GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2022

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

RE: License #: AS290085999
Investigation #: 2022A0466039
Arcada Home

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS290085999
Investigation #:	2022A0466039
Complaint Receipt Date:	05/04/2022
Investigation Initiation Date:	05/05/2022
Report Due Date:	07/03/2022
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	James Pilot
Licensee Designee:	James Pilot
Name of Facility:	Arcada Home
Facility Address:	4107 Arcada Drive Alma, MI 48801
Facility Telephone #:	(989) 463-5927
Original Issuance Date:	07/01/1999
License Status:	REGULAR
Effective Date:	04/01/2022
Expiration Date:	03/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Direct care worker (DCW) Riley Crawford took Resident A forcefully by his arm and dragged him from the kitchen.	Yes
DCW Riley Crawford placed a plastic bag over the tap in the kitchen sink to prevent Resident A from getting a drink of water.	Yes

III. METHODOLOGY

05/04/2022	Special Investigation Intake- 2022A0466039.
05/05/2022	Special Investigation Initiated – Letter email from Complainant.
05/05/2022	APS Referral- Denied APS Complaint- No need to refer.
05/05/2022	Contact - Telephone call made to ORR Rachel MacGregor.
05/13/2022	Inspection Completed On-site.
05/13/2022	Contact - Document Sent to ORR- Rachel MacGregor.
05/17/2022	Contact - Document Received from Rachel MacGregor, Recipient Rights Officer.
05/27/2022	Contact - Document Received from Rachel MacGregor, Recipient Rights Officer.
06/23/2022	Contact- Telephone call made to DCW Riley Crawford, interviewed.
06/23/2022	Contact- Telephone call made to house manager Cindy Fisher, message left.
06/23/2022	Contact - Document Received from Rachel MacGregor, Recipient Rights Officer.
06/24/2022	Exit Conference with James Pilot, message left.

ALLEGATION: Direct care worker (DCW) Riley Crawford took Resident A forcefully by his arm and dragged him from the kitchen.

INVESTIGATION:
On 05/04/2022, Complainant reported that Resident A is 55 years and non-verbal. Complainant reported that on 04/30/2022, DCW Riley Crawford took Resident A, who was sitting on the floor of the kitchen, by the arm and forcefully dragged Resident A from the kitchen to the dining room area. Complainant reported Resident A did not sustain any injuries.

On 05/04/2022, I reviewed an *AFC Incident/Accident Report* (incident report) dated 04/30/2022 at 1:15pm and written by DCW Alicia McGillis. The incident report did not include any signatures including DCW Alicia McGillis or licensee designee James Pilot. In the "explain what happened" section of the report it stated, "I as staff A was assisting another consumer in the there [sic] bedroom. As I walked out to the kitchen that's when I noticed Staff B [Crawford] dragging [Resident A] by his arm across the kitchen to the dining room on the floor. [DCW Crawford] then put a plastic bag over the kitchen faucet so [Resident A] couldn't have any water." In the "action taken" section of the report it stated, "I filled out a recipient rights complaint and contacted home manager." In the "corrective measures" section of the report it stated "Let her know that if something like this happens again that I am to be contacted as soon as possible so I can come in and send the person home. Called regional manager to let her know what was going on."

On 05/05/2022, I interviewed Rachel MacGregor, Recipient Rights Officer from Gratiot Integrated Health Network Recipient Rights Office (ORR), who reported she has an open investigation and has started interviews with involved individuals. ORR MacGregor reported DCW Riley Crawford is suspended until the investigation is completed. ORR MacGregor reported she has communicated with Resident A who is nonverbal but was able to answer written yes or no questions. ORR MacGregor and I agreed to interviewed DCW Crawford together.

On 05/13/2022, I conducted an unannounced investigation and I interviewed DCW McGillis who reported she was working on 4/30/2022 at 1:15pm. DCW McGillis reported when she walked into the living room, she witnessed DCW Crawford dragging Resident A across the floor by his left arm while Resident A was sitting on the floor. DCW McGillis reported DCW Crawford's wrist was wrapped around Resident A's wrist. DCW McGillis reported DCW Crawford was not aware she saw him pulling/dragging Resident A. DCW McGillis reported DCW Crawford was dragging Resident A backwards and let go of him once he had pulled him past the kitchen counter. DCW McGillis reported no other residents witnessed this incident. DCW McGillis reported she did not say anything to DCW Crawford. DCW McGillis reported she froze when she saw DCW Crawford dragging Resident A across the floor. DCW McGillis reported she contacted house manager Cindy Fisher and ORR and reported the incident.

On 05/13/2022, I interviewed house manager Cindy Fisher who reported that on 04/30/2022, DCW McGillis reported she witnessed DCW Crawford pull Resident A by the arm, while he was sitting on the floor, out of the kitchen and into the dining room area. DCW Fisher reported that on 04/30/2022, DCW McGillis contacted her and ORR and filed a complaint. DCW Fisher reported DCW Crawford has been suspended. DCW Fisher reported DCW Crawford and DCW McGillis were the only DCWs on shift on 04/30/2022 when the incident took place. DCW Fisher reported Resident B is the only verbal resident in the facility and he did not witness this incident. DCW Fisher reported Resident A did not sustain any marks or bruises as a result of the incident. DCW Fisher reported that after the incident the DCWs on shift were keeping an eye on Resident A monitoring him for marks/bruising. DCW Fisher reported DCW Crawford had no reaction when she suspended him. DCW Fisher reported that typically DCW Crawford is quiet and a good DCW. DCW Fisher reported she was surprised to hear about this incident as this is not typical of DCW Crawford's behavior.

On 05/13/2022, I interviewed Resident A who is nonverbal and deaf but is able to read and write. I wrote the following questions to Resident A and these were his answers:

- "Did Riley pull you by the arm?" Answer "Yes"
- "Did Riley hurt your arm?" Answer "Yes"

On 05/13/2022, ORR MacGregor reported DCW Crawford is on suspension but she will be calling to schedule a joint interview early next week with ORR and this AFC consultant.

On 05/17/2022, ORR MacGregor reported she contacted DCW Crawford by phone to schedule an interview for Thursday (05/19/2022) morning over the phone. ORR MacGregor reported DCW Crawford reported that he thought he had an appointment that morning and would let me know.

On 05/27/2022, ORR MacGregor reported she attempted to speak with DCW Crawford last week by phone and he informed her that he would call back to schedule an interview. ORR MacGregor reported DCW Crawford has not returned phone calls. ORR MacGregor reported she substantiated neglect based on a preponderance of evidence and witness reports. ORR MacGregor reported she is going to reach out one more time before closing out the case.

On 06/23/2022, I interviewed DCW Crawford who reported he did not remember any incident on 04/30/2022 including any incident of him dragging Resident A by his arm from one place in the facility to another. DCW Crawford reported that he no longer works at this facility.

On 06/23/2022, I interviewed, ORR MacGregor who reported that she substantiated against DCW Crawford based on witnesses and the recipient reporting. ORR

MacGregor reported substantiated citations listed were abuse-unreasonable force, suitable services-least restrictive setting, as well as impeding investigation for not responding to any communication and not participating in the investigation process. ORR MacGregor reported that she attempted to contact DCW Crawford on 05/13/2022, 05/17/2022 and 05/27/2022. ORR MacGregor reported that she was sent a corrective action plan this morning and DCW Crawford has been terminated.

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:	Complainant and DCW McGillis reported that on 04/30/2022, DCW Riley Crawford took Resident A, who was sitting on the floor of the kitchen, by the arm and forcefully dragged Resident A from the kitchen to the dining room area. Resident A reported DCW Crawford pulled him by his arm and hurt his arm. DCW Crawford reported that he did not recall any incident on 04/30/2022 where he grabbed Resident A by the arm and dragged him across the floor. Based on the information provided through multiple interviews, Resident A was not treated with dignity and a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: DCW Riley Crawford placed a plastic bag over the tap in kitchen sink to prevent Resident A from getting a drink of water.

INVESTIGATION:
On 05/04/2022, Complainant reported DCW Riley Crawford placed a plastic bag over the kitchen faucet to prevent Resident A from getting a drink of water for at least 45 minutes.

On 05/13/2022, I conducted an unannounced investigation and I interviewed DCW McGillis who reported she was working on 4/30/2022 with DCW Crawford and they were the only two DCWs on shift. DCW McGillis reported that after DCW Crawford left for the day she noticed that a plastic bag was wrapped around the kitchen faucet and knotted. DCW McGillis reported that based on the needs of the residents none of them are capable of putting a plastic bag with a knot over the kitchen faucet and she denied doing so. DCW McGillis reported she did not say anything to DCW Crawford about the plastic bag over the faucet as she noticed this after he left for the day. DCW McGillis reported Resident A is on 64-80 daily oz fluid restriction from a doctor. DCW McGillis reported DCW Crawford may have been struggling to redirect

Resident A away from drinking water and that may have been why he was dragging Resident A from the kitchen.

On 05/13/2022, I interviewed DCW Fisher who reported Resident A has a doctor's order for restricted fluid. DCW Fisher reported Resident A likes to drink a lot of water and although they can encourage/redirect him, the facility cannot take water away from him nor should anyone being covering the faucet with a plastic bag so that the faucet cannot be used. DCW Fisher reported that based on the needs of the residents none of them are capable of putting a plastic bag with a knot over the kitchen faucet.

On 05/13/2022, I interviewed Resident A who is nonverbal and deaf but is able to read and write. I wrote the following questions to Resident A and these were his answers:

- "Did Riley cover the faucet?" Answer "Yes"

On 05/13/2022, 05/17/2022 and 05/27/2022, ORR MacGregor reported she attempted to speak with DCW Crawford to schedule an interview and he informed her that he would call back to schedule an interview. ORR MacGregor reported DCW Crawford has not returned any of her calls.

On 05/27/2022, ORR MacGregor reported she has enough information to substantiate neglect based on a preponderance of evidence and witness reports. ORR MacGregor reported that she is going to reach out one more time before closing out the case.

On 06/23/2022, I interviewed DCW Crawford who reported he did not remember any incident on 04/30/2022 including covering the kitchen faucet with a plastic bag and knotting it so no one could access it. DCW Crawford reported that he no longer works at this facility.

On 06/23/2022, I interviewed, ORR MacGregor who reported that she substantiated against DCW Crawford based on witnesses and the recipient reporting. ORR MacGregor reported citations listed were abuse-unreasonable force, suitable services-least restrictive setting, as well as impeding an investigation for not responding to any communication and not participating in the investigation process. ORR MacGregor reported she substantiated all of them. ORR MacGregor reported that she was sent corrective action this morning and DCW Crawford has been terminated.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Complainant, DCW McGillis and Resident A reported DCW Crawford placed a plastic bag over the kitchen faucet. DCW McGillis and DCW Fisher reported none of the residents are capable of putting a plastic bag with a knot over the kitchen faucet. Although DCW Crawford did not recall placing a plastic bag over the kitchen faucet on 04/30/2022, based on interviews with DCW McGillis and Resident A there is enough evidence establish a violation as the residents were not treated with consideration and respect, with due recognition of personal dignity when the faucet was covered and unable to be used.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, no change to status of current license recommended.

06/24/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

06/28/2022

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Dawn N. Timm Date
Area Manager