



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 #: 2026A0467027
Extended Care At Ramsdell

Dear Ms. Bailey:

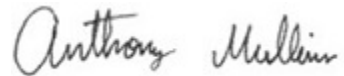
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 #:	2026A0467027
Complaint Receipt Date:	12/09/2025
Investigation Initiation Date:	12/10/2025
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, TRAUMATICALLY BRAIN INJURED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide transportation for Resident A, causing him to miss his scheduled physical therapy appointments.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/09/2025	Special Investigation Intake 2026A0467027
12/10/2025	Special Investigation Initiated - Telephone Kent County Recipient Rights Office, N180
03/10/2026	Inspection completed – onsite
03/10/2026	Contact – telephone call with Morgan Bailey
03/10/2026	Contact – document received from Morgan Bailey
03/11/2026	Contact – telephone call made to Ashton Bryne, Kent County Recipient Rights Officer
03/26/2026	Contact – telephone call made to Lindsey Kelly, NP through Home MD.
04/07/2026	Contact – telephone call made to Christina Crandle, guardian for Resident A
04/07/2026	APS Referral – not necessary based on investigative findings.
04/08/2026	Contact – telephone call made to Josh Dill at N180.
04/13/2026	Exit conference with licensee designee, Morgan Bailey and Chief Operations Officer, Jess Engstrom.

ALLEGATION: Staff did not provide transportation for Resident A, causing him to miss his scheduled physical therapy appointments.

INVESTIGATION: On 12/9/25, an online complaint was received regarding Resident A, who has prosthetic legs and requires ongoing physical therapy. The complaint alleged that although staff had agreed to transport Resident A to his essential health care appointments, they repeatedly canceled at the last minute. As a result,

Resident A missed multiple physical therapy appointments and is at risk of losing services if he misses one more appointment.

According to Resident A's guardian, Christina Crandle, she had scheduled several physical therapy appointments for him, and staff initially confirmed that transportation would be provided. The first appointment was scheduled for 9/24/25. On the day of the appointment, Ms. Crandle called the home to remind staff, and she was told that they were unaware of the appointment and could not transport him because staff called out. Ms. Crandle rescheduled the appointment for 9/29/25.

On 9/29/25, Ms. Crandle received a call from Life Beyond Barriers Physical Therapy notifying her that Resident A had not arrived for his therapy session. She contacted the home and spoke with Briendon Stevens, who was the manager at the time. Ms. Stevens reportedly stated she was unaware of the appointment and that a staff member had again called out. The appointment was once again rescheduled, this time to 10/9/25. On 10/9/25, staff at the facility contacted Ms. Crandle and reported that the appointment had been canceled due to a "bed bug concern" within the home. Ms. Crandle later determined that Resident A had not been exposed to bedbugs, causing him to miss his appointment for no valid reason.

On 3/9/26, this 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 member Jessica Balahoski and Andrea Alexander answered the door and allowed entry into the home. Ms. Balahoski explained that former manager, Briendon Stevens, had a pattern of missing scheduled medical appointments for several residents, including Resident A.

Ms. Balahoski reported that she is primarily responsible for transporting residents to their appointments and that she keeps a written log of all scheduled transports. She stated that she had no record of any appointments for Resident A during September 2025 and explained that if Ms. Stevens had informed her of the scheduled therapy sessions, she would have ensured Resident A was transported as planned. Ms. Balahoski shared that she is in the process of streamlining the appointment scheduling process. According to her, she will now have sole responsibility for scheduling and transporting residents throughout the week to medical appointments.

I also interviewed staff member Andrea Alexander. Ms. Alexander explained that she began working at the home on 10/1/25, and therefore had no knowledge of Resident A's earlier physical therapy appointments. She stated that when needed, staff from the company's other home would assist with transportation, and that staff at Network 180 had occasionally transported Resident A to appointments as well. Ms. Alexander was able to confirm that Resident A had a physical therapy appointment scheduled for 2/24/26 and she was unsure whether or not he attended. She noted that Resident A has a history of refusing to attend some appointments but added

that more recently, he had been consistently participating in his scheduled therapy sessions. It should be noted that I attempted to interview Resident A regarding the allegations while onsite. However, he refused.

Later that same day, I spoke to licensee designee, Morgan Bailey via phone. Ms. Bailey confirmed that former manager, Briendon Stevens had previously been responsible for transporting residents to their medical appointments. Since Ms. Stevens is no longer employed with the company, those responsibilities have transitioned to staff member Jessica Balahoski. According to Ms. Bailey, staff reported earlier in the week that Ms. Stevens had missed several medical appointments for Resident A and other residents during her time working at the home. Ms. Bailey agreed to send me a copy of Resident A's resident care agreement.

On 3/10/26, I received an email from Ms. Bailey with a copy of Resident A's resident care agreement as requested. The form indicated that AFC staff are responsible for "emergency transport and coordination."

On 3/11/26, I spoke to Recipient Rights worker, Ashton Bryne. Ms. Bryne confirmed that she completed an investigation regarding similar allegations. However, she did not cite a violation because Resident A refused to be interviewed and it was the guardian's word vs. former staff member, Briendon Stevens.

On 4/7/26, I spoke to Christina Crandle, guardian for Resident A via phone. Ms. Crandle confirmed that she had multiple physical therapy appointments scheduled for Resident A at Life Beyond Barriers in 2025, including 9/24, 9/29, and 10/9. Ms. Crandle stated that all three appointments were either cancelled or missed due to former staff member, Briendon Stevens, not communicating to other staff members about the appointments.

Ms. Crandle stated that she was not happy with the staff in September 2025. However, the facility is now under new management and new employees, and Ms. Crandle spoke highly of the staff members. She also spoke highly of the condition of the home, stating that staff are making required repairs and the home feels more positive overall. Ms. Crandle stated that Resident A is no longer attending Physical Therapy due to refusing. She is hopeful that he agrees to return to physical therapy at some point in the future.

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 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.

	<p>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</p> <p>(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.</p>
ANALYSIS:	<p>Resident A's guardian, and staff member Jessica Balahoski both confirmed that Resident A missed scheduled appointments for physical therapy due to the former home manager, Briendon Stevens not transporting him and/or not communicating appropriately with other staff to assist with transportation.</p> <p>Resident A's assessment plan indicates that AFC staff members are responsible for "emergency transport and coordination." Therefore, there is a preponderance of evidence to support this applicable licensing rule.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, I spoke to Lindsey Kelly, Nurse Practitioner with Home MD on 3/26/26. Ms. Kelly reported that while reviewing Resident A's medications, she discovered that he was receiving oral medications in addition to injectable medications that treated the same symptoms. This prompted her to conduct what she referred to as a "medication reconciliation" with Network 180, who confirmed that the medications in questions had been discontinued. Ms. Kelly stated that she addressed the concern with the staff member who was working at the time. However, she was unable to determine how long Resident A had been receiving his medications incorrectly.

On 4/8/26, I spoke to licensee designee, Morgan Bailey via phone. Ms. Bailey stated that in early March 2026, NP Lindsey Kelly informed her that Resident A's clozapine 150mg and Haldol 2mg had been discontinued by Network 180. According to Ms. Bailey, she updated the home's medications system immediately after receiving this information. She reported that she had no prior knowledge that these medications had been discontinued prior to being notified by Ms. Kelly.

On 4/8/26, I spoke to Josh Dill, case manager on the Delta Team at Network 180, to verify Resident A's prescribed medications and any recent changes. Mr. Dill explained that Resident A had a medication review on 12/29/25, at which point he was prescribed the following medications : Depakote 250mg Tablets, Haldol 100mg per 1ml oil (injection - administered by N180 nurse), Haldol 2mg Tablets, Melatonin

3mg, Uzedy 250mg per .7ml suspension (injection – also administered by N180 nurse).

Mr. Dill stated that Resident A had a follow-up medication review on 2/9/26 and his medications were updated to the following: Trazadone 50mg Tablet, Levothyroxine 50mcg Tablets, Hydroxyzine 25mg Tablet as needed, Depakote 250mg extended release Tablet, Uzedy 250mg (injection) and Clozapine 150mg Tablets, which replaced Haldol.

A subsequent medication review occurred on 3/16/26, and Resident A's medications were listed as follows: Clozapine 100mg Tablets, Depakote 250mg Tablets, Hydroxyzine 25mg Tablets as needed, Levothyroxine 50mcg Tablets, Trazadone 50mg, Uzedy 250mg (injection).

On 4/8/26, I received Resident A's Medication Administration Records (MAR) for January through March 2026. A review of his January MAR showed no discrepancies. His February MAR indicated that he did not receive his prescribed Melatonin on 2/6, 2/8, 2/15, 2/21 and 2/22. In addition, on 2/15, he did not receive his scheduled doses of Trazadone, Depakote, or Clozapine. His March MAR confirmed that on 3/13/26, Resident A received 600mg of Clozapine, which was twice the amount he was supposed to receive.

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.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A's MAR's were reviewed and confirmed that he did not receive his melatonin, trazadone, clozapine, and Depakote as prescribed. He also received twice the amount of Clozapine on 3/13/26. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's resident care agreement. In doing so, I observed that the form did not have a signature from his guardian or the licensee designee.

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 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.
ANALYSIS:	Resident A's resident care agreement was not signed by his guardian or the licensee designee. Therefore, there is a preponderance of evidence to support this applicable rule.
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 Date
 Licensing Consultant

Approved By:

Jerry Hendrick

04/13/2026

 Jerry Hendrick Date
 Area Manager