GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2023

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

RE: License #: AL370264709
Investigation #: 2023A0577012
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 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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2023A0577012
Complaint Receipt Date:	12/13/2022
Investigation Initiation Date:	12/13/2022
Report Due Date:	02/11/2023
Licensee Name:	Margarets Meadows, LLC
Licensee Address:	5257 Coldwater Rd. Remus, MI 49340
Licensee Telephone #:	(989) 561-5009
Licensee Designee:	Satish Ramade
Administrator:	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:	10/23/2021
Expiration Date:	10/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the emergency room due to having behaviors and the facility refused to accept Resident A back upon discharge from the hospital.	Yes

III. METHODOLOGY

12/13/2022	Special Investigation Intake 2023A0577012
12/13/2022	Special Investigation Initiated – Telephone call made to Jeanie Sage, SW with McClaren Hospital.
12/13/2022	APS Referral- Complainant filed APS Complaint.
12/13/2022	Referral – Other- Referral to the Ombudsman's Office was made by complainant.
12/13/2022	Referral – Other- LTC Ombudsman Office was made by McClaren Central Hospital.
12/14/2022	Contact - Telephone call made to The Care Team Hospice.
01/05/2023	Contact - Telephone call made- Interview with Relative A1.
01/11/2023	Inspection Completed On-site
01/11/2023	Inspection Completed-BCAL Sub. Compliance
01/12/2023	Exit Conference with licensee designee Satish Ramade.

ALLEGATION: Resident A was taken to the emergency room due to having behaviors and the facility refused to accept Resident A back upon discharge from the hospital.

INVESTIGATION:

December 13, 2022, a complaint was received alleging that on December 09, 2022 Margaret Meadows Assisted Living (MMAL) brought Resident A to McLaren Central Emergency Department due to alleged aggressive behaviors. According to the complaint, as of December 12, 2022, at 10:00am, Resident A has not demonstrated any

aggressive behaviors and has been easily redirectable. The complaint stated licensee designee Satish Ramade and home manager/staff member Pamela Pardee were contacted during the morning of December 11, 2022 but refused Resident A back to the facility as they deemed him to continue to be aggressive despite many conversations with hospital staff. The complaint alleged licensee designee Satish Ramade abandoned this resident in the emergency department (ED) by refusing to accept Resident A back at the facility especially given that he was no longer acting aggressively.

On December 13, 2022, I interviewed Jeannie Sage, Registered Nurse (RN) whose role is Chief Nursing Officer with McClaren Central Hospital. Ms. Sage reported Resident A was no longer at the McClaren Central Hospital ED after a placement for Resident A was found in the Kalamazoo area due to Margarets Meadow refusal to accept Resident A back at the facility. Ms. Sage reported Resident A was brought to the hospital by ambulance on December 09, 2022 and discharged from the ED on December 13, 2022. Ms. Sage reported on December 09, 2022 she received a call from the ED reporting home manager (HM) Pamela Pardee and licensee designee Satish Ramade were refusing to take Resident A back due to behaviors despite the ED observing Resident A was not displaying any aggressive behaviors as noted by the ED Medical Director. Ms. Sage reported she spoke with Pamela Pardee on December 13, 2022, regarding Resident A and HM Pardee reported their care goal for Resident A was to be without behaviors which was why Resident A was sent out to the hospital for evaluation. Ms. Sage reported HM Pardee was informed Resident A was easily redirected and no aggressive behaviors had been observed. Ms. Sage reported HM Pardee still refused to accept Resident A back at the facility due to her responsibility to protect the other residents and staff. Ms. Sage reported she questioned HM Pardee about direct care staff members' approach with Resident A and about his pain management but HM Pardee was not able to provide information about either issue. Ms. Sage reported learning Resident A receives services from The Care Team-Hospice so she attempted to contact The Care Team-Hospice case manager with no success. Ms. Sage reported she called the general number for The Care Team-Hospice and spoke with the on-call nurse and Community Liaison who confirmed Resident A has an active case with The Care Team. Ms. Sage reported The Care Team confirmed they would continue to manage Resident A at Margaret Meadows if HM Pardee and licensee designee/administrator Satish Ramade accepted Resident A back at the facility.

Ms. Sage reported she spoke with licensee designee/administrator Ramade who reported he would not accept Resident A back and when asked on what grounds he was refusing, licensee designee/administrator Ramade stated, "due to aggressive behaviors." Ms. Sage reported she informed licensee designee/administrator Ramade Resident A had not demonstrated any behaviors and was easily redirectable since being admitted and while in the ED. Ms. Sage reported licensee designee/administrator Ramade and HM Pardee stated, "the resident was hitting a pregnant staff person" and Ms. Sage reported she respectfully asked why a known resident with behaviors would be assigned to worked with the pregnant staff person as that is a liability on Margaret Meadows. Ms. Sage reported on December 10, 2022, she asked HM Pardee and licensee designee/administrator Ramade how all parties involved in Resident A's care

could best support facility direct care staff members to accept Resident A back and licensee designee/administrator Ramade clearly stated he would not accept Resident A back at the facility from the hospital.

On December 14, 2022, I contacted The Care Team Hospice and spoke with Kelle Noxon, Director of The Care Team, who reported Resident A was discharged from their services on December 09, 2022 due to Resident A having significant assaultive behaviors while at the facility. Ms. Noxon described those behaviors as punching direct care staff in the stomach, attempted to lock the staff in a room, and being so combative the police were called to assist in getting Resident A to the hospital. Ms. Noxon reported Resident A was discharged from Hospice Services due to anticipation of Resident A being admitted psychiatrically to a hospital. Ms. Noxon reported there is documentation of a conversation between The Care Team and RN Jeannie Sage, Chief Nursing Officer with McClaren Central Hospital, reporting Resident A displayed no physical/aggressive behaviors while in the emergency room and the Care Team reporting to Ms. Sage facility direct care staff members were not capable of meeting Resident A's needs. Ms. Noxon reported they did not receive any form of official discharge notice from the facility.

On January 05, 2023, I interviewed Relative A1 who reported Resident A was admitted into the facility on November 23, 2022. Relative A1 reported HM Pamela Pardee was aware of Resident A having behaviors when initially placed at a new facility but thought the behaviors would subside once Resident A became acclimated. Relative A1 reported she had many conversations with Ms. Pardee prior to Resident A being admitted ensuring they were prepared for Resident A. Relative A1 reported Ms. Pardee contacted Resident A's previous facility and had extensive conversations regarding Resident A's personality, behaviors, routines etc. to assure they were able to meet his needs. Relative A1 reported on December 09, 2022, she received a phone call from the facility around 7:20pm reporting Resident A has become aggressive with direct care staff and residents and was being taken to the hospital by ambulance for a psychiatric evaluation. Relative A1 reported no other explanation was provided regarding the cause of Resident A's behaviors, just that Resident A went from being calm to hitting others. Relative A1 reported the staff (name unknown) who called to report Resident A going to the hospital reported facility licensee designee/administrator Satish Ramade stated direct care staff members cannot take care of Resident A and cannot meet his needs, so they will not be accepting him back upon discharge from the hospital. Relative A1 reported she received a phone call from McClaren Hospital around 11:30pm on December 09, 2022, explaining they are looking for a hospital to complete a psychiatric assessment on Resident A to determine if hospitalization was warranted. Relative A1 reported she contacted the hospital in the afternoon of December 10, 2022 and was told by hospital staff Resident A has been cleared medically as no aggressive behaviors had been witnessed by the hospital staff and it had been determined Resident A would be discharged back to the facility. Relative A1 reported she received a call from HM Pamela Pardee who stated hospice personnel had advised facility administration not to take Resident A back and to try to force Resident A to be admitted into a psychiatric unit.

On January 11, 2023, I completed an unannounced onsite investigation and interviewed HM Pamela Pardee who reported on December 09, 2022, Resident A was taken to the hospital by ambulance under the recommendation from The Care Team Hospice due to Resident A displaying aggressive behaviors towards direct care staff. Ms. Pardee reported Resident A had grabbed a direct care staff, shoved the direct care staff into a cabinet, and punched a direct care staff in the stomach with the staff being pregnant. Ms. Pardee reported she was under the impression Resident A would be admitted to a psychiatric unit for evaluation but when Ms. Pardee spoke with the hospital on December 10, 2022, hospital staff explained Resident A had been cleared medically and was ready for discharge back to the facility. Ms. Pardee reported after many conversations with the hospital, The Care Team-Hospice, and licensee designee/administrator Ramade it was decided Resident A's personal care needs could not be met by direct care staff member nor could direct care staff assure the safety of all residents, so Resident A was not accepted back into the facility. Ms. Pardee reported the facility did not issue any formal discharge such as a 30-day notice or a 24-hour notice to Resident A.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based on the information gathered during the investigation, Resident A was taken by ambulance to the hospital on December 09, 2022, due to displaying aggressive behaviors towards staff. Resident A was cleared both medically and psychiatrically on December 10, 2022, but licensee designee/administrator Satish Ramade refused to allow Resident A to return back to the facility until another placement could be located. Ms. Pardee reported Resident A, The Care Team, nor Relative A1 was provided a written discharge notice from the facility as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend the current status of the license remains unchanged.

01/31/2023

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

01/31/2023

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Dawn N. Timm Date
Area Manager