



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

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

December 5, 2025

RE: License #: AL170399127 - Meridian Heights  
Investigation #: 2026A0873002

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(906) 250-9318  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL170399127
<b>Investigation #:</b>	2026A0873002
<b>Complaint Receipt Date:</b>	10/28/2025
<b>Investigation Initiation Date:</b>	10/29/2025
<b>Report Due Date:</b>	12/27/2025
<b>LicenseeName:</b>	Bay Human Services, Inc.
<b>Licensee Address:</b>	PO Box 741 3463 Deep River Rd Standish, MI 48658
<b>Licensee Telephone #:</b>	(989) 846-9631
<b>Administrator:</b>	James Pilot
<b>Licensee Designee:</b>	James Pilot
<b>Name of Facility:</b>	Meridian Heights
<b>Facility Address:</b>	1105 Meridian Sault Ste. Marie, MI 49783
<b>Facility Telephone #:</b>	(906) 635-8806
<b>Original Issuance Date:</b>	06/01/2019
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/01/2023
<b>Expiration Date:</b>	11/30/2025
<b>Capacity:</b>	18
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
During a pest treatment of the facility, appropriate resident arrangements were not made.	No
The facility is unclean.	No
Medications were missing.	Yes
Additional Findings	No

## III. METHODOLOGY

10/28/2025	Special Investigation Intake 2026A0873002
10/29/2025	Special Investigation Initiated - Telephone Call to Elizabeth Eidenier ORR HBH
10/29/2025	APS Referral Referred to APS
11/13/2025	Inspection Completed On-site
11/13/2025	Contact - Face to Face Onsite interviews
12/04/2025	Inspection Completed-BCAL Sub. Compliance
12/04/2025	Exit Conference

### **ALLEGATION:**

**During a pest treatment of the facility, appropriate resident arrangements were not made.**

### **INVESTIGATION:**

On 10/28/25, I received a complaint which alleged that during a pest treatment residents were supposed to stay in a local hotel but the appropriate arrangements were not made. Residents stayed in the facility garage and Big Bear Arena.

On 10/29/25, I interviewed Hiawatha behavioral health officer of recipient rights Elizabeth Eidenier about the allegations. The facility has been having trouble finding a local exterminator to do the work. Discussions have taken place to bring an exterminator up from lower Michigan. The residents did not stay in Big Bear Arena for the night, most likely they stayed in a local casino hotel.

On 11/13/25. I interviewed Bay Human Services regional manager Heather Raffaele at the facility. There were arrangements made for all the residents to stay at a local Comfort Inn hotel chain. The hotel unexpectedly cancelled the reservation. Arrangements were then made for residents to stay at a separate hotel. Ms. Raffaele produced a document indicating a reservation was placed at the hotel.

On 11/13/25, I interviewed home manager Alicia Hallesy-Laford at the facility. After the Comfort Inn reservation fell through, arrangements were made for residents to stay at another hotel. When some employees and residents arrived at the hotel they were told that they needed identification cards as well as separate credit cards for each resident staying there. The facility was unable to produce these. Residents were supposed to stay at the hotel for 4 days during the treatment. Instead, residents stayed out of the facility during the day for the treatments to take place. Some residents wanted to stay at the facility and chose to stay outside during the treatment. Other residents were taken to Big Bear Arena for the day by employees of the facility. This occurred every day for the four day treatment. Residents were allowed back into the facility in the evening.

<b>APPLICABLE RULE</b>	
<b>R 400.645</b>	<b>Environmental health.</b>
	<b>(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.</b>
<b>ANALYSIS:</b>	The facility made a good-faith effort to find alternative living arrangements for the pest treatment. Instead of having residents stay off-site for several days, the facility kept residents occupied in various locations throughout the community during the day, allowing them back into the facility in the evening.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**The facility is unclean.**

**INVESTIGATION:**

On 10/28/25, I received a complaint which alleged that the facility is unclean.

On 11/13/25, I interviewed Ms. Raffaele at the facility. The facility has a cleaning schedule and all residents clothes and rooms are cleaned regularly or when they request it. On this date, I had also arranged for the facility's license renewal inspection so I was able to extensively tour the facility, including bedrooms, and found no evidence of it being unclean or unmaintained.

<b>APPLICABLE RULE</b>	
<b>R 400.647</b>	<b>Safety and maintenance of premises.</b>
	<b>(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.</b>
<b>ANALYSIS:</b>	During my tour of the facility I did not observe it to be unclean.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Medications were missing.**

**INVESTIGATION:**

On 10/28/25, I received a complaint which alleged that a resident's narcotic medication went missing and was later found in the facility dumpster.

On 11/13/25, I interviewed Ms. Hallesy-Laford at the facility. The day the medications went missing employee Larry Savercool was responsible for passing medications. Mr. Savercool had not locked the medication room door and left to attend to something in another part of the facility. The medications were found the next day in the facility dumpster. It is suspected a resident took the medications and threw them in the dumpster. No medications were missing from those taken.

On 11/13/25, I interviewed Mr. Savercool at the facility. He went to pass the 10pm medications but the resident did not immediately arrive to take them. While waiting for the resident, Mr. Savercool left the medication room door as well as the narcotic safe unlocked and left the room. Some time later the resident and Mr. Savercool

arrived back at the medication room to pass the medication. At that time they noticed the resident's three full blister packs of Clonazepam were missing. The resident did not miss his usual dosage as he had others. The facility employees searched for the medication and when they could not locate them, called law enforcement. The three blister packs were found the next day in the facility dumpster. All medications were accounted for.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.</b>
<b>ANALYSIS:</b>	An employee of the facility left the medication safe and door unlocked allowing someone to enter the medication room and take several blister packs of medication.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 12/4/25, I explained the findings of this report to licensee designee Joe Pilot. He will review the report and then pass it on for Meridian to develop a corrective action plan.

**IV. RECOMMENDATION**

Contingent upon an appropriate corrective action plan, I recommend no changes to the status of this license.



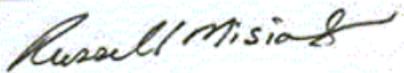
12/4/25

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Garrett Peters  
Licensing Consultant

Date

Approved By:



12/5/25

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Russell B. Misiak  
Area Manager

Date