a long time. Pam Pardee stated that they offer shift premiums for shifts covered and they also try to have staff work a split shift. Pam Pardee stated that Lomiya Reves, who did not work there very long, had a no-call no show and Employee #3 had to cover for her. Finding staff has been challenging and they're trying to get the staffing back up to 100%. Pam Pardee reviewed the staff schedules and reported that she did not see where any staff had worked 24-hours straight. I reviewed the staff schedule for August of 2024, and randomly selected dates to review. Based upon my review of the schedules, I did not observe that staff had worked 24-hours straight.

During my interview with Employee #2, she informed that the most consecutive hours she had worked were 19-hours, because someone did not arrive for their shift. Employee #2 reported to be very tired after working 19-hours straight. She also informed that Employee #6, who quit a few months ago had worked 22-hours straight, due to staff shortages.

On November 4, 2024, I interviewed Employee #1, and she confirmed that she has worked 24-hours straight; however, she also stated that it was "voluntary" and her choice to stay and work. Employee #1 could not recall the exact dates she worked these extended shifts.

On November 13, 2024, I interviewed Employee #8, who informed that she has not worked 24-hours straight, but she heard that a staff who no longer works there and Employee #6 has worked for 24-hours.

During the exit conference Satish Ramade stated that they do not schedule staff for more than a 12-hour shift, and when they work more hours, it is usually due to someone calling in a few minutes before their shift starts. They typically terminate staff if attendance becomes a problem. He reported that they have not scheduled anyone for a 24-hour shift. He did recall that during the Covid-19 Pandemic staff working longer hours was an issue.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	According to Pam Pardee, staff have worked longer shifts, up to 18-hours, due to staff shortages; however, they try to split the shifts and provide shift premiums. Employee #2 reported that she has worked 19-hours straight because someone did not arrive for their shift. Employee #1 reported that she has voluntarily worked 24-hours. Employee #8 informed that she has not worked 24-hours straight, but she heard that a staff who no longer works there and Employee #6 has worked for 24-hours. I reviewed the staff schedule for August of 2024, and randomly selected dates to review. Based upon my review of the schedules, I did not observe that staff had worked 24-hours straight. Pam Pardee reported that it has been a challenging finding direct care staff and they're working to increase their staffing. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that staff are required to work 24-hour shifts; thus, causing over worked staff to be unable to provide the residents with the personal care and protection they require.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS: New staff are not properly trained to pass medications.

INVESTIGATION:
As a part of this investigation, I reviewed the written complaint, and the following information was noted: If a new staff starts certain staff don't train the new staff properly on medications. This happens daily.

On September 30, 2024, Pam Pardee informed me that when new staff are trained to pass medications, they first shadow the experienced staff. Then the experienced staff shadow the new staff when they administer the medications. Lastly, the staff take a written test regarding medications. Staff are expected to receive 100% on the test. Pam Pardee stated that the staff must be trained as a Med Tech to administer medications. Pam Pardee stated there are three staff that are not Med Techs, which included Employee #3, Employee #7, and Employee #5. Pam Pardee stated that Employee #3 was still on-boarding, and she had not taken the written test.

I reviewed the employee files for Employee #3, Employee #7, and Employee #5. There was no documentation that they had completed the written medication training/test. Three resident medication logs were randomly selected and reviewed for Resident F, Resident G, and Resident H, and there was no documentation to

reflect that Employee #3, Employee #7, and Employee #5 initialed the medication administration logs.

On November 1, 2024, I interviewed Employee #2, and we discussed the training protocols. She stated that as new employee, she had to follow the trainer for a day or two, and on the third day, she administered the medications while being supervised. She did not recall the exact date of when she had to take the written test to pass medications, but it was a few days later.

On November 4, 2024, I interviewed Employee #1, and she informed me that they have a three-step process with training staff to administer medications. First the direct care staff observe medications being passed, the second day is more hands on, as they (new direct care staff) are shadowed by the experienced direct care staff, while they pass the medications. The experienced direct care staff are always with the new direct care staff while passing the medication. Last, they have a written test. According to Employee #1, only Med. Techs pass medications. If the experienced staff is not confident in the new direct care staff's ability to pass the medications, they continue to train them until they're comfortable with medications being passed.

During my interview with Employee #8, she informed that she did not have any concerns about the medication training; however, she thought that only shift leads should train the new workers, for consistency.

During the exit conference, Satish Ramade discussed their training protocol and informed that staff do not pass medications until they are Med Techs. He agreed with the conclusion of this investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	According to Pam Pardee, Employee #1 and Employee #2, there is a training process in place for new direct care staff who administer medications. The new direct care staff are expected to shadow the experienced direct care staff, then they are shadowed, and a written test is provided. Employee #8 informed that she did not have any concerns about the medication training; however, she thought that only shift leads should train the new workers, for consistency. Three resident medication logs were randomly selected and reviewed for Resident F, Resident G, and Resident H, and there was no documentation to reflect that Employee #3, Employee #7, and Employee #5, who are not Med Techs, initialed the MARs and passed medications. Based on this information, it's concluded that there is not a preponderance of the evidence to support the allegations that the direct care staff are not properly trained to pass medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

- **There is mold in the back bathroom and the toilet is wobbly.**
- **When the back bathrooms are out of order, residents are told to use staff bathroom. The toilets and shower drain back up when it rains or snows.**

INVESTIGATION:
As a part of this investigation, I reviewed the complaint and the following was noted: There is mold in the back bathroom on the right side of the toilet, down on the floor in between the shower and toilet. The toilet is wobbly in that bathroom. During this investigation, it was also alleged that when the back bathrooms are out of order, residents are told to use staff bathroom. The toilets and shower drain back up when it rains or snows.

During the unannounced on-site investigation, Pam Perdee and I observed two bathrooms. While there was nothing that appeared to be mold observed on the floor between the shower and toilet, the toilet was observed to be backed up, full of feces and tissue. The wall between the closet and shower was damaged, as a section of the drywall was missing, and required replacement. The tile on the shower floor was stained and required cleaning, repair or replacement. The tile around the base of the toilet was damaged; and the toilet was not steady and wobbled. Pam Pardee reported that there had been repairs to the toilet in the past. Photos were taken for the file.

On October 31, 2024, I interviewed Employee #2. I inquired about the bathrooms, and she informed that the back bathrooms were not working; and the residents were encouraged to use the staff bathroom in the meantime. Additionally, that when it rained or snowed the showers and toilets would back up.

On November 4, 2024, I spoke to Pam Pardee. I inquired about the toilets and shower drains in the back bathrooms backing up, and she informed that in the past, it was an issue, but not at that moment. She stated that in the spring they had gotten so much rain that the drain field could not keep up. Therefore, they contacted Country Wide Septic Service to come out and they pumped the septic tank. I inquired if she had a copy of the last billing statement, and Pam Pardee informed that she would check her files or with her boss to obtain a copy. In addition, that her boss, Satish Ramade, was out of town, so it might take until next week to get a copy of the documents. Pam Pardee stated that the facility is on a rotation and the septic tanks are pumped out every 6-months. She also informed me that the toilet bolts were broken in the second bathroom and the handyman would be coming to fix it soon. Pam Pardee stated that approximately once a week or so, when the toilet is observed to be plugged, staff will lock the door and instruct the residents to use the staff bathroom. After staff plunge and unplug the toilet, the bathroom is available for resident use. The showers in both bathrooms are operational. On this same day, I spoke to Pam Pardee again, for a follow-up and clarification. She informed me that the toilet bolts on one toilet were broken, and that toilet was not working. The other bathroom was fully operational. They have also had the plumber snake the toilet and wipes and excessive amounts of toilet paper have been found. Pam Pardee confirmed that it had been raining outside, but that the drains were not backing up.

Employee #1 informed me that residents have flushed lots of toilet paper or briefs down the toilet, causing it to become clogged. I inquired about the shower backing up and she informed that it has not happened in a while. The shower was backing up because the septic tank needed to be emptied. Employee #1 stated that the septic tank was full so when they flushed the toilet, the water would come up through the shower drain. As soon as they figured it out, they would have the septic tanks emptied. Employee #1 stated that this has not happened in a long time.

On November 5, 2024, I received four invoices, dated for January, April, May, and July of 2024, documenting that the septic tanks had been pumped out on those dates.

During the exit conference, Satish Ramade stated that they have a maintenance person who was quick to fix things in the facility. He stated that they have a contract to have the septic tank pumped on a regular basis. They also had an issue with the water softener, and he believed that might have been a contributing factor to the iron deposit stains on the shower floor. Satish Ramade informed that he would address the established violations.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It should be noted that there were issues with the toilets backing up from either being plugged or the septic tank being full; however, based on the information gathered during this investigation, it's determined that there is not a preponderance of the evidence to support the allegations, as the licensee has been actively working to address the issue either by closing the bathroom and redirecting residents to the staff bathroom and plunging the toilet, or having the septic tank pumped. While there was no mold observed in the bathrooms, between the shower and toilet, one toilet was observed to be plugged and not working correctly, as it was full of feces and tissue, the flooring around the base of the toilet was damaged, the toilet wobbled, the wall was damaged, and the shower floor was stained. Based on this information, it's concluded that there is preponderance of the evidence to support the allegations that the bathroom had not been adequately maintained to provide for the health and safety of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
I reviewed the employee records for Employee #3 and noted that the reference checks were not completed. Pam Pardee stated that she called the references on the date that Employee #3 applied but the information was not documented.

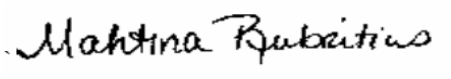
I reviewed the employee records for Employee #7 and noted that the reference checks were not completed. Pam Pardee again stated that she called the references on the date that Employee #7 applied but the information was not documented.

During the exit conference, Satish Ramade stated that they have had a high turnover rate, they are constantly hiring new staff, and this may have contributed to how the files were being maintained.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f) Verification of reference checks.**
ANALYSIS:	There was no documentation that the reference checks for Employee #3 and Employee #7 had been verified.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



11/14/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

11/14/2024

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Dawn N. Timm Date
Area Manager