GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 23, 2024

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

RE: License #:	AS090395688
Investigation #:	2024A0123012 Rose Home

Dear Mr. Pilot:

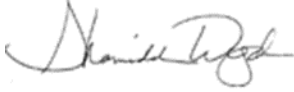
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090395688
Investigation #:	2024A0123012
Complaint Receipt Date:	12/08/2023
Investigation Initiation Date:	12/11/2023
Report Due Date:	02/06/2024
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:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Vonnetta Jones was physically abusive towards Resident A and Resident B on separate occasions. Staff Jones smacked Resident A on the leg and/or back of the hand. Resident B came out of their room and was sitting on the couch being loud. Staff Jones lifted the couch, causing Resident B to slide onto the floor. Staff Jones then shoved Resident B on the floor in the room and shut the bedroom door.	Yes

III. METHODOLOGY

12/08/2023	Special Investigation Intake 2024A0123012
12/11/2023	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Kevin Motyka via phone.
12/13/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
12/18/2023	Contact - Document Sent I requested documentation from the facility via email.
12/19/2023	Contact - Document Received Requested documentation received via email.
12/21/2023	APS Referral Information received regarding APS referral.
01/04/2024	Contact - Telephone call made I made an attempted call to staff Vonnetta Jones. There was no voicemail set up, and no answer.
01/04/2024	Contact - Telephone call made I left a voicemail requesting a return call from APS worker Sarah LaBarge.
01/04/2024	Contact - Telephone call made I left a voicemail requesting a return call from Complainant 1.
01/08/2024	Contact - Telephone call made I made a second unsuccessful attempt to contact staff Vonnetta Jones.
01/10/2024	Contact - Telephone call received

	I spoke with APS worker Sarah LaBarge via phone.
01/16/2024	Contact- Telephone call received I received a call from staff Vonnetta Jones via phone.
01/16/2024	Contact- Telephone call made I attempted to contact Complainant 1 via phone.
01/17/2024	Contact- Telephone call made I spoke with Resident A and Resident B's public guardian.
01/17/2024	Contact- Telephone call received I received a call from Complainant 1.
01/17/2024	Contact- Telephone call made I made a follow-up call to the facility. I spoke with staff Amanda Black, Resident C, and Resident F.
01/23/2024	Exit Conference I spoke with administrator/designated person Tammy Unger via phone.

ALLEGATION: Staff Vonnetta Jones was physically abusive towards Resident A and Resident B on separate occasions. Staff Jones smacked Resident A on the leg and/or back of the hand. Resident B came out of their room and was sitting on the couch being loud. Staff Jones lifted the couch, causing Resident B to slide onto the floor. Staff Jones then shoved Resident B on the floor in the room and shut the bedroom door.

INVESTIGATION: On 12/11/2023, I spoke with recipient rights investigator Kevin Motyka via phone. Kevn Motyka stated that staff Vonnetta Jones is suspended. Resident A and Resident B are both non-verbal. Resident C, Resident B's roommate, may have witnessed Resident B getting pushed into her room and Staff Jones shutting the door. There were no other witnesses besides Complainant 1 who was afraid staff Vonnetta Jones would retaliate. Complainant 1 also did not know they had to report within 24-hours. The date(s) of the alleged incidents are unknown.

On 12/13/2023, I conducted an unannounced on-site at the facility. I spoke with staff Christina Salo. Staff Salo stated that she has only worked with staff Vonnetta Jones twice on third shift. Staff Salo stated that Staff Jones comes off as "*cold*". Staff Salo stated that she heard that Staff Jones put her hands on the residents, but she never personally witnessed it.

During this on-site, I observed five residents in the facility. They appeared clean and appropriately dressed. Resident A and Resident B were not interviewed due to

verbal limitations. Resident C, (Resident B's roommate) was asleep. I interviewed Resident D.

Resident D stated that Staff Jones worked third shift. Resident D stated that she does not like Staff Jones and felt Staff Jones would tell Resident D what to do. Resident D stated that Staff Jones always yelled and made Resident D upset. Resident D stated that Staff Jones would upset the whole house. Resident D stated that Staff Jones "*talks rough to all of us, even [Resident A] and [Resident E]. They can't talk. Why would she be mean to them*?" Resident D stated that Staff Jones was aggressive with her, and Resident D stated she told Staff Jones she cannot be that way, and Staff Jones told Resident D "*oh yeah, I can*" in response. Resident D stated that she told recipient rights that she wanted Staff Jones out of the home.

On 12/19/2023, I received requested documentation via email from regional manager Molly Meyer. A copy of an *AFC Licensing Division- Incident/Accident Report* dated 11/07/2023 at 3:30 am, states the following:

"[*Resident A] woke up, was making noises, and stripping in her room. So Vonn* (Staff Vonnetta Jones) *went and brought [Resident A] out of her room and into the recliner. Vonn was trying to watch tv but was bothered by [Resident A] making noises and trying to strip. After many times of [Resident A] trying to take her brief off, Vonnetta smacked [Resident A] on the leg herself. Vonnetta told [Resident A] that she don't have time for all that noise. Also, Vonnetta told [Resident A] if she kept it up, she would go back to her room. I ended up taking over the care for [Resident A]. Since Vonnetta was being mean to [Resident A], I figured it's best for me to take care of her."*

A copy of an *AFC Licensing Division- Incident/Accident Report* dated 11/16/2023 at 4:45 am states the following:

"[Resident B] woke up a little on the early side. She then headed out to the living room to sit on couch and watch tv. Vonnetta asked me why I let [Resident B] out into the living room. I told Vonnetta I wasn't going to stop [Resident B] from coming out of her room. [Resident B] sat on the couch rocking back and forth being very loud. Vonetta got upset/mad and tried to get [Resident B] off the couch. When [Resident B] didn't listen to Vonnetta, Vonnetta tried to grab [Resident B] and guide her to her room. When that attempt failed, Vonnetta went behind the couch and lifted the back end of it in the air, making [Resident B] very upset and fall off the couch onto the floor. [Resident B] remained sitting on the floor. Vonnetta told [Resident B] to get up off the floor and go to her room. [Resident B] didn't listen, so Vonnetta started to shove [Resident B] across the floor with her foot/leg. When that didn't work too well, Vonnetta then bent over and used her hands to push [Resident B]. Vonnetta continued to push [Resident B] across the floor until she got into her room. Then Vonnetta shut the door so [Resident B] would stay in there."

A copy of an *Employee Corrective Action* dated 12/19/2023, with an incident date of 12/07/2023 signed by assistant home manager Amanda Black states "*staff reported that Vonnetta physically hit [Resident A] and physically dumped [Resident B] off the sofa and pushed her to her room. Recipient rights was contacted.*"

On 01/10/2024, I spoke with adult protective services worker Sarah LaBarge via phone. Sarah LaBarge stated that Staff Jones denied the allegations and said that she has long fingernails and cannot lift a couch, or Resident B who is bigger than Staff Jones. Staff Jones reported that she felt she had a target on her back and is walking on eggshells at work. Law Enforcement was informed of the incident but is not pursing anything. Staff Jones told Sarah LaBarge that she may not go back to work at the facility.

On 01/16/2024, I received a call from staff Vonnetta Jones. Staff Jones denied the allegations. Staff Jones stated that she did not lift Resident B up from a love seat or make her go to her room. Staff Jones stated that she keeps her own nails done and would not do anything to try to break her nails. Staff Jones also stated that Resident B is bigger than she is and that she would not try to lift Resident B. Staff Jones denied smacking Resident A. Staff Jones went on stating that she goes to work, does her job, but is on pins and needles because Resident D has been making allegations against her (Staff Jones). Staff Jones stated that Resident D has said that she (Staff Jones) is rough with Resident D and forces Resident D to take medication. Staff Jones stated that Resident D requires personal care assistance from two staff, and she requests a staff to witness her conduct Resident D's med passes, so she is not alone with providing personal care to Resident D. When asked to respond to whether or not she has ever been accused of yelling at Resident D, Staff Jones did not directly answer the question. Staff Jones stated instead that other staff spend too much time with Resident D, while she (Staff Jones) focuses on her work tasks.

On 01/17/2024, I received a call from Complainant 1. Complainant 1 stated that they witnessed Resident B coming out of Resident B's room in the middle of the night. Resident B was sitting on the living room love seat being loud and not listening to Staff Jones. Staff Jones then lifted the love seat, and Resident B fell on the floor. Resident B was sitting on the floor, then staff Vonnetta Jones pushed Resident B with her feet and hands all the way back to Resident B's room and shut the door. Resident C is Resident B's roommate. Complainant 1 reported being uncertain if Resident C witnessed this incident. Staff Jones appeared irritated at Resident B being loud. It is normal for Resident B to be loud.

Complainant 1 stated that Resident A likes to sit in the recliner chair a lot. Resident A strips her clothing and briefs frequently. One day, Resident A was trying to take her brief off. Staff Jones has smacked Resident A at least two to three times in response to Resident A's behavior and has yelled things like "*No. Bad [Resident A]*!" Complainant 1 stated that no other staff have come to Complainant 1 with any concerns about Staff Jones' behavior. Complainant 1 stated they were scared to

report the incidents because of how Staff Jones is. Staff Jones has made comments about how she would fight anyone she has a problem with. Complainant 1 stated that not a lot of staff get along with Staff Jones, as Staff Jones is not the nicest person. Complainant 1 stated that Resident A and Resident B did not have any marks or bruises that they were aware of. Complainant stated that with Resident D, Staff Jones always had another staff person present when providing Resident D with personal care. Resident D was not fond of Staff Jones and Complainant 1 is not sure of why. Complainant 1 stated that Staff Jones has yelled at both Resident A and Resident B and has told Resident A "*If you don't want to keep your brief on, you can go to your room*!"

On 01/17/2024, I spoke with Resident A and Resident B's public guardian, Guardian 1 via phone. Guardian 1 could not recall whether or not their office was notified of the alleged incidents. Guardian 1 denied having any concerns.

On 01/17/2024, I made a follow-up call to the facility. I interviewed staff Amanda Black, Resident C, and Resident F.

Assistant home manager Amanda Black stated that Staff Jones never came in to receive her written disciplinary action. Staff Black stated that she completed the write up on behalf of another manager. Staff Black denied ever witnessing Staff Jones acting inappropriately towards any residents.

Resident C was interviewed. Resident C stated that she did experience issues with staff Vonnetta Jones being rude and responding loudly/snapping at both her and another staff person on different occasions. Resident C stated that she witnessed Staff Jones push Resident B into her bed, and there were times Resident B almost fell on the floor as a result. Resident C stated that she has witnessed Staff Jones shut the bedroom door on Resident B at least twice. She stated that Resident B wakes up in the middle of the night to watch television in the living room, and she guessed that Staff Jones did not want Resident B in the living room and has made Resident B go back to her room and shut the bedroom door on Resident B.

Resident F was interviewed. Resident F stated that she did not know staff Vonnetta Jones well, and that Staff Jones was kind of okay. Resident F stated that she doesn't think she's ever witnessed Staff Jones mistreat anyone.

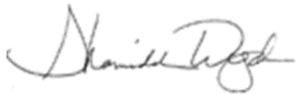
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Two incident reports detail two incidents Complainant 1 witnessed between Resident A, Resident B, and Staff Jones,

	with Staff Jones being physically aggressive with both residents. Written disciplinary action dated 12/19/2023 was reviewed during the course of this investigation for Staff Jones that was completed due to the reported physical assault of Resident A and Resident B. On 01/16/2024, staff Vonnetta Jones was interviewed and denied the allegations. On 01/17/2024, Complainant 1 was interviewed and confirmed the incidents reported on the *AFC Licensing Division- Incident/Accident Reports.* Guardian 1 denied having any concerns regarding to Resident A and Resident B. On 01/17/2024, Resident C was interviewed and reported witnessing Staff Jones forcing Resident B back to her bedroom at least twice and shutting the door on Resident B. Resident C also reported witnessing Staff Jones being rude to both other staff and Resident C on two occasions. There is a preponderance of evidence to substantiate a rule violation in regard to Staff Vonnetta Jones not treating residents with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/23/2024, I conducted an exit conference with administrator/designated person Tammy Unger via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

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



01/23/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:

01/23/2024

Mary E. Holton Date
Area Manager