



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 11, 2025

Brenda Kirtley  
Meadows by the Lake Inc.  
PO Box 213  
Stanton, MI 48888

RE: License #: AL590404706  
Investigation #: 2025A0466020  
Meadows by the Lake

Dear Ms. Kirtley:

Attached is the Special Investigation Report for the above referenced facility. Due to the physical plant and quality of care 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:

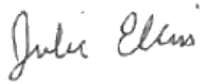
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended due to the physical plant violations cited in the report. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 284-9727.

Sincerely,

A handwritten signature in cursive script that reads "Julie Elkins".

Julie Elkins, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL590404706
<b>Investigation #:</b>	2025A0466020
<b>Complaint Receipt Date:</b>	02/24/2025
<b>Investigation Initiation Date:</b>	02/25/2025
<b>Report Due Date:</b>	04/25/2025
<b>Licensee Name:</b>	Meadows by the Lake Inc.
<b>Licensee Address:</b>	731 S. Nevins Road Stanton, MI 48888
<b>Licensee Telephone #:</b>	(616) 232-2221
<b>Administrator:</b>	Brenda Kirtley
<b>Licensee Designee:</b>	Brenda Kirtley
<b>Name of Facility:</b>	Meadows by the Lake
<b>Facility Address:</b>	904 Oak Drive Greenville, MI 48838
<b>Facility Telephone #:</b>	(616) 894-8198
<b>Original Issuance Date:</b>	09/24/2021
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/24/2024
<b>Expiration Date:</b>	03/23/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

## II. ALLEGATIONS:

	Violation Established?
Resident A was not administered nebulizer treatments as prescribed.	No
Resident A was not provided with proper nutrition.	No
The facility has a failed septic system.	Yes
Additional Findings	Yes

## III. METHODOLOGY

02/24/2025	Special Investigation Intake 2025A0466020.
02/25/2025	Special Investigation Initiated – Telephone call Complainant interviewed.
03/05/2025	Inspection Completed On-site.
03/06/2025	EHI referral made to Mid-Michigan District Health Department.
03/06/2025	Email from Adam Byrne, Environmental Health Supervisor Mid-Michigan District Health Department.
03/14/2025	Email from Adam Byrne, Environmental Health Supervisor Mid-Michigan District Health Department.
04/07/2025	Email to Adam Byrne, Environmental Health Supervisor Mid-Michigan District Health Department.
04/09/2025	Email from Adam Byrne, Environmental Health Supervisor Mid-Michigan District Health Department, EHI report.
04/11/2025	Exit Conference with licensee designee Brenda Kirtley.

**ALLEGATION: Resident A was not administered nebulizer treatments as prescribed.**

### INVESTIGATION:

On 02/24/2025, Complainant reported that Resident A has gone to the hospital 23 times for respiratory system issues and has since passed away from an upper respiratory failure. Complainant reported direct care staff members were missing nebulizer treatments and/or having Resident A complete these treatments herself when she was too weak to do so.

On 02/25/2025, I interviewed Complainant who reported that direct care workers (DCW)s Emily and Cathy (last names unknown) are aware of the missed nebulizer treatments. Complainant reported that DCW Ashley (last name unknown) reported that Resident A does the nebulizer treatment herself and when Complainant came to the facility (date unknown) the nebulizer was full of medication and Resident A was too weak to administer the treatment.

On 03/05/2025, I conducted an unannounced investigation and I interviewed DCW Debbie Sharpe who denied that Resident A self-administered nebulizer treatments. DCW Sharpe reported all Resident A's prescribed medications were stored in the medication cart and direct care staff trained to administer medication would put the medication in the nebulizer and then put the mask on Resident A for the medication to be administered. DCW Sharpe reported Resident A had respiratory issues which included wheezing and difficulty time breathing. DCW Sharpe reported Resident A's nebulizer treatments were administered as prescribed.

I interviewed DCW Kimberly Graverson who reported that Resident A's nebulizer treatment was administered by a DCW as prescribed.

I interviewed DCW Ashley Partridge who reported that Resident A's nebulizer treatment was administered by a DCW as prescribed. DCW Ashley Partridge reported that Resident A never refused the nebulizer treatment and she would hold the mouth piece/mask to complete the treatment because these would take 15-20 minutes to complete.

I interviewed licensee designee Brenda Kirtley who reported that all nebulizer treatments were administered by a direct care staff member trained to administer medication as prescribed. Licensee designee Kirtley reported that Resident A was weak and could no longer hold the mouthpiece for the treatment so they had a mask that she could wear during the treatment. Licensee designee Kirtley reported Resident A was discharged from the facility on 1/06/2025 after being hospitalized and then transferred to a rehabilitation facility.

I reviewed Resident A's record which did not contain any medication administration records (MAR)s. Resident A had been discharged from the facility so Resident A's medications were not available for review.

<b>APPLICABLE RULE</b>	
<b>R 400.15312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>

<b>ANALYSIS:</b>	Complainant reported Resident A's nebulizer treatments were not administered as prescribed. Resident A no longer resides at the facility. DCW Sharpe, DCW Graverson, DCW Ashley Partridge and licensee designee Kirtley all reported that Resident A's nebulizer treatments were administered as prescribed by a direct care staff member and not Resident A. Previously discharged Resident A's resident medications were no longer available for review and the MARs were also not available for review. Therefore there was not enough evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident A was not provided with proper nutrition.**

**INVESTIGATION:**

On 02/24/2025, Complainant reported direct care staff members were not providing Resident A with the right nutrition so she lost 1-2 pounds a day.

On 02/25/2025, I interviewed Complainant who reported Resident A did not have any teeth and the facility would serve taco salad which she could not eat. Complainant reported that Resident A would not eat food that was pureed in the blender.

On 03/05/2025, I conducted an unannounced investigation and I interviewed DCW Sharpe who reported that Resident A did not always want to eat. DCW Sharpe reported that Resident A was prescribed a special diet where her food had to be ground up fine. DCW Sharpe reported that when Relative A1 visited she gave Resident A cookies leading to Resident A aspirating. DCW Sharpe denied that Resident A lost any weight while living at the facility. DCW Sharpe reported that Resident A is offered proper nutrition she just does not always eat it.

I interviewed DCW Graverson who reported that Resident A was prescribed a soft food blended diet and that she would eat the food given to her. DCW Graverson denied that Resident A lost any weight while at the facility. DCW Graverson reported that Relative A1 would bring her lot of food that she was not supposed to eat and leave it with her. DCW Graverson reported that Resident A is offered proper nutrition she just does not always eat it.

I interviewed DCW Ashley Partridge who reported that Resident A did not like her liquids thickened and she routinely refused breakfast. DCW Ashley Partridge reported that Resident A's food were physician ordered to be chopped up finely/pureed but Resident A was "not a fan" of the ground-up meat, mashed potatoes and vegetables. DCW Ashley Partridge reported that Resident A never reported that she was hungry and she was not losing weight. DCW Ashley Partridge reported that Relative A1 brought Resident A in snacks and things to eat, even

though they were food items that were not soft/chopped up and gave them to her anyway. DCW Ashley Partridge reported that Relative A1 would bring Resident A bottled water which was supposed to be thickened but Resident A does not like the thickening agent so she preferred the water Relative A1 brought. DCW Ashley Partridge reported that Resident A is offered proper nutrition, she just does not always eat it.

I interviewed licensee designee Kirtley who reported that all the food served at the facility is homemade but Resident A will not eat it so she had been losing weight. Licensee designee Kirtley reported Relative A1 brings Resident A food that is not physician prescribed and leaves it with her. Licensee designee Kirtley reported that although the facility serves a lot of meat, it is all soft as it is slow cooked until tender and falling apart. Licensee designee Kirtley reported that potatoes are served mashed and vegetables are cooked. Licensee designee Kirtley reported that Resident A is offered proper nutrition she just does not always eat it.

I was at the facility during lunchtime and I observed the residents eating soft pulled pork, corn and mashed potatoes. I reviewed the menus which contained a variety of meat, vegetables and fruits throughout the month.

I reviewed Resident A's record which contained a blank *Weight Record*. Resident A's name was on the document, but no weights were recorded since the date of admission. Resident A's record contained documentation of how to serve a "minced and moist" diet. Resident A's record contained a completely blank *Health Care Appraisal*. Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* was dated 11/23/2023 and it did not document any dietary orders.

I reviewed a Corewell Health *After Visit Summary* that documented on 01/15/2024, Resident A was "4'11" and weighed 145 pounds. A Corewell Health *After Visit Summary* documented on 01/05/2025, Resident A was "4'11" and weighed 122 pounds so that was a weight loss of 23 pounds over a year.

APPLICABLE RULE	
R 400.15313	Resident nutrition.
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.

<b>ANALYSIS:</b>	Complainant reported that staff was not providing Resident A with the right nutrition and resulted in Resident A losing 1-2 pounds a day. DCW Sharpe, DCW Graverson, DCW Ashley Partridge and licensee designee Kirtley all reported that Resident A is offered proper nutrition daily but Resident A occasionally chooses not to eat it. At the time of the unannounced investigation, I observed lunch which was soft pulled pork, corn and mashed potatoes. I reviewed the menus which contained a variety of meat, vegetables and fruits throughout the month therefore there is not enough evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: The facility has a failed septic system.**

**INVESTIGATION:**

On 02/25/2025, Complainant reported that Resident A could not open her window because of the smell from the failed septic system, which is located outside of bedrooms #13, #14 and #15.

On 03/05/2025, I conducted an unannounced investigation and I interviewed DCW Sharpe, DCW Graverson, DCW Ashley Partridge, maintenance worker Russel Partridge and licensee designee Kirtley who all confirmed that the facility septic field has failed. Licensee designee Kirtley reported there are currently 18 residents admitted to the facility. Licensee designee Kirtley reported the Environmental Health Supervisor from Mid-Michigan District Health Department (name unknown) is aware of the septic field failure and is aware that licensee designee Kirtley is trying to secure funding to fix the field. Licensee designee Kirtley reported that until the septic field is replaced the septic tanks are being pumped every two weeks per the recommendation of the environmental health department. Licensee designee Kirtley reported that Richard Septic Services has been the company pumping the septic tanks every two weeks. Maintenance worker Russel Partridge reported that once a month he has been putting 1-2 bags of lime on the field to help with the smell per the health department's recommendation.

I reviewed receipts provided by licensee designee Kirtley which documented that Richards Septic Services was at the facility on 01/30/2025, 02/13/2025, 02/21/2025, and 03/03/2025.

On 03/06/2025, Adam Byrne, Environmental Health Supervisor Mid-Michigan District Health Department (MMDHD) reported that the last routine environmental health inspection was conducted on 12/1/2023 as requested by the department of licensing and regulatory affairs (LARA). Mr. Byrne reported that licensee designee Kirtley applied for the replacement septic system on 04/01/2024. Mr. Byrne reported when MMDHD completed the site evaluation the system was in a



state of failure at that time. Mr. Byrne reported that although the septic field was in a state a failure an EHI report was not issued documenting the failure as MMDHD was working with licensee designee Kirtley to have the septic field replaced. Mr. Byrne reported that licensee designee Kirtley was working on securing funding for the repairs and that is why this took so long. Mr. Byrne reported that this is when the health department told licensee designee Kirtley to keep the septic tanks pumped and apply lime over the area. Mr. Byrne reported that Department of Environment, Great Lakes, and Energy (EGLE) approved the design and the permit was issued 10/23/2024 for the new septic field to be installed. (According to Mr. Byrne this took time going back and forth with the system designer to ensure all EGLE criteria was met for the design.) Mr. Byrne reported that area sanitarian Austin Armentrout would be able to get out the facility next week to complete the EHI as requested by LARA on 03/06/2025.

On 03/17/2025, Mr. Byrne reported that the environmental health inspection (EHI) would be completed this week.

On 04/08/2025, Mr. Byrne reported that he thought the completed EHI was completed on 03/18/2025. Mr. Byren reported that he would confirm with the sanitarian. Mr. Byren reported that he spoke with the septic installer and the road weight restrictions have been removed. Mr. Byren reported that the septic installer reported that he has ordered all the materials and plans to start the system next week.

On 04/09/2025, Mr. Byrne emailed the *EHI Report* completed on 03/18/2025 by sanitarian Austin Armentrout. The report documented “bacteria” detected and that the “system is in failure, permits have been issued. Owners should install as soon as possible. Owners should also chlorinate and flush well due to positive bacteriological sample” Additionally the report documented that “one bathroom was out of order at the time of inspection.”

APPLICABLE RULE	
R 400.15401	Environmental health.
	(1) Private water systems shall be in compliance with R 325.10101 et seq. of the Michigan Administrative Code. A bacteriological report confirming water quality shall be required during the initial inspection and every 2 years thereafter. Group homes that use a community-approved water system need not be in compliance with this requirement.

<b>ANALYSIS:</b>	DCW Sharpe, DCW Graverson, DCW Ashley Partridge, maintenance worker Russel Partridge and licensee designee Kirtley all confirmed that the facility septic field has failed. Mr. Byrne reported that licensee designee Kirtley applied for the replacement septic system on 04/01/2024 because the system was in a state of failure at that time. Mr. Byrne and licensee designee Kirtley both reported that the system has not yet been replaced because licensee designee Kirtley was working on securing fundings for the repairs. Mr. Byrne reported that this is when the health department told licensee designee Kirtley to keep the septic tanks pumped and apply lime over the area to control the sewage smell. Mr. Byrne reported that Department of Environment, Great Lakes, and Energy (EGLE) approved the design and the permit was issued 10/23/2024 for the new septic field to be installed. The system has been in state of a failure for over a year and creates such a strong odor that residents cannot open their windows. Therefore a violation has been established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ADDITIONAL FINDINGS:**

#### **INVESTIGATION:**

On 03/05/2025, I conducted an unannounced investigation and I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* that was dated 11/25/2023 therefore this document has not been updated at least annually as required. At the time of the investigation licensee designee Kirtley reported that she would look to see if the updated *Assessment Plan for AFC Residents* could be located. As of the writing of this report no documents or communication was received from licensee designee Kirtley.

<b>APPLICABLE RULE</b>	
<b>R 400.15301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.</b>

<b>ANALYSIS:</b>	Resident A's record contained a written <i>Assessment Plan for AFC Residents</i> dated 11/25/2023. This document has not been updated at least annually as required.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 03/05/2025, I conducted an unannounced investigation and I reviewed Resident A's record which did not contain any MARs. Licensee designee Kirtley reported that MARs for discharged residents could not be obtained as they were no longer accessible through the computerized MAR system. Consequently, these documents were not printed nor available for review at the time of the unannounced investigation.

Resident A's record contained a blank *Weight Record*. I reviewed a Corewell Health *After Visit Summary* for Resident A which documented on 01/15/2024, Resident A was "4'11" and weighed 145 pounds. A Corewell Health *After Visit Summary* documented on 01/05/2025, Resident A was "4'11" and weighed 122 pounds which is a weight loss of 23 pounds over a year.

At the time of the investigation licensee designee Kirtley reported that she would look to see if she could locate Resident A's *MARs* and *Weight Record*. As of the writing of this report no documents or communication was received from licensee designee Kirtley.

<b>APPLICABLE RULE</b>	
<b>R 400.15316</b>	<b>Resident records.</b>
	<p><b>(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:</b></p> <p><b>(ii) Medication logs.</b></p> <p><b>(g) Weight record.</b></p> <p><b>(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.</b></p>

<b>ANALYSIS:</b>	At the time of the unannounced investigation Resident A's medication administration records were not available for review and according to licensee designee Kirtley, these records were not accessible for discharged residents. Additionally, Resident A's record contained a blank <i>Weight Record</i> with no documentation of monthly weights as required. Therefore a violation has been established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 04/09/2025, Mr. Byrne emailed the *EHF Report* completed on 03/18/2025 by sanitarian Austin Armentrout. The report documented that "one bathroom was out of order at the time of inspection."

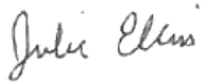
On 03/05/2025, I conducted an unannounced investigation and licensee designee Kirtley reported there are currently 18 residents admitted to the facility.

On 04/10/2025, I conducted a review of the facilities file in the Bureau Information Tracking System (BITS) which documented that the facility has three bathrooms.

<b>APPLICABLE RULE</b>	
<b>R 400.15407</b>	<b>Bathrooms.</b>
	<b>(4) A home shall have a minimum of 1 toilet, 1 lavatory, and 1 bathing facility for every 8 occupants of the home.</b>
<b>ANALYSIS:</b>	On 03/18/2025 sanitarian Austin Armentrout reported that "one bathroom was out of order at the time of inspection." On 03/05/2025, the facility had 18 residents admitted and only two working bathrooms therefore a violation has been established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan a provisional license is recommended for physical plant violations. The corrective action plan will also need to address any quality of care violations.



04/09/2025

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Julie Elkins  
Licensing Consultant

Date

Approved By:



04/11/2025

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Dawn N. Timm  
Area Manager

Date