GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2026

Satish Ramade
Margarets Meadows, LLC
5257 Coldwater Rd.
Remus, MI 49340

RE: License #: AL370264709
Investigation #: 2026A1033039
Margarets Meadows

Dear Mr. Ramade:

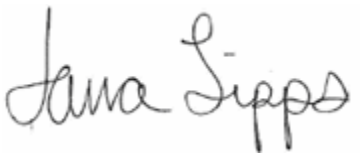
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,



Jana Lipps, 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2026A1033039
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/27/2026
Licensee Name:	Margarets Meadows, LLC
Licensee Address:	5257 Coldwater Rd. Remus, MI 49340
Licensee Telephone #:	(248) 470-4862
Administrator:	Satish Ramade
Licensee Designee:	Satish Ramade
Name of Facility:	Margarets Meadows
Facility Address:	5257 Coldwater Road Remus, MI 49340
Facility Telephone #:	(989) 561-5009
Original Issuance Date:	10/11/2004
License Status:	REGULAR
Effective Date:	10/23/2025
Expiration Date:	10/22/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not kept clean. Resident bathrooms/bedrooms and common areas are dirty. Visible feces on bathroom surfaces.	Yes
Resident medications are not being given as prescribed. Medications are given two hours early or being administered with incorrect doses. Medications have been left out in resident rooms and found on the floor.	No
Resident personal care needs are being neglected. They are not provided with clean clothing daily.	No
Direct care staff are rude and disrespectful to the residents. Residents are fearful of direct care staff.	Yes

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A1033039
06/01/2026	Special Investigation Initiated - On Site Interviews conducted with direct care staff/home manager, Pam Pardee, direct care staff, Jordan Wilson, Resident A, Resident B, and Resident C.
06/02/2026	Contact - Document Sent Email correspondence sent to licensee designee, Satish Ramede, direct care staff/home manager, Pam Pardee.
06/02/2026	Contact - Document Sent Email correspondence sent to direct care staff/home manager, Pam Pardee. Awaiting response.
06/03/2026	Contact - Document Received Email correspondence with requested documents received from home manager/direct care staff, Pam Pardee.
06/15/2026	Inspection Completed On-site Follow-up on-site inspection to check status of housekeeping. Interview conducted with Pam Pardee.
06/24/2026	Inspection Completed-BCAL Sub. Compliance
06/25/2026	Contact – Telephone call made

	Attempt to interview Guardian #1. Voicemail message left. Awaiting response.
06/25/2026	Contact – Telephone call made Interview conducted with direct care staff, Bobbie Jo Galehouse.
06/25/2026	Contact – Telephone call made Interview conducted with direct care staff, Emma Johnson.
06/25/2026	Contact – Telephone call made Interview conducted with Citizen 1, via telephone.
06/26/2026	Contact – Telephone call made Interview conducted with Guardian #1 & Guardian #2, via telephone.
06/29/2026	Contact – Telephone call made Interview with adult foster care, licensing consultant, Julie Elkins.
07/01/2026	Exit Conference Conducted via telephone and email with licensee designee, Satish Ramade.

ALLEGATION: The facility is not kept clean. Resident bathrooms/bedrooms and common areas are dirty. Visible feces on bathroom surfaces.

INVESTIGATION:

On 5/28/26 I received an online complaint regarding the Margaret's Meadows, adult foster care facility (the facility). The complaint was submitted anonymously and alleged that the facility is not kept in a clean and sanitary condition. I conducted an unannounced on-site investigation at the facility on 6/1/26. I spoke with direct care staff/home manager, Pam Pardee, who provided me with a guided walkthrough of the facility. I walked through all common areas, all resident bedrooms, and all bathrooms. I observed that most of the resident bedrooms have a half bathroom located in their apartment. I observed that every resident bathroom was found in unclean, unsanitary conditions. The toilet bowls appeared to have not been cleaned in weeks, potentially longer. The toilet bowls were stained with urine and feces. Some of the toilets had feces on the toilet seats, the toilet base, and on the floor surrounding the toilet. I observed two empty apartments which had bathrooms located in these apartments. These toilets were also found in the same condition. I asked Ms. Pardee how long it had been since a resident occupied those apartments. Ms. Pardee reported that it had been at least two months. I asked Ms. Pardee what the process is for cleaning these apartments when a resident vacates an apartment. She reported that the direct care staff are responsible to clean these apartments as soon as someone moves out. The sinks that were observed

in the resident half bathrooms were also soiled with soap scum, toothpaste, and hair. These sinks and countertops appeared to have not been wiped down in a prolonged period. As I walked through the resident bedrooms I observed a large pile of clothing on the chair in Resident A's bedroom. The clothing was clean and folded but not put away. Resident A reported that she asks direct care staff to put her clothing away and she does not receive assistance with this task. She reported that the clothing will sit there for weeks until someone finally assists. By the time I completed my walkthrough Resident A's clothing had been put away in her closet/drawers.

During the walkthrough I observed two main bathrooms used for resident showers and toileting. One of the showers had a bucket placed under the shower head on the shower floor. This bucket was overflowing with water. I asked Ms. Pardee the purpose for the bucket and she reported that the showerhead leaks/drips and they use the bucket to catch this water because if they do not the water will drip on the floor of the shower and splash out onto the bathroom floor. I informed Ms. Pardee that this showerhead needs to be repaired as this is a safety concern and not a reasonable solution. The second shower room was found to have an old, rusted, and dirty toilet seat riser over the toilet. This device had feces on the front leg and appeared to have not been kept clean and in good condition. In the shower of this bathroom I found a wash basin sitting on the shower floor. This basin appeared to have urine in the bottom. I asked Ms. Pardee about this basin and she did not know why this was sitting on the floor of the shower. There was an open trash can sitting next to the toilet that contained soiled sanitary wipes with feces on them.

During the on-site investigation I interviewed Resident A regarding the allegation. When asked about the cleanliness of the facility, Resident A stated, "You should look at my toilet!" She reported that her bathroom has not been cleaned regularly and she was frustrated by this situation. She reported that her clothing is also not put away as she would like, in her closet or in her drawers.

During the on-site investigation I interviewed Resident B regarding the allegation. Resident B reported that the facility is not kept in a clean and sanitary condition. She reported, "There is shit on the shower floor". She further reported that the toilet seat riser frequently has feces on it as well. She reported that there can be two week periods of time where the direct care staff leave the bathroom in these conditions. Resident B reported that she never takes a shower at the facility because it is too unsanitary. She reported that she would prefer to do a bed bath and has someone come assist her with this task. She reported that there was a day when someone "shit" on the shower floor and it took two says for someone to go into the bathroom and clean this up. Resident B reported that the direct care staff who work nights do some cleaning but the direct care staff who work during the days do not clean.

During the on-site investigation I interviewed Resident C regarding the allegation. When asked about the cleanliness at the facility Resident C responded, "Well, I don't let my grandbabies go into those bathrooms." She reported that when her family members come to visit her she does not allow them to use the bathroom because they are usually

soiled with feces on multiple surfaces. Resident C reported that she does take a shower in the bathroom only because she is a Hoyer lift transfer and her feet do not touch the floor.

During the on-site investigation on 6/1/26 I observed Resident D's bedroom. Resident D was not in his bedroom at the time of the investigation. When the bedroom door was opened I was struck by a strong odor of urine. Ms. Pardee reported that Resident D had peed all over the floor of his bedroom and the direct care staff had not been presented with an opportunity to clean this yet and closed his door until they could clean the room. I observed a soiled incontinence brief lying on the floor, urine covering the floor, and a bed with urine saturated sheets. Ms. Pardee reported that Resident D has behaviors and will urinate on the floor of his bedroom as one of his behaviors.

On 6/2/26 I sent email correspondence to licensee designee, Satish Ramade, and Ms. Pardee, regarding the conditions of the facility. I reported what was observed on 6/1/26 and noted a follow-up inspection would be conducted to ensure compliance with housekeeping standards.

On 6/15/26 I conducted an unannounced, follow-up, on-site investigation. I observed that the bathrooms were now clean, the showerhead was repaired, and Resident D's bedroom was clean and sanitary.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon the interviews conducted with Resident A, Resident B, and Resident C, as well as observations made during the unannounced, on-site investigation, it can be determined that the facility was not being kept in a clean and sanitary condition at the time of this investigation. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident medications are not being given as prescribed. Medications are given two hours early or being administered with incorrect doses. Medications have been left out in resident rooms and found on the floor.

INVESTIGATION:

On 5/28/26 I received an online complaint regarding the facility. The complaint alleged that residents are being forced to take medications, direct care staff are not observing

residents take their medications and instead leave medications by residents bedsides, resident medications have been found on the floor, and resident medications are being administered two hours prior to when they are scheduled. On 6/1/26 I conducted an unannounced, on-site investigation at the facility. I conducted a walkthrough of the entire facility with Ms. Pardee. I did not observe any resident medications left on bedside tables, on the floor, or any other area they are not permitted. All resident medications were locked in a medication cart at the time of the on-site investigation.

During the unannounced, on-site investigation on 6/1/26, I interviewed Ms. Pardee regarding the allegations. Ms. Pardee reported that direct care staff are trained to remove medications from packaging, take to residents, observe the resident swallow the medications, and then return to the medication cart to document the administration of the medications. Ms. Pardee reported that she has no knowledge of pills being left by resident bedsides, no knowledge of direct care staff not supervising a resident swallow their pills, and no knowledge of pills being found lying on the floor of the facility. Ms. Pardee reported that the direct care staff utilize a computer system known as I-Care for medication administration. She reported that the computer program will tell direct care staff members when it is time to administer medications to residents. She reported that the system will only give a window of one hour prior to administration or one hour after administration is scheduled to be able to administer resident medications. She reported that direct care staff would not be able to administer or mark medications as administered if they were giving medications more than an hour prior or after the scheduled administration time.

During the on-site investigation on 6/1/26 I interviewed direct care staff, Jordan Wilson, regarding the allegation. Ms. Wilson reported the direct care staff previously had an issue with Resident D pocketing his medications in his cheeks and then spitting them out. She reported that he has lived at the facility for about a year and when he first moved in they were learning his behaviors and realized he had been spitting his medications on the floor after the direct care staff would leave the room. She reported that as soon as this was discovered they educated the direct care staff to check his mouth and wait a longer period after administration to ensure that Resident D swallowed his medications. Ms. Wilson reported that Resident D does have behaviors of this nature where he will act out. Ms. Wilson reported that this has not been an issue for several months. She reported that she is not aware of any direct care staff leaving medications unattended in resident rooms, not watching residents swallow their medications, or administering medications prior to scheduled times. Ms. Wilson reported that the computer system only give the direct care staff a two-hour window to administer all resident mediations and document them in the system. She reported that there is not a way to administer medications early.

During the on-site investigation on 6/1/26 I interviewed Resident A, Resident B, and Resident C, all separately, regarding the allegation. All three residents reported that the direct care staff stay and watch them swallow their medications. They all reported that their medications are not left at the bedside, and they have never observed medications left out or on the floor. All three residents reported that medications are administered at

the same time every day and they are not aware of any medications being administered early.

On 6/15/26 I conducted a follow-up on-site investigation at the facility. I conducted a walkthrough of the entire facility on this date. I did not observe any resident medications on the floor or left at a resident's bedside.

On 6/25/26 I interviewed direct care staff, Bobbie Jo Galehouse, via telephone regarding the allegation. Ms. Galehouse reported that she works at the facility on a part-time basis. She reported that she has not observed resident medications to be left lying around on bedside tables or on the floor. She had no information about resident medications being administered early.

On 6/25/26 I interviewed direct care staff, Emma Johnson, via telephone regarding the allegation. Ms. Johnson reported that she does administer medications at the facility. She reported that when she administers medications she stays in the room with the resident and watches until they swallow their medications. Ms. Johnson reported that there have been instances when she has found loose medications in the medication cart and she was not certain who the medication belonged to due to the medication being loose in the cart. She reported that this occurs on an infrequent basis. She reported that months prior she had seen a resident medication on the floor but this was disposed of when found. She reported that this was not a regular occurrence and she did not know which resident's medication was found on the floor.

On 6/25/26 I interviewed Citizen 1 via telephone regarding the allegations. Citizen 1 reported that they are a former direct care staff member at the facility. Citizen 1 reported that they had previously observed Ms. Wilson administer resident medications and she would prepare all the medication cups and just go from one room to the next handing the medication cups to the residents to take. She reported that when she had handed out all the medications she would return to the resident rooms and pick up the medication cups. Citizen 1 reported that the only resident Ms. Wilson actually watched swallow medications was Resident H. Citizen 1 reported that they had observed loose medication lying on the ground in the medication room on occasion. Citizen 1 could not give dates of these occurrences.

On 6/26/26 I interviewed Guardian #1 and Guardian #2, who are the legal guardians for Resident D, Resident G, Resident H, Resident J, Resident L, Resident M, Resident N, and Resident O. Guardian #2 reported that she has primary responsibility for the eight residents at this facility they are charged with guardianship services. Guardian #2 reported that she makes monthly, unannounced visits to the facility to check on these eight residents. She reported that she has never observed medications to be lying loose on bedside tables or on the floor of the facility.

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:	Based on the interviews conducted and observations made during the unannounced on-site investigation, there is not an adequate amount of evidence to identify that resident medications are not being administered as prescribed and in an appropriate manner by direct care staff members. There were some concerns that resident medications have been found loose in resident rooms and in the medication cart, however this was not observed by this licensing consultant during the two conducted on-site investigations at the facility. The majority of those interviewed had not observed this practice and there was no concrete evidence to substantiate this claim. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident personal care needs are being neglected. They are not provided with clean clothing daily.

INVESTIGATION:

On 5/28/26 I received an online complaint regarding the facility. The complaint alleged that the direct care staff are not adequately providing for resident personal care and are not changing resident clothing daily. On 6/1/26 I conducted an unannounced, on-site, investigation at the facility. I interviewed Ms. Pardee regarding the allegation. Ms. Pardee reported that there are currently 17 residents at the facility. She reported that of these residents only eight require any type of assistance with changing their clothing daily. She reported that these eight residents are, Resident A, B, C, E, F, G, H, & I. She reported that these eight residents require some level of support with changing their clothing and getting ready for the day. Ms. Pardee reported that she has no concerns about their care needs being met by the direct care staff and noted she feels they are assisted with clean clothes daily. She reported that the direct care staff do not document personal care provided for residents, but they do maintain a shower log for residents. Ms. Pardee did provide the shower log for the dates 5/25/26 – 5/31/26 for my review. I observed the following information:

- Each of the 17 residents are tracked on this shower log.
- The residents who receive their showers from a hospice provider are noted in purple.
- The residents who receive their shower from direct care staff are noted in yellow.
- Each resident is offered at least three showers per week.

- If a resident refuses a shower it is noted on the log.
- The direct care staff initial next to each refusal or shower provided.

During the unannounced, on-site, investigation on 6/1/26 I interviewed Ms. Wilson regarding the allegation. Ms. Wilson reported direct care staff assist every resident, except Resident B, Resident J, and Resident K, with daily personal care and clothing changes. Ms. Wilson reported that Those three residents can independently perform their own clothing changes without cues or reminders. Ms. Wilson reported that she has no reason to believe that direct care staff are not assisting residents with their personal care or clothing changes daily.

During the on-site investigation on 6/1/26 I interviewed Resident A regarding the allegation. Resident A reported that there have been times when she has been left in a soiled incontinence brief for a period of two hours. She reported that she is offered clean clothing daily and clean pajamas every night. She reported no issues with having clean clothing every day.

During the on-site investigation on 6/1/26 I interviewed Resident B regarding the allegation. Resident B reported that she can change her own clothing with limited assistance. She reported that her showers are done by her hospice provider. She reported that she has no concerns about the overall appearance of the other residents at the facility and does not feel like they are being kept in soiled clothing.

During the on-site investigation on 6/1/26 I interviewed Resident C regarding the allegation. Resident C reported direct care staff provide for her personal care needs every day. She reported that she is always given clean clothing daily, and she is assisted in putting her clothing on by the direct care staff. Resident C reported no concerns about the personal care being provided and offered by the direct care staff at the facility. Resident C reported that the direct care staff are responsive to the call light system and will attend to her needs when she utilizes the call light. She reported that response times to the call light may vary depending on what tasks the direct care staff are currently managing.

During the unannounced, on-site investigation I conducted a walkthrough of the entire facility. I did not observe any residents to be wearing dirty clothes or appearing unkempt.

On 6/15/26 I conducted a follow-up on-site investigation at the facility. I conducted a walkthrough of the entire facility on this date. I did not observe any residents to be in soiled clothing or appearing unkempt.

On 6/25/26 I interviewed Ms. Galehouse, via telephone regarding the allegation. In response to the inquiry about resident hygiene and being provided with clean clothing daily, Ms. Galehouse reported “yes and no, it could be better”. She did not elaborate much on this statement and noted that there are days, depending on the direct care staff, when resident hygiene is attended to better.

On 6/25/26 I interviewed Ms. Johnson, via telephone, regarding the allegation. Ms. Johnson reported that residents are offered and provided with clean clothing daily. She reported that the quality of the personal care and hygiene provided to residents varies based on who is working. She reported that two direct care staff members recently quit and these two individuals did not provide quality personal care. She reported that when she begins her shift after these individuals the residents would be soaking wet. She identified these former direct care staff as Citizen 1 and Citizen 2. She reported that since these direct care staff have quit, she feels the residents are being kept clean and in clean clothing.

On 6/25/26 I interviewed Citizen 1 via telephone, regarding the allegation. Citizen 1 reported that they no longer work at the facility. Citizen 1 reported that they observed residents not receiving timely changes of their incontinence briefs. She reported that clean clothing was not offered daily and it usually occurred when the resident would have an outing to go to the PACE community center or another appointment.

On 6/26/26 I interviewed Guardian #1 and Guardian #2 via telephone regarding the allegation. Guardian #2 reported that she makes unannounced, monthly visits to the facility. She reported that she had not observed any of their eight residents in dirty clothing or unclean during her visits. She reported that Resident H has issues with his hygiene as he is incontinent of urine and feces. She reported that this is a concern as he will urinate on the floor of his bedroom. She reported that Resident D can no longer attend the PACE community center during the week because of this issue. She reported that the PACE staff have advised that he can no longer attend as he exhibits these behaviors and they cannot keep the area sanitary for the other guests.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(a) Bathing at least weekly.** **(b) Toileting as needed.** **(c) Assistance with resident hygiene as needed.** **(d) Availability of all the following resident hygiene supplies:** **(i) Deodorant.** **(ii) Feminine hygiene products.** **(iii) Razors and shaving cream.** **(iv) Shampoo.** **(v) Soap.** **(vi) Toothpaste.** **(vii) Toothbrushes.** **(viii) Toilet paper.**

ANALYSIS:	Based upon the interviews conducted and observations made during unannounced on-site investigation on 6/1/26 and 6/15/26, it can be determined that there is not adequate evidence to suggest that resident's are not being provided with clean clothing daily and assistance with their personal care and hygiene. During the on-site investigations a complete walkthrough was conducted, and observations were made of each resident. I did not observe any residents who appeared unkempt or lacking personal care assistance. Guardian #2 reported that she makes unannounced visits monthly and has not observed resident hygiene or personal care to be an issue for any of the eight residents for whom she is guardian. Based on this information a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff are rude and disrespectful to the residents. Residents are fearful of direct care staff.

INVESTIGATION:

On 5/28/26 I received an online complaint regarding the facility. The complaint alleged that residents are fearful of the direct care staff as the direct care staff are rude and disrespectful to them. The complaint was anonymous in nature, and a Complainant was not available for interview.

On 6/1/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Wilson regarding the allegation. Ms. Wilson reported no knowledge of direct care staff treating residents in a rude manner.

On 6/1/26, during the unannounced, on-site investigation, I interviewed Resident A regarding the allegation. Resident A reported that Ms. Wilson is rude to her, and she does not appreciate how Ms. Wilson treats her. She reported that Ms. Wilson will sneak up behind her and try to scare her and thinks this is funny. She reported "I don't think that's funny". Resident A reported Ms. Wilson has called her "Big Booty [Resident A]" and this has hurt her feelings as she feels she is body shaming her. Resident A reported that she told Ms. Pardee about the name calling and Ms. Pardee did speak with Ms. Wilson about this situation. Resident A reported that it has improved and she is no longer calling Resident A by that name. Resident A reported that if she has a bowel movement in her incontinence brief Ms. Wilson will say, "You stink! You smell like a rotten animal!" Resident A reported that Ms. Wilson is the only direct care staff member who treats her in this manner.

On 6/1/26 during the unannounced, on-site investigation, I interviewed Resident B regarding the allegations. Resident B reported that Ms. Wilson did not treat her well

when she first admitted to the facility. She reported that this has gotten better. She stated, “I can’t stand the way they treat [Resident H].” She reported that the direct care staff must escort Resident H outside to smoke because he has a guardianship. She reported that they have scheduled cigarette times for Resident H and the first time of the day is 10am. Resident B reported that Resident H wakes up at 6am but is made to wait four hours before he can have his first cigarette. Resident B reported that she has overheard Ms. Wilson threaten Resident H if he asks too much for a cigarette. She reported that Ms. Wilson will threaten to take away his cigarette breaks to punish him for asking too frequently. She gave the example that if Resident H asks too many times prior to 10am then they will take away his 10am cigarette break and make him wait until 1pm. Resident B reported, “[Ms. Wilson] is very controlling!”

During the unannounced, on-site investigation on 6/1/26 I interviewed Resident C regarding the allegation. Resident C reported that she observed Ms. Wilson lock Resident H in his bedroom by holding his door handle so that he could not exit the bedroom. Resident C reported that on the date she observed Ms. Wilson restraining Resident H in his bedroom, Resident H had been experiencing behaviors and had been hitting the walls. She reported that this occurred about one year ago. Resident C reported that Ms. Wilson and other direct care staff members will deny Resident H cigarettes if he is “being bad”. She noted that “being bad” means if he is having behaviors and hitting the walls but also noted that some behaviors are caused by waiting too long for cigarette breaks.

On 6/15/26 during the follow-up on-site investigation I interviewed Ms. Pardee regarding the allegation. Ms. Pardee reported that Resident A did come to her and express concern that Ms. Wilson was calling her “Big Booty Judy”. She reported that Ms. Wilson was just joking around with Resident A. She reported that she counseled Ms. Wilson about this and this behavior has stopped. Ms. Pardee confirmed that this situation occurred about one month prior. She reported that she doesn’t feel Ms. Wilson is rude to the residents and noted that she just speaks in a loud voice as many residents are hard of hearing. Ms. Pardee reported that because Resident H is guarded, he requires an attendant when he goes outside for cigarette breaks. She reported that the facility has scheduled times to take Resident H out for a cigarette which are 9am, 1pm, 4pm, 7:15pm, and 9pm. She reported that she has never heard a direct care staff threaten to eliminate one of these cigarette breaks for Resident H as a form of punishment. She reported that she has no knowledge of Ms. Wilson restraining Resident H in his bedroom by holding the door handle to keep the door closed.

On 6/25/26 I interviewed Ms. Galehouse, via telephone, regarding the allegation. When asked about the demeanor of the current direct care staff, she responded, “Some of them are very rude and mean.” She reported that Ms. Wilson will yell at residents and has used profanity at the residents. She reported that Ms. Wilson name calls and she has observed her calling Resident A a “bitch”. Ms. Galehouse reported that this occurred after Resident A became upset with Ms. Wilson and first called Ms. Wilson a “bitch”. Ms. Galehouse reported that she has observed Ms. Wilson telling Resident H to not come out of his bedroom and has observed her yelling at him, “Go back to your

room!" Ms. Galehouse reported that Resident H does have some behaviors of screaming, hitting things, and name calling of direct care staff, but the direct care staff have been told to redirect him in a nice tone. Ms. Galehouse reported that she has never observed Ms. Wilson physically harm any of the residents.

On 6/25/26 I interviewed Ms. Johnson, via telephone, regarding the allegation. Ms. Johnson reported that Resident H receives regularly scheduled cigarette breaks at 10am, 1pm, 4pm, 7:15pm, and 9pm. She reported that direct care staff members must take him outside for these cigarette breaks as he is guarded. Ms. Johnson reported that she is not aware of any direct care staff threatening to take away a cigarette break as a form of punishment to Resident H. She reported that she had never observed Ms. Wilson restraining Resident A in his bedroom. Ms. Johnson reported that she is unaware of direct care staff swearing at residents or speaking rudely to them. She reported that at times they may raise their voice due to a resident being hard of hearing.

On 6/25/26 I interviewed Citizen 1 via telephone regarding the allegation. Citizen 1 reported that Ms. Wilson and Ms. Johnson are both rude to the residents. She reported that they would yell at the residents. She reported that she observed Ms. Wilson taking smoke breaks away from Resident H as a form of punishment. She reported that Resident H can become "mouthy" with direct care staff and that Ms. Wilson will yell at him, "Fuck you, you're stupid!" and "You're the reason you're in your wheelchair!" Citizen 1 reported that Ms. Wilson would say this to Resident H because the reason he is wheelchair bound is due to him getting in a fight with another person and becoming injured. Citizen 1 reported that they had never observed Ms. Wilson restrain Resident H in his bedroom. Citizen 1 reported that she observed Resident A being ridiculed by Ms. Wilson and Ms. Johnson because she wanted to get out of bed and they felt she had just laid down and they didn't want to assist her.

On 6/26/26 I interviewed Guardian #1 and Guardian #2 via telephone regarding the allegations. Guardian #2 reported that she is not aware of any instance where the direct care staff have treated her wards in a disrespectful manner. She reported that Resident H is scheduled to have cigarette breaks every three hours and a direct care staff goes outside with him for these breaks. Guardian #2 reported that she feels Resident H would share with her if direct care staff were mean to him but also confirmed that she has never asked him if this were the case. She reported that Resident H is good friends with Resident M. She reported that Resident M would be a good historian to interview concerning how the direct care staff are treating Resident H. She gave permission for Resident M to be interviewed regarding the allegations. Guardian #2 reported that she has observed Ms. Wilson and Ms. Johnson at the facility and has not previously had concerns about how they were treating the residents.

On 6/29/26 I interviewed Adult Foster Care licensing consultant, Julie Elkins, regarding the allegation. Ms. Elkins also had an open special investigation at the facility. Ms. Elkins reported that she interviewed Resident M via telephone on 6/29/26. She reported that Resident M stated he wanted his interview to be kept confidential as he had no other place to live. He reported to Ms. Elkins that Ms. Wilson yells at residents and Ms.

Johnson does not. Resident M reported that Ms. Wilson is “sweet as pie” when others are around. He reported that he tries to avoid Ms. Wilson as much as possible as he does not want to be around her. Resident M reported that Ms. Wilson has physically blocked him from being able to exit the building and grabbed his arm during this interaction. He reported to Ms. Elkins that he could not recall the date of this encounter. Resident M reported none of the other residents like her. Resident M reported that Ms. Wilson is mean to Resident H and Ms. Johnson is not mean. He could not provide specific examples of Ms. Wilson being “mean” to Resident H but noted that he hopes Ms. Wilson will quit or get fired.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon the interviews conducted a preponderance of evidence has been established to conclude that Ms. Wilson does not treat the residents of the facility with dignity and respect. Four residents interviewed made statements of Ms. Wilson, name calling, swearing, restraining residents in their bedrooms, threatening residents with taking away cigarette breaks, and overall rude behaviors. These residents voice concern that Ms. Wilson treats the current residents in a derogatory manner. There were also statements from current and former direct care staff members who observed similar behaviors from Ms. Wilson. As a result, a violation is being established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

6/30/26

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Jana Lipps Date
Licensing Consultant

Approved By:

07/01/2026

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Dawn N. Timm Date
Area Manager