GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 1, 2023

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

RE: License #:	AS060068988
Investigation #:	2023A0123032
	Almont AFC

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 #:	AS060068988
Investigation #:	2023A0123032
Complaint Receipt Date:	03/13/2023
Investigation Initiation Date:	03/16/2023
Report Due Date:	05/12/2023
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:	Almont AFC
Facility Address:	140 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9648
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 03/09/2023, Resident A chose to ride with staff Tiara Mervyn to drop off a staff. Upon turning off Parish Rd. in Kawkawlin, Resident A slowly tipped backwards in her wheelchair. Resident A complained her big toe on her right foot hurt.	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0123032
03/15/2023	Contact - Document Sent I sent recipient rights investigator Kevin Motyka an email.
03/16/2023	Special Investigation Initiated - Letter
03/16/2023	APS Referral APS referral completed.
03/24/2023	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
03/24/2023	Contact - Telephone call made I made a call to the administrator Tammy Unger.
04/04/2023	Contact - Document Sent I sent an email to Resident A's public guardian.
04/04/2023	Contact - Document Received I received an email response from Guardian 1.
04/04/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Tiara Mervyn.
04/13/2023	Inspection Completed On-site I conducted a follow-up on-site visit at the facility.
04/14/2023	Contact - Telephone call received I interviewed Staff Mervyn via phone.
04/25/2023	Exit Conference I spoke with administrator Tammy Unger.

ALLEGATION: On 03/09/2023, Resident A chose to ride with staff Tiara Mervyn to drop off a staff. Upon turning off Parish Rd. in Kawkawlin, Resident A slowly tipped backwards in her wheelchair. Resident A complained her big toe on her right foot hurt.

INVESTIGATION: On 03/09/2023, I received a copy of an *AFC Licensing Division-Incident/Accident Report*. The incident report, written by staff Tiara Mervyn states that on 03/09/2023 at 8:50 am "[Resident A] chose to ride with me to drop a staff member. [Resident A] was buckled in correctly front and back. Upon turning off Parish Rd. in Kawkawlin [Resident A] slowly tipped backwards in her wheelchair. I believe the front buckle straps did not lock after being hooked to her chair. [Resident A] complained of only her big toe on her right foot hurt." Staff noted for actions taken by staff that they did an "*IR, head assessment, vitals, checked over her body head to toe*." In the corrective measures section, it states "*no bruises present at this time. Will check [Resident A] over again tomorrow for bruises due to being on a blood thinner. All vitals are good. [Resident A] has no complaints of pain. Contacted [Resident A's] primary care doctor to get an order for anti-tip bars for her wheelchair*."

On 03/16/2023, I submitted an Adult Protective Services referral to the Michigan Department of Health and Human Services Centralized Intake.

On 03/24/2023, I conducted an unannounced on-site visit at the facility. There was no answer at the door. No one appeared to be home.

On 03/24/2023, I made a call to the administrator Tammy Unger while parked outside the home. Ms. Unger stated that the facility is down to three residents, and that they are on an outing, as they recently experienced positive cases of COVID-19, and that they just got clear of it. She stated that she obtained four new tie downs and an anti-tip device for Resident A's wheelchair. She stated that she does not know if staff are tying the chair down correctly, or if Resident A is pressing the release button. She stated that this issue does not happen with the other two resident's wheelchairs. She stated that they cannot rule out that staff did not do something right. She stated that they are going to do a hands-on training with staff. She stated that Resident A did hook her toe on the seat belt and said "oh my toe" but there was no bruise.

On 04/04/2023, I sent an email to Resident A's public guardian, Guardian 1, asking if she has any personal care concerns or concerns regarding Resident A and her wheelchair not being properly secured in the van. Guardian 1 replied that she does not have any concerns at this time.

On 04/13/2023, I conducted a follow-up on-site inspection to see Resident A. Resident A was observed during this on-site laying down on the living room couch under a blanket. The other two residents of the home were also observed during this on-site. They appeared clean and appropriately dressed. Resident A stated that she

does not recall the incident that occurred in the van. She stated that she has a new wheelchair.

Home manager Tabitha Johnson was present during this on-site. She stated that Resident A has a loaner wheelchair due to her other chair being repaired. She stated that they got an order for tip bars that fits her chair that is in repair. She stated that if they cannot get her chair repaired, they will have to order proper fitting tip bars for the loaner. She stated that Ms. Unger came out and provided new straps "Q-straints" for the van, and they had their third in-service on van tie-downs. Staff Johnson stated that Resident A's foot was swollen, not bruised, and that x-rays showed there were no issues. She stated that she assumes the foot swelling was caused by the van incident.

On 04/13/2023, during this on-site, I received requested documentation. Resident A's Assessment Plan for AFC Residents dated 11/22/2022, states under *Moves Independently in Community* that she "*utilizes wheelchair for all outings with assistance from staff in community*." Wheelchair is noted as an assistive device on page two. A copy of her Health Care Appraisal dated 09/22/2022 has *uses wheelchair* marked. A copy of her physician authorization for her wheelchair was obtained as well. It is dated 1/12/2021. A copy of her Ascension St. Mary's Hospital's *Patients Results* documentation dated 3/15/2023 shows that she was seen for right foot pain and swelling. The findings are noted to be "*There is osteopenia. There is soft tissue swelling over the dorsum of the foot. There is arthritis in the interphalangeal joints and at the first MTP junction. There is no fracture or dislocation*." The *impression* listed is *severe osteopenia and soft tissue swelling*.

On 04/14/2023, I interviewed Staff Mervyn via phone. She stated that she and Resident A had went to drop off a staff person, and on the way back to the facility, she was pulling out at an intersection. She stated that she pressed on the gas, then saw Resident A in the back, slowly tip backwards. She stated that she slowed down. She stated that Resident A did have a small bruise on her foot, and her foot was swollen. She stated that Resident A's wheelchair tipped all the way back slowly. Staff Mervyn stated that it is a possibility that the tie down straps were faulty. She stated that Resident A was taken to the doctor, and staff were instructed to do the RICE method (i.e., rest, ice, compression, elevation). She stated that a head assessment was conducted as well. Staff Mervyn stated that Resident A was strapped properly, and that she knows she buckled Resident A in. She stated that they got new straps the next day, and also a tip bar for the wheelchair. She stated that Resident A moves around and fidgets a lot, so it is hard to tell if she messed with the straps. She stated that around 3:30 pm she and Resident A went back out to pick up the other staff, and there were no issues.

On 11/17/2022, I concluded Special Investigation Report #2023A0123009. The allegations were that staff Joe Krystyniak was driving with Resident A in the van. Her wheelchair became unsecured and went backwards causing Resident A to hit her

head on the back of the van, after Staff Krystyniak accelerated. Resident A complained of pain at the time. Staff Krystyniak stated that he may not have tightened/secured the straps properly. The corrective action plan dated 11/29/2022, stated that the home manager is responsible for training employees on the proper use and operation of the vehicle tie downs and securing them properly. Staff Krystyniak received a written corrective action, and the home manager completed a hands-on training with the staff.

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:	An incident report dated 03/09/2023, details an incident where Resident A's wheelchair tips backwards while staff Tiara Mervyn was driving. Guardian 1 denied having any concerns. Staff Tiara Mervyn was interviewed and reported that Resident A's wheelchair tipped backwards while she was driving. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0123009, dated November 17, 2022**

On 04/25/2023, I conducted an exit conference with administrator and designated person Tammy Unger via phone. I informed her of the finding and conclusion.

IV. RECOMMENDATION

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

05/01/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:

05/01/2023

Mary E. Holton Date
Area Manager