GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 18, 2024

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

RE: License #:	AS090395688
Investigation #:	2024A0123044
	Rose Home

Dear James Pilot:

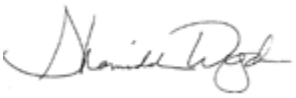
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 E. Genesee Ave.
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 #:	AS090395688
Investigation #:	2024A0123044
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/20/2024
Report Due Date:	08/19/2024
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?
On 06/15/2024, staff Lisa Corrion asked staff Jennifer Palmateer for assistance getting Resident F out of bed to Resident F's walker. Staff Palmateer grabbed Resident F's left wrist and the front of Resident F's gait belt and jolted Resident F with force. Staff Palmateer stated "I don't have time for this shit!" then walked out of Resident F's bedroom. Resident F was very upset.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0123044
06/20/2024	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Melissa Prusi.
06/21/2024	APS Referral APS referral completed.
06/28/2024	Inspection Completed On-site I conducted an unannounced on-site. I interviewed staff and Resident F.
07/12/2024	Contact- Document Sent I sent an email requesting a copy of Resident F’s gait belt script.
07/12/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Jennifer Palmateer.
07/12/2024	Contact- Telephone call received I interviewed staff Jennifer Palmateer.
07/12/2024	Contact- Telephone call made I made a follow-up call to staff Amanda Black.
07/12/2024	Contact- Document sent I sent an email to regional manager Tabatha Barnes requesting documentation.

07/12/2024	Contact- Document Received I received an email response from staff Tabatha Barnes.
07/17/2024	Exit Conference I spoke with administrator/designated person Tammy Unger.

ALLEGATION: On 06/15/2024, staff Lisa Corrion asked staff Jennifer Palmateer for assistance getting Resident F out of bed to Resident F's walker. Staff Palmateer grabbed Resident F's left wrist and the front of Resident F's gait belt and jolted Resident F with force. Staff Palmateer stated "I don't have time for this shit!" then walked out of Resident F's bedroom. Resident F was very upset.

INVESTIGATION: On 06/20/2024, I spoke with Melissa Prusi of Recipient Rights. She stated that Resident F confirmed that they were grabbed and pulled by the left wrist by staff Jennifer Palmateer, and that it hurt. Resident F went from a lying position to sitting upright in bed. An incident report was written by staff Lisa Corrion. Resident F reported that they were not too happy Staff Palmateer pulled their arm. There were no bruises. Staff Palmateer denied being in a hurry and denied the allegations.

On 06/28/2024, I conducted an unannounced on-site at the facility. I interviewed Resident F. Resident F stated that it is not very good that staff Jennifer Palmateer did what she did. Resident F stated that they were lying in bed. Staff Palmateer yanked Resident F with both arms. Resident F stated that staff Lisa Corrion witnessed it. Resident F reported being scared at the time it happened. Resident F stated they could not remember if this has ever happened before. Resident F stated that they are shaky in the morning. Resident F stated that they cannot remember what Staff Palmateer said, but Staff Palmateer did use a swear word. Resident F denied having any marks or bruises after the incident. No marks or bruises were observed during this interview.

On 06/28/2024, I interviewed staff Lisa Corrion at the facility. Staff Corrion stated that on 06/15/2024, during first shift, she was checking on the residents. Staff Corrion stated that she went to Resident F's room, checked on Resident F, and Resident F was shaky. Staff Corrion stated that she asked staff Jennifer Palmateer for assistance. Staff Corrion stated that she was waiting for Resident F to open their eyes. Staff Palmateer came into the room and grabbed Resident F by the left wrist, used a gait belt, and yanked Resident F to sitting position. Staff Corrion stated that Staff Palmateer said "*I don't have time for this shit.*" Staff Corrion stated that she comforted Resident F and told Resident F she would return to the room to check on Resident F. Staff Corrion stated that Resident F was very upset and told Staff Corrion that she did not like what was said or what Staff Palmateer did.

On 06/28/2024 I interviewed assistant home manager Amanda Black at the facility. Staff Black stated that she was a 3rd shift worker still present in the home on

06/15/2024 as Staff Corrion and Staff Palmateer were starting their shift. Staff Black stated that she checked Resident F for marks and bruises and there were none. Staff Black stated that she has seen Staff Palmateer be a little rough, but she does not think that Staff Palmateer does it on purpose.

During this on-site, other residents in the home were observed to be clean and appropriately dressed. No issues were noted.

I obtained documentation pertaining to Resident F during this on-site. Resident F's walker script is dated 04/03/2023. The rolling walker was ordered due to Resident F having arthritis of the left hip. Resident F's *Assessment Plan for AFC Residents* dated 12/07/2023 notes that Resident F uses both a walker and gait belt for *Walking/Mobility*.

A copy of the *AFC Licensing Division- Incident/Accident Report* written by staff Lisa Corrion, dated 06/15/2024 at 7:35 am states the following:

"Asked another staff member to assist getting [Resident F] out of bed. As [Resident F] is usually very shaky in the morning wanted [Resident F] safe. The staff assisting myself and [Resident F] to [Resident F's] walker didn't even wait for [Resident F] to open [Resident F's] eyes or be alert or even aware of what was going on. The other staff grabbed [Resident F's] left wrist also the front of [Resident F's] gait belt jolted with force, and [Resident F] was sitting straight up, still with [their] eyes closed. I was appalled at the force used. The other staff said, "I don't have time for this shit!" then walked out of [Resident F's] bedroom. I checked [Resident F] wrist, arm, waiting for [Resident F] to wake fully. [Resident F] was very upset. I calmed [Resident F] down. Apologized to [Resident F]."

Under *Action taken by Staff* it states:

"Assist mgr (manager) was here. She assessed the situation. Checked [Resident F] out for the second time. Did skin audit, gave [Resident F] a cold pac. There was no bruising, swelling or fracture. [Resident F] was able to move [their] wrist, fingers. Home mgr (manager) was also contacted."

On 07/12/2024, I received a copy of Resident F's Bay Arenac Behavioral Health *Nursing Care Plan* via email. On page 2 it states, "*Staff will assist [Resident F] as needed with ambulation. Staff will remind and encourage [Resident F] to use [their] Walker, Gait belt, and Ankle braces as ordered by Physician*."

On 07/12/2024, I interviewed staff Jennifer Palmateer via phone. Staff Palmateer denied the allegations. She stated that on 06/15/2024, she was at work in the kitchen cooking, making breakfast. Staff Corrion asked her to assist with Resident F. Staff Palmateer stated that she used the gait belt and Resident F's arm as she was trained to. Staff Palmateer stated that Resident F is capable of getting out of bed independently. Staff Palmateer stated that Staff Corrion claims she said, "*I don't have*

time for this shit!" Staff Palmateer denied saying this. She stated that Staff Corrion was in Resident F's room for quite a while, and Staff Corrion did not help her with Resident F. Staff Palmateer stated that she was suspended after this incident was reported, then was fired. Staff Palmateer stated that she thinks this was done in retaliation because she has made complaints about Staff Corrion in the past.

On 07/12/2024, I made a follow-up call to assistant home manager Amanda Black. She stated that both she and staff Tina Anderson were present in the facility at the time of the alleged incident, but neither were in Resident F's room when it occurred. Staff Black stated that she was in the medication room at the time and did not hear Staff Palmateer cursing, and that Staff Anderson was sitting down doing paperwork. She stated that all Resident F said was that Staff Palmateer hurt their arm, and that Resident F was upset. Staff Black stated that Resident F did not have a red mark or anything. Staff Black stated that when Staff Palmateer first started working, she just did not know how to turn (reposition) the residents, and once she showed Staff Palmateer how to do so, there were no issues afterwards.

On 01/23/3034, I concluded in Special Investigation Report #2024A0123012 that R400.14305(3) had been violated due to staff Vonnetta Jones not treating Resident A, Resident B, and Resident C with dignity. Staff Jones received written disciplinary action for a reported physical assault of Resident A and Resident B. The corrective action plan dated 02/01/2024 states Staff Jones was suspended on 12/07/2023 and terminated from employment. The corrective action plan also noted that Bay Human Service's quality improvement director Melissa Rood would conduct a training on 02/02/2024 including rights on individuals, reporting all concerns to management in a timely manner, and the Culture of Gentleness.

On 07/17/2024, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusions. Tammy Unger stated that Staff Palmateer was fired on 06/18/2024. Tammy Unger stated that dignity/respect, etc. can be added to the next staff meeting agenda, and follow-up will be made in regard to obtaining the gait belt script.

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:	On 06/28/2024, I conducted an unannounced on-site at the facility. Resident F was interviewed and stated that staff Jennifer Palmateer yanked their arms and used a swear word. Resident F denied having any marks or bruising from the incident.

	Staff Lisa Corrion was interviewed on-site. Staff Corrion stated that Staff Palmateer yanked Resident F to a sitting position while using a gait belt. Staff Corrion stated that Staff Palmateer also swore. Staff Amanda Black was interviewed on-site. She stated that she checked over Resident F and there were no marks or bruises. I made a follow-up call to Staff Black on 07/12/2024. She stated that Resident F was upset and stated that Staff Palmateer hurt their arm. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR#2024A0123012, dated January 23, 2024**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/28/2024, I conducted an unannounced on-site at the facility. I requested copies of paperwork for Resident F's assistive devices. The only copy of a physician order obtained during this on-site was a copy of Resident F's rolling walker script dated 04/03/2023.

On 07/12/2024, I received an email response from regional manager Tabatha Barnes. Tabatha Barnes stated that she attached Resident F's nursing care plan which references use of the gait belt but was unable to locate the original order for the gait belt. Tabatha Barnes stated that they will reach out to the physician on 07/15/2024 to get a new script.

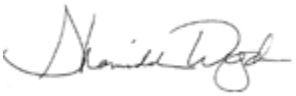
On 07/17/2024, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusions. Tammy Unger stated follow-up will be made in regard to obtaining the gait belt script.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	On 06/28/2024, I conducted an unannounced on-site at the facility. While there I requested copies of documentation including Resident F's gait belt script. On 07/12/2024, staff Tabatha Barnes confirmed via email that Resident F's physician order for use of a gait belt could not be located.

	There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

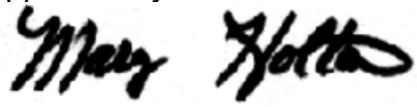
IV. RECOMMENDATION



07/17/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



07/18/2024

Mary E. Holton Date
Area Manager