GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Judith Schiavone
Schiavone Enterprises Ltd
1690 N Center
Saginaw, MI 48638

RE: License #: AM730259474
Investigation #: 2023A0576001
Schiavone AFC VI

Dear Mrs. Schiavone:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730259474
Investigation #:	2023A0576001
Complaint Receipt Date:	10/06/2022
Investigation Initiation Date:	10/06/2022
Report Due Date:	12/05/2022
Licensee Name:	Schiavone Enterprises Ltd
Licensee Address:	1690 N Center, Saginaw, MI 48638
Licensee Telephone #:	(989) 992-9400
Administrator:	Judith Schiavone
Licensee Designee:	Judith Schiavone
Name of Facility:	Schiavone AFC VI
Facility Address:	1027 N Michigan, Saginaw, MI 48602
Facility Telephone #:	(989) 753-9188
Original Issuance Date:	06/24/2005
License Status:	REGULAR
Effective Date:	05/06/2022
Expiration Date:	05/05/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Ariel LaPlaunt was assisting with showering Resident A and walked away. Resident A fell resulting in a head injury.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/06/2022	Special Investigation Intake 2023A0576001
10/06/2022	APS Referral Received from APS.
10/06/2022	Special Investigation Initiated - Letter Received email from Jessire Ramos, Saginaw County Adult Protective Services (APS)
10/31/2022	Inspection Completed On-site Interviewed Aundre Buckley
10/31/2022	Contact - Telephone call received Interviewed Licensee Designee, Judith Schiavone
10/31/2022	Contact - Document Received Reviewed Resident A's AFC Assessment Plan
10/31/2022	Contact - Document Received Text received from Judith Schiavone
11/01/2022	Contact - Document Received Reviewed Incident Reports (IR)
11/28/2022	Contact - Telephone call made Interviewed Staff, Ariel LaPlaunt
11/28/2022	Contact - Telephone call made Left message for Guardian A to return call
11/28/2022	Contact - Telephone call made Interviewed Beth Burns, Saginaw County Medical Examiner’s Office

11/28/2022	Exit Conference Exit Conference conducted with Licensee Designee, Judith Schiavone
11/29/2022	Contact - Telephone call made Interviewed Guardian A

ALLEGATION:

Staff, Ariel LaPlaunt was assisting with showering Resident A and walked away. Resident A fell resulting in a head injury.

INVESTIGATION:

On October 6, 2022, I received this complaint from Adult Protective Services (APS). I sent an email to Jessire Ramos advising I did not receive an AFC Licensing Division Accident / Incident Report (IR) regarding Resident A falling in the shower. Ms. Ramos advised she is substantiating neglect on the staff person for leaving Resident A alone, resulting in the fall on September 3, 2022.

On October 31, 2022, I completed an unannounced on-site inspection at Schiavone AFC VI and interviewed Home Manager, Aundre Buckley who advised Resident A no longer resides at the home as of October 18, 2022. Resident A is nonverbal, utilized a walker, and required staff assistance to hold her up while in the shower. I inquired of Ms. Buckley if an IR was written regarding Resident A falling in the shower. Ms. Buckley confirmed there was however she was unable to locate it. Ms. Buckley advised she would find the IR and forward it to my attention.

There are 10 residents who reside at the home. I observed several residents walking throughout the home and sitting in the dining room area. No concerns were noted, and the residents appeared to be receiving adequate care and supervision.

On October 31, 2022, I interviewed Licensee Designee, Judy Schiavone regarding Resident A. Resident A was 71 years old, had lived at the facility since 2005, and her health recently began to decline. The facility was no longer able to meet her needs and Resident A was provided a discharge notice October 17, 2022. Regarding the allegations, Resident A did fall in the shower on September 3, 2022, when the staff person, Ariel LaPlaunt left to go get her some clothes. Ms. LaPlaunt was given a written warning for this incident.

On October 31, 2022, I reviewed a Notice of Warning for Ariel LaPlaunt. The notice is dated for September 4, 2022, and authored by Licensee Designee, Judith Schiavone. The notice documented that Resident A fell September 3, 2022, and injured herself because she was not supervised at all times in the shower. Staff, Ms. LaPlaunt left

Resident A in the shower to retrieve socks and it was at this time that Resident A fell. Mrs. Schiavone advised that Resident A cannot be left alone in any area where she may injure herself. Mrs. Schiavone directed Ms. LaPlaunt to always put resident safety first and not leave vulnerable residents alone until they are in safe areas.

On October 31, 2022, I reviewed Resident A's AFC Assessment Plan. The plan indicated that Resident A needs help with bathing and is "full assist". Resident A has poor communication, mumbles, and her "language is not discernable". Per the assessment plan, it is "not clear" if Resident A understands verbal communication. Resident A does not follow directions and "repeating is necessary whether she ignores direction or does not understand". I also viewed a written discharge notice for Resident A. The discharge notice was dated for October 17, 2022, and addressed to Resident A's guardian, Guardian A. The notice documented that the home had concerns regarding their ability to properly care for the Resident A given her increased health and behavior issues and this is the reason for discharge.

On October 31, 2022, I received a text message from Judy Schiavone indicating that Resident A was in the hospital and "arrested tonight". Resident A subsequently passed away. According to Mrs. Schiavone, she was told Resident A had water around her heard and died due to congestive heart failure.

On November 1, 2022, I received 2 IR's regarding Resident A. The first IR was dated for September 3, 2022, and authored by Ariel LaPlaunt. The IR documented that on September 3, 2022, Staff, Ariel LaPlaunt showered Resident A. Ms. LaPlaunt left the shower area to get socks for Resident A and Resident A was sitting on the shower bench. As Ms. LaPlaunt was walking back to the bathroom, Ms. LaPlaunt saw Resident A lose her balance and hit her head on the door. Resident A was bleeding from the right side of her head and Ms. LaPlaunt called for another staff to help her get Resident A up. Resident A was responding and alert. The ambulance was called to transport Resident A to the hospital. The second IR is dated for September 4, 2022, and authored by Ariel LaPlaunt. The IR indicated that on September 3, 2022, Resident A required 6 staples on the right side of her head due to her fall in the shower. Corrective measures include providing the best care to Resident A and utilizing ice packs for Resident A's swelling and applying ointment to her injury.

On November 28, 2022, I interviewed Staff, Ariel LaPlaunt regarding the allegations. Ms. LaPlaunt advised she showered Resident A on September 3, 2022, and realized she forgot her socks. Resident A was sitting on the shower bench and Ms. LaPlaunt told her to stay on the bench. Ms. LaPlaunt went to Resident A's room to get socks and on the way back to the bathroom saw Resident A starting to get up. Ms. LaPlaunt could not get to Resident A in time and Resident A fell. Resident A hit her head on the door and started to bleed. Ms. LaPlaunt put towels on Resident A's head and got her dressed. The ambulance was called and transported Resident A to the hospital.

On November 28, 2022, I called Resident A's guardian, Guardian A. There was no answer, and I left a message requesting a return call. On November 29, 2022, I

interviewed Guardian A who reported Resident A died on October 31, 2022. Resident A was in the hospital and had liquid by her heart. Resident A's heart began to bleed, and she was taken into surgery to stop the bleeding. Resident A died and medical staff tried to revive her for 40 minutes however it was unsuccessful.

According to Guardian A, Resident A lived at Schiavone AFC VI for 7-8 years. Resident A had a hard time communicating and could not answer questions. Additionally, Resident A's speech was not that good. Guardian A reported she was told Resident A would throw herself on the floor resulting in bruises however Guardian A never witnessed this behavior. Regarding the allegations, Guardian A was aware Resident A fell in the shower. Guardian A did not think staff should have left Resident A in the shower to go get socks.

On November 28, 2022, I interviewed Beth Burns from the Saginaw County Medical Examiner's Office. Ms. Burns advised Resident A did not have an autopsy completed and the death occurred at Covenant Hospital on October 31, 2022. Resident A was having cardiac issues and went to the operating room. Resident A deteriorated and went into cardiac arrest. Medical staff tried to resuscitate Resident A and they were not successful. Resident A's manner of death was natural, and cause was cardiac tamponade and renal failure.

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:	It was alleged that Resident A fell in the shower after being left alone by staff. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Staff, Ariel LaPlaunt showered Resident A. Ms. LaPlaunt left Resident A in the shower to retrieve socks. Resident A tried to get up and fell resulting in a head injury that required staples to treat. Per Resident A's AFC Assessment Plan, Resident A requires full assistance in the shower. There is a preponderance of evidence to conclude Resident A's protection and safety was not adhered to at all times by staff resulting in injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On October 31, 2022, I completed an unannounced on-site inspection at Schiavone AFC VI. I interviewed Home Manager, Aundre Buckley and inquired as to whether an IR (incident report) was written regarding Resident A falling in the shower. Ms. Buckley confirmed there was and would forward to my attention.

On November 1, 2022, I received a fax from Aundre Buckley. Ms. Buckley provided 2 IR's regarding Resident A falling in the shower and being treated at the hospital respectively.

APPLICABLE RULE	
R 400.14311	**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: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	On September 4, 2022, Resident A fell in the shower, which resulted in a head injury. Resident A went to the hospital to be treated for the injury. Adult foster care licensing was not provided a written report of the fall or hospitalization within 48 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 28, 2022, I completed an Exit Conference with Licensee Designee, Judith Schiavone. I advised Mrs. Schiavone I would be requesting a corrective action plan for the cited rule violations.

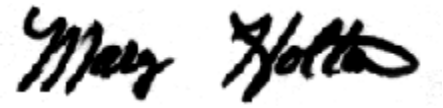
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

12/01/2022

Christina Garza Date
Licensing Consultant

Approved By:



12/01/2022

Mary E. Holton Date
Area Manager