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 #: 2026A0467029
Extended Care At Ramsdell

Dear Ms. Bailey:

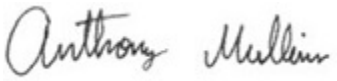
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,



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 #:	2026A0467029
Complaint Receipt Date:	03/05/2026
Investigation Initiation Date:	03/05/2026
Report Due Date:	05/04/2026
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, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's room is deplorable and has urine on the floor.	No
Resident A is not receiving his medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/05/2026	Special Investigation Intake 2026A0467029
03/05/2026	Special Investigation Initiated - Letter Email to Director of Recipient Rights per Arlene Smith
03/05/2026	APS Referral – complaint received from Kent County APS
03/10/2026	Inspection Completed On-site
03/10/2026	Contact – telephone call made to licensee designee, Morgan Bailey
03/11/2026	Contact – telephone call made Kent County Recipient Rights Officer, Ashton Byrne.
03/26/2026	Contact – telephone call made to Lindsey Kelly, NP through Home MD
03/26/2026	Contact – telephone call made to Stacy Ellison, clinical coordinator through Ela Caring Hospice.
04/13/2026	Exit conference with licensee designee, Morgan Bailey and Chief Operations Officer (COO), Jess Engstrom.

ALLEGATION: Resident A's room is deplorable and has urine on the floor.

INVESTIGATION: On 3/5/26, I received a complaint from Kent County Adult Protective Services (APS) alleging that approximately six weeks earlier, Resident A's bedroom had not been kept clean and that urine had been observed on the floor. 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 members Jessica Balahoski and Andrea Alexander allowed entry into the home and agreed to discuss the case allegation. Ms. Balahoski explained that

Resident A had been using a catheter since returning home from a rehab facility in December 2025. She stated that Resident A can empty the catheter bag himself. Ms. Balahoski reported that she had no knowledge of any instance in which urine was found on Resident A's bedroom floor or incidents in which his room had not been clean.

Ms. Alexander stated that Resident A had been using a catheter since returning home from a physical rehab facility in December 2025. She explained that Resident A sometimes intentionally disconnected the catheter tubing, which caused urine to leak onto himself and the floor. According to Ms. Alexander, Resident A did not always inform staff when this occurred. However, whenever staff noticed urine in his room, they cleaned it immediately. She reported that she had personally mopped Resident A's bedroom floor the previous day after observing urine on it.

After speaking to staff, they escorted me to Resident A's room so that I could meet him. Resident A declined to be interviewed before I could introduce myself. During the brief time I spent in his room, I did not observe urine on the floor or note any conditions that would indicate the room was unclean or in a deplorable state.

On 3/10/26, I also spoke to licensee designee, Morgan Bailey via phone regarding the allegation. Ms. Bailey stated that staff at the home had informed her that Resident A had been intentionally disconnecting his catheter bag, causing it to leak. She reported that she had no knowledge of staff failing to clean urine from his floor. Ms. Bailey added that resident bedrooms are expected to be cleaned at least once per week and more often if deemed necessary.

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 denied having any questions.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Resident A refused to be interviewed regarding the allegation. However, his room was observed to be free of any urine or foul odor. Ms. Balahoski and Ms. Alexander reported that they clean Resident A's room as needed to address any concerns with urine. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not receiving his medications as prescribed.
INVESTIGATION: On 3/5/26, I received a complaint from Kent County Adult Protective Services (APS) alleging that Resident A's health had been declining due to medication mismanagement at the home, including missed doses of prescribed antibiotics. According to the complaint, Resident A experienced stroke-like symptoms in November 2025 that were believed to be related to his prescribed medications, which were also causing low blood pressure. He was reportedly taken off this medication regimen and placed on a new one. However, staff at the home allegedly restarted his previous medications without authorization from his physician. The complaint further alleged that due to his worsening condition, Resident A now requires assistance with is ADL's. The complaint also stated that Resident A was diagnosed with a urinary tract infection (UTI) in February 2026 and prescribed antibiotics. He later developed another UTI, which could have been caused by staff not administering all doses of his antibiotics.

On 3/10/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff members Jessica Balahoski and Andrea Alexander allowed entry into the home and agreed to discuss the allegation. Ms. Balahoski reported that she previously worked in the home from August 2025 through October 2025, when she was let go by former manager, Briendon Stevens. She explained that her dismissal was related to ongoing concerns with Ms. Stevens. Ms. Balahoski stated that she was rehired in late January or early February 2026 after Ms. Stevens and her mother were no longer employed by the company. Due to this gap in employment, Ms. Balahoski denied any knowledge of Resident A experiencing any stroke-like symptoms or low blood pressure in November 2025. She also denied Resident A needing assistance with his ADL's.

Ms. Balahoski confirmed that Resident A had recently been prescribed antibiotics to treat his UTI. She acknowledged that as of recent, at least four doses of the prescribed antibiotic remained in the medication cart, indicating that they were never administered. She also confirmed that Resident A had developed a second UTI. Ms. Balahoski stated that she did not know why staff did not provide Resident A with all of his antibiotics as prescribed.

While onsite, I reviewed the medication cart and observed that Resident A's physician ordered the antibiotic Cefuroxime Axetil 250mg on 2/28/26 and it was to be taken

orally twice daily for ten days. Based on the date the medication was ordered, the full course of the antibiotics should have been completed by 3/10 or 3/11 at the latest. Resident A's medication pack showed five unused doses, confirming Ms. Balahoski's report that he had not received all of his antibiotics as prescribed.

Regarding Resident A's overall health, Ms. Alexander stated that she was aware he had been experiencing issues because he frequently complained of chest pain. However, she was unsure whether these concerns were related to stroke-like symptoms reported in November 2025. She denied any knowledge of Resident A being restarted on previously discontinued medications. Ms. Alexander also stated that she had not been aware that Resident A had a UTI or that any doses of his antibiotic had been missed. She reported that Resident A had recently signed on with Ela Caring for Hospice the previous weekend for comfort care and to prevent further hospital readmissions. Ms. Alexander confirmed that Resident A required assistance with his ADL's, but added that he would often refuse help.

On 3/10/26, I spoke to licensee designee, Morgan Bailey via phone. Ms. Bailey denied any knowledge of Resident A having stroke-like symptoms in November 2025 that was reportedly causing him to have low blood pressure. Ms. Bailey reported that last week, Ms. Balahoski contacted her while speaking to Lindsey Kelly, Nurse Practitioner with Home MD, and informed her that the former home manager had failed to notify the pharmacy about several discontinued medications. Ms. Bailey stated that shat Ms. Stevens also did not have the after-visit summaries needed to notify the pharmacy of the medication changes. As a result, Ms. Bailey and Ms. Kelly reviewed Resident A's medications and discontinued those that had been previously stopped by his prescribing physician.

Ms. Bailey stated that she could not recall the specific medications that had been discontinued but were still being administered to Resident A. However, she added, "it was quite a few." She agreed to provide Resident A's MARs from 1/1/26 to present. Ms. Bailey also explained that Resident A does not have a guardian and APS is in the process of trying to obtain a court-appointed guardian "but no one wants to pick-up the case." Ms. Bailey reported that Resident A had recently required prompting to complete his ADL's. Ms. Bailey denied any knowledge that staff had failed to provide Resident A with his prescribed antibiotics for his UTI.

On 3/10/26, I reviewed Resident A's MARs, which did not clarify exactly when certain medications were discontinued for Resident A.

On 3/11/26, I spoke to Recipient Rights Officer, Ashton Byene. Ms. Byene stated that this morning, she spoke to Lindsey Kelly, NP and she confirmed that while she was at the home earlier this month, she noted that several medications had been discontinued by herself and hospital staff. Despite this, staff were still giving medications to Resident A. One medication in particular, Xanax, was supposed to be

weaned for Resident A. However, this never occurred and staff discontinued the medication without gradual reduction instead.

On the same day, Ms. Byrne sent me an email and included a list of the following medications that were discontinued but Resident A continued to receive them in the home; Melatonin, Trazadone, Benadryl, and Aripiprazole (Abilify).

On 3/26/26, I spoke to Nurse Practitioner (NP) Lindsey Kelly with Home MD. Ms. Kelly confirmed that Resident A had experienced stroke-like symptoms in November 2025, which she attributed to his prescribed medications that were also affecting his blood pressure. To address this concern, several of his medications were discontinued by both hospital staff and herself. Despite the changes, Ms. Kelly reported that she later observed the discontinued medications still being administered to Resident A. She identified the medications as Melatonin,Trazadone, Benadryl, and Abillify. Ms. Kelly confirmed that Resident A had been prescribed antibiotics for a UTI. She stated that Resident A did not receive the full course of this medication and explained that this could have contributed to the second UTI he developed although he was prone to UTI's due to having a catheter in place.

Later that same day, I spoke to Stacy Ellison, clinical coordinator with Ela Caring Hospice regarding Resident A. Ms. Ellison reported that Resident A was admitted to hospice services on 3/10/26 with a primary diagnosis of protein calorie malnutrition and frontal temporal cognitive disorder with dementia. She stated that the hospice agency is managing Resident A's medications and a hospice nurse visits him one to two times per week, depending on his condition and level of need. Ms. Ellison confirmed that Resident A has a catheter in place and hospice staff have been overseeing care for this. She denied any concerns regarding medication management since Hospice began providing services.

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:	Ms. Balahoski confirmed that Resident A did not receive all scheduled doses of his prescribed antibiotic for his UTI. During my onsite investigation on 3/10/26, I verified that five doses of the antibiotic remained unused and were still in the medication cart.

	In addition to the missed antibiotics, both the licensee, Morgan Bailey and NP Lindsey Kelly confirmed that Resident A had been receiving medications that had previously been discontinued by his prescribing provider. Therefore, there is a preponderance of evidence to support a violation of this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

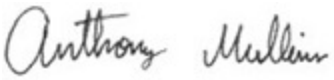
INVESTIGATION: During my onsite investigation on 3/10/26, I observed that the flooring in the living room had been removed and required replacement. I also noted that the flooring in the common area and dining room was significantly slanted, with multiple cracks of varying lengths and widths across the surface. Based on the current condition, it was evident that this flooring also requires replacement.

Licensee Designee Ms. Bailey confirmed that the living room flooring was already in the process of being replaced, and she stated that the remaining damaged floor would also be addressed. Chief Operations Officer Jess Engstrom confirmed this as well during our call on 4/13/26.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.
ANALYSIS:	During the onsite investigation, I observed the flooring in both the living room and the common area/dining room was either missing entirely or showed multiple significant cracks throughout. These conditions pose safety concerns and require immediate attention to ensure the well-being of residents. Therefore, there is a preponderance of evidence to support this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

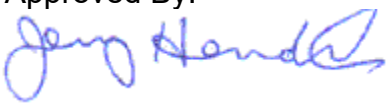
Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



04/13/2026

Anthony Mullins, Licensing Consultant Date

Approved By:



04/13/2026

Jerry Hendrick, Area Manager Date