GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2021

Dianne Schmiege
400 S Walnut St
Bay City, MI 48706

RE: License #: AM090278806
Investigation #: 2021A0572043
Pine Ridge AFC Home

Dear Mrs. Schmiege:

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 (989) 732-8062.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM090278806
Investigation #:	2021A0572043
Complaint Receipt Date:	08/09/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/08/2021
Licensee Name:	Dianne Schmiege
Licensee Address:	400 S Walnut St Bay City, MI 48706
Licensee Telephone #:	(989) 892-7210
Administrator:	Kayla Schmiege
Licensee Designee:	N/A
Name of Facility:	Pine Ridge AFC Home
Facility Address:	1672 Ridge Rd Bay City, MI 48708
Facility Telephone #:	(989) 892-3438
Original Issuance Date:	05/13/2006
License **Status:**	REGULAR
Effective Date:	04/01/2021
Expiration Date:	03/31/2023
Capacity:	12
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was gone for hours without being noticed.	Yes
Owners constantly fighting in front of residents.	No
Medications distributed are not being documented.	No
Complete general lack of care as residents are being left sitting in feces for hours at a time.	No
None of the staff have any certifications.	No

III. METHODOLOGY

08/09/2021	Special Investigation Intake 2021A0572043
08/09/2021	APS Referral APS made referral.
08/13/2021	Special Investigation Initiated - Letter
08/18/2021	Contact - Face to Face Staff, Kristen Schmiege; Licensee, Dianne Schmiege; Resident A, B, C, D, E, F, G, H, I, J and K.
08/18/2021	Contact - Document Sent APS, Jacqueline Campbell.
09/23/2021	Exit Conference Licensee, Dianne Schmiege.
09/23/2021	Contact - Document Received Resident A's Assessment Plan.
09/23/2021	Contact - Document Received Incident Report.
09/27/2021	Exit Conference Licensee, Dianne Schmiege.

ALLEGATION:
Resident A was gone for hours without being noticed.

INVESTIGATION:
On 08/09/2021, the local licensing office received a complaint for investigation. Adult Protective Service (APS) were also investigating this facility. APS did not substantiate.

On 08/18/2021, an unannounced onsite was conducted at Pine Ridge AFC Home, located in Bay County, Michigan. Interviewed and/or observed were Staff, Kristen Schmiege; Licensee, Dianne Schmiege; Residents A, B, C, D, E, F, G, H, I, J and K.

On 08/18/2021, I interviewed Staff, Kristen Schmiege regarding an allegation that Resident A was gone for hours without being noticed. She informed that the allegation must be in reference to Resident A when he wandered off to the neighbors when he went for a walk. He has dementia so he forgot how to get home. He told a neighbor his name and the police brought him home when they were out to look for him. Resident A was not harmed at all.

On 08/18/2021, I interviewed Licensee, Dianne Schmiege regarding an allegation that Resident A was gone for hours without being noticed. She informed that Resident A went next door and got lost. There's a hill between them and the subdivision and once he got over the hill, he was lost. The police brought him back and they did not write a police report because they saw that they were enroute to find him. He has dementia, so as soon as he leaves the yard, he gets lost. He was only gone a short period of time.

On 08/18/2021, I interviewed Resident A regarding him being missing. He informed he remembers getting lost and stated, "I had decided to take a little Sunday walk and got a little turned around. I just told the neighbor my name and they called the police to take me home." Resident A denied being gone for hours and was not injured.

On 09/23/2021, I received Resident A's Assessment Plan. On 09/27/2021, I reviewed the Assessment Plan and it indicates that Resident A is unable to go out into the community as he has dementia and will forget where he is going most times.

On 09/23/2021, I received the Incident Report. On 09/27/2021 I reviewed it and the Administrator, Kayla Schmiege stated, "Just finished changing my physically disabled resident (take 30 to 45 minutes). I was running a little bit behind on my round check before I finished. Did my round check and noticed (Resident A) was missing. Before I could call 911, the cops were here asking if (Resident A) lives here." The staff will continue to conduct hourly checks on Resident A.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A has dementia and walked next door when he became lost. Resident A is unable to go out in the community on his own. Staff started searching for him immediately, but the neighbors called 911 to take him back home. Staff and Resident A denied that he went missing for several hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Owners constantly fighting in front of residents.

INVESTIGATION:
On 08/18/2021, I interviewed Staff, Kristen Schmiege regarding an allegation that the owners are constantly fighting in front of residents. Ms. Schmiege denies that this ever occurs.

On 08/18/2021, I interviewed Licensee, Dianne Schmiege regarding an allegation that the owners are constantly fighting in front of residents. Mrs. Schmiege denied that this is occurring. She is unsure where this allegation is coming from.

On 08/18/2021, I interviewed Resident C regarding an allegation that the owners are constantly fighting in front of them. Resident C informed that there is no arguing going on at the facility.

On 08/18/2021, I interviewed Resident F regarding an allegation that the owners are constantly fighting in front of them. Resident F informed that there is no fighting or nothing at the facility.

On 08/18/2021, I interviewed Resident G regarding an allegation that the owners are constantly fighting in front of them. Resident G informed that there are no issues at the home and there is no fighting at all.

On 08/18/2021, I interviewed Resident H regarding an allegation that the owners are constantly fighting in front of them. She informed that she feels safe and there is no fighting in the home.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	The Licensee, Staff and several residents denied that the owners of the home are fighting in front of them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Medications distributed are not being documented.

INVESTIGATION:
On 08/18/2021, I interviewed Staff, Kristen Schmiege regarding an allegation that medications distributed are not being documented. Ms. Schmiege denied this allegation and informed that they have an electronic monitoring system for their medications. She informed that the system was down approximately 2 weeks ago, and they contacted the pharmacy to make them aware. The company was contacted to troubleshoot, and they fixed it. None of the residents missed their medications.

On 08/18/2021, I interviewed Licensee, Dianne Schmiege regarding an allegation that medications distributed are not being documented. She denied this allegation. She informed that their medication system is connected to the pharmacy, and it tells them when to pass medications and when meds are discontinued. As soon as the medications are administered, the pharmacy knows right away. Their system was down a couple weeks ago, and it was fixed by the company. All of the residents received their medications that day.

I reviewed Residents A, B and K's medication records and it appeared that the medications are being administered, which would automatically notify the pharmacy.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Staff denied that the medications are not being documented. I observed the electronic MAR's system and the medications appeared to be documented.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Complete general lack of care as residents are being left sitting in feces for hours at a time.

INVESTIGATION:
On 08/18/2021, I interviewed Staff, Kristen Schmiege regarding an allegation that there's a complete general lack of care as residents are being left sitting in feces for hours at a time. She denied this and informed that I can check on all of the residents now if I would like. She stated, "The ones who would have an accident, will let one of us know."

On 08/18/2021, I interviewed Licensee, Dianne Schmiege regarding an allegation that there's a **c**omplete general lack of care as residents are being left sitting in feces for hours at a time. Mrs. Schmiege denied this allegation and informed that residents are always changed when they need to.

On 08/18/2021, I met with each resident in the home and none of them smelled of feces or urine and appeared to be clean and in adequate health.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Staff denied that residents are being left in feces. I observed all of the residents in the home, and they were all clean and did not smell of feces or urine.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
None of the staff have any certifications.

INVESTIGATION:
On 08/18/2021, I interviewed Staff, Kristen Schmiege regarding an allegation that none of the staff have any certifications. Ms. Schmiege informed that all of the staff are trained and go through 2-3 weeks of training. Since Resident C has a Hoyer Lift, they all had to be trained on how to use the Hoyer Lift.

On 08/18/2021, I interviewed Licensee, Dianne Schmiege regarding an allegation that none of the staff have any certifications. Mrs. Schmiege informed that all of the staff are trained at the facility and have to be in order to work there.

On 08/18/2021, I reviewed staff records and observed that all staff are currently trained to work in the afc group home.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	Staff informed that all staff are trained. I reviewed employee records which indicates that staff are trained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 09/23/2021, an Exit Conference was held with Licensee, Dianne Schmiege regarding the allegations against Pine Ridge AFC Home. On 09/27/2021, another Exit Conference was held with Licensee, Dianne Schmiege. She was informed that a violation was established and a corrective action plan would need to be submitted within 15 days of receiving the Special Investigation Report.

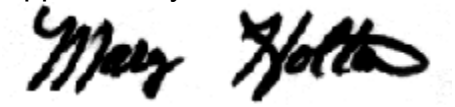
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend no change to the licensing status of this AFC medium sized group home (capacity 1-12).

09/27/2021

Anthony Humphrey Date
Licensing Consultant

Approved By:



09/27/2021

Mary E Holton Date
Area Manager