GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 5, 2022

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

RE: License #: AS290251434
Investigation #: 2022A0577048
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 #:	2022A0577048
Complaint Receipt Date:	06/28/2022
Investigation Initiation Date:	06/28/2022
Report Due Date:	08/27/2022
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?
Resident A wandered from the facility on June 26, 2022, due to not being supervised by direct care staff members.	Yes

III. METHODOLOGY

06/28/2022	Special Investigation Intake 2022A0577048
06/28/2022	Special Investigation Initiated – Telephone call made to Mary Barnum.
06/28/2022	Contact - Document Received- IR Received.
06/28/2022	Referral - Recipient Rights- Rachel MacGregor, GIHN-ORR
06/28/2022	APS Referral
06/28/2022	Contact - Document Received from Bobbi Barrett, CM-GIHN sent PCP and BTP.
06/29/2022	Contact - Document Received from Deb Martin, HM.
07/11/2022	Contact - Document Sent from Deb Martin, Staff contact information requested and received.
07/12/2022	Contact - Telephone call made- Interviews with direct care staff members.
07/12/2022	Contact - Telephone call made- Interviews with direct care staff members.
07/21/2022	Inspection Completed On-site- Interviews and review of plans.
07/21/2022	Contact - Telephone call made- direct care staff interviews.
07/22/2022	Inspection Completed-BCAL Sub. Compliance
07/22/2022	Exit Conference with licensee designee Joseph Pilot.
07/29/2022	Inspection Completed On-site- Attempt to interview staff.

08/01/2022	Contact - Telephone call received- Interview with Nick Wood, DCS.

ALLEGATION: Resident A wandered from the facility on June 26, 2022, due to not being supervised by staff.

INVESTIGATION:

On June 28, 2022, I received an *AFC Licensing Division-Incident Accident Report* (IR) documenting that on June 26, 2022, Resident A eloped from the facility and entered into a neighbor's home without direct care staff members' knowledge. The direct care staff members working were Nick Wood, Matthew Stroebel, and Mitchel Schwartz.

On June 28, 2022, I received a voicemail message from Mary Barnham, Regional Manager, reporting she was with home manager Deb Martin on June 27, 2022, when they were notified Resident A eloped and got into the neighbor's home on June 26, 2022. The message stated there were three direct care staff working at the time of Resident A's elopement with one direct care staff member at the store while the other two direct care staff members remained at the AFC home. Ms. Barnham stated the direct care staff members did not report or contact anyone regarding this elopement.

On June 28, 2022, I contacted Rachel MacGregor, Office of Recipient Rights with Gratiot Integrated Health Network who will be opening up an investigation also.

On June 28, 2022, I contacted Bobbi Barrett, Case Manager with Gratiot Integrated Health Network, and requested and received a copy of Resident A's *Personal Center Plan* (PCP). Resident A's PCP documented Resident A is non-verbal and, per Relative A1, Resident A needs constant supervision due to Resident A having no sense of fear or danger. Resident A's family home had two-way locking-against-egress locks to prevent Resident A from wandering from the home which he would do if not supervised. Resident A's PCP documented Resident A has been known to "bust into the neighbor's house" when wondering from his personal home. Resident A's PCP documented those working with Resident A need to monitor Resident A closely.

On June 29, 2022, I contacted Deb Martin, Home Manager and requested and received a copy of Resident A's *Assessment Plan for AFC Residents* which documented Resident A can move independently in the community, Resident A is non-verbal, but may understand some verbal communication.

On July 12, 2022 and July 21, 2022, I left messages with direct care staff (DCS) Nick Wood requesting a call to complete an interview and no return call was received.

On July 12, 2022, I interviewed DCS Matt Stroebel, who reported on June 26, 2022, he worked with DCS Nick Wood and DCS Mitchell Schwartz. Mr. Stroebel reported he was

leaving the facility with a resident and saw DCS Mr. Schwartz and Resident A outside in the front yard. Mr. Stroebel stated, “I specifically told Mitchell to keep an eye on [Resident A] while out in the yard, I am heading on an outing.” Mr. Stroebel reported he was away from the facility for about two hours and upon his return was notified by DCS Mr. Wood and DCS Mr. Schwartz of the neighbor coming to the facility and reporting Resident A was in their home. Mr. Stroebel stated DCS Mr. Wood went to the neighbors to assist Resident A back to the facility.

On July 12, 2022, I interviewed DCS Mitchell Schwartz who reported he was in the front yard with Resident A when DCS Matt Stroebel left the facility to go on an outing with another resident. Mr. Schwartz reported he did leave Resident A unattended in the front yard briefly, but stated, “[Resident A] was still in clear visual sight and did not leave the property at this time.” Mr. Schwartz reported after being outside for a little bit, himself and Resident A went back into the facility. Mr. Schwartz reported he was not sure when Resident A left the facility and went over the neighbor’s house. Mr. Schwartz reported he was made aware of Resident A being at the neighbor’s house when the neighbor came to the facility to report Resident A being inside their home. Mr. Schwartz reported someone went to the neighbor’s home and brought Resident A back to the facility but cannot remember which staff. Mr. Schwartz reported he does not think Resident A has any enhanced supervision requirements while inside the facility but believes Resident A cannot be left alone while outside.

On July 21, 2022, I completed an unannounced onsite investigation and interviewed DCS Michelle Martinez who reported she was not working when Resident A eloped from the facility. DCS Ms. Martinez reported she overheard a conversation between staff regarding the incident and this is when she became aware of the elopement. Resident A was not at the facility during the onsite investigation, but due to Resident A being nonverbal, Resident A could not provide specifics to their elopement at any point in time.

On July 29, 2022, I completed a second onsite investigation with an attempt to interview DCS Nick Wood, but DCS Mr. Wood was not available for interview.

On August 01, 2022, I interviewed DCS Nick Wood who reported on June 26, 2022, he worked second shift and arrived at the facility around 6:00pm. Mr. Wood reported upon arrival to the facility DCS Mitchell Schwartz was getting out of his car to start the shift, another staff was in the garage getting ready to leave but was supervising Resident A and Resident B while all three were in the garage. Mr. Wood reported DCS Matt Stroebel came out into the garage to supervise Resident A and Resident B. Mr. Wood reported DCS Mr. Stroebel told DCS Mr. Schwartz he was leaving to go to the store and DCS Mr. Schwartz needed to supervise Resident A and Resident B because DCS Mr. Wood had gone into the facility. Mr. Wood reported he had been inside the facility for about three minutes when DCS Mr. Schwartz came into the facility without Resident A and Resident B and started talking to DCS Mr. Wood. Mr. Wood reported DCS Mr. Schwartz turned to look into the garage and stated, “[Resident A] must have wondered off because the neighbor is in the garage.” Mr. Wood reported he ran into the garage

and the neighbor was saying, “he is in my house, he is in my house.” Mr. Wood reported he got permission from the neighbor to enter their home, ran over to their home and found Resident A inside the home and escorted Resident A back to the facility. DCS Mr. Wood reported as he and Resident A came out of the neighbor’s home, DCS Mr. Schwartz was standing outside of the neighbor’s home and had left the other residents unsupervised at the facility.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was not provided supervision and protection according to Resident A’s written assessment plans. Specifically Resident A’s *Personal Center Plan* documented Resident A’s need for constant supervised due to Resident A having no sense of fear or danger and a history of going into neighbors’ homes without permission while living at his personal home. On June 26, 2022, Resident A wandered from the facility without direct care staff’s knowledge and was found in a neighbor’s home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 08/04/2022

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 08/05/2022

Dawn N. Timm Date
Area Manager