GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2020

Randolph Scholtus
West Shore AFC Homes, L.L.C.
4040 Co. Road 633
P.O. Box 128
Grawn, MI 49637

RE: License #: AL280312738
Investigation #: 2020A0870010
West Shore AFC Home, LLC

Dear Mr. Scholtus:

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 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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280312738
Investigation #:	2020A0870010
Complaint Receipt Date:	01/22/2020
Investigation Initiation Date:	01/22/2020
Report Due Date:	03/22/2020
Licensee Name:	West Shore AFC Homes, L.L.C.
Licensee Address:	2651 Leaf Lane Grawn, MI 49637
Licensee Telephone #:	(231) 276-9434
Administrator:	Randolph Scholtus
Licensee Designee:	Randolph Scholtus
Name of Facility:	West Shore AFC Home, LLC
Facility Address:	2651 Leaf Lane Grawn, MI 49637
Facility Telephone #:	(231) 276-9795
Original Issuance Date:	01/26/2012
License **Status:**	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	14
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was discovered to have a black eye. It is hard to believe his eye would be that black from hitting himself.	No
Resident A was not taken for medical treatment until two days after it was noted that he had a black eye.	Yes
Resident A has a black eye. His Responsible Agency, Northern Lakes Community Mental Health, did not receive an incident/Accident report regarding this injury.	No

III. METHODOLOGY

01/22/2020	Special Investigation Intake 2020A0870010
01/22/2020	APS Referral Email from Grand Traverse County DHHS Adult Protective Services worker Traci Doran. She stated she had received an APS referral concerning the above state allegations.
01/22/2020	Special Investigation Initiated - On Site Interviews conducted with Licensee Designee Randy Scholtus and facility staff members. Attempted interview with Resident A and other facility residents.
01/23/2020	Contact - Telephone call made Telephone interview with facility staff.
01/29/2020	Contact - Telephone call made Telephone call with Northern Lakes CMH Recipient Rights Officer Paul Keller.
01/29/2020	Contact - Telephone call made Telephone interview with Complainant-1.
01/29/2020	Contact - Telephone call made Telephone interview with facility manager Kristi Cole.
01/30/2020	Inspection Completed-BCAL Sub. Compliance
01/30/2020	Exit Conference Completed with Licensee Designee Randy Scholtus

ALLEGATION: Resident A was discovered to have a black eye. It is hard to believe his eye would be that black from hitting himself.

INVESTIGATION: On January 22, 2020, I received an email from Grand Traverse County Department of Health and Human Services, Adult Protective Services worker, Traci Doran. She stated she had received an APS referral with the above stated allegations and would be initiating an investigation. I informed her that I will be initiating an investigation this day.

On January 22, 2020, I conducted an on-site investigation at the West Shore AFC home. I met with Licensee Designee Randy Scholtus and Assistant Home Manger Sarah Patterson. Mr. Scholtus described, as relayed to him by facility staff, that on Saturday, January 18, 2020, Resident A began striking the side of his head/face with his hand. He stated that this behavior began in the afternoon and continued, on and off, for approximately six hours. Mr. Scholtus stated the two staff who were working in the facility that day were Courtney Gaylord and Kurstin Sumner. He further stated that this is a common behavior for Resident A, repeatedly striking himself or the arm of a chair. Mr. Scholtus stated staff contacted "on-call" supervisor Sherry Scheffer who directed staff to provide an over the counter pain medication and provide an ice pack. Ms. Patterson stated she observed Resident A the morning of January 20, 2020, noted his eye was swollen and called the Crystal Lake Clinic to have him medically evaluated. She noted he was seen by his doctor, referred for an X-Ray, which was not able to be completed due to Resident A's disability, and now is currently awaiting the scheduling of an MRI. She further stated she was informed by facility staff that the bruising was caused by Resident A striking himself in the head/face area over a six-hour period of time on January 18, 2020. Ms. Patterson stated this is not an unusual behavior for Resident A.

On January 22, 2020, I conducted an interview with staff member Courtney Gaylord. Ms. Gaylord stated that she worked the afternoon shift of January 18, 2020. She noted Resident A began striking himself on the left side of his face with his left hand at approximately 3:00 p.m. Ms. Gaylord noted this is not an unusual behavior for Resident A. She stated this behavior continued "on and off" over the next six hours during which time she had contacted "on call" staff Sherry Scheffer, who instructed her to give Resident A Tylenol. Ms. Gaylord stated she changed Resident A, helped him dress for bed and put him to bed around 7:00 p.m. She stated she checked on him at 9:00 p.m. and noted he had "a shiner" and he fell asleep shortly thereafter. Ms. Gaylord stated she worked again the following day, January 19, 2020, arriving at 7:00 a.m. She stated she checked on Resident A and he "didn't want to get up to eat breakfast." Ms. Gaylord noted "his eye was swollen shut" and she give him another over the counter pain medication. She stated he continued to hit himself periodically throughout the day and at dinner time his eye was still swollen shut. Ms. Gaylord denied striking, abusing or causing the bruising to Resident A and denied knowledge of any other staff or any facility resident striking him or causing the bruising to his eye/face.

On January 22, 2020, I conducted an interview with staff member Kurstin Sumner. Ms. Sumner stated she worked the afternoon shift of January 18, 2020. She stated Resident A began hitting himself at approximately 3:30 p.m. She stated that "on call" was contacted and instructed staff to provide Resident A with Tylenol. She stated Resident A also had a drink and that he was changed. Ms. Sumner noted the morning staff did not mention to her that he had been hitting himself. She stated this behavior lasted until after dinnertime and he went to bed shortly thereafter. Ms. Sumner stated she did not observe any bruising but did note "some swelling" to his face. Ms. Sumner stated she did not work on January 19th. She denied striking, abusing or causing the bruising to Resident A and denied knowledge of any other staff or any facility resident striking him or causing the bruising to his eye/face.

On January 22, 2020, I attempted to conduct an interview with Resident A. I was unable to obtain a reliable interview due to Resident A's significant developmental disabilities which include Autism and Profound Mental Retardation. I observed that he had bruising near both eyes and his eyes were both open.

On January 22, 2020, I observed several facility residents. I determined that all of the residents at home on this day appeared to be unable to provide a reliable interview.

On January 23, 2020, I conducted a telephone interview with staff member Sherry Scheffer. Ms. Scheffer stated that Ms. Gaylord had contacted her at approximately 9:45 p.m. on January 18, 2020, informing her that Resident A had been hitting himself in the head but had now gone to bed and was sleeping. She stated she instructed Ms. Gaylord to document this behavior and give Tylenol if needed. Ms. Scheffer noted that Ms. Gaylord told her that Resident A "was getting a black eye, that's it." Ms. Scheffer stated she worked at the facility beginning January 19, 2020 at 11:00 p.m. She stated she checked on him and observed that his eye was "black and blue" and "swollen but not swollen shut." Ms. Scheffer stated Resident A has hit himself before and that this is not unusual behavior for him. She noted he has previously given himself bruises.

On January 29, 2020, I conducted a telephone interview with NLCMH Caseworker Sara Saddler. Ms. Saddler is the CMH caseworker assigned to Resident A. She stated Resident A has a history of hitting himself in the head "but not his face" and also will strike the arm of his chair.

On January 29, 2020, I conducted a telephone interview with facility manager Kristi Cole. Ms. Cole stated Resident A has a history of self-abuse. She stated that she was informed by staff that Resident A began striking himself in the head/face on January 18, 2020, and staff had contacted Ms. Scheffer for instructions. Ms. Cole noted it was reported that Resident A's eye was swollen and bruised on January 19, 2020, and "really bruised" on January 20, 2020, at which time Ms. Patterson took him for medical care. Ms. Cole confirmed my observation that Resident A, nor any other facility resident is capable of providing a reliable interview.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Licensee Designee Randy Scholtus, staff members Cole, Scheffer, and Patterson all state that Resident A has a known history of striking himself and the noted behavior of January 18, 2020, is not unusual. Northern Lakes CMH Caseworker Sara Saddler stated Resident A has a known history of striking himself in the head. Staff members Gaylord and Sumner both deny using any kind of physical force with Resident A or doing anything to cause the noted bruising to his face. There is insufficient evidence to determine that any form of physical force, other than Resident A striking himself in the head/face, caused the bruising and swelling to his eyes/face.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was not taken for medical treatment until two days after it was noted that he had a black eye.

INVESTIGATION: Both Ms. Gaylord and Ms. Sumner state that Resident A began striking himself in the head/face at approximately 3:00 p.m. on Saturday January 18, 2020.

Ms. Gaylord noted that Resident A had a “shiner” when she checked on him at 9:00 p.m. on January 18, 2020. Ms. Gaylord stated she worked again the following day, January 19, 2020, arriving at 7:00 a.m. She stated she checked on Resident A and he “didn’t want to get up to eat breakfast.” Ms. Gaylord noted “his eye was swollen shut”

An *AFC Licensing Division Incident/Accident Report (BCAL-4607)* completed by Ms. Gaylord on January 18, 2020, notes; “I checked him (Resident A) around 6:30 p.m. and the side of his face was still swelling, and a black eye appeared on his left side.

When Resident A got his 8:00 p.m. meds his eye was bright purple, and his face was still swollen."

Ms. Sumner stated that at bedtime on January 18, 2020, she did not observe any bruising but did note "some swelling" to Resident A's face.

Ms. Scheffer stated she worked at the facility beginning January 19, 2020 at 11:00 p.m. She noted she checked on Resident A and observed that his eye was "black and blue" and "swollen but not swollen shut."

Ms. Patterson stated she took Resident A for a medical evaluation, due to the bruising and swelling to his eyes/face, the morning of Monday January 20, 2020. An *AFC Licensing Division Incident/Accident Report (BCAL-4607)* completed by Ms. Patterson states that on January 20, 2020 at 10:15 a.m. she took Resident A for a medical evaluation because Resident A "woke up with black/blue eye swollen shut."

Mr. Scholtus provided me with copies of staff shift notes concerning Resident A from January 18 – 20, 2020. The following are excerpts taken from these notes:

January 18, 2020 – Notes completed by Ms. Gaylord

- Resident A was repeatedly hitting himself in the head on the left side. Staff tried a prn to see if it was a possible headache at 4pm. At 6 pm after dinner Resident A continued to hit himself so staff asked if he wanted to go to bed. Staff changed him into pajamas and made sure he was dry. When he laid down staff noticed that the left side of his face was red and starting to swell. Before 8 pm meds he had a black eye.

January 19, 2020 – Notes completed by staff member Bella Huizar.

- 7a-3p shift, Resident A woke up with a black and blue and swollen shut left eye. Staff gave him some OTC Tylenol 2x500mg for pain. Resident A was still very agitated and hitting himself in his left eye. Staff tried redirecting with many unsuccessful attempts. Finally, just before 9:30 am. Resident A laid in bed watching cartoons.

- Staff called on-call and Sherry said it would be ok to give Resident A Tylenol as needed for pain for his eye while also giving him ibuprofen in between for swelling.

January 20, 2020 – Notes completed by Ms. Patterson

- Took Resident A to see Dr. Flynn. Ordered X-rays on left eye/face. Couldn't get X-rays. Dr. Flynn ordered sedation for a CT scan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Ms. Gaylord and Ms. Sumner stated Resident A began striking his head/face at approximately 3:00 p.m. on Saturday, January 18, 2020. Ms. Gaylord documented that at 6:30 p.m. on January 18, 2020, the side of Resident A's face was still swelling, and a black eye appeared on his left side. When Resident A got his 8:00 p.m. medications his eye was bright purple, and his face was still swollen. Ms. Gaylord stated she worked again on January 19, 2020, arriving at 7:00 a.m. She stated she checked on Resident A and he "didn't want to get up to eat breakfast." Ms. Gaylord noted "his eye was swollen shut". Staff member Bella Huizar documented that on January 19, 2020, Resident A woke up with a black and blue and swollen shut left eye. Staff member Sherry Scheffer stated she worked at the facility beginning January 19, 2020 at 11:00 p.m. She noted she checked on Resident A and observed that his eye was "black and blue" and "swollen but not swollen shut." Staff member Sarah Patterson Patterson stated she took Resident A for a medical evaluation, due to the bruising and swelling to his eyes/face, the morning of Monday January 20, 2020. Resident A caused an injury to himself by repeatedly striking his head/face over a several hour period on January 18, 2020. Staff noted bruising and swelling to his face/eye that evening. Staff noted Resident A's eye was swollen shut the morning of January 19, 2020. Staff noted Resident A's eye was black and blue the evening of January 19, 2020. Staff took Resident A for a medical evaluation on January 20, 2020, at 10:15 a.m.

	The facility staff did not obtain needed care immediately upon noting that Resident A had obtained an injury to his face/eye.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has a black eye. His Responsible Agency, Northern Lakes Community Mental Health, did not receive an incident/Accident report regarding this injury.

INVESTIGATION: On January 22, 2020, I observed, in the Licensing and Regulatory Affairs casefile for the West Shore AFC home, an *AFC Licensing Division – Incident/Accident Report (BCAL-4607)*, signed by Ms. Patterson and dated January 20, 2020. This report described Resident A's behaviors, striking himself, and staff action from January 18, 2020. This report was date stamped at the LARA office January 20, 2020 at 3:46 p.m. A second report, signed by Ms. Patterson and dated January 20, 2020, describing that Resident A was taken for medical care on January 20, 2020. This report was also date stamped at the LARA office January 20, 2020 at 3:46 p.m.

Ms. Patterson stated that she sent the two reports, mentioned above, to NLCMH Caseworker Sara Saddler and NLCMH Office of Recipient Rights Officer Paul Keller contemporaneously with the reports sent to the LARA office, AFC Consultant Rhonda Richards.

On January 29, 2020, I conducted a telephone interview with NLCMH ORR Paul Keller. Mr. Keller stated the above two reports, outlined above, were received at NLCMH January 20, 2020, at 2:37 p.m.

On January 29, 2020, Ms. Saddler stated she did not receive the above-mentioned reports, nor did she receive a telephone call from the facility related to Resident A's injuries.

It is noted that Resident A was not hospitalized as a result of the injuries sustained when he injured himself.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(a) The death of a resident. **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	None of the criteria outlined in the above rule, which would require a telephone call and/or a report to be completed and submitted to Resident A's designated representative, responsible agency and AFC Licensing, occurred. Thus, a telephone or written report would not have been required.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved and the care given. (d) The name of the individuals who were notified and the time of notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.

	(f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	Resident A's behavior, which resulted in an injury requiring medical evaluation, would be considered a "highly unusual behavior episode." The facility did prepare two *AFC Licensing Division – Incident/Accident Reports (BCAL-4607)*, both dated January 20, 2020, related to Resident A's behavior and medical treatment. These reports are on file at the facility and were submitted to the AFC Licensing Division and to Resident A's Responsible Agency.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On January 30, 2020, I conducted an exit conference with Licensee Designee Randy Scholtus. Mr. Scholtus stated he understood the findings, concurred with the conclusions noted above, and would submit a corrective action plan to address the established rule violation. He had no further questions pertaining to this special investigation.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

January 31, 2020

Bruce A. Messer Date
Licensing Consultant

Approved By:

January 31, 2020

Jerry Hendrick Date
Area Manager