GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2022

Todd and Barbara Stoutenburg
3190 Downington Rd
Snover, MI 48472

RE: License #: AF760310324
Investigation #: 2022A0871021
The Downington Inn

Dear Mr. and Mrs. Stoutenburg:

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. In any event, the corrective action plan is due within 15 days.

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,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF760310324
Investigation #:	2022A0871021
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/25/2022
Report Due Date:	03/22/2022
Licensee Name:	Todd and Barbara Stoutenburg
Licensee Address:	3190 Downington Rd Snover, MI 48472
Licensee Telephone #:	(810) 404-3190
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	The Downington Inn
Facility Address:	3190 Downington Rd Snover, MI 48472
Facility Telephone #:	(810) 404-4413
Original Issuance Date:	05/23/2011
License **Status:**	REGULAR
Effective Date:	11/23/2021
Expiration Date:	11/22/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was abandoned at the hospital. He was left outside with no coat and no oxygen tank. Resident A passed away on 01/17/2022 due to injuries he sustained at the AFC home and catching pneumonia by being left outside.	No
The AFC home has not contacted Resident A's family.	Yes

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A0871021
01/21/2022	APS Referral Denied to Sanilac County MDHHS
01/25/2022	Special Investigation Initiated - On Site Interviewed Licensees Todd and Barb Stoutenburg
01/25/2022	Contact - Telephone call made Telephone contact with Nurse Michelle from Hills and Dales Hospital
01/25/2022	Contact - Telephone call made Telephone contact with Family Member 1
03/07/2022	Contact - Telephone call received Received telephone call from Licensee's Son-in-Law Aaron Taylor
03/07/2022	Exit Conference Telephone Exit Conference with Licensee Barbara Stoutenburg
03/07/2022	Inspection Completed-BCAL Sub. Compliance
03/07/2022	Inspection Completed On-site Interviewed Residents A-D via face time.

ALLEGATION:

Resident A was abandoned at the hospital. He was left outside with no coat and no oxygen tank. Resident A passed away on 01/17/2022 due to injuries he sustained at the AFC home and catching pneumonia by being left outside.

INVESTIGATION:

On January 25, 2022, I conducted an unannounced onsite investigation and interviewed Licensee Barbara Stoutenburg. Ms. Stoutenburg indicated the social worker at Hills and Dales Hospital called her the evening of December 23, 2021, and asked if she could take Resident A and that he was homeless. Ms. Stoutenburg agreed to take him, and Licensee Todd Stoutenburg picked Resident A up from the hospital. Ms. Stoutenburg said Resident A was released from the hospital with no paperwork and she did not know much about him. The social worker told her that Resident A could not go to his house because the windows are knocked out and there is no power.

Ms. Stoutenburg said when Resident A came to her house, she felt that something was wrong with him medically and he was complaining that he could not breathe. Ms. Stoutenburg said Resident A had a hard time breathing and was complaining that he needed Norco and meds. Ms. Stoutenburg indicated Resident A was still not well all-day Friday, December 24, 2021, and Resident A was taken to Caro Hospital in the morning of December 25, 2021. Ms. Stoutenburg said he was at her home less than 48 hours.

I also interviewed Licensee Todd Stoutenburg on January 25, 2022. Mr. Stoutenburg stated Resident A was a handful and "shit all over the floor and his bed." Mr. Stoutenburg said he took Resident A to Caro Hospital emergency room on December 25, 2022, and took two oxygen tanks with him. Mr. Stoutenburg said he took his son-in-law Aaron Taylor with him to the hospital because he thought he would need a witness. Mr. Stoutenburg said Resident A was an oxygen dependent person and was his own guardian. Mr. Stoutenburg said, "he didn't want to be here" and wanted to go home. Mr. Stoutenburg indicated when they got to the hospital, he went into the emergency room and talked to a worker. He got a wheelchair to wheel Resident A in the hospital and when he went back in, a nurse came and got Resident A quickly. Mr. Stoutenburg said he retrieved his oxygen tanks and left right away. Mr. Stoutenburg denied he left Resident A outside without his oxygen.

Ms. Stoutenburg said that on December 25, 2021, she called Cass City Hospital and was told not to bring Resident A back because he had been there many times and always wanted medications. Ms. Stoutenburg said Caro Hospital would take Resident A on December 25, 2021, and they also provide mental health services.

On January 25, 2022, a phone call was placed to Nurse Michelle Rae at Hills and Dales Hospital. Nurse Rae said Resident A "was in pretty bad health." Nurse Rae

said none of his family would take him and said, “he was here so much.” Nurse Rae said Resident A never had visitors in the hospital and there was nothing else Hills and Dales could do for Resident A. Nurse Rae said the hospital “tried and tried to help [Resident A] but there was nothing else they could do for him.”

On January 25, 2022, a phone call was placed to Family Member 1. Family Member 1 said Resident A was being treated for COPD (Chronic Obstructive Pulmonary Disease). Family Member 1 said one time, Family Member 2 picked Resident A up from the hospital and he wanted to go back to his own house. Family Member 2 called Family Member 1 and said she could not leave him at his house because there was no power and Resident A was on oxygen. Family Member 1 said that after about a week of being in Caro Hospital, he went to a hospice house and passed away shortly thereafter. Family Member 1 said Resident A had a history of using drugs. Family Member 1 said Resident A lived with her for almost a month, but she could not care for him.

On March 7, 2022, I received a telephone call from Licensee Todd and Barbara’s Stoutenburg’ s Son-in-Law Aaron Taylor. Mr. Taylor said he was with Mr. Stoutenburg when Resident A was transported to the hospital. Mr. Taylor indicated Resident A wanted to be dropped off at his house and Mr. Stoutenburg told him that he could not because of the condition of the house. Mr. Taylor said Mr. Stoutenburg asked him to go to the hospital with him because Resident A charged at Mr. Stoutenburg and he did not want that to happen while he was driving. Mr. Taylor indicated when they got to the hospital, Mr. Stoutenburg went in and talked to someone at the desk and got a wheelchair. Mr. Stoutenburg came back out with the wheelchair and Resident A got in it. Mr. Stoutenburg wheeled Resident A into the hospital. Mr. Taylor said Resident A had his oxygen while on the way to the hospital and the tank belonged to the facility. Mr. Taylor said Mr. Stoutenburg wheeled Resident A into the hospital and a worker from the hospital wheeled him away. Mr. Stoutenburg brought the oxygen tanks back out to the car.

On March 7, 2022, I interviewed Residents B-C via facetime. Resident B said Resident A “treated Barb and Todd rotten.” Resident B said Resident A “shit on the floor.” Resident B said Resident A treated him rotten too. Resident C said Resident A “wasn’t here long.” Resident C said Resident A “pooped in his pants and would steal people’s stuff.” Resident C said Resident A “treated Barb and Todd just as bad as he treated me.” Resident C said Resident A “was a nasty individual.

APPLICABLE RULE	
R 400.1408	**Resident care; licensee responsibilities.**
	(1) A licensee shall provide basic self-care and habilitation training in accordance with the resident's written assessment plan.

ANALYSIS:	Licensee Todd Stoutenburg said he did not leave Resident A outside of the hospital and took him inside. Mr. Stoutenburg said Resident A had his oxygen on all the way to the hospital. Mr. Stoutenburg' s Son-in-Law Aaron Taylor witnessed Mr. Stoutenburg take Resident A into the hospital with his oxygen. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The AFC home has not contacted Resident A's family.

INVESTIGATION:

On January 25, 2022, I asked Licensee Barbara Stoutenburg for the *AFC Licensing Division – Incident/Accident Report.* Licensee Barbara Stoutenburg said, "I never wrote anything."

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of the following: **(b) Any accident or illness requiring hospitalization.**
ANALYSIS:	On January 25, 2022, when I asked Licensee Barbara Stoutenburg for the *AFC Licensing Division – Incident/Accident Report,* Ms. Stoutenburg said she did not complete a report. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On March 7, 2022, I conducted a telephone exit conference with Licensee Barbara Stoutenburg. I advised Licensee Barbara Stoutenburg an *AFC Licensing Division – Incident/Accident Report* must be completed when a resident goes to the emergency room.

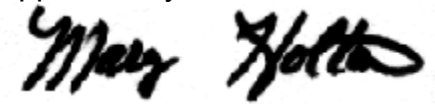
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care family home license remain unchanged (capacity 1-6).

03/09/2022

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



03/09/2022

Mary E Holton — Date
Area Manager