



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 13, 2026

Morgan Bailey
Extended Care at Ramsdell, Inc.
747 Tamarack Ave NW
Grand Rapids, MI 49504

RE: License #: AL410417948
Investigation #: 2026A0467028
Extended Care At Ramsdell

Dear Ms. Bailey:

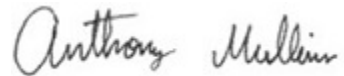
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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,

A handwritten signature in cursive script that reads "Anthony Mullins".

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410417948
Investigation #:	2026A0467028
Complaint Receipt Date:	12/09/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	01/08/2026
Licensee Name:	Extended Care at Ramsdell, Inc.
Licensee Address:	747 Tamarack Ave NW Grand Rapids, MI 49504
Licensee Telephone #:	(616) 361-6571
Administrator:	Morgan Bailey
Licensee Designee:	Morgan Bailey
Name of Facility:	Extended Care At Ramsdell
Facility Address:	12471 Ramsdell Dr. NE Rockford, MI 49504
Facility Telephone #:	(419) 494-4008
Original Issuance Date:	12/12/2023
License Status:	REGULAR
Effective Date:	06/12/2024
Expiration Date:	06/11/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/09/2025	Special Investigation Intake 2026A0467028
12/23/2025	Special Investigation Initiated - Telephone Kent County CMH - Network per Arlene Smith
03/10/2026	APS Referral – not warranted due to Resident A being deceased
03/10/2026	Inspection completed – Onsite
03/10/2026	Contact – telephone call made to licensee designee, Morgan Bailey
03/10/2026	Contact – document received from Morgan Bailey
03/26/2026	Telephone call made – Resident A’s guardian, Barb Cazier
03/26/2026	Contact – telephone call made to Cynthia Bacon of the Kent County Medical Examiner Office
03/26/2026	Contact – document sent. Email sent to Kent County Medical Examiner office requesting cause of death for Resident A.
03/26/2026	Contact – document received from Kent County Medical Examiner Office regarding Resident A’s cause of death.
04/13/2026	Exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom.

ALLEGATION: Resident A did not receive his medication as prescribed.

INVESTIGATION: On 12/9/25, an online complaint was received alleging concerns regarding Resident A, who was found deceased in his bed on 12/1/25. According to the complaint, Resident A had diabetes and often refused his prescribed medications. The complainant expressed concerns regarding how Resident A’s medications were being managed by staff, including whether his blood sugar levels were appropriately monitored following his medication refusal. The complaint further

alleged that inadequate care and oversight may have contributed to Resident A's death.

On 12/23/25, licensing consultant Arlene Smith contacted the Kent County Office of Recipient Rights to inform them of the concerns.

On 03/09/26, the investigation was assigned to me from licensing consultant Arlene Smith.

On 3/10/26, I conducted an unannounced onsite investigation at the facility. Upon arrival, staff members Jessica Balahoski and Andrea Alexander allowed entry into the home and agreed to discuss the case allegation.

Ms. Balahoski explained that she had been employed at the home from August 2025 through October 2025, when she was let go due to ongoing concerns with the former home manager, Briendon Stevens. Because of this, she was not employed at the time Resident A was found deceased in December 2025. Ms. Balahoski recalled working with Resident A prior to his death and reported that she had witnessed him refuse all of his oral medications on multiple occasions. She also recalled instances in which he refused his insulin, noting that Resident A's cooperation often depended on the manner in which staff approached him when offering his medications.

When asked about Resident A's blood sugar levels being monitored, Ms. Balahoski stated that he wore a Dexcom device but often became upset when staff attempted to check his readings. She believed that staff made efforts to monitor his blood sugar appropriately but was unsure how successful those efforts were due to his reluctance. Aside from the medication refusal she observed, Ms. Balahoski reported no knowledge of staff incorrectly managing his medications.

Staff member Andrea Alexander was interviewed and stated that she has worked at the home since 10/1/25. Ms. Alexander confirmed that Resident A passed away on the morning of 12/1/25. She stated that she arrived for her scheduled shift at 7:00am and shortly thereafter, Resident A's roommate came to her and reported that Resident A was on the floor. Ms. Alexander went to the bedroom and observed Resident A lying on the floor, noting that he was "cold to touch." She immediately contacted 911 and began chest compressions until emergency services arrived. When EMS arrived on scene, Ms. Alexander stated that the Fire Chief took over compressions. Resident A was eventually pronounced deceased. Ms. Alexander reported that she was never informed of Resident A's official cause of death.

According to Ms. Alexander, Resident A was reportedly last observed by staff around 12:30am. Ms. Alexander discussed 2-hour checks during sleeping hours. However, this is an internal policy and not a licensing rule. Resident A's assessment plan does not indicate that he requires 2-hour checks during sleeping hours.

Ms. Alexander reported that during the last two to three weeks of Resident A's life,

he consistently refused all oral medications. She added that he had refused his insulin for approximately one and a half weeks prior to his passing. According to Ms. Alexander, staff attempted to check Resident A's blood sugar levels every morning and before or after his meals as part of his routine care.

On 3/10/26, I spoke to licensee designee, Morgan Bailey via phone. Ms. Bailey stated that she had just spoken with staff prior to my call and that was the first time she had been informed of Resident A's death. She explained that the former home manager, Briendon Stevens often failed to communicate important information, which she believed was the reason she was just now learning of the incident. Ms. Bailey acknowledged that she was aware of Resident A being a diabetic, but she had no knowledge of any medication refusals. She also denied being aware of concerns related to Resident A's blood sugar not being monitored.

Later that same day, Ms. Bailey emailed me copies of Resident A's Medication Administration Record (MAR) for October and November 2025. The MARs showed multiple missed doses of the following prescribed medications: Amlodipine Besylate 10mg, Losartan Potassium 50mg, and Atorvastatin Calcium 20mg.

On 3/26/26, I spoke to Barb Cazier, who served as Resident A's guardian for less than a year leading up to his death. Ms. Cazier confirmed that Resident A was diabetic and often refused his medications. She stated that AFC staff communicated with her daily regarding his refusals and that Resident A was sent to the hospital often until his treatment regimen was adjusted and a medication was found that worked well for him. Ms. Xazier emphasized that staff consistently kept her informed and updated about Resident A's condition. She reported no concerns about staff actions and denied any suspicion of wrongdoing related to his death.

On 03/26/26, I spoke to Cynthia Bacon, staff at the Office of the Medical Examiner in Kent County. I requested Resident A's cause of death and she indicated that a former request must be made via email.

On 3/26/26, I sent a formal request to the Medical Examiner's office for Resident A's cause of death via email. Ms. Bacon responded and confirmed that Resident passed away on 12/1/25 and his cause of death was "Arteriosclerotic and Hypertensive Cardiovascular Disease with Diabetes Mellitus as other significant condition contributing to death. Manner of death is Natural."

On 04/13/26, I conducted an exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom. They were informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.675	Resident medications.

	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	<p>All staff members interviewed during the investigation confirmed that Resident A had a long history of refusing his medications. Based on the information obtained, there is no evidence to indicate that Resident A's death resulted from neglect by home staff.</p> <p>However, a review of his MARs for October and November 2025 showed multiple missed doses of Amlodipine Besylate 10 mg, Losartan Potassium 50mg, and Atorvastatin Calcium 20mg. Therefore, there is a preponderance of evidence to support a violation of this applicable licensing rule. Resident A had a history of refusing medications and therefore did not receive his medications as prescribed.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, staff members Jessica Balahoski and Andrea Alexander confirmed that Resident A's physician was never notified when Resident A would refuse his insulin medication as required per licensing rules. Ms. Balahoski and Ms. Alexander confirmed that this requirement was not a part of their training.

On 04/13/26, I conducted an exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom. They were informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.675	Resident medications
	<p>4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.</p>

ANALYSIS:	Ms. Balahoski and Ms. Alexander confirmed that they did not notify Resident A's physician when he refused his insulin medication. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION: While investigating the allegations listed above onsite, I requested to see Resident A's assessment plan, health care appraisal, resident care agreement, and MARs. Ms. Balahoski and Ms. Alexander were unable to locate these files in the facility.

Licensee Designee, Morgan Bailey eventually provided the requested forms via email on 3/10/26. She was informed that the forms are required to be onsite 2 years after the date of discharge. Ms. Bailey is aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.691	Resident records.
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless shorter retention is specified elsewhere in these rules.
ANALYSIS:	During the 3/10/26 onsite inspection, staff were unable to produce required records for Resident A. Therefore, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins

04/13/2026

Anthony Mullins
Licensing Consultant

Date

Approved By:



04/13/2026

Jerry Hendrick
Area Manager

Date