GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2025

Melissa Rood
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #: AS730311600
Investigation #: 2025A0576014
House of Hope

Dear Melissa Rood:

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.
- 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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730311600
Investigation #:	2025A0576014
Complaint Receipt Date:	12/20/2024
Investigation Initiation Date:	12/23/2024
Report Due Date:	02/18/2025
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:	Melissa Rood
Name of Facility:	House of Hope
Facility Address:	4326 N Michigan, Saginaw, MI 48604
Facility Telephone #:	(989) 401-5222
Original Issuance Date:	01/31/2011
License Status:	REGULAR
Effective Date:	10/10/2023
Expiration Date:	10/09/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On December 19, 2024, Resident A was on an outing with staff and other residents from House of Hope AFC home. Resident A was grabbed by her jacket and thrown into the train because she was moving slow by Staff, Angela Bryan.	Yes

III. METHODOLOGY

12/20/2024	Special Investigation Intake 2025A0576014
12/20/2024	APS Referral
12/20/2024	Contact - Document Received Reviewed Incident Report (IR)
12/23/2024	Special Investigation Initiated - Letter Received email from Jessica Bowman, Home Manager
02/07/2025	Inspection Completed On-site Interviewed Home Manager, Jessica Bowman, Staff, Carnecia Thomas, Resident B, and viewed Resident A
02/10/2025	Contact - Telephone call made Left message for Resident A's Case Manager, Danielle Dennis to return call
02/10/2025	Contact - Telephone call made Left message for Judy Saucedo, Saginaw County of Recipient Rights (ORR) to return call
02/10/2025	Contact - Telephone call made Interviewed Staff, Ay'shia Harris
02/10/2025	Contact - Telephone call made Interviewed Staff, Angela Bryan
02/11/2025	Contact - Telephone call received Interviewed Judy Saucedo
02/11/2025	Contact - Telephone call received

	Interviewed Danielle Dennis
02/11/2025	Exit Conference

ALLEGATION:

On December 19, 2024, Resident A was on an outing with staff and other residents from House of Hope AFC home. Resident A was grabbed by her jacket and thrown into the train because she was moving slow by Staff, Angela Bryan.

INVESTIGATION:

On December 20, 2024, I received an email from Home Manager, Jessica Bowman who provided telephone numbers for staff involved in the allegations. I also reviewed an AFC Licensing Division Incident / Accident Report (IR) dated for December 20, 2024, and authored by Carniecia Thomas. The IR documented that Assistant Manager, Angela Bryan slammed Resident A on the train the day prior. Assistant Manager Bryan was suspended pending investigation and Resident A was provided first aid for a small wound on her knee.

On February 7, 2025, I completed an unannounced on-site inspection at House of Hope and interviewed Home Manager, Jessica Bowman. Manager Bowman reported Resident A went on a train ride during an outing with staff and other residents. Staff, Ay'shia Harris texted Staff, Carniecia Thomas and stated she witnessed Assistant Manager, Angela Bryan push Resident A. Resident B was also on the outing, witnessed the abuse of Resident A, and verified what occurred. Saginaw County Office of Recipient Rights (ORR) has been in contact with Assistant Manager Bryan, and she has been suspended since this incident.

On February 7, 2025, I viewed Resident A at her home. Resident A appeared well and in good spirits as she was smiling and hugged me several times. Resident A had just eaten some oatmeal and appeared clean, and she was dressed in clean clothing. Resident A was not interviewed as Resident A is nonverbal.

On February 7, 2025, I interviewed Staff, Carniecia Thomas regarding the allegations. Staff Thomas has been employed at the facility for 2 years. Staff Thomas explained that Ay'shia Harris texted her and said Assistant Manager, Angela Bryan threw Resident A into the train. Resident B also witnessed this. Staff Thomas has worked with Assistant Manager Bryan in the past and she can be rude and sarcastic. Assistant Manager Bryan "clashed with staff and she was loud with the residents". Assistant Manager Bryan has not been working since ORR has been investigating this matter.

On February 7, 2025, I interviewed Resident B who reported Assistant Manager Angela Bryan grabbed Resident A because Resident A was having a behavior. Resident A did

not want to get on the train and Assistant Manager Bryan pushed Resident A and grabbed her by her jacket. Assistant Manager Bryan pushed Resident A on the train, and they went on the train ride. Assistant Manager Bryan has not been working at the facility and Resident B is glad she is not working at his home.

On February 7, 2025, I reviewed Resident A's individual plan of service (IPOS) which revealed Resident A is 33 years old and nonverbal. Resident A is diagnosed with Unspecified mood (affective) disorder, other pervasive developmental disorders, Autistic Disorder, moderate intellectual disabilities, and other health issues.

On February 10, 2025, I interviewed Staff, Ay'shia Harris regarding the allegations. Staff Harris reported that they were in Flint for an outing and staff and residents were getting on a train ride. Resident A was walking too slow onto the train and Assistant Manager Angela Bryan "slammed" Resident A down. Assistant Manager Bryan grabbed Resident A's jacket and pulled her down onto her seat. Resident A was trying to get to her seat and Assistant Manager Bryan may have been frustrated. When Assistant Manager Bryan pulled Resident A by her jacket into her seat, it was excessive according to Staff Harris. Assistant Manager did not direct Resident A to sit down, and Resident A could have sat down on her own. Staff Harris believed Assistant Manager Bryan was irritated and rushing Resident A. Staff Harris did not say anything to Assistant Manager Bryan, and she checked Resident A for injuries. Staff Harris stated Assistant Manager Bryan was an "aggressive talker" to the residents, and she is no longer working at the facility.

On February 10, 2025, I interviewed Assistant Manager Angela Bryan regarding the allegations. Assistant Manager Bryan denied grabbing or throwing Resident A while on the train and advised Resident A sat in her seat on her own accord. Assistant Manager Bryan explained the seating on the train was narrow and Resident A was trying to sit down. Assistant Manager Bryan assumed Resident A's "feet got caught and she fell into the seat." Assistant Manager Bryan denied grabbing Resident A by her jacket.

On February 10, 2025, I left a message for Danielle Dennis, Resident A's Case Manager from Saginaw County Community Mental Health to return my call. On February 11, 2025, I interviewed Case Manager Dennis who reported she is familiar with the home and did not have any concerns regarding the home or staff. Since this incident, staff could likely use additional training as Resident A and other residents of the home can display difficult behaviors.

On February 10, 2025, I left a message for Judy Saucedo, Saginaw County Office of Recipient Rights Officer from Saginaw County Community Mental Health to return my call. On February 11, 2025, I interviewed Officer Saucedo who confirmed she has competed her investigation regarding Resident A. Officer Saucedo interviewed Assistant Manager Angela Bryan who denied the allegations however another staff person and Resident B witnessed the abuse. Assistant Manager Bryan has a history of complaints and was suspended pending the investigation. Officer Saucedo concluded that Resident A was abused by Assistant Manager Bryan.

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:	It was alleged that Resident A was grabbed and thrown into a seat by Assistant Manager, Angela Bryan. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. On December 20, 2024, I reviewed an IR that documented Resident A was “slammed” by Assistant Manager Angela Bryan. I interviewed Staff, Ay’shia Harris and Resident B who both reported witnessing Assistant Manager Bryan behave aggressively with Resident A and grabbing her by her jacket. Staff Harris reported Assistant Manager pulled Resident A into her chair using excessive force. Assistant Manager Bryan denied grabbing or pulling Resident A and stated she assumed Resident A fell into her chair. Office of Recipient Rights opened an investigation into this matter and has concluded Assistant Manager Bryan abused Resident A. There is a preponderance of evidence to conclude Resident A’s safety and protection was not always adhered to given the Assistant Manager’s physical aggression toward her.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 11, 2025, conducted an exit conference with Licensee Designee, Melissa Rood. I advised Licensee Designee Rood I would be requesting a corrective action plan for the cited rule violation.

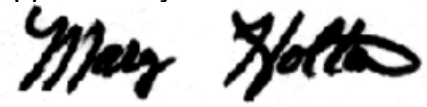
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change to the license status is recommended.

2/11/2025

Christina Garza Date
Licensing Consultant

Approved By:



2/12/2025

Mary E. Holton Date
Area Manager