GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 16, 2023

Holly Schlaud
Rt 1 Box 142
W8677 CR 356
Stephenson, MI 49887

RE: License #: AM550009067
Investigation #: 2023A0234017
Schlaud Afc Home

Dear Mrs. Schlaud:

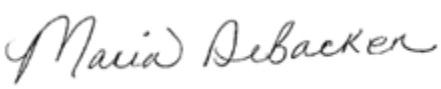
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Maria DeBacker, Licensing Consultant
Bureau of Community and Health Systems
305 Ludington St
Escanaba, MI 49829
(906) 280-8531

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM550009067
Investigation #:	2023A0234017
Complaint Receipt Date:	08/22/2023
Investigation Initiation Date:	08/23/2023
Report Due Date:	10/21/2023
Licensee Name:	Holly Schlaud
Licensee Address:	Rt 1 Box 142 W8677 CR 356 Stephenson, MI 49887
Licensee Telephone #:	(906) 753-4092
Administrator:	Holly Schlaud
Licensee Designee:	NA
Name of Facility:	Schlaud Afc Home
Facility Address:	W8677 Cr 356 Stephenson, MI 49887
Facility Telephone #:	(906) 753-4092
Original Issuance Date:	02/26/1988
License **Status:**	REGULAR
Effective Date:	08/25/2022
Expiration Date:	08/24/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff dropped Resident A at the ER and refused to pick him up	Yes
Additional Findings	No

III. METHODOLOGY

08/22/2023	Special Investigation Intake 2023A0234017
08/23/2023	Special Investigation Initiated - Telephone APS referral
08/23/2023	APS Referral
08/23/2023	Contact – Telephone call made Interview with Resident A.
08/23/2023	Inspection Completed On-site
08/23/2023	Inspection Completed-BCAL Sub. Compliance
09/14/2023	Exit Conference Exit conference with licensee Holly Schlaud
10/16/2023	Contact – Document Sent Email sent to Licensee Holly Schlaud.

ALLEGATION: Staff dropped Resident A at the ER and refused to pick him up.

INVESTIGATION:
On 8/22/23, a phone call was placed to licensee Holly Schlaud after an APS report that staff at Holly Schlaud's home were refusing to pick up Resident A from the hospital. She stated Resident A was brought to the hospital after calling 911 several times on 8/21/23. She stated that staff Megan Kelbach brought Resident A to the ER (Emergency Room) on 8/22/23 asked for a physical and psychiatric evaluation. She stated that Resident A was insistent on needing to be in the hospital. Resident A was threatening staff and wearing a body cam stating that he was being mistreated and that staff were not taking proper care of him. Residents and staff

were becoming increasingly afraid of his erratic behaviors. License Schlaud stated that Resident A was unsafe to return to the home. It was discussed that it would be a rule violation and Holly Schlaud understood but felt it was unsafe to return Resident A to the home.

On 8/23/23, Resident A was contacted via telephone, and he stated he hated living at the home and does not want to return to the home. Resident A stated that he recorded the staff and residents doing “illegal things” but refused to state what they were. Resident A was asked if he would show the recordings to myself, or the police and he stated no that he deleted them. Resident A stated that the hospital got him a hotel room and he wants to stay there. Resident A is his own person with no guardian or activated DPOA. Resident A stated he is choosing to stay at the hotel and has no desire to return to the AFC home.

Resident A is in a Wisconsin hotel and an APS referral was made in Wisconsin.

An unannounced investigation was conducted on 8/23/23. The home was clean, and the residents were dressed and watching TV.

Resident A’s record and several Incident Reports leading up to hospital visit were reviewed.

On 8/23/23, I spoke to worker Megan Kelbach. She stated that Resident A was extremely disruptive in the home and that the residents were increasingly afraid of him. Megan Kelbach stated that he walked around the home with a body cam on and recorded staff and residents. Resident A made threats continually and staff felt that Resident A showed the potential for violence. Megan Kelbach stated that Resident A called the police and ambulance several times during the week and insisted that he be brought to the hospital for an unknown illness. On 8/22/23 Megan Kelbach brought Resident A to the ER for an evaluation. The hospital refused to admit him, and Megan Kelbach stated to the hospital that Resident A was unsafe to return to the home and felt Resident A needed an evaluation.

Resident B was interviewed on 8/23/23. Resident B stated that he was afraid of Resident A and that Resident A was not very nice. Resident B stated that the police kept coming to the home and it frightened everyone. Resident B stated that he likes the staff and feels safe now that Resident A is gone.

Resident C was interviewed. Resident C stated that things are good now and an that she feels safe in the home. Resident C likes her room and staff.

An exit conference was held with Holly Schlaud, licensee, on 8/23/23. Holly Schlaud stated that Resident A was unsafe to return to the home. It was discussed that it would be a rule violation and Holly Schlaud understood but felt it was unsafe to return Resident A to the home.

On 10/16/2023 an email was sent to Holly Schlaud, licensee, to update case status.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Resident A was brought to the ER for evaluation. The AFC stated that he was a danger to others and the other residents were afraid of him and decided not to take him back in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no changes are recommended to this license.

Maria DeBacker 10/16/23

Maria DeBacker Date
Licensing Consultant

Approved By:

Mary Holton 10/16/23

Mary E. Holton Date
Area Manager