GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Dianne Schmiege
400 S Walnut St
Bay City, MI 48706

RE: License #: AM090278806
Investigation #: 2024A0572009
Pine Ridge AFC Home

Dear Mrs. Schmiege:

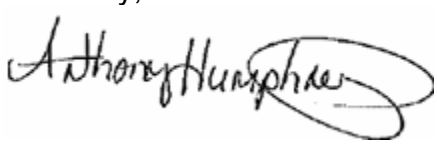
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM090278806
Investigation #:	2024A0572009
Complaint Receipt Date:	11/09/2023
Investigation Initiation Date:	11/09/2023
Report Due Date:	01/08/2024
Licensee Name:	Dianne Schmiege
Licensee Address:	400 S Walnut St Bay City, MI 48706
Licensee Telephone #:	(989) 892-7210
Administrator:	Kayla Schmiege
Licensee Designee:	N/A
Name of Facility:	Pine Ridge AFC Home
Facility Address:	1672 Ridge Rd Bay City, MI 48708
Facility Telephone #:	(989) 892-3438
Original Issuance Date:	05/13/2006
License **Status:**	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	12
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not allowed to return home without a proper care plan.	Yes
Several bottles of Resident A's MS medications were not administered.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/09/2023	Special Investigation Intake 2024A0572009
11/09/2023	Special Investigation Initiated - Letter APS
11/09/2023	Inspection Completed On-site Licensee, Dianne Schmiege.
11/09/2023	APS Referral APS made referral.
01/03/2024	Contact - Face to Face Staff, Caitlin Jankowski.
01/03/2024	Contact - Telephone call made Resident A Family Member #1
01/04/2024	Contact - Document Received Licensee, Dianne Schmiege.
01/04/2024	Contact - Telephone call made Nurse.
01/04/2024	Inspection Completed-BCAL Sub. Compliance
01/05/2024	Exit Conference Licensee, Dianne Schmiege.

ALLEGATION:
Resident A was not allowed to return home without a proper care plan.

INVESTIGATION:
On 11/09/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made a referral to licensing.

On 11/09/2023, I made an unannounced onsite to Pine Ridge AFC Home, located in Bay County, Michigan. Interviewed was Licensee, Dianne Schmiege. Resident A was not observed as he was no longer in the home.

On 11/09/2023, I interviewed Licensee, Dianne Schmiege regarding the allegation. Resident A did not return from the hospital because they were unable to fulfill his needs. Resident A was in the hospital and there was no way that they would be able to take Resident A back due to his physical condition. They did not give Resident A a 30-Day Discharge Notice because they did not expect him to leave, but the discharge planner at the hospital informed that Resident A needed a 3-person assist and the facility is unable to provide this. Ms. Schmiege does not have the discharge papers from the hospital because he never returned to their care.

On 01/03/2024, I made another unannounced onsite to Pine Ridge AFC and interviewed Staff, Caitlyn Jankowski regarding the allegation. Ms. Jankowski did not know exactly why Resident A did not return to the home but informed that Resident A was getting harder to change and transfer. Ms. Jankowski is unaware if a 30-Day Discharge Notice was given.

On 01/03/2024, phone contact was made with Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that Resident A had resided in the home for approximately 3 years and the facility provided reasonable care to Resident A, however; in his most recent visit to the Emergency Room, Resident A was discharged from the hospital and the facility would not take Resident A back. The reasoning is that they did not have enough staff to fulfill his needs. The discharge instructions from the hospital did not have anything too unreasonable for an AFC Home to handle in his opinion. Family Member #1 does not have the discharge papers from the hospital. Resident A is in a new placement and is doing well.

On 01/03/2024, phone contact was made with Licensee, Dianne Schmiege. Ms. Schmiege informed that Resident A's discharge papers from the hospital indicated that he would be a 3-person assist, so she suggested that Resident A go to rehab first and after Resident A gets his strength back, then he could return to their home. Resident A eventually was able to go into rehab, but the family decided not to return him to their home. Ms. Schmiege informed that they never charged Resident A while he was gone and called the family to let them know that he can return after he is discharged from rehab, but they decided to place Resident A in a nursing home where there is more staffing and equipment.

On 01/04/2024, phone contact was made with Resident A's Family Member #2 regarding the allegation. Family Member #2 informed that weeks prior to Resident A going to the Emergency Room, the Ms. Schmiege was saying that they don't know how long that they will be able to keep Resident A because her staff are tired and hurting from having to lift him. Family Member #2 believes that Resident A going to the hospital was a way for them not to except him back. A 30-Day discharge letter was not given, they just refused to take him back from the hospital. Family Member #2 does not have the discharge papers from the hospital. Resident A is placed in a Nursing Home and is doing fine.

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:	Based upon my investigation of this allegation, there is enough evidence to establish a violation. Resident A was never given a discharge notice from Pine Ridge AFC Home. Pine Ridge did not accept Resident A back to the home due to his physical condition, however; did not put anything in writing as to why they would not accept Resident A back.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
During Resident A's discharge from the home, the family found 3 unused bottled of Resident A's medication for MS.

INVESTIGATION:
On 11/09/2023, I interviewed Licensee, Dianne Schmiege regarding the allegation. Ms. Schmiege informed that Administrator, Kayla Schmiege was on maternity leave when the pharmacy sent the medication. Kayla Schmiege is the person who writes in the new medications that are not on the medication sheet or that is coming from a sperate pharmacy. Because she was off, no one added the medication to the

medication sheet, so it was missed. When Kayla Schmiege returned to work, she realized the error. The medication was never discarded and returned to Resident A's family when Resident A moved to another facility.

On 01/03/2024, I made another unannounced onsite to Pine Ridge AFC and interviewed Staff, Caitlyn Jankowski regarding the allegation. Ms. Jankowski did not know exactly what happened with the medications. Staff Jankowski only heard that there were some medications left over from when Administrator, Kayla Schmiege was on maternity leave, and it somehow was missed.

On 01/03/2024, phone contact was made with Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that there were several bottles of Resident A's Multiple Sclerosis (MS) medications that were not administered. Family Member #1 is unsure why his MS medication was not administered when it's a scheduled medication. Family Member #1 is unsure if that is why Resident A was going back and forth to the hospital. The family were going to push from Resident A to return to the home, but when they saw that Resident A wasn't getting his scheduled medications, they decided to move him. Licensee, first said that it must have been a replacement bottle, but then said that there was a staff who was negligent, and she is no longer working in the home.

On 01/03/2024, I reviewed the Incident Report regarding the missed medications. It indicates that Resident A was not receiving his Aubagio medication for MS. The medication comes in a separate bottle from the other medications (pop out packet) and from a different pharmacy. The medication is not listed on the medication sheet and must be written in. In the action steps, it indicates that Kayla Schmiege noticed that the medication error when returned from maternity leave and that it was not charted in the med book. As a result, additional med training was provided. If Kayla Schmiege is unable to write in the additional medications in the med book, then Licensee, Dianne Schmiege will write it in.

On 01/03/2024, phone contact was made with Licensee, Dianne Schmiege. Ms. Schmiege indicated that she believes that an incident report was written and will send it to me. Ms. Schmiege was also asked if she could send me the Assessment Plan as well as the Health Care Appraisal. Ms. Schmiege does not believe that the family or case manager were ever notified of the medication error.

On 01/03/2024, I reviewed the healthcare appraisal, and it indicates that Resident A is diagnosed with MS and is not ambulatory.

On 01/03/2023, I reviewed Resident A's Assessment Plan. Resident A is fully handicapped from the waist down and needs assistance for all of his basic needs.

On 01/03/2023, according to Google, Aubagio is a MS medication that slows the progression of the disease. The effects of not taking this medication for a period of

time varies. It could cause the symptoms of MS to progress, or it may not have any major side effects at all.
On 01/04/2024, phone contact was made with Resident A's Family Member #2 regarding the allegation. Family Member #2 was not sure of the explanation for the missed medication but knows that it prevents the progression of the disease. It may cause Resident A to become shakier. At one point Resident A was able to feed himself, now he is unable to, but does not know if this is a direct correlation of him not receiving his medication. Family Member #2 currently has the bottles and informed that they can't be used. Family Member #2 was only made aware of the medication error when they came to pick up Resident A's belongings, and the medication unopened medication bottles were given.

On 01/04/2024, I made an attempt to contact Nurse to learn of any possible major side effects as it pertains to Resident A not receiving his MS medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation of this allegation, there is enough evidence to establish a violation. Resident A had multiple bottles of his Aubagio medication that were never administered. Licensee, Dianne Schmiege informed that it was missed while the Administrator was off on Maternity Leave.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/05/2024, an Exit Conference was held with Licensee, Dianne Schmiege regarding the results of the special investigation. She was informed to send me a corrective action plan within 15 days of receipt of this report.

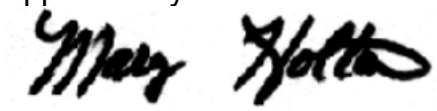
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium sized group home, pending the receipt of an acceptable corrective action plan for all violations established (Capacity 1-12).

01/05/2024

Anthony Humphrey — Date
Licensing Consultant

Approved By:



01/05/2024

Mary E. Holton — Date
Area Manager