

VIRGINIA:

BEFORE THE BOARD OF LONG-TERM CARE ADMINISTRATORS

IN RE: SCOTT C. SCHUETT, A.L.F.A.
License No: 1706-000506
Preceptor Registration No.: 1707-000060
Case No.: 145346, 143951 & 146464

ORDER

Pursuant to §§ 2.2-4020, 54.1-110 and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was held before a panel of the Board of Long-Term Care Administrators ("Board") on December 11, 2012, in Henrico County, Virginia, to inquire into evidence that Scott C. Schuett, A.L.F.A., may have violated certain laws and regulations governing assisted living facility administration practice in Virginia. The case was presented by David W. Kazzie, Adjudication Specialist, Administrative Proceedings Division. Erin L. Barrett, Assistant Attorney General, was present as legal counsel for the Board. Mr. Schuett was not present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Scott C. Schuett, A.L.F.A., was issued License No. 1706-000506 to practice as an assisted living facility administrator in the Commonwealth on February 13, 2009. It was scheduled to expire on March 31, 2013, prior to its summary suspension on September 13, 2012. Mr. Schuett also held Registration No. 1707-000060 to practice as an assisted living facility administrator preceptor prior to its summary suspension on September 13, 2012.

2. Based upon the representations of Mr. Kazzie and Commonwealth's Exhibit #1, the Amended Notice of Formal Hearing and Affidavit of Mailing, the presiding officer ruled that adequate notice was

provided to the respondent and the hearing proceeded in his absence.

3. During the course of Mr. Schuett's employment as owner/administrator of Madison Retirement Center, Williamsburg, Virginia:

- a. On May 8 and 9, 2012, Schuett failed to ensure that a diabetic resident who was experiencing high glucose readings received proper supervision, care, and attention, by failing to notify the resident's primary care physician immediately, and the next of kin, legal representative, contact person, case manager and social services agency within 24 hours after the resident fell and after the resident refused transport to the hospital and failing to document any such notification in the resident's record.
- b. On May 9, 2012, Mr. Schuett failed to notify the Department of Social Services in a timely manner of the death of the resident referenced in the first allegation, who was transported to the hospital after staff discovered the resident unresponsive.
- c. In May 2012, Mr. Schuett failed to ensure that resident call bells were operational in at least four rooms of the facility.
- d. In May 2012, Mr. Schuett failed to ensure that a resident had a complete Uniform Assessment Instrument and Individualized Service Plan on file in that the resident's record did not reflect his substance abuse history, his history of unstable insulin-dependent diabetes, or his need for assistance with grooming and bathing.
- e. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that residents' medications were administered in accordance with doctors' order and in a manner consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.
- f. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient supply of food on hand for the residents, and he failed to ensure that residents were provided three well-balanced meals daily that conformed to physicians' orders pertaining to special dietary needs

where applicable.

- g. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that residents' medication administration records were properly maintained.
 - h. On multiple occasions in 2012, Mr. Schuett failed to ensure that the facility had enough staff on hand to properly care for and supervise residents.
 - i. On multiple occasions in 2012, Mr. Schuett failed to ensure that significant changes in residents' conditions were reported to the residents' physicians, including significant weight loss in approximately nine residents.
 - j. On multiple occasions in 2011 and 2012, Mr. Schuett failed to properly maintain the facility's building and physical plant in good repair, clean, free of foul odors and free of pest infestation.
 - k. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that all residents had updated tuberculosis screening assessments on file with the facility.
 1. On or about March 12, 2012, Mr. Schuett failed to appoint an interim administrator to perform the duties of Administrator in the absence of the facility Administrator while she was out on medical leave and failed to notify the Board and the regional licensing Office of the Department of Social Services that the facility was operating without a licensed assisted living facility administrator.
4. During the course of his employment as owner/administrator of Ashwood Assisted Living Facility:
- a. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient supply of food on hand for the residents, and he failed to ensure that residents were provided three well-balanced meals per day that conformed to physicians' orders pertaining to special dietary needs, where applicable.
 - b. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had enough staff on hand to properly care for and supervise residents.

- c. On multiple occasions in 2011 and 2012, Mr. Schuett failed obtain sexual offender registry information for new facility residents.
 - d. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that PRN medications that had been prescribed to residents were available on-site.
 - e. On multiple occasions in 2011 and 2012, Mr. Schuett failed to maintain the building in good repair, clean, free of foul odors, and free of pest infestation.
 - f. On multiple occasions in 2011 and 2012, Mr. Schuett failed to obtain mental health screenings and complete physical examinations of prospective residents prior to admission to the facility.
 - g. On multiple occasions in 2011 and 2012, Mr. Schuett failed to obtain mental health reports and individualized service plans in a timely fashion.
 - h. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient backup supply of emergency drinking water on hand.
 - i. In or about January 2012, Mr. Schuett failed to ensure the preparation of staff/resident assignment sheets, records of activities of daily living, or 24-hour report sheets, as well as menus and activity schedules.
 - j. On multiple occasions in 2011, Mr. Schuett failed to ensure that all resident medications were available and being administered in accordance with physicians' orders and in accordance with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.
 - k. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that medication administration records were being maintained properly.
5. During the course of his employment as owner/administrator of Oakwood Assisted Living Facility:
- a. Mr. Schuett failed to ensure that residents were properly supervised, as evidenced by

the occurrence of 19 reported assaults that occurred in the facility between January 1, 2012, and August 27, 2012.

b. Mr. Schuett failed to take appropriate steps to ensure the safety and well-being of a resident who had stopped taking his anti-seizure medication and declined to be treated by the facility's in-house physician, including failing to notify the resident's community services board case manager that the resident was declining to see the physician, and he failed to ensure that observations of that resident's seizure activity and transfer of the resident to the hospital following a seizure were documented in the resident's facility record.

c. In or about April 2012, Mr. Schuett failed to document the discharge of a resident from the facility who had been facility attacked by another resident, hospitalized and who never returned to Oakwood.

d. Mr. Schuett failed to maintain complete and/or updated records for multiple residents, and failed to ensure the charting of significant happenings experienced by residents in the communication log book and the resident records, including one who had refused his medication and refused to meet with his physician, two who committed violent assaults on fellow residents, and the two resident victims of those assaults.

e. Mr. Schuett failed to obtain a mental health screening for a resident as recommended by the uniform assessment instrument assessor.

CONCLUSIONS OF LAW

The Board concludes that Findings of Fact Nos. 3(a) through 3(l), 4(a) through 4(k), and 5(a) through 5(e) constitute violations of 18 VAC 95-30-210(1), (2), and (4) of the Regulations Governing the Practice of Assisted Living Facility Administrators.

ORDER

WHEREFORE, the Virginia Board of Long-Term Care Administrators, effective upon entry of this Order, hereby ORDERS as follows:

1. License No. 1706-000506 and Registration No. 1707-000060 issued to Scott C. Schuett, A.L.F.A., to practice as an assisted living facility administrator and preceptor, respectively, in the Commonwealth of Virginia, are hereby REVOKED.

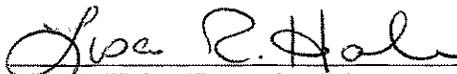
2. The license and registration of Mr. Schuett will be recorded as REVOKED and no longer current. Pursuant to § 54.1-2408.2 of the Code, should Mr. Schuett seek reinstatement of his license and registration after three years, he shall be responsible for any fees that may be required for the reinstatement of his license and registration and shall satisfy all terms and conditions of this Order prior to issuance of his license to resume practice and registration to act as a preceptor. The reinstatement of Mr. Schuett's license and registration shall require the affirmative vote of three-fourths of the members at a meeting of the Board.

3. At such time as Mr. Schuett shall petition the Board for reinstatement of his license and registration, a hearing will be convened to determine whether he is able to return to the safe and competent practice of assisted living facility administrator and preceptor.

4. Mr. Schuett shall pay a MONETARY PENALTY of TWENTY-FIVE THOUSAND DOLLARS (\$25,000.00) to the Board prior to the reinstatement of his license to practice as an assisted living facility administrator and registration as preceptor.

Pursuant to §§ 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as public record and shall be made available for public inspection or copying on request.

FOR THE BOARD



Lisa R. Hahn, Executive Director
Virginia Board of Long-Term Care Administrators

1/2/13

ENTERED

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with Lisa R. Hahn, Executive Director, Board of Long-Term Care Administrators, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.