GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2022

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #: AS730287264
Investigation #: 2022A0779018
Glenvale

Dear Mr. Pilot:

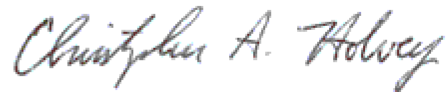
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (906) 226-4171.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730287264
Investigation #:	2022A0779018
Complaint Receipt Date:	01/24/2022
Investigation Initiation Date:	01/24/2022
Report Due Date:	03/25/2022
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Glenvale
Facility Address:	7026 Shattuck Saginaw, MI 48603
Facility Telephone #:	(989) 790-2322
Original Issuance Date:	03/01/2007
License **Status:**	REGULAR
Effective Date:	08/31/2021
Expiration Date:	08/30/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/21/2022 the facility was found to be short staffed with only one staff. The home has a lot of very high needs individuals and for one staff to take on the responsibility of this home alone can leave room for consumers to be unattended or neglected.	Yes

III. METHODOLOGY

01/24/2022	Special Investigation Intake 2022A0779018
01/24/2022	APS Referral Complaint was referred to APS centralized intake
01/24/2022	Special Investigation Initiated - Telephone Spoke to Resident A's CMH case manager.
01/24/2022	Contact - Telephone call made Interview conducted with administrator, Tammy Unger.
02/01/2022	Contact - Telephone call made Interview conducted with staff person, Miesha Little.
02/01/2022	Contact - Telephone call made Interview conducted with staff person, Demetria Bediford.
02/01/2022	Contact - Telephone call made Interview conducted with home manager, Tyrisha Martinez.
02/11/2022	Inspection Completed On-site
02/11/2022	Exit Conference Conducted with administrator, Tammy Unger.

ALLEGATION:

On 1/21/2022 the facility was found to be short staffed with only one staff. The home has a lot of very high needs individuals and for one staff to take on the responsibility of this home alone can leave room for consumers to be unattended or neglected.

INVESTIGATION:

On 1/24/22, a phone conversation took placer with CMH Supports Coordinator, Rochelle Bellinger, who confirmed that she was one of several people who were at this home on 1/21/22 for a meeting regarding Resident A. Ms. Bellinger stated that from 2:30-3:30 pm, she observed there to be only one staff person working in the home caring for all six residents. She reported that the staff was part of the meeting and that left no staff there to address the needs of the residents. Ms. Bellinger stated that at one point, the staff had to leave the meeting to go address a situation where one resident was kicking another resident.

On 1/24/22, a phone interview was conducted with administrator, Tammy Unger, who stated that a ratio of one staff to six residents at this home should not have happened. She stated that if a staff person had to leave, they should have taken one or more residents with them or if no residents wanted to go, they should have waited and/or rescheduled the errand. Ms. Unger stated that there are two residents who utilize wheelchairs, but one of them gets around independently. She reported that there are no residents in this home that require 1-on-1 staffing, that are an elopement risk or that have medical needs requiring a 2-person assist.

On 1/25/22, an email from Ms. Unger was received, which contained the written assessment plans and GHS Individual plan of service (IPOS) for each of the six residents at this home. The plans confirmed that all six residents have significant cognitive deficiencies and those deficiencies prevented any resident interviews from taking place. All six residents require varying levels of assistance from staff in order to complete all their activities of daily living (ADL's). Resident A and Resident B utilize wheelchairs, with Resident B requiring staff assistance for any/all mobility issues. Resident F utilizes a walker. Resident C has limited vision and hearing impairment, whose main form of mobility is to crawl and requires staff assistance in order to walk. The plans state that Resident C, Resident D and Resident E are not alert to their surroundings and have limited or no safety skills. Four residents exhibit some type of self-injurious behavior. Resident A bites his wrists/fingers and pounds his chest. Resident C bangs his head and hits himself in the head with toys and cups, Resident D bangs her head on walls and windows. Resident F bites his fingers and bends them backwards when nervous or upset.

On 2/1/22, a phone interview was conducted with staff person Miesha Little, who confirmed that she worked 2nd shift on 1/22/22 and that she was the staff that worked alone on that day for approximately one hour. Ms. Little stated that the second staff person working that shift with her was Demetria Bediford, and that Ms. Bediford left the

home to run an errand shortly after she arrived to work at 2:00 pm. She confirmed that she was the only staff person at the home during this time with all six residents in the home. She stated that she does not remember exactly what time Ms. Bediford arrived back at the home, but stated that the meeting regarding Resident A was still taking place and that it was after 3:00 pm. When asked about the care needs of the residents, Ms. Little stated that Resident A and Resident B use wheelchairs, but Resident A gets around and is able to transfer himself in and out of his wheelchair. When asked if any residents display self-injurious behaviors, Ms. Little stated that Resident A has been known to bite himself, pull his own hair, and pound on his own chest. Ms. Little stated that they have a few residents who are quite busy, but that she feels that one staff person can handle working a lone for short periods of time but not for an entire shift.

On 2/1/22, a phone interview was conducted with staff person, Demetria Bediford, who confirmed that she was the second staff person who worked second shift on 1/22/22. She stated that she left the home at approximately 2:30 pm to do a supply run to another home and that she arrived back at this home at 3:18 pm. Ms. Bediford admits that she did not take any residents with her and that Ms. Little was left in the home with all six residents during that time. Ms. Bediford reported that she feels that the residents are not difficult to handle and one staff is able to work alone with six residents for short periods of time. A short discussion regarding the care needs of the residents took place and Ms. Bediford confirmed that Resident C is partially blind and deaf and is very busy, but stated that she has not seen him get into anything that would hurt him.

On 2/1/22, a phone interview was conducted with home manager, Tyrisha Martinez. She stated that residents are given the choice to go on a ride along with staff to run quick errands or for medical appointments, but that they cannot make them go if they do not want too and that this type of situation does happen from time to time. Ms. Martinez stated that they have several "busy" residents at this home but that staff know how to keep the residents busy and/or occupied, so one staff person can work alone for short time frames. She reported that she would never allow a staff to be left alone if that staff person was uncomfortable with it. Ms. Martinez agreed that on paper, when looking at resident's assessment plans and CMH IPOS's, it appears that only one staff working seems to not be enough, but that it is different when working with the residents in person.

On 2/11/22, an on-site inspection was conducted and all six residents were viewed to be clean and well-groomed. Resident A and Resident B were viewed to be in wheelchairs. Resident A was moving around the home independently in his wheelchair. Resident B was viewed to be kept close to staff in her wheelchair, as it was evident that she requires full assistance from staff in order to be moved in the wheelchair and with completing all her ADL's. Resident C was viewed to be independently crawling around on the floor, but appeared to stay close to staff.

During the on-site inspection on 2/11/22, home manager, Ms. Martinez, stated that this home contracts with Saginaw County CMH and that all the residents receive CMH services. She stated that in their contract with CMH, they are provided and/or paid for

408 hours a week to schedule staff to meet the needs and/or provide care to the six residents. Further details regarding Resident B's care was obtained. Ms. Martinez stated that Resident B is a 2-person assist only in an emergency situation. She stated that Resident A is a 1-person assist with the aid of a Hoyer lift and that Resident A spends the majority of her waking hours in her wheelchair.

During the on-site inspection, the home's fire drill logs were reviewed. This home's fire drill logs indicate that they are utilizing two staff during their drills and have been able to successfully evacuate all six residents between three and four minutes and under the five-minute goal.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
	There was sufficient evidence found to prove that on 1/21/22, staff person Miesha Little was left alone to provide care for all six residents for approximately one hour. Ms. Little confirmed this fact to be true. Staff person, Demetria Bediford, who was the second staff scheduled to work second shift on 1/21/22, admits that she left the home at approximately 2:30 pm, leaving Ms. Little as the only staff in the home, and did not return until 3:18 pm. The licensing written assessment plans and CMH individual plans of service confirm that all six residents have significant cognitive deficiencies and require assistance from staff in order to complete all their activities of daily living (ADL's). Resident C, Resident D and Resident E are not alert to their surroundings and have limited or no safety skills. Resident A and Resident B utilize wheelchairs, with Resident B requiring staff assistance for any/all mobility issues. Resident F utilizes a walker. Resident C has limited vision and hearing impairment and requires staff assistance in order to walk. Resident A, Resident C, Resident D, and Resident F display various types of self-injurious behavior.

	The home has been utilizing two staff persons in order to adequately evacuate all six residents during a fire drill. Due to the cognitive deficiencies and mobility issues of the residents, it would be very difficult for only one staff person to evacuate all six residents in a safe timely manner. Due to the significant cognitive deficiencies of the six residents and requirement of staff assistance with completing activities of daily living, having only one staff person on duty places the residents at substantial risk of receiving insufficient supervision, personal care and protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/11/22, an exit conference was conducted with administrator, Tammy Unger. She was informed that a corrective action plan is required to address the above cited licensing rule violation.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, it is recommended that the status of this home's license remain unchanged.

Christopher A. Holvey 2/23/2022

Christopher Holvey Date
Licensing Consultant

Approved By:
Mary Holton 02/23/2022

Mary E Holton Date
Area Manager