



STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

November 26, 2025

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

RE: License #:	AS090016193
Investigation #:	2026A0123003 Kasemeyer

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,

A handwritten signature in cursive script, appearing to read "Shamidah Wyden".

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 #:	AS090016193
Investigation #:	2026A0123003
Complaint Receipt Date:	10/22/2025
Investigation Initiation Date:	10/23/2025
Report Due Date:	12/21/2025
Licensee Name:	Bay Human Services, Inc.
LicenseeAddress:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Melissa Rood
Licensee Designee:	James Pilot
Name of Facility:	Kasemeyer
Facility Address:	5181 Kasemeyer Bay City, MI 48706
Facility Telephone #:	(989) 667-0470
Original Issuance Date:	02/01/1995
License Status:	REGULAR
Effective Date:	10/24/2024
Expiration Date:	10/23/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has physical limitations and is allowed to leave the premises of the facility unaccompanied to walk along heavy traffic roads with no sidewalks. Resident A narrowly avoids being struck by vehicles. The facility is aware of everything, and no action has been taken to ensure Resident A's safety.	No
Resident A's name and personal health information were publicly disclosed on a neighborhood watch Facebook page. A staff person confirmed Resident A's identity and provided additional private information regarding Resident A.	Yes

III. METHODOLOGY

10/22/2025	Special Investigation Intake 2026A0123003
10/23/2025	APS Referral
10/23/2025	Special Investigation Initiated - Letter
10/23/2025	Contact - Document Sent Sent referral to Recipient Rights via email.
10/23/2025	Contact - Document Received Received email response from recipient rights manager.
10/28/2025	Inspection Completed On-site I conducted an unannounced on-site.
11/12/2025	Inspection Completed On-site I conducted a follow-up on-site. I interviewed staff Alexandra Berg.
11/26/2025	Contact-Document Sent I sent an email to the facility home manager requesting documentation.
11/26/2025	Exit Conference I spoke with licensee designee Joe Pilot via phone.
11/26/2025	Contact- Document Received I received requested documentation.

ALLEGATION:

- **Resident A has physical limitations and is allowed to leave the premises of the facility unaccompanied to walk along heavy traffic roads with no sidewalks. Resident A narrowly avoids being struck by vehicles. The facility is aware of everything, and no action has been taken to ensure Resident A's safety.**
- **Resident A's name and personal health information were publicly disclosed on a neighborhood watch Facebook page. A staff person confirmed Resident A's identity and provided additional private information regarding Resident A.**

INVESTIGATION: On 10/28/2025, I conducted an unannounced on-site at the facility. Upon arrival at the facility, while standing at the front door, signing in, I observed Resident A walking around the home without any assistive devices.

I interviewed home manager Autumn Blake. She stated she had a conversation with staff Alexandra Berg about the comments left on Facebook. She stated that Staff Berg said she was *"trying to help the home."* Staff Blake stated that recipient rights are involved. She stated Resident A has community access rights. Staff Berg sent Staff Blake the Facebook post, and Staff Blake sent it to Resident A's care team. She stated that she only saw what Staff Berg sent her and did not see any of Staff Berg's comments on the post. Staff Blake stated that there is action being taken to ensure Resident A's safety. She stated that wearing a safety vest, light colored clothing, and reflective gear was just implemented into Resident A's care plan. Staff Blake stated that Resident A walks with a walker, but not while inside the home, and that it has been a long time since Resident A fell while out in the community. Resident A is on the list to move somewhere more suitable. Resident A declined another AFC placement last year because Resident A would have had less access to the community.

During this unannounced on-site, I interviewed Resident A. Resident A reported not falling a lot. Resident A uses a walker while in the community, but not in the home. Resident A goes out in the community daily. Resident A reported sometimes taking a walk down the street. Resident A reported feeling safe while walking on the street and denied going out at nighttime because it is too dark. Resident A confirmed having a reflective vest but does not know where it is currently. Resident A reports returning home by 5:00 pm, and that a friend provides rides. Resident A denied falling in the roadway. Resident A reported being hit once by a car a long time ago and has not been hit since. Resident A denied almost getting hit by a car recently. What appeared to be a bruise was observed on Resident A's left forearm. Resident A stated that it was just *"blood coming to the surface."* Resident A reported having four walkers and also uses a public transportation service.

During this unannounced on-site, I obtained a copy of Resident A's Bay Arenac Behavioral Health Authority *Behavioral Treatment Plan Revision #1* dated 10/21/2025, signed by Heather Nix, PhD, LP. On page two of the plan, it notes what

Resident A is recommended to do, if Resident A plans to leave the property without staff. This includes taking medications beforehand, letting staff know where Resident A is planning to go, utilizing a walker with reflective tape on it, wearing other reflective items (i.e. reflective clothing, reflective vest, lights, etc.), and wearing bright clothing. The plan also states that staff should assist Resident A in following these steps, “*as they are able*” and to calmly remind/encourage Resident A to follow them. It also states that if Resident A does not want to take the reflective items/wear due to it being daylight, to remind Resident A to take the reflective items as it might be dark when Resident A returns home.

During the course of this investigation, I reviewed the Facebook social media posts written by staff Alexandra Berg. In summary, a Facebook user identified Resident A by name, and provided other information about Resident A, and Staff Berg confirmed Resident A’s identity by stating “*please don’t release her personal information.*” On one post, Staff Berg replied to a Facebook user telling them “*we are in the process of fixing her plan for safe leaves as we understand the dangers.*” Staff Berg replied, “*she has one*” and “*sometimes she just refuses. Unfortunately, I’ve asked a few times*”, in response to another individual’s comment saying that Resident A needed a blinking bike light to attach to Resident A’s walker. Staff Berg also commented “*I work for the afc home she resides and we unfortunately can’t stop her from leaving as much as we have reported it repeatedly.*” On another comment, Staff Berg stated “*she gets rides. Are you watching her cause that’s a little bold to assume serveal times lol. I work almost everyday and she leaves in the am and comes back at dinner leaves again. And is back by meds lol*”

On 11/12/2025, I conducted a follow-up on-site at the facility. I spoke with home manager Autumn Blake. Autumn Blake stated that Resident A is currently in the hospital after having a seizure on the facility’s porch.

During this on-site, staff Madina Scott and I walked into Resident A’s bedroom. In the bedroom, I observed Resident A’s reflective vest, and the reflective tape on Resident A’s walker.

During this on-site, I interviewed staff Alexandra Berg. Staff Berg stated that she has been a direct care worker for about seven months. Staff Berg stated that she had been expressing the need for “*safe leaves*” for Resident A with management. Staff Berg stated that someone else put Resident A’s personal information on a Facebook post, and she just asked them not to. Staff Berg stated that she went back and deleted the comments. Staff Berg stated that she tried to explain on the Facebook thread how they cannot stop residents from leaving home, but they encouraged them not to. Staff Berg stated that she did not mean anything by the comments she made and did not know that it may be against any policy. Staff Berg stated that since she has worked at the facility, she has no knowledge of Resident A falling in the roadway. Staff Berg stated that she usually sees Resident A from about 6:00 am to 10:00 am, and Resident A is usually away from home for the day. Staff Berg stated Resident A had a seizure yesterday, then fell on the porch. Staff Berg stated that she was not

present when this occurred. Staff Berg stated that Resident A uses Dial-A-Ride, but Resident A will cancel the service, and have a friend provide transportation instead.

During this on-site, I reviewed Resident A's file. Resident A's *Health Care Appraisal* dated 10/24/2025 signed by Shelbi Ramon, NP-C, states that Resident A is fully ambulatory. Resident A's *Assessment Plan for AFC Residents* dated 10/14/2024 has "yes" checked for moves independently in the community and states "*able to be by self in community.*" It also notes that Resident A uses a walker. I reviewed recent incident reports for Resident A. On 06/29/2025, Resident A complained of pain of the left leg. Staff noted a black/blue bruise and took Resident A to MyMichigan ER for a hematoma of the left lower leg, after contacting nursing. Resident A reported tripping over a wheelchair. On 09/15/2025 at 8:20 pm, it was brought to staff's attention that Resident A was bleeding. There was blood on Resident A's face, and in Resident A's hair. 911 was contacted, as well as the nurse, management, and the public guardian. Resident A was taken to MyMichigan Health ER and was diagnosed with a "*fall, initial encounter, head injury, traumatic head injury with multiple laceration.*" The incident report did not indicate where the fall occurred. A body assessment form attached to the incident report notes staff found a cut on Resident A's forehead, and Resident A received stitches at the hospital. An incident report dated 10/28/2025, at 10:10 am notes that Resident A tripped over the weight scale after opening the front door. Staff assisted Resident A back up, made sure Resident A was okay, called the nurse, watched for symptoms of pain.

On 11/26/2026, I received an email confirming Resident A has a physician authorization for a walker dated 04/21/2023 electronically signed by Shelbi Ramon, FNP-C.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	<p>On 10/28/2025, I conducted an unannounced on-site at the facility. I interviewed home manager Autumn Blake, and Resident A. Staff Blake stated that Resident A has community access rights. She stated that wearing a safety vest, light colored clothing, and reflective gear was just implemented into Resident A's care plan. Staff Blake stated it's been a while since Resident A had a fall while out in the community.</p> <p>Resident A was interviewed. Resident A reported not having a lot of falls. Resident A confirmed having a reflective. Resident</p>

	<p>A denied falling in the roadway. Resident A reported being hit once by a car a long time ago and has not been hit since. Resident A denied almost getting hit by a car recently.</p> <p>Resident A's Bay Arenac Behavioral Health Authority <i>Behavioral Treatment Plan Revision #1</i> was reviewed. It is dated 10/21/2025. On page two of the plan, it notes what Resident A is recommended to do, if Resident A plans to leave the property without staff. This includes taking medications beforehand, letting staff know where Resident A is planning to go, utilizing a walker with reflective tape on it, wearing other reflective items (i.e. reflective clothing, reflective vest, lights, etc.), and wearing bright clothing. The plan also states that staff should assist Resident A in following these steps, "<i>as they are able</i>" and to calmly remind/encourage Resident A to follow them. A copy of Resident A's <i>Assessment Plan for AFC Residents</i> notes that Resident A is capable of being in the community without staff supervision. Resident A's <i>Health Care Appraisal</i> notes that Resident A is fully ambulatory.</p> <p>On 11/12/2025, I conducted a follow-up on-site at the facility. I observed Resident A's reflective vest as well as the reflective tape on Resident A's walker.</p> <p>During this on-site, I interviewed Staff Berg. She stated that since she has worked at the facility, she has no knowledge of Resident A falling in the roadway. Staff Berg stated that Resident A uses Dial-A-Ride, but Resident A will cancel the service, and have a friend provide transportation instead.</p> <p>There is no preponderance of evidence to substantiate a rule violation. Per Resident A's assessment plan, and behavioral treatment plan, Resident A can be in the community unsupervised. Resident A has reflective tape on the walker, and a reflective vest.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	<p>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</p> <p>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</p>
ANALYSIS:	<p>On 10/28/2025, I conducted an unannounced on-site at the facility. I interviewed home manager Autumn Blake. Staff Blake was not aware of the specific Facebook posts that staff Alexandra Berg wrote on the social media thread.</p> <p>On 11/12/2025, I conducted a follow-up on-site at the facility. During this on-site, I interviewed Staff Berg. She stated that she tried to explain on the Facebook thread how they cannot stop residents from leaving home, but they encouraged them not to. She stated that she did not mean anything by the comments she made and did not know that it may be against policy.</p> <p>During the course of this investigation, I reviewed the Facebook social media posts written by staff Alexandra Berg. Posts made by Staff Berg not only confirmed Resident A's identity, but Staff Berg also made comments about Resident A's care plan and Resident A's day to day movements.</p> <p>There is a preponderance of evidence to substantiate a rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 11/26/2025, I conducted an exit conference with licensee designee Joe Pilot. I informed LD Pilot 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 3-6).



11/26/2025

Shamidah Wyden
Licensing Consultant

Date

Approved By:



11/26/2025

Mary E. Holton
Area Manager

Date