GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2023

Steve Gerdeman
3109 Lawton Drive NE
Grand Rapids, MI 49525

RE: License #: AL410007158
Investigation #: 2023A0350029
Ramsdell AFC

Dear Steve Gerdeman:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- 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 contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410007158
Investigation #:	2023A0350029
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	08/24/2023
Licensee Name:	Extended Care at Ramsdell, Inc.
Licensee Address:	3109 Lawton Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	(616) 361-6571
Administrator:	Steve Gerdeman
Licensee Designee:	Steve Gerdeman
Name of Facility:	Ramsdell AFC
Facility Address:	12471 Ramsdell Drive NE Rockford, MI 49341
Facility Telephone #:	(616) 696-4885
Original Issuance Date:	12/02/1991
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not provided to the hospital when he was sent there on 07/25/2023.	No
A 24-Hour Discharge Notice for Resident A not sent to his Legal Guardian or Case Manager. Also, the discharge notice did not contain information as to where Resident A went or what alternatives to discharge were tried.	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A0350029
07/25/2023	Contact - Telephone call made I spoke with Steve Gerdeman, Licensee Designee
07/26/2023	Special Investigation Initiated - Telephone I spoke with Misti Graham, Home Manager
07/26/2023	Contact - Telephone call made I spoke with Resident B
07/26/2023	Contact - Telephone call made I spoke with Cheryl Masalkowski, Resident A's Legal Guardian
07/26/2023	Contact - Telephone call made I spoke with Emily Worst, Social Worker at Butterworth Hospital
07/26/2023	Contact - Telephone call made I spoke with Dorie Sullivan, Resident A's Case Manager from Network 180
07/26/2023	Contact - Document Received I received a copy of the 24-Hour Discharge Notice
07/26/2023	APS Referral
07/27/2023	Exit conference – Held with Steve Gerdeman, Licensee Designee

ALLEGATION: Resident A's medications were not provided to the hospital when he was sent there on 07/25/2023.

INVESTIGATION: On 07/26/2023, I called and spoke with Misti Graham, Home Manager. Ms. Graham informed me that they typically do not provide a resident's medications to either the resident of Emergency Medical Technician when the resident is taken by ambulance to the hospital. Ms. Graham stated that usually the resident's guardian will pick up the medications and take them to the hospital. Ms. Graham did say, however, that she spoke with someone at the hospital by telephone and gave that person a list of Resident A's medications, and that the hospital will provide these medications until his are sent there.

On 07/26/2023, I called and spoke with Emily Worst, Social Worker at Butterworth Hospital. Ms. Worst told me that the hospital is not typically given the medications of "drop offs," people who are brought and left at the hospital for evaluations. Ms. Worst stated that if they are provided a list of the medications for whoever is dropped off, they will supply that person with their medications. Ms. Worst confirmed that the hospital did receive a list of Resident A's medications, and that he will get whatever he was prescribed while he is there.

On 07/26/2026, I sent the referral source an email asking if she had referred this matter to Adult Protective Services (APS). That same day I received an email reply from the referral source who confirmed that she had also referred this complaint to APS.

On 07/27/2023, I called and held an exit conference with Steve Gerdeman, Licensee Designee. I informed Mr. Gerdeman that I was not citing violation of this rule. He reiterated that medications are usually taken to where the resident went within 48-hours.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Although Resident A's medications were not sent to the hospital with him, Misti Graham, Home Manager, spoke with someone from Butterworth Hospital and provided that person with a list of his medications. Emily Worst, Social Worker at Butterworth confirmed that they received a list of Resident A's medications and that the hospital would provide those medications to him. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: A 24-Hour Discharge Notice for Resident A not sent to his Legal Guardian or Case Manager. Also, the discharge notice did not contain information as to where Resident A went or what alternatives to placement were tried.

INVESTIGATION: On 07/26/2023, I received a copy of the 24-Hour Discharge Notice regarding Resident A that was sent to Licensing and Regulatory Affairs (LARA) from Ramsdell AFC. I read the notice and observed that it did not include information as to where Resident A went or what alternatives to discharge had been tried.

On 07/26/2023, I called and spoke with Misti Graham, Home Manager. Ms. Graham informed me that on 07/25, Steve Gerdeman, Licensee Designee, wrote the 24-Hour Discharge Notice regarding Resident A and faxed it to her. She then handed a copy to Resident A at about 5:00 p.m., as well as faxed it to Dorie Sullivan, Case Manager from Network 180, at about 5:30 p.m. and Cheryl Masalkowski, Resident A's court-appointed Legal Guardian. She informed me that if the faxes didn't go through, she would have received a message stating so; but she did not get a message after sending either of these faxes. Ms. Graham stated that the reason for the discharge was that on 07/25, Resident A became very upset and punched several holes in the walls and threated Resident B. She reported that she called Mr. Gerdeman who advised her to call an ambulance to have him taken to the hospital for a psychological evaluation, which she did. Ms. Graham told me that she also spoke with Ms. Sullivan on 07/25 and she told Ms. Graham she did not receive the fax of the discharge notice, so she re-faxed it. Ms. Graham informed me that various things have been tried to help Resident A with his destructive acting-out behaviors, but he refused to cooperate with his Community Mental Health (CMH) Treatment Plan, including refusing to go to appointments that were scheduled to help him address this issue. I asked if I could speak to Resident B, and she gave him her cell phone and Resident B went to a private area.

On 07/26/2023, I spoke with Resident B by telephone. I asked him what happened on 07/25 between him and Resident A, and he stated that Resident A came at him with his fists and was swinging at him. He said another resident held Resident A to prevent him from hitting him. Resident B told me that during this incident Resident A threatened to kill him. Resident B stated that Resident A has threatened him before as well.

On 07/26/2023, I called and spoke with Ms. Masalkowski, and she stated that she did not receive a copy of the 24-Hour Discharge Notice, but did receive a voicemail message from someone from Ramsdell AFC, informing her of the discharge notice. Ms. Masalkowski told me that she has been Resident A's Legal Guardian for five or six years, and that he has been evicted from his placements several times for the same reasons (threatening others, destroying property). Ms. Masalkowski said that Resident A has called the police and Licensing and Regulatory Affairs many times

before, and then denied that he called them. Ms. Masalkowski described Resident A as a “very, very hard case.”

On 07/26/2023, I called and spoke with Steve Gerdeman, Licensee Designee. Mr, Gerdeman reported that on 07/25, Resident A began punching holes in the walls and threatened another resident. He said that he wasn’t there, but Ms. Graham called him and he advised her to call the non-emergency police. Ms. Graham did so, and Resident A was willingly taken to the hospital by ambulance. I informed Mr. Geredeman that I reviewed a copy of the discharge notice he wrote and that there was information missing from it, such as what alternatives were attempted to prevent him from being discharged, and mention of where he was sent to. Mr. Gerdeman stated he appreciated my informing him of this information.

On 07/26/2023, I called and spoke with Dorie Sullivan, Resident A’s Case Manager from Network 180. Ms. Sullivan explained that she did not receive a copy of the 24-Hour Discharge Notice from anyone at Ramsdell, but did receive a copy from the hospital social worker. Ms. Sullivan stated that she spoke with Misti Graham this morning (07/26) and Ms. Graham told her she would resend the discharge notice. Ms. Sullivan informed me that faxes go to a central fax machine, not to her directly.

On 07/27/2023, I called and held an exit conference with Steve Gerdeman, Licensee Designee. I informed Mr. Gerdeman that I was citing a violation of this rule. Mr. Gerdeman stated that he has already updated their 24-Hour Discharge Policy, and that he would send me a corrective action plan shortly.

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24** **hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.**

	(iii) The location to which the resident will be discharged, if known. **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Misti Graham handed Resident A a copy of the 24-Hour Discharge Notice and reportedly faxed a copy to his Legal Guardian, Cheryl Masalkowski and his Case Manager, Dorie Sullivan. LARA also received a copy of the notice. Ms. Masalkowski stated that she did not get a copy of the notice but did receive a voicemail message from someone from Ramsdell AFC, informing her of the discharge notice. Ms. Sullivan also reported that she did not receive a copy of this notice from Ramsdell, but did receive a copy from the hospital social worker. Ms. Sullivan stated that she spoke with Ms. Graham who said she would resend the notice. I read the notice and observed that it did not include information as to where Resident A went or what alternatives to discharge had been tried. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

July 27, 2023

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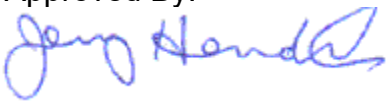
Ian Tschirhart Date
Licensing Consultant

Approved By:



July 27, 2023

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Jerry Hendrick Date
Area Manager