GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 24, 2023

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

RE: License #:	AS090016193
Investigation #:	2023A0123020
	Kasemeyer

Dear Mr. Pilot:

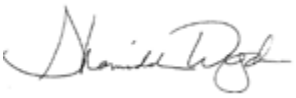
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090016193
Investigation #:	2023A0123020
Complaint Receipt Date:	01/17/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/18/2023
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:	Kasemeyer
Facility Address:	5181 Kasemeyer Bay City, MI 48706
Facility Telephone #:	(989) 667-0470
Original Issuance Date:	02/01/1995
License Status:	REGULAR
Effective Date:	10/24/2022
Expiration Date:	10/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Katie Hatt pushed Resident A at approximately 3:00 PM on 1/13/22 and was also being verbally abusive towards Resident A. This occurred in Resident A's bedroom at the AFC Home.	Yes

III. METHODOLOGY

01/17/2023	Special Investigation Intake 2023A0123020
01/17/2023	APS Referral Information received regarding APS referral.
01/18/2023	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Jeff Wells via phone.
01/19/2023	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
01/19/2023	Contact- Document Received I received a copy of the incident report via fax, and from recipient rights.
02/03/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Crystal Clark.
02/03/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Katie Hatt.
02/03/2023	Contact - Document Sent I sent an email to Resident A's public guardian.
02/06/2023	Contact - Document Received I received an email response from Guardian 1.
02/06/2023	Contact - Telephone call made I interviewed Staff Hatt via phone.
02/08/2023	Contact - Telephone call made I made a call to the facility and interviewed Staff Clark.
02/23/2023	Contact- Telephone call made I spoke with regional manager Ursula Acklen via phone.

02/23/2023	Exit Conference I spoke with licensee designee Joe Pilot via phone.
02/24/2023	Exit Conference I spoke with administrator/designated person Tammy Unger.

ALLEGATION: Staff Katie Hatt pushed Resident A at approximately 3:00 PM on 1/13/22 and was also being verbally abusive towards Resident A. This occurred in Resident A's bedroom at the AFC Home.

INVESTIGATION: On 01/18/2023, I spoke with Bay Arenac Behavioral Health recipient rights investigator Jeff Wells via phone. He stated that he does not know if there are any witnesses yet, but he received an incident report, and that he requested written reports.

On 01/19/2023, I conducted an unannounced on-site at the facility. I interviewed home manager Cassaundra Southgate. She stated that she received a call from staff Crystal Clark who reported that Resident A was bent forward in her wheelchair, as staff was trying to get her in bed. Staff Katie Hatt became frustrated and pushed Resident A's shoulders, pushing Resident A back into her wheelchair. Staff Southgate stated that she does not know Staff Clark Hatt well, and per other staff this is shocking. Staff Southgate stated that she was informed that Resident A told Staff Hatt that it was inappropriate how Staff Hatt touched her and that she will never touch her like that again. Staff Hatt is suspended right now until further notice. She stated that Staff Hatt has been employed since May 2020.

On 01/19/2023, I received a copy of the *AFC Licensing Division- Incident/Accident Report* from Mr. Wells via email and the same copy from the facility via fax. The incident date is noted to be 01/13/2023. The report states the following:

"Staff went into bedroom to help resident into bed. Resident was leaning to the side and was having a hard time sitting up. Med observer tried to sit her up but resident just leaned back over. Med observer then shoved resident will sitting in wheelchair. Resident said "you don't have to push me like that. You don't have to be so mean." Med observer said "I don't care, you need to sit up straight. Then resident was pushed. Med passer called house manager. Then filled out and I.R. filled out a skin audit." The corrective measures are noted to be "*sent staff home until further notice of investigation.*" The incident report completed by staff Crystal Clark.

On 01/19/2023, I interviewed Resident A the facility. Resident A stated that Staff Hatt and Staff Clark took her over to her bed. She could not get in bed. Staff Hatt pushed her hard and she told Staff Hatt that she pushed her hard. She stated that Staff Hatt told her that she didn't. Resident A stated that her chest hurt afterward, as she was sore from being pushed. She stated that during the night she told Staff Hatt if she ever pushes her down again, she'll have hell to pay. She stated that she would prefer not to deal with Staff Hatt anymore, and that was the first time Staff Hatt has

done anything like this. She stated that Staff Clark told her that she would vouch for her because Staff Hatt did hurt her.

It should be noted that since April 2021, there have been at least two special investigation reports that were not substantiated regarding Resident A making accusations about staff making verbally abusive comments and/or physically assaulting her.

On 02/06/2023, I interviewed staff Katie Hatt via phone. Staff Hatt stated that she has worked at the facility for about two years. She stated that her co-worker staff Crystal Clark, asked her for help to get Resident A in bed because Resident A is a two-person assist. They went to help transfer Resident A, but Resident A put all her body weight on her (Staff Hatt). She stated that they sat Resident A back, but Resident A kept leaning forward, so she (Staff Hatt) put her hand on Resident A's shoulder and pushed Resident A straight up. She stated that Resident A flopped back, they re-set her up straight, then transferred Resident A into bed. She stated that she then left the room, and Staff Clark finished assisting Resident A. She stated that Resident A never said anything to her about being upset or express anything that she did wrong. She stated that if she did, she would have apologized to Resident A. She stated that she was not being aggressive with Resident A, and that she had to use her strength to push Resident A up. She denied saying "*I don't care. You need to sit up straight*." She stated that Resident A has made allegations against her (Staff Hatt) for the past year or so, but this is the first formal complaint.

On 02/06/2023, I received an email response from Resident A's public guardian, Guardian 1. She denied having any concerns regarding Resident A's care.

On 02/08/2023, I interviewed staff Crystal Clark via phone. Staff Clark stated that Resident A wanted to lay down in bed, so she asked Staff Hatt for assistance. Staff Hatt was frustrated and shoved Resident A. Resident A responded by saying that Staff Hatt did not have to be mean, and that it hurt. Then Staff Hatt responded by saying she did not care and that she needed to sit up. Then they got Resident A transferred to her bed. She stated that this is the first incident that she has witnessed Staff Hatt act this way. She stated that she checked Resident A for marks, and there were none. She then stated that Staff Hatt is stern/firm with Resident A, not mean. She stated that they were the only two staff persons in the home at the time, and there were no other witnesses.

On 02/23/2023, I spoke with regional manager Ursula Acklen via phone. She stated that Resident A has always picked on Staff Hatt, and another staff person. She stated that Resident A has a behavior of wanting to make herself fall. She stated that whenever Resident A has UTI's or experiencing confusion she will lean in her wheelchair. She stated that she believes that Staff Hatt pushed Resident A to prevent her from falling. She stated that Staff Hatt is a great worker, works all shifts, and is reliable. She stated that she has never heard Staff Hatt speak disrespectfully towards any residents. She stated that Staff Hatt always called her whenever she

was having difficulty with Resident A. She stated that Resident A would target Staff Hatt and accuse Staff Hatt of being a “whore” and having a sexually transmitted infection, and that she has witnessed Resident A speaking to Staff Hatt like this firsthand. She stated that Resident A has a history of falling, and she does not think that the alleged incident happened the way Staff Clark took it.

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:	Home manager Cassaundra Southgate stated that Staff Clark informed her of the alleged incident. She stated that per other staff, the alleged incident was shocking. The incident report submitted by this home indicated on 1/13/22, Resident A was shoved and pushed by med passer requiring an incident report to be completed by Crystal Clark. Resident A was interviewed and reported that Staff Hatt pushed her hard and hurt her. She stated that Staff Hatt told her that she did not push her. Resident A did not disclose that Staff Hatt said anything else to her. Staff Katie Hatt denied the allegations. She stated that she was not being aggressive, and that she had to use her strength to get Resident A to sit upright. She denied saying anything verbally abusive to Resident A and reported that Resident A has made allegations against her for the past year or so. Staff Crystal Clark was interviewed and initially stated that Staff Hatt shoved Resident A, then stated that Staff Hatt is stern/firm with Resident A not mean. She denied that Resident A had any marks or bruising. Resident A’s public guardian denied having any concerns regarding her care. I spoke with regional manager Ursula Acklen who stated that Resident A has targeted Staff Hatt and another staff person for some time. She stated that Staff Hatt has never been observed to speak abusively toward any residents.

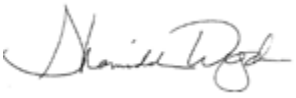
	There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/23/2023, I conducted an exit conference with licensee designee Joe Pilot via phone. I informed him of the findings and conclusion.

On 02/24/2023, I conducted a follow-up exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the small group AFC license (capacity 1-6).

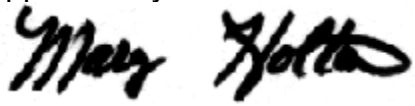


02/24/2023

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



02/24/2023

_____

Mary E. Holton Date
Area Manager