GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2022

Scott and Lisa Ostrander
1943 N. Verona Rd.
Bad Axe, MI 48413

RE: License #: AM320298210
Investigation #: 2023A0871005
Talaski Adult Foster Care Home

Dear Mr. and Ms. Ostrander:

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,

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 #:	AM320298210
Investigation #:	2023A0871005
Complaint Receipt Date:	11/04/2022
Investigation Initiation Date:	11/04/2022
Report Due Date:	01/03/2023
Licensee Name:	Scott and Lisa Ostrander
Licensee Address:	1943 N. Verona Rd. Bad Axe, MI 48413
Licensee Telephone #:	(989) 269-8883
Administrator:	Lisa Ostrander
Licensee Designee:	N/A
Name of Facility:	Talaski Adult Foster Care Home
Facility Address:	1943 N. Verona Rd. Bad Axe, MI 48413
Facility Telephone #:	(989) 269-8883
Original Issuance Date:	08/31/2009
License **Status:**	REGULAR
Effective Date:	03/12/2022
Expiration Date:	03/11/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's arm was black and blue from her wrist to her arm pit. It was swollen and hot to the touch. Resident A did not receive medical attention.	Yes
Residents are not allowed to go to day program and are made to stay home.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/04/2022	Special Investigation Intake 2023A0871005
11/04/2022	Special Investigation Initiated - Letter Received information from Complainant 1
11/21/2022	Contact - Face to Face Interviewed Day Program Staff Ellen Rothfuss
11/22/2022	Contact - Face to Face Interviewed Residents A-D at day program
11/22/2022	Inspection Completed On-site Interviewed Licensee Lisa Ostrander
11/30/2022	Inspection Completed On-site Interviewed Licensee Scott Ostrander
11/30/2022	APS Referral Through Central Intake to Huron County MDHHS
11/30/2022	Exit Conference Face to face exit conference with Licensee Scott Ostrander
12/05/2022	Inspection Completed On-Site

	Interviewed Licensee Scott Ostrander
12/06/2022	Contact – Telephone call received Telephone call from Licensee Lisa Ostrander

ALLEGATION:

Resident A's arm was black and blue from her wrist to her arm pit. It was swollen and hot to the touch. Resident A did not receive medical attention.

INVESTIGATION:

On November 21, 2022, I conducted an onsite investigation at Resident A's day program and interviewed Day Program Staff Ellen Rothfuss. Ms. Rothfuss indicated Resident A's "arm was totally swollen, black and blue." Ms. Rothfuss indicated Friend 1 of Resident A at day program took pictures of Resident A's arm and they were provided to me by Friend 1. The pictures showed Resident A's arm to be black and blue and swollen. Resident A's hand was also swollen with black and blue marks. Ms. Rothfuss indicated that they helped Resident A by putting ice on it.

On November 22, 2022, I interviewed Resident A at day program. Resident A said, "I fell at Lisa's house." I asked Resident A if she went to the hospital and she replied "no, Scott said he was medical and could help" and she was not treated at a medical facility. Resident A said she still cannot lift her arm up all the way like she used to, but it is getting better.

I also interviewed Resident A's Friend 1. Friend 1 stated "her elbow was on fire and her arm was swollen." Friend 1 said her arm was swollen to her elbow, so they put ice on it.

On November 30, 2022, I conducted an unannounced onsite investigation and interviewed Licensee Scott Ostrander. Mr. Ostrander indicated that on the day Resident A fell, he was doing pills, and "I heard a thud." Mr. Ostrander stated Resident A tripped on the door frame coming out of the bathroom on November 6, 2022. Mr. Ostrander said he checked her arm for any protruding bones or a Hairline Fracture. Mr. Ostrander did not feel anything, so he treated her with ice and gave her Tylenol. Mr. Ostrander noticed the bruising the next day and thought that her meds could have contributed to the bruising. Mr. Ostrander said she was not treated at a medical facility and never did have an X-ray on her arm. I advised Mr. Ostrander that the bruising on Resident A's arm was severe, and she should have been treated by a medical professional. Mr. Ostrander indicated he will take Resident A for an X-ray.

On November 22, 2022, I conducted an onsite investigation and interviewed Licensee Lisa Ostrander. Ms. Ostrander stated the physician that comes to the facility was there the next day and examined Resident A. On November 22, 2022, I conducted an onsite investigation and interviewed Licensee Lisa Ostrander. Ms. Ostrander indicated Resident A was seen by a physician on November 8, 2022. Ms. Ostrander said the physician did not have any concerns about Resident A's arm, but her arm was not X-rayed.

On December 5, 2022, I conducted an onsite investigation and interviewed Licensee Scott Ostrander. Mr. Ostrander indicated he did forget about Resident A going to the doctor on November 8, 2022 and said she did go to Dr. Kala. Mr. Ostrander stated Dr. Kala is a neurosurgeon and treats Resident A for seizures. Mr. Ostrander said Dr. Kala did not check on Resident A's arm.

On December 5, 2022, at the onsite investigation, Mr. Ostrander was asked for a record of the physician's contact. Mr. Ostrander said he did not have a physician's contact log. I also asked Mr. Ostrander if an *AFC Licensing Division – Incident/Accident Report* was completed for Resident A's injury. Mr. Ostrander said he did not feel that an incident report was warranted for her fall.

On November 22, 2022, several of the residents were present. They all appeared happy and to be receiving adequate care.

APPLICABLE RULE	
R 400.14310	**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:	Resident A's arm was severely bruised and swollen. Her arm was black and blue from her hand to her arm pit. Resident A said Licensee Scott Ostrander treated her and did not seek professional medical attention for her but then admitted he forget Resident A saw Dr. Kala on November 8, 2022. Ms.

	Ostrander reported Resident A was treated on November 8, 2022, by Dr. Kala who is a neurosurgeon and treats Resident A for a seizure disorder, and her arm was not examined. Ms. Ostrander reported Resident A was treated by the visiting physician the next day after the fall. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not allowed to go to day program and are made to stay home.

INVESTIGATION:

On November 21, 2022, Day Program Staff Ellen Rothfuss stated that the residents tell her that sometimes they are kept home because of their behaviors. Ms. Rothfuss indicated that she was told that one time, the toilet was plugged, and no one would tell Licensee Scott Ostrander who did it, so they had to stay home from program.

On November 22, 2022, I asked Resident A if they have to stay home sometimes when she wants to come to program. Resident A said, “sometimes they have to stay home when she wants to come to program.” Resident A did not say why she had to stay home.

I then interviewed Resident B at day program. I asked Resident B if they are sometimes kept home from program and she replied, “they won’t let us come to program, I don’t know why.” I asked Resident C if she is made to stay home and she said, “it happens a lot.” I asked Resident C about the time the toilet was plugged, and she said someone confessed to doing it and “they had to stay home one day” because of it.

On November 30, 2022, at the unannounced onsite investigation, I asked Licensee Scott Ostrander about when the toilet was plugged. Mr. Ostrander indicated he wanted to know who plugged the toilet and someone did confess. Mr. Ostrander said because of that incident, he did keep the residents home from program.

On November 22, 2022, at the unannounced onsite investigation, Licensee Lisa Ostrander indicated that Mr. Ostrander decides to keep the residents home from day program.

On November 30, 2022, I conducted a face-to-face exit conference with Licensee Scott Ostrander. I also informed Mr. Ostrander he cannot keep the residents home

from day program because of things that happen in the home. Mr. Ostrander was informed of the rule violation.

On December 6, 2022, Ms. Ostrander indicated that there has been a problem with the residents plugging the toilets. Ms. Ostrander stated that the residents were not admitting who plugged it. Ms. Ostrander said on that day when the toilets were plugged, they did keep home some of the residents and she admitted it was wrong to do that.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(h) The right to participate in the activities of social, religious, and community groups at his or her own discretion.**
ANALYSIS:	Residents A-C all stated that they are sometimes kept home from day program because of things that happen in the house. Licensee Scott Ostrander admitted he kept the residents home from day program because someone plugged the toilet. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On December 5, 2022, at the onsite investigation, Mr. Ostrander was asked for a record of the physician's contact. Mr. Ostrander said he did not have a physician's contact log. I also asked Mr. Ostrander if an *AFC Licensing Division – Incident/Accident Report* was completed for Resident A's injury. Mr. Ostrander said he did not feel that an incident report was warranted for her fall.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(iv)A record of physician contacts.**
ANALYSIS:	Licensee Scott Ostrander said he did not have a log of the physician contacts for Resident A. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(c) Incidents that involve any of the following:** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Licensee Scott Ostrander did not complete an *AFC Licensing Division – Incident/Accident Report* regarding Resident A's fall. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 5, 2022, I conducted a face-to-face exit conference with Licensee Scott Ostrander. I advised Mr. Ostrander that Resident A's arm was black and blue, swollen, and he should have obtained medical treatment for her. I also advised him there were additional findings as there was no physician contacts recorded or no *AFC Licensing Division – Incident Accident Report* written for Resident A's fall and injury.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

12/07/2022

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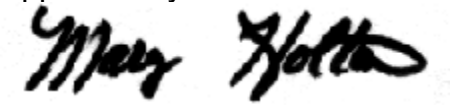
Kathryn A. Huber Date
Licensing Consultant

Approved By:



12/07/2022

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Mary E. Holton Date
Area Manager