GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 16, 2023

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

RE: License #: AS290251434
Investigation #: 2023A0783021
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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS290251434
Investigation #:	2023A0783021
Complaint Receipt Date:	06/28/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/27/2023
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:	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:	04/13/2023
Expiration Date:	04/12/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not protected nor was his written *Person Centered Plan* followed when he was left alone in the shower and physically attacked by Resident B.	Yes

III. METHODOLOGY

06/28/2023	Special Investigation Intake - 2023A0783021
06/29/2023	Contact - Telephone call made to Complainant, unsuccessful
06/30/2023	Contact - Telephone call made to Complainant, unsuccessful
07/03/2023	Special Investigation Initiated – Telephone call with direct care staff member Ashley Boyles
07/03/2023	Contact - Telephone call made to Complainant, unsuccessful
07/03/2023	APS Referral not needed as APS already involved.
07/06/2023	Contact - Document Received - Resident A's resident record
07/06/2023	Contact - Document Received - Resident B's resident record
07/06/2023	Inspection Completed On-site
07/06/2023	Contact - Face to Face interviews with direct care staff members Debra Martin, Donny Harris, and Emily Beltinck
07/10/2023	Contact - Telephone call made to direct care staff member Jessica Rose
07/10/2023	Contact - Telephone call made to Resident A's case manager Bobby Barrett, unsuccessful
07/10/2023	Contact - Telephone call made to Guardian A1, unsuccessful
08/11/2023	Contact - Telephone call made to assigned APS investigator Brooke Seamon
08/11/2023	Contact - Telephone call made to direct care staff member Aubree Cervantes

08/11/2023	Contact - Telephone call made to Bobby Barrett, unsuccessful
08/11/2023	Contact - Telephone call made to facility administrator Tammy Unger
08/15/2023	Contact - Document Received - Resident B's *Positive Support Plan*
08/15/2023	Contact - Telephone call made to Guardian A1, unsuccessful
08/15/2023	Exit Conference with Licensee Designee James Pilot

ALLEGATION:

Resident A was not protected nor was his written *Person Centered Plan* followed when he was left alone in the shower and physically attacked by Resident B.

INVESTIGATION:

On June 29, 2023 I received a complaint via centralized intake that stated on June 25, 2023 Resident A was in the shower when Resident B went into the bathroom and locked the door. The written complaint stated Resident A exited the bathroom and was observed bleeding from the ear.

On June 29, 2023, June 30, 2023 and July 3, 2023 I telephoned Complainant but was unsuccessful at reaching Complainant.

On July 6, 2023 I received and reviewed Resident A's written *Person Centered Plan* (PCP) from Gratiot Integrated Health Network. I noted that the PCP was dated July 19, 2022 and was effective until July 18, 2023. The PCP stated that Resident A required "help with all daily community living and personal care needs." The PCP stated Resident A required "24 hour supervision and GIHN services." The PCP stated Resident A required help with "toileting, bathing, [and] dressing." The PCP stated, "[Resident A] should continue to receive 24 hour care and supervision to ensure that all his personal care needs are met at a sufficient level." The PCP documented that Resident A is nonverbal. On July 25, 2023 I reviewed Resident A's most recent PCP that was updated in July 2023 and noted the language regarding supervision in the shower remained the same.

On July 3, 2023 I spoke to direct care staff member and facility assistant manager Ashley Boyles who stated she was working at the facility on June 25, 2023 when Resident A was injured by Resident B while he was in the shower. Ms. Boyles said

Resident A requires supervision and assistance in the shower, but he often stays in the shower alone and “plays” which is what he was doing on June 25, 2023 when Resident B entered the bathroom and locked the door behind him. Ms. Boyles denied that Resident B had shown any signs of aggression and stated he had been watching television in the living room and got up to use the restroom. Ms. Boyles said a short time later before staff members could get to the door to unlock it, Resident B exited the bathroom and Resident A was seen with blood dripping from his ear. Ms. Boyles said Resident A was taken to the emergency room for an ear laceration for which he received approximately three stitches. Ms. Boyles denied any history of aggression between Residents A and B in the past.

On July 10, 2023 I spoke to direct care staff member Jennifer Rose who stated she was working at the facility on June 25, 2023 when Resident A was injured by Resident B in the shower at the facility. Ms. Rose said Resident A required hand-over-hand assistance with washing his body and assistance with washing his hair but that he liked to “play” in the water alone in the bathroom. Ms. Rose said she was responsible for assisting Resident A in the shower on June 25, 2023 and once she had him in the shower she noted a bruise on his right arm close to his shoulder so she left the bathroom with the bathroom door cracked to go document the bruise and while she was documenting the bruise her coworker Aubree Cervantes told her she heard the bathroom door close. Ms. Rose said the last time she saw Resident B he was in the living room watching TV and she denied that she saw him or heard him go into the bathroom with Resident A. Ms. Rose said she immediately went to open the door and it was locked so she went to get the key and Resident B came walking out before she could unlock the door. Ms. Rose said Resident A was “gushing” blood from his left ear and Resident B had scratches on his forehead but she does not know what happened between the two because no staff member was in the bathroom at the time. Ms. Rose said it was typical for staff members to allow Resident A to “play” in the shower alone because it calmed him.

On August 11, 2023 I spoke to direct care staff member Aubree Cervantes who said she was working at the facility on June 25, 2023 when Resident A was injured by Resident B while he was alone in the shower. Ms. Cervantes acknowledged that she read Resident A’s PCP and that he was supposed to be always supervised but stated that staff members often allowed him to “play” in the water unsupervised in the bathroom because Resident A enjoyed that activity. Ms. Cervantes said staff members assist Resident A with hand-over-hand assistance with bathing and wash his hair for him but as stated, do allow him to spend time in the water “playing” unsupervised. Ms. Cervantes said on June 25, 2023 she was responsible for assisting Resident A in the shower and she left him in there unsupervised to “play” while she went to complete paperwork and she left the bathroom door open as Resident A did not like it closed. Ms. Cervantes said Resident B was calmly sitting in the living room and the next thing she knew she heard the bathroom door close and she approached the door and it was locked so she knocked and she heard a “grunting” noise from Resident A from inside the bathroom. Ms. Cervantes said she asked a coworker to get the key to the bathroom, but Resident B came out before

staff members could get the door unlocked. Ms. Cervantes said Resident B appeared upset and “stormed off,” and Resident A appeared “scared” and had blood “dripping” from his ear. Ms. Cervantes said since the incident on June 25, 2023 staff members have been directed to stay with Resident A in the shower at all times.

On July 6, 2023 I interviewed direct care staff member Donny Harris who stated he was working on June 25, 2023 when Resident A was injured in the shower by Resident B. Mr. Harris said Resident A required hand– over–hand assistance with washing his body and assistance with washing his hair but that he often spends time alone in the shower “playing” as that is something he enjoys doing. Mr. Harris said on June 25, 2023 when he arrived to work Resident A had already been injured and was still in the bathroom and scared to come out. Mr. Harris said staff members Jennifer Rose and Aubree Cervantes were working at the time Resident A got hurt and they told him they did not know what happened, just that Resident A was playing in the shower and Resident B went in there and something happened. Mr. Harris stated he took Resident A to the hospital for medical treatment and Resident A had to get four stitches in his ear to repair the laceration left by Resident B.

On July 6, 2023 I interviewed direct care staff member Emily Beltinck who stated she was not working on June 25, 2023 when Resident A was injured in the shower by Resident B. Ms. Beltinck said while Resident A requires assistance with washing his body and hair it is not uncommon for staff members to allow Resident A to “play” in the shower without supervision or assistance from a staff member as that was an activity Resident enjoyed. Ms. Beltinck stated there have been physical incidents between Resident A and Resident B in the past and staff members “try to keep an eye on where [all residents are] at all times” however none of the residents admitted to the facility require 1:1 staffing, including Residents A or B.

On July 6, 2023 and August 16, 2023, I interviewed facility home manager and direct care staff member Debra Martin who stated she was not present at the facility on June 25, 2023 when Resident A was injured by Resident B but was telephoned by a staff member later who told her that Resident A’s ear was scratched by Resident B while Resident A was playing alone in the shower. Ms. Martin said Resident A required hand–over– hand assistance in the shower and 24–hour supervision but that he had a diagnosis of autism and enjoyed the sensation of the water, so staff members allowed him to “play” in the shower alone while they completed paperwork. Ms. Martin said this was the second time Resident B went into the bathroom while Resident A was “playing” in the water and Resident A was injured. Ms. Martin said the first incident occurred in February 2023 and Resident A was in the bathroom without a staff member and Resident B entered the bathroom and Resident A was found with scratches on his body but was not seriously injured and did not require medical attention. Ms. Martin said staff members are “mindful” of where Resident B is when Resident A is in the bathroom playing because Resident A does not like to close and lock the door. Ms. Martin said Resident A did not acquire a serious injury on June 25, 2023, but he did go to the emergency room where he received stitches for a laceration to his ear lobe.

On August 11, 2023 I spoke to assigned adult protective services investigator Brooke Seamon who stated she will be substantiating the neglect of Resident A by staff members at the facility who neglected to supervise him according to his *Person Centered Plan* and as a result Resident A was injured.

On August 11, 2023 I spoke to facility administrator Tammy Unger who stated she understood that Resident A's *Person Centered Plan* was not followed when Resident A was left to "play" alone in the shower while staff members completed written documentation. Ms. Unger stated all staff members have been retrained on Resident A's *Person Centered Plan* and at this time he is being supervised according to the written plan.

On July 6, 2023 I received and reviewed a written incident report that indicated it was authored by direct care staff member and facility manager Debra Martin and it was dated June 25, 2023. The written incident report stated Resident A was in the bathroom taking a shower and Resident B entered the bathroom. The report stated staff member Aubree Cervantes knocked on the bathroom door and heard a noise from either Resident A or Resident B and then Resident B came out of the bathroom. The written report stated Resident B went into his bedroom and locked the door and Resident A had "blood running down him coming from his ear." The written incident report stated Resident A was taken to the emergency room where he received four stitches for a laceration to his ear for which he had to be sedated.

On July 6, 2023 I received and reviewed Resident A's written *After Visit Summary* from MyMichigan Medical Center dated June 25, 2023. The summary indicated Resident A was treated in the emergency department for an ear laceration for which he received moderate sedation and sutures which would need to be removed in 10 days.

On July 6, 2023 I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated February 17, 2023. I noted that according to the assessment plan Resident A "needs assistance with washing, otherwise likes to be alone" concerning bathing.

On July 6, 2023 I received and reviewed Resident B's written *Assessment Plan for AFC Residents* dated January 31, 2023 which stated Resident B has been aggressive with his peers. On the same day I received and reviewed Resident B's written *Person Centered Plan* which had a goal of "Be nice" and the objectives *listed* were "[Resident B] will display increased ability to cope with frustration in his environment as evidenced by reduction in targeted behaviors. Data will include elopement, yelling, physical aggression and inappropriate touching." "[Resident B] will display less than 1 episode of physical aggression per month." On August 15, 2023 I received and reviewed Resident B's written *Positive Support Plan* dated March 25, 2023. The written report stated, [Resident B's] mood can change quickly when asked to do something. [Resident B] has a history of non-compliance,

aggression, and yelling." The target behaviors listed in the *Positive Support Plan* were hitting, pushing, grabbing other people, throwing items, property destruction, and slamming doors. Yelling and loud vocal utterances were also listed as target behaviors. The plan indicated Resident B displayed several episodes of physical aggression according to written incident reports submitted to Gratiot Integrated Health Network.

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:	Despite the fact that direct care staff members Jessica Rose and Aubree Cervantes, both of whom assumed responsibility for assisting Resident A with his shower on June 25, 2023 were aware that Resident A was alone in the shower with the door open and Resident B who has a history of and a current *Positive Support Plan* for aggression was nearby, no precautions were taken to protect Resident A. Direct care staff members were not properly supervising Resident A nor Resident B when they did not notice that Resident B went into the bathroom and physically attacked Resident A to the point that he required four stitches in his ear.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Resident A's most recent *Person Centered Plan* from Gratiot Integrated Health Network as well as the plan that was current on June 25, 2023 at the time Resident A was not supervised in the shower was not implemented by direct care staff members as Resident A's plans indicate he should be supervised at all times in the shower. Rather, Resident A was left alone to "play" in the shower alone while direct care staff members completed written documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

08/15/2023

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Leslie Herrguth Date
Licensing Consultant

Approved By:

08/16/2023

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Dawn N. Timm Date
Area Manager