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 #:	2023A0123069
	Mason AFC

Dear James Pilot:

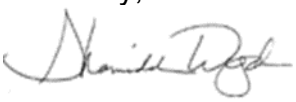
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
This Report Contains Quoted Profanity.

I. IDENTIFYING INFORMATION

License #:	AS090238706
Investigation #:	2023A0123069
Complaint Receipt Date:	09/15/2023
Investigation Initiation Date:	09/18/2023
Report Due Date:	11/14/2023
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?
On 8/25/23, Resident C was having a self-harm incident in her home. Staff Halie Frost grabbed Resident C by her wrist and pinned her hands down to her side to prevent her from hitting herself. It is unknown how long Resident C's wrist was held down by Staff Frost. Resident C's wrist was sore. Resident C had no bruises. It is not in Resident C's behavior plan to be restrained. Staff Frost was not supposed to restrain Resident C.	Yes

III. METHODOLOGY

09/15/2023	Special Investigation Intake 2023A0123069
09/15/2023	APS Referral Information received regarding APS referral.
09/18/2023	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility. I interviewed residents.
09/25/2023	Contact- Document Sent I sent an email to the facility's home manager requesting documentation for Resident C.
09/26/2023	Contact- Document Received Requested documentation received via email.
10/13/2023	Contact - Telephone call made I spoke with case manager Jennifer DeShano via phone.
10/20/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Halie Frost.
10/20/2023	Contact - Telephone call made I interviewed staff Jessica Dirker via phone.
10/20/2023	Contact - Telephone call received I interviewed staff Halie Frost via phone.
10/23/2023	Exit Conference I spoke with administrator/designated person Tammy Unger.

ALLEGATION: On 8/25/23 Resident C was having a self-harm incident in her home. Staff Halie Frost grabbed Resident C by her wrist and pinned her hands down to her side to prevent her from hitting herself. It is unknown how long Resident C's wrist was held down by Staff Frost. Resident C's wrist was sore. Resident C had no bruises. It is not in Resident C's behavior plan to be restrained. Staff Frost was not supposed to restrain Resident C and was suspended from work pending investigation.

INVESTIGATION: On 09/18/2023, I conducted an unannounced on-site visit at the facility. I interviewed Resident C, Resident B, and Resident D.

Resident C stated that staff Halie Frost got mad and pulled Resident C off of the couch by Resident C's arms. Resident C stated that she was still asleep on the couch and did not hear Staff Frost call for meds. Resident C stated that she punched herself in the head after that, then Staff Frost restrained Resident C. Resident C stated that when she was restrained by Staff Frost, she was lying in her bed, and Staff Frost was standing over her. Resident C stated that Staff Frost was grabbing her by the arms and was not allowing Resident C to get up from the bed. Resident C stated that Resident B and Resident D were witnesses. Resident D is Resident C's roommate and was in bed at the time of the incident. Resident C stated that she told the home manager, and staff Jessica Dirker was the other staff on shift at the time of the incident. Staff Frost no longer works here.

Resident B was interviewed and stated she witnessed staff Halie Frost pour water from a medicine cup onto Resident C. Staff Halie Frost also pulled Resident C from the couch by Resident C's arms. Staff Frost was yelling at Resident C to get up, trying to force Resident C to take her medications and eat food. Resident B stated that she heard from Resident C that staff Halie Frost tried to restrain Resident C while Resident C was lying in bed as well. Resident B stated that she was shocked to see what Staff Frost did, because she was not expecting that, and that she feels bad for Resident C.

Resident D was interviewed and stated that staff Halie Frost told Resident C to get off of the couch. Resident D witnessed Staff Frost try to restrain Resident C. Staff Frost no longer works here. Staff Frost also threw Resident C's blankets, and Staff Frost hollered at Resident C for sleeping on the couch. Staff Frost was mean towards Resident D as well and would tell Resident D "*go away, I don't want to hear it*", and also told Resident D, that Resident D could not go into the garage. Resident D stated that Staff Frost was rude.

On 09/18/2023, during this on-site I took a photo of an *AFC Licensing Division-Incident/Accident Report* on 08/25/2023 at 7:45 am written by staff Halie Frost. The location of the incident report is listed as the living room. The report states "*Staff HF called [Resident C] for 8 am meds. [Resident C] didn't come. Staff HF woke her up. [Resident C] said 'my meds don't fucking help me' and punched herself and pulled her hair. Staff HF gave her a few to calm down then [Resident C] chose to take her*

meds." *Gentle Teaching* was noted as action taken by staff. Under *Corrective Measures Taken to Remedy and/or Prevent Recurrence* it notes "*Staff will continue to encourage [Resident C] to use healthy coping skills. [Resident C] has a med review today*."

On 09/26/2023, I received requested documentation regarding Resident C, including Resident C's *Assessment Plan for AFC Residents* dated, 07/12/2022, and Resident C's Bay Arenac Behavioral Health *Plan of Service* dated 08/02/2023. The assessment plan notes that staff are to pass medications to Resident C as prescribed. It also notes that Resident C exhibits self-injurious behavior, and it is noted to "*follow behavior guidelines*." Resident C's Plan of Services states "[Resident C uses self-harm as a coping mechanism when she is frustrated, upset or angry with others. She needs to be monitored and re-directed throughout the day to use her coping skills to reduce the number of self-harm incidents." Activities staff are to encourage her to partake in if she seems anxious or agitated are *"looking at the feelings sheet with her, calmly taking with her, encouraging her to move to a calmer area if she wants, listening to music or singing, coloring or painting, using fidget toys, calmly encouraging her to do any other calm activities that she likes to do*." If Resident C displays any self-harm staff are to:

"1. Provide her with any necessary attention to ensure that she is safe. Keep conversation and interactions brief and matter of fact. (Do not show strong emotional reaction, and do not have long conversations about the incident.)"
"2. Make a brief statement reminding [Resident C] that she can use healthy coping skills when upset."
"3. Consult home nursing as needed/required and follow any advice given."

On 10/13/2023, I spoke with Bay Arenac Behavioral Health case manager Jennifer DeShano. Case manager DeShano is the case manager for Resident B and Resident C. She stated that it is not in Resident C's plan of care to be restrained. She stated that she was told that Staff Frost pulled Resident C by her ankles off of the couch. Resident C told Case Manager DeShano that Resident C was on the couch, had refused medications, and Staff Frost grabbed Resident C by the ankles off the couch, then Resident C took her medications. Resident B told Jennifer DeShano that Staff Frost trickled water onto Resident C. There were not good boundaries between Staff Frost and the residents as they acted like "sisters." Jennifer DeShano stated that the only consistent thing between the allegations and what she was told is about the water being poured on Resident C and being pulled off the couch.

On 10/20/2023, I interviewed former staff Jessica Dirker via phone. Staff Dirker stated that she is now a former employee of the facility. She stated that when working at the facility, she did witness staff Halie Frost push Resident C down on the couch once but does not remember all of the details of the incident. She stated that there was one day that Resident C did not want to take her medication, and she was hitting herself in the face. Resident C is not supposed to be restrained. Resident B

and or/Resident D were witnesses to the incident. Staff Dirker stated that she was outside when the incident occurred, for about two to three minutes. Staff Frost was inappropriate with Resident C, and the two did play around but it was too much at times. Resident C made a complaint about it. She stated that Resident C told her about Staff Frost about pulling her arms, and she could tell that Resident C was uncomfortable. She also stated that Resident A mentioned how they as residents were not being treated right. She stated that it was a weird situation because Staff Frost was the assistant home manager.

On 10/20/2023, I interviewed staff Halie Frost via phone. She stated that she worked at the facility for two and a half years, and "*never had a single problem, it's just funny*." After letting her know I needed to interview her regarding the allegations she stated, "*This is some fuck shit, but whatever.*" She stated that the allegations "*don't sound familiar*" and stated that she would never touch Resident C. Staff Frost stated that I was the first person to reach out to her for an interview and stated "*I quit that bitch. Bay Human Services can go fuck themselves.*" She stated that no one called her, she was not suspended, and that she was switched to work at a new home, and eventually quit. She denied the allegations. Staff Frost appeared to have a very negative attitude during this conversation, so I ended the call.

On 10/23/2023, I spoke with administrator/designated person Tammy Unger via phone. She stated that staff Halie Frost did not quit but was terminated from her position.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 09/18/2023, I interviewed Resident B, Resident C, and Resident D. Resident B was interviewed and stated she witnessed staff Halie Frost pull Resident C from the couch by Resident C's arms. Staff Frost was yelling at Resident C. Resident C stated that staff Halie Frost got mad and pulled Resident C off of the couch by Resident C's arms. Resident C stated that Staff Frost was grabbing her by the arms and was not allowing Resident C to get up from the bed.

	Resident C's Assessment Plan for AFC Residents and BABHA Plan of Service was reviewed. There was no indication in either assessment that Resident C requires physical restraint. Resident D saw Staff Frost try to restrain Resident C. Resident C's case manager, Jennifer DeShano stated there were not good boundaries between Staff Frost and the residents, and that she was informed that Staff Frost pulled Resident C by her ankles. Staff Dirker stated that she witnessed Staff Halie Frost push Resident C onto the couch once, and she was told by Resident C that Staff Frost grabbed Resident C. Staff Frost was inappropriate with Resident C, and the two did play around but it was too much at times. Staff Halie Frost denied the allegations. There is a preponderance of evidence to substantiate a rule violation in regard to staff Halie Frost using physical force, and physical restraint towards Resident C. It is not in Resident C's behavioral plan to use physical restraint.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	On 09/18/2023, I interviewed Resident B, Resident C, and Resident D. Resident B reported that she witnessed staff Halie Frost pour water onto Resident C, pulled Resident C from the couch, and yelled at Resident C. Resident C reported that staff Halie Frost pulled Resident C from the couch, and also restrained Resident C in her bed. Resident D reported that Resident D witnessed Staff Frost restrain Resident C, threw Resident C's blankets, and hollered at Resident C. Resident D also stated that Staff Frost was rude to her as well.

	Case manager Jennifer DeShano stated that it was reported to her that Staff Frost poured water onto Resident C, pulled Resident C by the ankles, and also reported that Staff Frost had an inappropriate relationship with the residents. Staff Jessica Dirker was interviewed and reported witnessing staff Halie Frost push Resident C on the couch once, and also reported that Staff Frost had an inappropriate relationship/behavior with Resident C. Staff Halie Frost denied the allegations. There is a preponderance of evidence to substantiate a rule violation in regard to the suitability of Staff Halie Frost to meet the physical, intellectual, and emotional needs of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/26/2023, I received requested documentation regarding Resident C, including Resident C's *Assessment Plan for AFC Residents* dated, 07/12/2022.

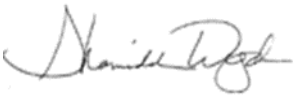
On 10/24/2023, I received a follow-up email from administrator Tammy Unger confirming there was not up to date assessment plan on file.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 09/26/2023, I received a copy of Resident C's Assessment Plan for AFC Residents. The plan dated 07/12/2022 was outdated. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/23/2023, I conducted an exit conference with administrator/designated person Tammy Unger via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

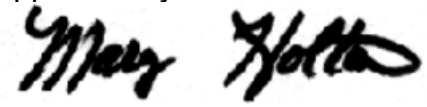
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



10/24/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



10/24/2023

Mary E. Holton Date
Area Manager