GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2022

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

RE: License #: AS090391446
Investigation #: 2022A0572028
Bangor

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,

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 #:	AS090391446
Investigation #:	2022A0572028
Complaint Receipt Date:	03/21/2022
Investigation Initiation Date:	03/21/2022
Report Due Date:	05/20/2022
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:	Bangor
Facility Address:	3501 Bangor Rd Bay City, MI 48706
Facility Telephone #:	(989) 846-9631
Original Issuance Date:	03/14/2018
License **Status:**	REGULAR
Effective Date:	09/14/2020
Expiration Date:	09/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's wheelchair was not properly secured in the van. Stopping at a red light, Resident A's knees slapped against the back of the seat causing injury.	Yes

III. METHODOLOGY

03/21/2022	Special Investigation Intake 2022A0572028
03/21/2022	APS Referral APS made referral.
03/21/2022	Special Investigation Initiated - Letter APS
03/30/2022	Contact - Face to Face Tabitha Barnes; staff Tina Reikowsky and Resident A.
05/05/2022	Inspection Completed-BCAL Sub. Compliance
05/05/2022	Exit Conference Licensee Designee, Joe Pilot.

ALLEGATION:
Resident A's wheelchair was not properly secured in the van. Stopping at a red light, Resident A's knees slapped against the back of the seat causing injury.

INVESTIGATION:
On 03/21/2022, the local licensing office received a complaint for investigation. Adult Protective Service (APS) sent the referral to licensing.

On 03/30/2022, an unannounced onsite was made at Bangor, located in Bay County, Michigan. Present for an interview were, Tabitha Barnes; staff Tina Reikowsky and Resident A.

On 03/30/2022, an interview was conducted with the Director of Residential Services, Tabitha Barnes. She informed that the staff, Tina Reikowsky got Resident A into the van to transport the residents to a funeral. She secured Resident A with the front two latches but was unable to figure out how to secure him with the front latches. Ms. Reikowsky assumed that he was secure enough for the transport, but when they made a stop at a stop sign or red light, Resident A slid forward. Resident A received some bruising to both knees. He went to the ER and the x-rays were negative.

On 03/30/2022, an interview was conducted with Staff, Tina Reikowsky. She informed that they had to borrow a van from another home. She wasn't familiar with how to latch a resident in a wheelchair in with this vehicle. She asked some of the staff at her home, but they didn't know who to do it, so she latched him into the best of her abilities. While on the way to a funeral, she had to come to a stop and that's when Resident A rolled forward. Other than saying, "Ouch", he did not complain. He started complaining of pain the next day and he was transported to the ER. She found out from the Regional Director how to work the latches on the van.

On 03/30/2022, an interview was conducted with Resident A. He informed that there was some trouble with the van and his right knee got hurt. Resident A stated, "I went to the hospital, and they told me that I would be okay." Resident A does not have any pain today.

On 03/30/2022, I reviewed the Discharge Instructions for Resident A. It indicates that he should rest the bruised area, use an elastic bandage to limit swelling, place an ice pack on the injury every 1-2 hours for 10-15 minutes and take an ibuprofen for pain.

On 03/30/2022, I reviewed the Incident Report for the incident where Resident A was not strapped properly in his seatbelt. The Incident Report confirms what Staff, Tina Reikowsky stated during her interview, that she was unfamiliar with the van, so Resident A was not strapped in properly and when she came to a stop at the stop light, his wheelchair continued to roll forward and his legs hit the back of the seat in

front of him. The corrective measure is for staff to be trained on any vehicle that they are using to transport residents.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff did not secure Resident A in his seatbelt properly, causing him to roll forward during a traffic light stop and hurting his knees. Staff, Resident A, Incident Report and Discharge Instructions confirms that there was an injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/05/2022, an Exit Conference was held with Licensee Designee, Joe Pilot regarding this investigation. He was informed of the citation and was asked to submit a correction action plan within 15 days of receiving a copy of this report.

IV. RECOMMENDATION

Contingent upon receipt of an appropriate corrective action plan, I recommend no change to the licensing status of this small adult foster care group home (capacity 1-6).

05/05/2022

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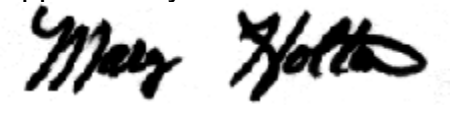
Anthony Humphrey Date
Licensing Consultant

Approved By:



05/05/2022

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Mary E Holton Date
Area Manager