GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 24, 2023

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

RE: License #:	AS090238706
Investigation #:	2023A0123067
	Mason AFC

Dear Mr. Pilot:

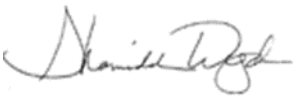
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090238706
Investigation #:	2023A0123067
Complaint Receipt Date:	08/31/2023
Investigation Initiation Date:	09/01/2023
Report Due Date:	10/30/2023
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:	Mason AFC
Facility Address:	2540 Mason Street Bay City, MI 48708
Facility Telephone #:	(989) 894-0312
Original Issuance Date:	08/01/2001
License Status:	REGULAR
Effective Date:	07/15/2022
Expiration Date:	07/14/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Brittany Scott and staff Briana Ahrens were working third shift when Resident A yelled/called out to be assisted out of bed and to the restroom and staff did not answer. Resident B got up to get staff for Resident A. When Resident B got to the living room Resident B saw staff Brittany Scott and staff Briana Ahrens were asleep on the couch. Resident A was talked with and stated this also happened a couple of weeks ago.	Yes

III. METHODOLOGY

08/31/2023	Special Investigation Intake 2023A0123067
09/01/2023	APS Referral APS referral information received.
09/01/2023	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
09/15/2023	Contact - Document Received I received requested documentation via email.
09/18/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Briana Ahrens.
09/18/2023	Contact - Telephone call made I interviewed staff Brittany Scott via phone.
09/20/2023	Contact - Telephone call made I made a second attempt to contact Staff Ahrens. There was no answer.
09/27/2023	Contact - Telephone call made I spoke with Resident A's case manager via phone.
10/13/2023	Contact- Telephone call made I spoke with Resident B’s case manager Jennifer DeShano via phone.
10/20/2023	Exit Conference I spoke with Joe Pilot via phone.

10/20/2023	Contact- Telephone call made I spoke with staff Jessica Dirker via phone.

ALLEGATION: Staff Brittany Scott and staff Briana Ahrens were working third shift when Resident A yelled/called out to be assisted out of bed and to the restroom and staff did not answer. Resident B got up to get staff for Resident A. When Resident B got to the living room, Resident B saw staff Brittany Scott and staff Briana Ahrens were asleep on the couch. Resident A was talked with and stated this also happened a couple of weeks ago.

INVESTIGATION: On 09/01/2023, I conducted an unannounced on-site at the facility. I interviewed Resident A and Resident B.

Resident A stated that she needed to use the bathroom, and she called out for assistance. She was being ignored by staff as they were asleep. Resident B is her roommate. Resident A stated that this situation has happened twice. She stated that she waited until first shift got to the home. She stated that she called out for assistance a lot during the middle of the night and just gave up. She stated that staff were asleep because they did not hear her, and that Resident B saw them sleeping as well. She stated that she held it in (her urine) all night and went back to sleep. She stated that she does not wear briefs.

Resident B stated that she was sleeping. Resident A needed to use the bathroom, so she (Resident B) used her personal cell phone to call staff. Both staff were asleep on the couch. Resident B stated that she had gotten up to use the bathroom during third shift and saw the staff sleeping. She stated that staff are lazy at night.

On 09/15/2023, I received requested documentation via email for Resident A. Resident A's *Assessment Plan for AFC Residents* dated 01/30/2023 states that Resident A utilizes a wheelchair, is unable to walk, and needs transferring assistance for toileting.

A copy of disciplinary action for staff Brittney Scott dated for 08/29/2023 states she received a written warning for the following: "*Resident called out to use the restroom, staff did not come, residents roommate went to get them. Both staff were sleeping. Staff was not aware a resident was LOA all night & marked in his book that he was checked on. Floors not mopped. Bathrooms not stocked*." Home manager Kelsey Schairer and staff Brittney Scott's signature appears at the bottom of the form.

On 09/18/2023, I interviewed staff Brittany Scott via phone. Staff Scott denied knowing anything about the situation until receiving disciplinary action. She denied sleeping while during her shift and denied that staff Briana Ahrens was asleep. Staff Scott reported not recalling Resident A calling out for assistance, but that Resident B said that Resident A had called out for assistance. Resident A did not ask to use the bathroom. Resident A has behaviors and Resident B lies a lot. Staff Scott stated that Resident A may have called out while she (Staff Scott) was in the bathroom, but she

did not hear Resident A. Resident A blows situations out of proportion and if any of the residents have an issue with anything, it leads to behaviors. Staff Scott stated that her disciplinary action was a verbal write up.

On 09/18/2023, I attempted to contact staff Briana Ahrens via phone. I left a voicemail message requesting a return call. On 09/20/2023, I made a second attempt to contact staff Briana Ahrens. The call appeared to have been sent to voicemail.

On 09/27/2023, I spoke with Bay Arenac Behavioral Health case manager Holli Vogel via phone. She reported the following:

There has been a lot of staff turnover in the facility which has created some issues. Case managers have been checking in more to educate new staff for a smoother transition. She asked Resident A last week how things were going, and Resident A only mentioned other residents having more behaviors, and Resident A did not mention any specific issues related to Resident A. Resident A denied that anything has been going on, and Holli Vogel that she just wants to give staff a chance, and that Resident A just gets frustrated. Last week, Resident A was with both case manager Holli Vogel and Guardian 1 and Resident A did not report any issues. Resident A has been recently struggling with the loss of a relative. Resident A was asked four different ways if there has been anything going on in the home, and Resident A denied that anything has happened.

On 10/13/2023, I spoke with Resident B and Resident C's case manager Jennifer DeShano via phone. She stated that she has been visiting the home weekly. Things are better now with the new staffing the facility has. About a month and a half ago, Resident C informed her (Jennifer DeShano) that there was a staff sleeping on shift, but it is unknown who the staff person was. She stated that she was informed the matter was addressed by the home manager. Resident B did not say anything about staff sleeping.

On 10/13/2023, I received an email with a copy of the facility's personnel policy attached, from administrator Tammy Unger. On page 25 of the personnel policy manual, under "Sleeping on Duty" it states:

"Sleeping on duty is strictly prohibited. Giving the appearance of sleeping on company premises is not permitted. Secluding oneself for the purpose of sleeping may result in immediate termination. Sleeping on duty is strictly prohibited unless special work situations are involved and prior approval has been granted, ie: travel."

On 10/20/2023, I made a call to former staff Jessica Dirker via phone. Staff Dirker stated that she worked first shift. She stated that there were a few times she came in to work on first shift and Resident A would say "*finally, I've been yelling for hours*." Staff Dirker stated that other staff would give her an attitude when she would come in on her shift and ask if anyone had checked on Resident A during the night. Staff

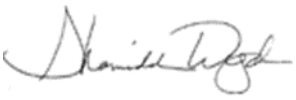
Dirker stated that Resident A was not toileting during several nights, and there was no reason Resident A should have had to hold her urine all night with staff present in the home.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(b) Resident care related prohibited practices.**
ANALYSIS:	Resident A was interviewed and reported that she had to use the bathroom and was ignored due to staff being asleep. Resident B stated that she observed staff sleeping. Resident A's assessment plan indicates a need for assistance with transferring for toileting. Record of disciplinary action for staff Brittney Scott was obtained. Staff Scott received a written warning for not completing some third shift duties including sleeping while on duty, and not assisting Resident A to the restroom. Staff Brittany Scott denied the allegations. Two attempts were made to contact Staff Briana Ahrens. Staff Ahrens did not return my calls. Staff Jessica Dirker was interviewed and reported that there were multiple times Resident A held her urine because she was not toileted on third shift. A copy of the staff's personnel policy was obtained. It strictly prohibits sleeping while on duty. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/20/2023, I conducted an exit conference with licensee designee Joe Pilot via phone. I informed him of the findings 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 6).

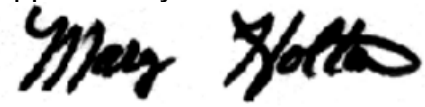


10/23/2023

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



10/24/2023

_____

Mary E. Holton Date
Area Manager