GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 20, 2024

Megan Charboneau
Linda Margaret's Retirement Community LLC
722 S. Huron St.
Cheboygan, MI 49721

RE: License #: AM160417504
Investigation #: 2024A0360019
Linda Margaret's Retirement Community

Dear Megan Charboneau:

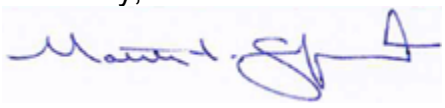
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste 3
Gaylord, MI 49735
(989) 370-8320
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM160417504
Investigation #:	2024A0360019
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/29/2024
Report Due Date:	09/24/2024
Licensee Name:	Linda Margaret's Retirement Community LLC
Licensee Address:	3723 Long Lake Rd Cheboygan, MI 49721
Licensee Telephone #:	(231) 445-2010
Administrator/Licensee Designee:	Megan Charboneau
Name of Facility:	Linda Margaret's Retirement Community
Facility Address:	3723 Long Lake Rd Cheboygan, MI 49721
Facility Telephone #:	(231) 445-2010
Original Issuance Date:	11/09/2023
License **Status:**	REGULAR
Effective Date:	05/09/2024
Expiration Date:	05/08/2026
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility is over capacity.	Yes
Resident A fell and broke her hip.	No

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A0360019
07/29/2024	Special Investigation Initiated - On Site
07/29/2024	Inspection Completed On-site Resident A, DCS Leslie Vipperman, DCS Jennifer Morris
07/29/2024	Contact - Telephone call received Megan Charboneau
08/06/2024	Inspection Completed On-site DCS Mariah Meyers, DCS Heather Schaefer, Resident A, B, C, D, E, F, G, H, I, J, K, L, M., DCS Steven MacLeod.
08/06/2024	Contact - Telephone call received Licensee Megan Charboneau
08/07/2024	Contact - Telephone call received Licensee Megan Charboneau
08/16/2024	Contact - Document Received Licensee Megan Charboneau
09/19/2024	Contact - Telephone call made Relative A
09/19/2024	Contact – Telephone call made Licensee Megan Charboneau
09/20/2024	Exit Conference Megan Charboneau

ALLEGATION:

Facility is over capacity.

INVESTIGATION:

On 8/6/24, I conducted an unannounced onsite inspection at the facility. Direct care staff (DCS) Mariah Meyers stated the facility currently has 13 residents. She stated they were down to 11 residents however two residents were admitted from another facility the licensee was closing within the past week. Ms. Meyers stated Resident B is on end-of-life care through Hospice and it is anticipated that she may pass within the next week. I then interviewed DCS Heather Schaefer who confirmed there are currently 13 residents at the facility. I then interviewed DCS Steven Macleod who confirmed there were 13 residents at the facility.

On 8/6/24, while at the facility, I reviewed the resident register which listed 13 residents currently admitted to the facility. I then observed all 13 residents in the facility.

On 8/7/24, I interviewed the licensee designee Megan Charboneau by telephone. Ms. Charboneau stated she did admit an additional resident over her licensed capacity within the past week due to closing another home. She stated Resident B had no place to go and that she anticipated that another resident may pass in the next few days who is on hospice care. She stated she understands she cannot admit residents over her licensed capacity and will get back in compliance as soon as possible.

On 8/16/24, I was contacted by the licensee designee Megan Charboneau by telephone. She stated the facility is back in compliance at 12 resident capacity.

On 9/19/24, I contacted the licensee designee Megan Charboneau by telephone. Ms. Charboneau stated the facility currently has 10 residents.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.

ANALYSIS:	Interviews with Ms. Meyers, Ms. Schaefer, Mr. Macleod, and Ms. Charboneau as well as a review of the resident register and an onsite inspection in which 13 residents were observed in the facility revealed that the facility was operating over the licensed capacity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A fell and broke her hip.

INVESTIGATION:

On 7/29/24, I conducted an unannounced onsite inspection at the facility. I interviewed the licensee, Megan Charboneau. Ms. Charboneau stated Resident A had two falls, one on 6/27/24 and another on 7/1/24. She provided me with a fall report for each incident. Ms. Charboneau also provided me with Resident A's written assessment plan which documented no needs for walking/mobility. Ms. Charboneau stated leading up to Resident A's first fall on 6/27/24 Resident A would walk the entire house without any assistance. She stated on 6/27/24 direct care staff Mariah Meyers was working and documented the fall, contacted Resident A's family, hospice staff and EMS. Ms. Charboneau stated Resident A was treated and released back to the facility with a deep bruise and recommendation for follow-up with primary care for worsening conditions. Ms. Charboneau stated Resident A was sitting in the living room and bent down to pick up a baby doll that she had dropped on the floor and fell on her side again. Ms. Charboneau stated DCS Mariah Meyers was the staff present for this fall and completed the fall report. Ms. Charboneau stated that Ms. Meyers again contacted the resident's family, hospice and EMS. Ms. Charboneau provided me with discharge paperwork from McLaren Northern Michigan that Resident A was diagnosed with a fracture of femoral neck.

On 7/29/24, while at the facility, I observed Resident A. Resident A was not oriented to time, person or place and could not be interviewed. I then interviewed DCS Leslie Vipperman. Ms. Vipperman stated she was not on shift during either of Resident A's falls. Ms. Vipperman stated Resident A was mobile prior to her falls and would often walk around the facility unassisted. Ms. Vipperman denied that Resident A required any additional supervision or assistance due to any fall risk. I then interviewed DCS Jennifer Morris. Ms. Morris stated Resident A had no previous need for walking, transferring or mobility assistance. Ms. Morris stated she was not working during either of Resident A's falls.

On 8/6/24, I conducted an unannounced onsite inspection at the facility. I again observed Resident A who was sleeping on a chair in the living room. I interviewed

DCS Mariah Meyers. Ms. Meyers stated on 6/27/24 she was in the kitchen and heard a noise in Resident A's bedroom. Ms. Meyers stated she went into the bedroom and found Resident A on the floor. Ms. Meyers stated it looked like she had become entangled in some of the bedding. Ms. Meyers stated Resident A was sent to the hospital and later discharged with bruising. Ms. Meyers stated Resident A was fully mobile and did not require any supervision or assistance for transferring or walking. Ms. Meyers denied that Resident A used any type of walker or assistive device. Ms. Meyers stated on 7/1/24 Resident A fell again, this time in the living room. Ms. Meyers stated Resident A had a baby doll that she carried around and it looked like she may had dropped it and bent over to pick it up when she fell. I then interviewed DCS Heather Schaefer. Ms. Schaefer stated she was working during Resident A's 7/1/24 fall. Ms. Schaefer stated that she did not witness the fall but came into the living room immediately after hearing the fall and saw Resident A on the floor with a baby doll. Ms. Schaefer stated they contacted the hospice nurse who immediately came to the facility and completed an evaluation and recommended that Resident A be sent to the hospital.

On 9/19/24, I contacted Relative A by telephone. Relative A stated he has no concerns at all with the home. He stated Resident A has lived at the home for two years and there has been nothing to complain about. He stated at the end of June Resident A got tangled in her bedding and had a fall. Relative A stated Resident A received some bruises and was sent home. He stated a few days later Resident A fell and fractured her hip after trying to pick up a baby doll. Relative A stated Resident A has advanced dementia and is not oriented to person, place or time. He stated he is in the facility weekly to spend time with Resident A and the staff have always provided appropriate supervision and protection. Relative A stated Resident A has never required any special assistance regarding mobility or at a high risk for a fall prior to breaking her hip. Relative A stated Resident A is now receiving physical therapy in the facility and continues to receive hospice care several times a week.

On 9/19/24, I contacted the licensee designee Megan Charboneau by telephone. Ms. Charboneau stated Resident A is recovering well.

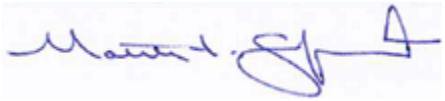
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Interviews with Ms. Vipperman, Ms. Morris, Ms. Schaefer, Ms. Meyers, Ms. Charboneau and Relative A all revealed that Resident A did have two falls, one that resulted in a hip fracture. However, documentation provided including the written assessment plan, interviews with Relative A and Ms. Charboneau revealed that Resident A did not require any additional supervision or protection due to being at a high risk for a fall injury. The staff took immediate action during both incidents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/20/24, I conducted an exit conference with the licensee Megan Charboneau. Ms. Charboneau concurred with the findings and stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

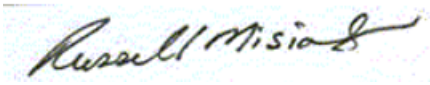
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



9/20/24

Matthew Soderquist Date
Licensing Consultant

Approved By:



9/20/24

Russell B. Misiak Date
Area Manager