GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 6, 2022

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

RE: License #: AS290251434
Investigation #: 2022A0577026
Riverside

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS290251434
Investigation #:	2022A0577026
Complaint Receipt Date:	02/28/2022
Investigation Initiation Date:	03/01/2022
Report Due Date:	04/29/2022
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:	Riverside
Facility Address:	1020 Cheesman St. Louis, MI 48880
Facility Telephone #:	(989) 681-3881
Original Issuance Date:	10/03/2002
License Status:	REGULAR
Effective Date:	04/13/2021
Expiration Date:	04/12/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Family was told by staff they were no longer allowed to have visits in Resident A's bedroom.	No
Resident B was found by staff putting a pillow over Resident A's head and staff did not report incident.	Yes
Resident A refused his medications and appropriate parties were not contacted regarding the medication refusal.	Yes

III. METHODOLOGY

02/28/2022	Special Investigation Intake 2022A0577026
03/01/2022	Special Investigation Initiated – Telephone call made- Interview with Complainant.
03/01/2022	Referral - Recipient Rights- Rachel MacGregor, ORR-GIHN.
03/02/2022	Inspection Completed On-site- Interview with staff and reviewed documents.
03/04/2022	Contact - Telephone call made- Interview with staff.
03/15/2022	Contact - Telephone call made- Interview with staff.
03/15/2022	Exit Conference conducted with licensee designee Joseph Pilot.
03/15/2022	Inspection Completed-BCAL Sub. Compliance
03/16/2022	Contact-Telephone call made- Interview with staff.

ALLEGATION: Family was told by staff they were no longer allowed to have visits in Resident A's bedroom.

INVESTIGATION:

On February 28, 2022, a complaint was received alleging direct care staff member and home manager Debra Martin were not allowing Resident A's family to visit Resident A in his bedroom where Resident A likes to visit.

On March 01, 2022, the Complainant reported when the family would visit Resident A at the facility, they would like to visit in Resident A's bedroom, where there was less noise and distractions. The Complainant reported the family has been told by Deb Martin, DCS, visits can no longer happen in Resident A's bedroom. Complainant reported not being denied access to Resident A's bedroom but have been visiting in the common areas of the home.

On March 02, 2022, I interviewed direct care staff member (DCS) Deb Martin who reported she advised the family that visits would be better if they were held in the common area due to the protection of everyone. Ms. Martin reported Resident A's family visits daily and it has been upsetting to some of the residents having so many new people in and out of the home causing behaviors and residents to become anxious. Ms. Martin reported she did not stop the family from going back to Resident A's bedroom at any time she just advised she thought it would be better to have visits in the common area.

On March 04, 2022, I interviewed DCS Stephanie Martin who reported she was not aware of DCS Deb Martin requesting Resident A's family or any resident's family or visitors to visit in the common area. Ms. Martin reported when Resident A's family has visited while she has been working, the visits took place in both the common area and Resident A's bedroom.

On March 15, 2022, I interviewed DCS Donny Harris who reported he was not instructed by DCS Deb Martin to deny Resident A's family the opportunity to visit in Resident A's bedroom. Mr. Harris reported Resident A's family has been visiting in Resident A's bedroom or wherever they feel most comfortable.

On March 16, 2022, DCS Matt Stroebel reported he was not aware of Resident A's family being told they cannot visit in Resident A's bedroom. Mr. Stroebel reported family visits almost daily and they visit wherever they would like, including in Resident A's bedroom, outside, or in the common areas.

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: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on the investigation, Resident A's family was never denied the opportunity to conduct visits in Resident A's bedroom as desired. None of the direct care staff members interviewed reported being direct to deny Resident A's family members the opportunity to visit in Resident A's bedroom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B was found by staff putting a pillow over Resident A's head and staff did not report incident.

INVESTIGATION:

The complaint received on February 28, 2022, reported Resident A had an altercation with Resident B on February 12, 2022, when Resident B put a pillow over Resident A's face and staff walked in during the altercation but did not report the altercation.

On March 01, 2022, Ms. MacGregor, Office of Recipient Rights with Gratiot Integrated Health Network (ORR-GIHN), reported she received an incident report on March 01, 2022, regarding the altercation between Resident A and Resident B documenting the incident occurred on February 19, 2022. Ms. MacGregor provided me with a copy of the incident reported she received.

On March 01, 2022, the Complainant reported they were notified on February 26, 2022, by Debra Martin, Direct Care Staff and Home Manager (DCS-HM) of an altercation that occurred on February 12, 2022, between Resident A and Resident B where Resident B covered Resident A's face with a pillow. Complainant reported staff walked in on the altercation but did not notify anyone of the incident. Complainant reported being at the facility on February 12, 2022, from 7:15pm until 8:00pm and upon leaving the facility Resident A was asleep on the couch. Complainant reported calling the facility around 8:30am on February 13, 2022, to check on Resident A and was told by staff Resident A was still asleep on the couch.

During the onsite investigation on March 02, 2022, I received a copy of staff notes from RUDI-GIHN case management system input on February 26, 2022, by DCS Donny Harris documenting that on February 19, 2022 Mr. Harris went to Resident A and Resident B's bedroom to get them for dinner and found Resident B with a pillow over Resident A's face. Mr. Harris documented he asked Resident B what he was doing and then checked to ensure Resident A was safe and uninjured.

On March 02, 2022, I interviewed DCS Michelle Martinez who stated DCS Donny Harris relayed to her the incident of observing the altercation involving Resident B holding a pillow over Resident A's face. Ms. Martinez reported she asked Mr. Harris if he reported this to anyone and he stated, "no." Ms. Martinez reported she contacted DCS-HM Deb Martin immediately who advised Mr. Harris to document the incident in RUDI.

On March 04, 2022, I interviewed DCS Stephanie Martin, who reported on February 19, 2022, she was working with DCS Donny Harris. Ms. Martin reported she was in Resident A and Resident B's bedroom while Resident A's family left to ensure Resident A did not become upset. Ms. Martin reported she was in the bedroom with both residents for about 45 minutes but left the bedroom around 4:45pm to start her charting. Ms. Martin reported when she left the bedroom Resident A and Resident B were playing peek a boo. Ms. Martin reported around 5:00pm Mr. Harris went to Resident A and Resident B's bedroom and Mr. Harris yelled," hey Stephanie, you will not believe this, [Resident A] is holding his pillow over [Resident B's] head." Ms. Martin reported Mr. Harris jokes a lot and thought this was a joke because nothing else was said until the following weekend when Mr. Harris was talking about the incident to another staff. Ms. Martin reported she said to Mr. Harris, "I thought you were joking, why would you not report this?" Ms. Martin reported she does not believe this incident was reported on February 19, 2022.

On March 15, 2022, I interviewed DCS Donny Harris who reported on February 19, 2022, a staff was in the bedroom playing with Resident A and Resident B, but then came out to help with making supper. Mr. Harris reported he walked back to their bedroom and found the bedroom door was closed. Mr. Harris reported he knocked on the door, walked into the bedroom and found Resident A lying on his bed with a pillow over his face. Mr. Harris reported Resident B was standing over Resident A with his hands on the pillow. Mr. Harris reported he asked what was going on and Resident A started laughing and Resident B said, "nothing" as Resident B removed the pillow from Resident A's face. Mr. Harris reported he got Resident A and Resident B to the table for supper and said to his coworker, "you are not going to believe what I just walked into, I walked into [Resident B] putting a pillow over [Resident A's] face." Mr. Harris reported for the remainder of the night if Resident A and Resident B were in the bedroom alone, Mr. Harris did constant bed checks, stating, "I did bed checks about every 15 minutes." Mr. Harris reported there were no other incidents of concern for the remainder of his shift. Mr. Harris reported he believed this was an isolated incident and did not report the incident to any other staff.

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:** **(i) Displays of serious hostility.** **(iii) Attempts at self-inflicted harm or harm to others.**

ANALYSIS:	Based on the information gathered during the investigation there was sufficient evidence found to support the allegations of Resident B putting a pillow over Resident A's head and direct care staff Donny Harris witnessing the incident and not documenting or reporting the incidents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A refused his medications and appropriate parties were not contacted regarding the medication refusal.

INVESTIGATION:

On February 28, 2022, a complaint was received alleging Resident A went three days without prescription medication due to Resident A refusing the medication and the facility did not contact the guardian.

On March 01, 2022, I interviewed Complainant who reported Resident A moved into the facility on February 08, 2022 and Resident A is nonverbal. Complainant reported upon Resident A being admitted, Resident A refused to take his prescription medication on February 9, 10, and 11, 2022. Complainant reported direct care staff members were trained how to administer Resident A's medication so Resident A would not refuse medications. Complainant reported direct care staff did not notify Resident A's guardian of Resident A refusing his prescription medication for three days and voiced concern because Resident A's medications cannot just be stopped without potential health concerns. Complainant was not sure if Resident A's physician was notified after Resident A refused his prescription medications. Complainant reported Resident A was administered his nighttime doses of medication on February 12 and 13, 2022.

On March 02, 2022, I completed an unannounced onsite investigation where I received a copy of Resident A's *Medical Administration Record* (MAR) for February 2022. Resident A's MAR documented the following information:

- Resident A is prescribed Clonidine, 0.2mg tablet, take 1 table by mouth twice a day, administered at 8:00am and 8:00pm. The MAR documented at 8:00am on February 11, 12, and 13th Resident A refused the medications. The MAR documents at 8:00pm on February 9 and 10th Resident A refused the medication and refused again on February 12 and 13th.
- Resident A is prescribed Divalproex Sod Dr 500mg tablet, take 2 tables by mouth at 8:00am and 2 tables by mouth at 8:00pm. The MAR documented Resident A refused the 8:00am dose on February 11, 12, and 13th and the 8:00pm dose on February 10 and 11th.
- Resident A is prescribed Mirtazapine 15mg tablets, take 1 tablet by mouth every night at bedtime and on February 10 and 11th Resident A refused the medication.

- Resident A is prescribed Olanzapine 2.5 mg tablet, take 1 tablet by mouth at bedtime and on February 10 and 11th Resident A refused the medication.

While at the facility I received copies of *AFC Licensing Division-Incident/Accident Report* (IR) for February 10, 11 and 12th which documented Resident A refused his medications. The IRs were completed and provided to Rachel MacGregor, GIHN-ORR and filed in Resident A's resident record. The IR dated February 11, 2022, in the section entitled, *Action Taken by Staff*, it documented that Resident A's physician was contacted but other IRs received did not document that a physician was contacted. In the *Corrective Measures* section on the it documented direct care staff will continue to encourage Resident A to take medications and upon Resident A refusing his medications an IR will be completed. I received a copy of the facility's *Medication Error Procedure* which includes missed medications or late dose instructions as follow:

- "Monday-Friday if staff discover a medication has been missed or a person is gone from the home and medicine will be given late staff is to contact the residents family doctor, give the doctor 30 minutes to call back, if no call back then call pharmacy for instructions, then notify home manager, complete IR." After hours or weekends if staff discover a medication has been missed or a person is gone from the home and medicine will be given late staff are to contact the pharmacy and follow instructions given, contact manager, and complete IR."

On March 02, 2022, I interviewed DCS Jennifer Rose who reported she worked with DCS Stephanie Martin on February 12 and 13, 2022 and reported Resident A's medications were passed by Ms. Martin and Resident A's mother. Ms. Rose reported she is not sure why the MAR does not reflect the medications being administered.

On March 02, 2022, I interviewed DCS Michelle Martinez who reported she worked on February 11 and 12, 2022 and administered medications in the morning but reported Resident A refused his morning medications both days. Ms. Martinez reported she completed an IR for both days and contacted Resident A's physician on February 11, 2022, regarding Resident A refusing his medications and also contacted Resident A's mother and GIHN medical staff. Ms. Martinez reported she did not contact anyone on February 12, 2022, regarding Resident A refusing his morning medications rather she only completed an IR.

On March 03, 2022, I interviewed DCS Stephanie Martin who reported on February 12 and 13, 2022, Resident A was administered his medications, but what happened was Ms. Martin popped the medication out of the bubble pack, into the cup and gave the cup to Resident A's parent to administer to Resident A. Ms. Martin reported even though she popped the medication from the bubble packs she did not feel comfortable writing her initials on the MAR because she did not physically administer the medications to Resident A. Ms. Martin reported she documented in RUDI and in the staff notes that Resident A received his medications but the medications were administered by his parent rather than a direct care staff member. Ms. Martin reported Resident A did not refuse his medications any other shift she worked.

On March 15, 2022, I interviewed DCS Donny Harris who reported he does not pass medications and does not know anything about Resident A refusing his medications or Resident A's medications not being administered.

On March 16, 2022, I interviewed DCS Matt Stroebel who reported on February 10 and 11, 2022 he administered nighttime medications to residents. Mr. Stroebel reported Resident A refused all of his medications and an IR was completed for both incidents. Mr. Stroebel stated, "I am sure I contacted the doctor both times Resident A refused his medications." Mr. Stroebel reported he did not put the physician contact on the IR's he completed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based on the information gathered during the investigation it has been found that on February 10, 11, and 12, 2022, Resident A's Medication Administration Record reflected Resident A refused his medications however direct care staff members only documented contacting Resident A's physician about the refusal on the *AFC Licensing Division-Incident/Accident Report* (IR) dated February 11, 2022. Direct care staff member Michelle Martinez reported she contacted Resident A's physician after only one of Resident A's medication refusals while DCS Matt Stroebel reported he contacted Resident A's physician about each medication refusal but did not document the contact. Consequently, there is enough evidence found to support that Resident A's physician was not contacted for direction after Resident A refused his medications on multiple occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended continuation of the current status of the license of this AFC adult small group home, capacity of 6.

3/23/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

04/06/2022

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Dawn N. Timm Date
Area Manager