GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 6, 2026

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

RE: License #: AL370264709
Investigation #: 2026A0466039
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,

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

License #:	AL370264709
Investigation #:	2026A0466039
Complaint Receipt Date:	05/10/2026
Investigation Initiation Date:	05/12/2026
Report Due Date:	07/09/2026
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. ALLEGATIONS:

	Violation Established?
Residents get their meals late.	No
Residents are getting their medications late.	No
Residents are being left in wet briefs.	No
Residents are not getting showers	No
Direct care workers (DCW)s Jordan Wilson and Emma Johnson do not help the residents get out bed.	No
Direct care workers (DCW)s Jordan Wilson and Emma Johnson yell at the residents.	Yes
Additional Findings	Yes

**Please note: other allegations were listed in the referral however were not AFC rule or statute related and were not investigated.*

III. METHODOLOGY

05/10/2026	Special Investigation Intake 2026A0466039.
05/10/2026	APS Referral denied.
05/12/2026	Special Investigation Initiated – Telephone call to Jennifer Browning, licensing consultant.
05/15/2026	Inspection Completed On-site.
06/25/2026	Contact- document sent to/from email to house manager Pam Pardee to request needed documents.
06/25/2026	Contact- telephone call made to house manager Pam Pardee, she had already left for the day.
06/29/2026	Contact- telephone call made to licensing worker Jana Lipps, interviewed.
06/29/2026	Contact- telephone call made to house manager Pam Pardee, interviewed.
06/29/2026	Contact- telephone call made to Resident I, interviewed.
06/30/2026	Exit Conference with licensee designee Satish Ramade.

ALLEGATION: Residents get their meals late.

INVESTIGATION:
On 05/10/2026, this Adult Protective Services (APS) Centralized Intake referral was transferred to the Department of Licensing and Regulatory Affairs (LARA) for investigation. Anonymous Complainant reported that residents get their food late. Complainant reported there are 19 residents currently living at Margaret's Meadows Assisted Living Facility. Complainant reported that the food portions are small and when a resident asks for more food, residents are told they just ate. Complainant was anonymous and therefore additional details could not be obtained to determine which residents were being impacted by this concern.

On 05/15/2026, I conducted an unannounced investigation and interviewed direct care worker (DCW) Johnson who reported that breakfast is served between 8am and 9am, lunch is serviced at noon, dinner is served at 5pm and snacks are served at 7pm. DCW Johnson reported that meals are served timely. DCW Johnson reported that although meal portions may seem small, she thinks that the facility purchases enough food. DCW Johnson stated residents ask for more food however there is not usually leftovers to serve for second helpings. DCW Johnson reported that routinely Resident B, Resident F, Resident G, Resident H, and Resident I ask for second helpings of food. DCW Johnson reported that for 18 residents when they make goulash it calls for 2 pounds of meat, 2 pounds of noodles, 2 cans tomatoes and 64 oz tomato juice. DCW Johnson reported that she tries to fill the bowls ½ full or at least 2 ladles of the meal, but it does not always make 18 bowls so she then needs to take food out of the already plated bowls to ensure there is enough for everyone. DCW Johnson reported that food plates cannot be served until all plates are plated to ensure that everyone gets a plate as food may have to be taken from other plates if there is not enough to go around. DCW Johnson reported that this is difficult as the census fluctuates so when there are less residents here there is more food to go around than when the census is higher. DCW Johnson reported that the food orders/meal ingredient amounts do not change based on the number of people at the facility. DCW Johnson reported that there are no residents who are ordered any special diets.

I interviewed DCW Wilson who reported that breakfast is served between 8am-8:30am, lunch is served between 12pm and 12:30pm, dinner is served at 5p/5:30pm and snacks are served at 7pm. DCW Wilson reported that meals are served timely. DCW Wilson reported that the facility serves adequate portion sizes and that typically there is enough leftover food for seconds. DCW Wilson reported some of the residents are healthy eaters who, for example, want two hotdogs when served. DCW Wilson reported that if a resident wanted more food and the meal is gone, they find something else to feed them, typically leftovers from another meal. DCW Wilson reported that Resident K is a picky eater and typically just wants oatmeal and Resident E does not like meat. DCW Wilson reported that there are no residents who are prescribed special diets. DCW Wilson reported that house manager Pam Pardee does the grocery shopping.

I was at the facility when they were preparing lunch. At the time there were 18 residents living at the facility and they were cooking 24 hot dogs, they had 16 hot dog buns, 30 oz can of chili and ¾ bag of potatoes to make potato salad. The potatoes were already cooked and the bag had been thrown away so I was not able to determine how many pounds of potatoes were cooked but it was in a large dish.

I interviewed Kari Keller, Home Health Aid with Optimal Care, who reported that Resident A is not a big eater, so the portion size is adequate for him. Ms. Keller reported that she is at the facility five days a week to give him a bed bath and she purposely comes at lunchtime so that she can help feed him. MS. Keller reported that lunch is typically served around noon and because there are many high need residents living here with only two DCWs on duty she fears that no one would help to feed Resident A.

I interviewed Resident B who reported that the meals served are “boring” but that there is enough food for everyone. Resident B reported that the meals are served on time. Resident B reported that she had one hotdog and some potato salad for lunch.

I interviewed Resident C who reported that she is not a big eater and the portion sizes served are adequate. Resident C reported that meals are typically on time or early.

I interviewed Resident G who reported that the “food sucks” and there is not enough food for everyone and not enough food for anyone to have seconds. Resident G reported that today she had one hotdog and some potato salad. Resident G reported that meals are served on time.

I interviewed Resident M who reported that lunch as “ok.” Resident M reported that sometimes the staff tell me that I cannot have any more food. Resident M is hard of hearing and he could not hear any of the other questions that I attempted to ask him.

On 06/25/2026, Pam Pardee, house manager, reported that all caregivers are trained and qualified for food preparation

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(3) Not more than 14 hours must elapse between the evening and morning meal. **(8) A facility that is licensed for 7 or more residents shall have a minimum of 1 staff who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to ensure regular and timely meals.**

ANALYSIS:	DCW Wilson and DCW Johnson reported that breakfast is served between 8am/9am, lunch is served around noon, dinner is served at 5pm/5:30pm. DCW Wilson and DCW Johnson reported that a snack is served at 7pm therefore 14 hours is not elapsing between the evening and morning meal. Resident B, Resident C and Resident G all reported that meals are served on time. Pam Pardee, house manager, reported that all caregivers are trained and qualified for food preparation therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are getting their medications late.

INVESTIGATION:
On 05/10/2026, this APS Centralized Intake referral has been transferred to the LARA for investigation. Anonymous Complainant reported that residents are not getting their medications on time. Complainant was anonymous so no additional details such as resident names or medications could be obtained.

On 05/15/2026, I conducted an unannounced investigation and interviewed DCW Johnson and DCW Wilson who both reported being trained to administer medication and both reported that they administer medications. DCW Johnson and DCW Wilson both denied that medications were/are passed late. DCW Wilson reported that medications are classified as a priority. DCW Johnson reported that the two DCWs on duty work together to ensure that all resident needs are met timely.

I interviewed Resident B and Resident C who both reported that medications are administered on time. I interviewed Resident G who reported that medications are administered late especially on the days that she does not come out of her room as DCWs attend to all other residents first with Resident G provided with medications last.

On 06/25/2026, I reviewed May 2026 MARs for Resident A, Resident B, Resident C, Resident G, Resident M, Resident K and none of the MARs indicated that medications were administered late. Most of the prescriptions that were reviewed were not prescribed an assigned medication administration time (like 8AM) rather were prescribed as, “take twice a day, take at bedtime.”

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:	I reviewed May 2026 MARs for Resident A, Resident B, Resident C, Resident G, Resident M, Resident K and none of the MARs indicated that medications were administered late. Most of the prescriptions that were reviewed were not prescribed an assigned medication administration time rather were prescribed as, “take twice a day, take at bedtime.” Resident B and Resident C both reported that medications are administered on time. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are being left in wet briefs.

INVESTIGATION:
On 05/10/2026, this APS Centralized Intake referral was transferred to the LARA for investigation. Anonymous Complainant reported that DCWs Jordan Wilson and Emma Johnson leave resident in their briefs. Complainant was anonymous so no additional details such as resident names could be obtained.

On 05/15/2026, I conducted an unannounced investigation and interviewed DCW Johnson who reported that Resident A, Resident B, Resident C, Resident D, Resident E, Resident F and Resident G all wear adult incontinent briefs. DCW Johnson reported that currently Resident A and Resident B have skin breakdown which is being treated with ointments. DCW Johnson denied that residents are left in wet briefs. DCW Johnson reported that there are currently 18 residents at the facility and they always have two DCWs on shift. DCW Johnson reported that one DCW administers medications while checking and changing residents’ briefs and the second DCW on duty works on meals while checking and changing residents’ briefs. DCW Johnson reported that all residents are checked and briefs changed at least every two hours and typically more often than that. DCW Johnson denied ever leaving any resident in a wet brief. DCW Johnson reported that she has never witnessed any other DCW leaving a resident in a wet brief either.

I interviewed DCW Wilson who reported that all residents except Resident I, Resident L and Resident M wear adult incontinence briefs. DCW Wilson reported additionally that Resident B, Resident E and Resident K are all “bedbound.” DCW Wilson reported that Resident K currently has a rash as he produces a lot of stools and he is always in bed. DCW Wilson reported that all residents are checked and briefs changed at least every two hours and typically more often than that. DCW

Wilson denied ever leaving any resident in a wet brief. DCW Wilson reported that she has never witnessed any other DCW leave a resident in a wet brief either.

I interviewed Resident B who reported that she is checked and her brief changed every two hours. Resident B reported having a sore on her bottom but stated it was almost healed and it was not from lack of being changed.

I interviewed Resident C who reported that she utilizes the toilet and she can change her own brief as needed so she does not rely on DCWs for this. Resident C reported that she had witnessed other residents complaining that they were left in a wet brief for too long.

I interviewed Resident G who reported that she is never checked and changed during the day even when she uses the call light, DCWs just never come to her room. Resident G reported that she has waited two hours to be changed after using the call light. Resident G reported that DCWs tell her that they are busy. Resident G reported that the midnight staff do check and change her brief every two hours.

I interviewed Ms. Keller who reported that the facility doubled pads Resident K's briefs consistently and that he has been left in a wet brief. Ms. Keller reported that Resident K does not have any current skin breakdown.

On 06/24/2026, I reviewed written *Assessment Plans for Adult Foster Care (AFC) Residents* for Resident F and Resident G. Resident F's assessment plan documented in the "toileting" section of the report, "Brief changes, 1 person assist with transferring." Resident G's assessment plan documented in the "toileting" section of the report, 1 person assisted with clean up, extensive cueing to use restroom, wears briefs."

On 06/25/2026, I reviewed *Shower Logs* dated 4/27/2026-5/31/2026 for all 15 residents. These logs documented that although some residents did refuse showers, all residents were showered at least weekly and some residents had showers multiple times throughout the week.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**

ANALYSIS:	DCW Johnson and DCW Wilson both reported that all residents are checked and changed at least every two hours and typically more often than that. DCW Johnson and DCW Wilson both denied every leaving any resident in a wet brief. DCW Johnson and DCW Wilson reported that they have never witnessed any other DCW leaving a resident in a wet brief either. Although Resident G reported having to wait long periods of time before being assisted with a brief change, no DCWs interviewed reported that residents waited long periods in wet briefs. Written *Assessment Plans for Adult Foster Care (AFC) Residents* for Resident F and Resident G were reviewed and the amount of personal care, supervision, and protection required by the resident that is available at the facility therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are not getting showers.

INVESTIGATION:
On 05/10/2026, this APS Centralized Intake referral has been transferred to the LARA for investigation. Anonymous Complainant reported that DCWs Jordan Wilson and Emma Johnson do not shower residents. Complainant was anonymous so no additional details such as resident names could be obtained.

On 05/15/2026, I conducted an unannounced investigation and interviewed DCW Johnson and DCW Wilson who both reported that all residents receive a shower weekly and are they offered additional showers as needed.

I interviewed Resident B who reported that she is assisted with showering three times a week.

I interviewed Resident C who reported that hospice provides her with bed baths.

I interviewed Resident G who reported that she receives one shower once a week and she may receive a second shower that same week if she has diarrhea. Resident G reported that she would like to have a shower every three days.

I interviewed Ms. Keller who reported that she gives Resident K a bed bath five days a week.

On 06/25/2026, I reviewed *Shower Logs* dated 4/27/2026-5/31/2026 for all 15 residents. These logs documented that although some residents refused showers at times, all residents were showered at least weekly and some residents showered multiple times throughout the week.

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.**
ANALYSIS:	I reviewed *Shower Logs* dated 4/27/2026-5/31/2026 for all 15 residents. These logs documented that although some residents refused showers at times, all residents were showered at least weekly and some residents showered multiple times throughout the week. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care workers (DCW)s Jordan Wilson and Emma Johnson do not help residents get of bed.

INVESTIGATION:
On 05/10/2026, this APS Centralized Intake referral was transferred to the LARA for investigation. Anonymous Complainant reported that if a resident wants to get up/help them out of their rooms, DCW Wilson and DCW Johnson ignore them. Complainant was anonymous so no additional details such as which residents are impacted by these concerns could be identified.

On 05/15/2026, I conducted an unannounced investigation and DCW Johnson reported that she and other DCWs help get the residents that want to come out of their rooms up, but DCW Johnson reported that not all residents want to leave their rooms. DCW Johnson reported that Resident A, Resident B, Resident C, Resident D and Resident E like to “self isolate.” DCW Johnson reported that Resident C likes to be in her room half time and in the common areas half the time. DCW Johnson denied that residents are ignored by her or any other DCW. DCW Johnson reported that all residents have call lights and that she estimates on average it takes about 5 minutes for a DCW to answer a call light and if they are actively helping another resident, it could take 10-15 minutes to answer that call light. DCW Johnson reported that the two DCWs on duty work together to ensure that all resident needs are met timely.

I interviewed DCW Wilson who reported that she tries to encourage residents to get up out of bed and into the common area but that she cannot force them to do that. DCW Wilson reported that Resident A, Resident D, Resident E, Resident G and Resident K like to “self-isolate” and stay in their rooms by their choice. DCW Wilson denied ignoring residents and reported that if she is helping another resident, it may take some time to get to the next resident but reported that all call lights are answered. DCW Wilson reported that call lights are typically answered in less than 5 minutes but if they are changing or showering another resident it could take up to 15

minutes to answer a call light. DCW Wilson denied that she or DCW Johnson yell at the residents. DCW Wilson reported that she and DCW Johnson are both naturally loud people and several of the residents are hard of hearing, so they must raise their voices to be heard. DCW Wilson reported that Resident M is deaf and does not wear hearing aids so he must be spoken to loudly. DCW Wilson reported that Resident K will tell her when she is speaking too loud to him. DCW Wilson reported that no residents, family member, visitor or other staff members have ever complained to her about her or DCW Johnson yelling at residents. DCW Wilson reported that she always treats residents with dignity and respect and she has always witnessed DCW Johnson doing the same.

I interviewed Resident B who reported that the DCWs use the Hoyer to get her out of bed if she wants to. Resident B reported that a lot of the residents do not want to come out of their rooms.

I interviewed Resident G who reported that if she wants to get up and out of bed she will ask and the DCWs will assist her. Resident G reported that she does not want to get up and out of bed every day.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**
ANALYSIS:	DCW Johnson and DCW Wilson reported that they assist residents who want to get out of their rooms and out of bed. They also stated that not all residents choose to leave their rooms, as several prefer to self-isolate, and DCWs cannot force residents to get up. Resident B and Resident G both stated that when they want to get up, the DCWs on duty assist them. They also reported that there are days when they prefer to remain in bed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care workers (DCW)s Jordan Wilson and Emma Johnson yell at the residents.

INVESTIGATION:
On 05/10/2026, this APS Centralized Intake referral was transferred to LARA for investigation. Anonymous Complainant reported that DCW Wilson and DCW Johnson yell at the residents. Complainant reported that residents do not feel safe and want to leave. Complainant reported that there has been no physical abuse

seen. Complainant was anonymous so no additional details such as which residents are impacted by these concerns could be identified.

On 05/15/2026, I conducted an unannounced investigation and DCW Johnson denied that she or DCW Wilson yell at residents. DCW Johnson reported that she and DCW Wilson are both naturally loud people and several of the residents are hard of hearing, so they must elevate their voices for them to be able to hear what they are saying. DCW Johnson reported that no residents, family member, visitor or other staff member have ever complained to her about her or DCW Wilson yelling at residents. DCW Johnson reported that she always treats residents with dignity and respect and she has always witnessed DCW Wilson doing the same. DCW Johnson reported that Resident J has panic attacks and she verbalizes that she does not feel safe here. DCW Johnson reported that Resident J is diagnosed with dementia, so when Resident J is feeling anxious direct care staff redirect Resident J to an activity or a television show. DCW Johnson reported that Resident J spends most of her day in the common areas and DCWs keep a close eye on her and remind her that she is safe.

I interviewed DCW Wilson who denied that she or DCW Johnson yell at the residents. DCW Wilson reported that she and DCW Johnson are both naturally loud people and several of the residents are hard of hearing, so they must raise their voices to be heard. DCW Wilson reported that Resident M is deaf and does not wear hearing aids so he must be spoken to loudly. DCW Wilson reported that Resident K will tell her when she is speaking too loud to him. DCW Wilson reported that no resident, family member, visitor or other staff member have every complaint to her about her or DCW Johnson yelling at residents. DCW Wilson reported that she always treats residents with dignity and respect and she has always witnessed DCW Johnson doing the same.

I interviewed Resident B who denied that DCW Wilson and DCW Johnson yell.

I interviewed Resident C who reported that DCWs yell at Resident N. Resident C reported DCWs get frustrated with Resident N because they have to go out and smoke with him and he always wants to smoke at times that are inconvenient for DCWs. Resident C reported that Resident N will yell back at the DCWs and then the DCWs will take his smoke breaks away.

I interviewed Resident G reported that DCW Wilson yells at Resident M and makes him cry. Resident G reported that Resident M is hard of hearing and DCW Wilson tries to raise her voice so that he can hear her. Resident G reported that DCW Wilson also screams at Resident N when he wants a cigarette.

I attempted to interview Resident M who is known to be hard of hearing and he did not respond to the questions that I asked him about DCW Wilson and DCW Johnson yelling. DCW Johnson and DCW Wilson were the only DCWs on duty while I was at

the facility and therefore, they could not assist me in communicating with Resident M.

At the time of the unannounced investigation Resident N was asleep and unable to be interviewed.

On 06/29/2026, I interviewed licensing consultant Jana Lipps who reported that when she was at the facility on 6/01/2026, Resident N was also asleep and unable to be interviewed. Licensing consultant Lipps reported that she was told by several residents that DCW Wilson and DCW Johnson yelled at Resident N. Ms. Lipps reported that she contacted Guardian N1 who reported being at the facility monthly unannounced. Guardian N1 reported that Resident N never reported any concerns about how he was treated at the facility by any DCW including DCW Johnson and DCW Wilson. Guardian N1 reported that Resident N has the capacity to voice concerns if he is being mistreated. Guardian N1 reported that she has never asked Resident N if he is being mistreated. Guardian N1 reported that Resident I spends a lot of time with Resident N and that Resident I may be able to speak to if Resident N is being mistreated.

I interviewed Ms. Pardee who denied that any DCW, resident or family member has ever reported to her that DCW Wilson and DCW Johnson yell at any resident. Ms. Pardee reported that she has never observed DCW Wilson or DCW Johnson yelling at any resident. Ms. Pardee reported that DCW Wilson and DCW Johnson are loud people and many residents are hard of hearing, so everyone must talk loudly to certain residents for them to hear what you are saying. Ms. Pardee reported that Resident N is sleeping now and therefore cannot be interviewed. Ms. Pardee reported additionally that Resident N is difficult to communicate with because he does not speak well and he has a diagnosis of having a traumatic brain injury (TBI). Ms. Pardee reported that Resident J has panic attacks and she verbalizes that she does not feel safe here. Ms. Pardee reported that Resident J is diagnosed with dementia and she can be redirected to find something to do and reminded that she is safe.

I interviewed Resident I privately by phone who asked for this conversation to be confidential as he does not want any problems here as he has nowhere else to live. Resident I reported that DCW Wilson yells but DCW Johnson does not. Resident I reported that DCW Wilson is “sweet as pie” when others are around. Resident I reported that he just avoids DCW Wilson as much as he can as he does not want to be around her. Resident I reported that none of the residents like DCW Wilson. Resident I reported that DCW Wilson has physically blocked him from being able to exit the building and go outside. Resident I reported that during this instance (date unknown) DCW Wilson grabbed him by the arm. Resident I reported that DCW Wilson is mean to Resident N but DCW Johnson is not mean to Resident N. Resident I could not provide any examples about DCW Wilsons behavior, but he reported that she is bossy. Resident I reported that he hopes she will quit or get fired as she should work “as a grade schoolteacher where she can boss all of the

little kids around." Resident I reported that most of the residents that live at this facility do not speak clearly and their memory is bad so they cannot articulate nor recall what occurs. Resident I reported that he had a book that he had been documenting all the things that had been happening at the facility and he believes that someone stole it from his room because he can no longer locate that book.

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:	DCW Wilson and DCW Johnson both denied that they yell at residents. DCW Wilson and DCW Johnson both reported that they are both naturally loud people and several of the residents are hard of hearing, so they must raise their voices to be heard. Although residents admitted that DCW Wilson and DCW Johnson are loud people, they also reported that they both do yell at the residents. Resident C reported that DCWs yell at Resident N because DCWs get frustrated with Resident N because must be supervised while smoking and always wants to smoke at times that are inconvenient for DCWs. Resident C reported that Resident N will yell back at the DCWs and then the DCWs will take his smoke breaks away. Resident G reported that DCW Wilson yells at Resident M and makes him cry.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/15/2026, I conducted an unannounced investigation and DCWs Johnson and Wilson were on duty. Neither DCW was able to access and provide resident records for department review.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.

ANALYSIS:	At the time of the unannounced investigation DCW Johnson nor DCW Wilson could produce the resident records for department review therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/15/2026, I conducted an unannounced investigation and neither DCW Johnson nor DCW Wilson were aware if the facility had a *Resident Register* nor could they produce the document for department review.

APPLICABLE RULE	
R 400.617	**Records.**
	(1) A licensee shall maintain the following records: **(e) Resident register.**
ANALYSIS:	At the time of the unannounced investigation, a copy of the *Resident Register* was not available for review as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 05/15/2026, I conducted an unannounced investigation and a resident using a wheelchair was trying to wheel themselves back into the facility. There was gap in the cement on the wheelchair ramp where the wheelchair tire was stuck. This required a DCW to come out of the facility and push the resident into the building.

On 06/29/2026, licensing consultant Jana Lipps reported that when she was at the facility on 6/15/2026 and she observed a resident using a wheelchair get their wheelchair tire stuck in the gap in the cement on the wheelchair ramp as well which also required a DCW to come out of the facility and push the resident into the building.

APPLICABLE RULE	
R 400.625	**Means of egress.**
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.

ANALYSIS:	On 5/15/2026 and again on 6/15/2026 while licensing consultant Elkins and licensing consultant Lipps were conducting unannounced investigations both observed a resident get their wheelchair tire stuck in the gap in the cement on the wheelchair ramp which required a DCW to come out of the facility and push the resident into the building. The entire means of egress did not provide a method of passage for the residents to move the wheelchair independently. The ramp requires repair and a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/30/2026

_____

Julie Elkins Date
Licensing Consultant

Approved By:

07/01/2026

_____

Dawn N. Timm Date
Area Manager