GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 13, 2026

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

RE: License #:	AS090064224
Investigation #:	2026A0123023
	Georgetown

Dear James Pilot:

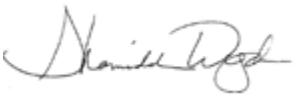
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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
THIS REPORT CONTAINS QUOTED PROFANITY.

I. IDENTIFYING INFORMATION

License #:	AS090064224
Investigation #:	2026A0123023
Complaint Receipt Date:	02/27/2026
Investigation Initiation Date:	02/27/2026
Report Due Date:	04/28/2026
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	3463 Deep River Rd PO Box 741 Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Melissa Rood
Licensee Designee:	James Pilot
Name of Facility:	Georgetown
Facility Address:	4784 Zielinski Lane Auburn, MI 48611
Facility Telephone #:	(989) 662-7047
Original Issuance Date:	07/11/1995
License Status:	REGULAR
Effective Date:	12/09/2025
Expiration Date:	12/08/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 02/22/2026, staff Kelsea Smith was arguing back and forth yelling inappropriate comments at Resident A.	Yes
Staff Kelsea Smith reportedly slept while on shift on 02/22/2026.	Yes

III. METHODOLOGY

02/27/2026	Special Investigation Intake 2026A0123023
02/27/2026	APS Referral Information received regarding APS referral.
02/27/2026	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Bridget Hayes.
03/10/2026	Inspection Completed On-site I conducted an unannounced on-site at the facility.
03/18/2026	Contact - Document Sent I sent an email to the facility requesting documentation.
03/18/2026	Contact - Document Received I received requested documentation via email.
03/31/2026	Contact- Telephone call made I made a follow-up call to staff Kinsey Sanders.
03/31/2026	Contact- Telephone call made I interviewed staff Kelsey Schairer, home manager.
03/31/2026	Contact- Telephone call made I interviewed staff Kelsea Smith.
03/31/2026	Contact- Telephone call made I interviewed staff Cassandra Latter.
04/08/2026	Contact- Telephone call made I interviewed staff Catrina Heslewood.

04/08/2026	Contact- Telephone call made I left a voicemail for staff Jenna Santoyl, requesting a return call.
04/09/2026	Contact- Telephone call made I made a call to the facility, and interviewed staff Jenna Santoyl and residents.
04/10/2026	Exit Conference I conducted an exit conference with LD Joe Pilot.

ALLEGATION: On 02/22/2206, staff Kelsea Smith was arguing back and forth yelling inappropriate comments at Resident A.

INVESTIGATION: On 02/26/2026, the Bureau of Community and Health Systems received a complaint regarding the allegations noted above. The complaint specifically states that staff Kelsea Smith was arguing back and forth with Resident A. Resident A told Staff Smith "*fuck you*" and Staff Smith kept yelling at Resident A to go to his room or go outside. Resident A told Staff Kelsea to "*go outside*." Staff Smith told Resident A, "*If I go outside, I'm dragging you out there and into the street*" and "*Holy fuck! I don't like you either, at least not right now, you race baiter. I'll meet you out there and frickin' pull you into the street*!"

On 02/27/2026, I spoke with recipient rights investigator Bridget Hayes via phone. She stated that there is a recording of the incident between Resident A and Staff Kelsea Smith. She stated that Staff Smith told Resident A that she would drag Resident A outside to the street.

On 02/27/2026, I received the voice recording from recipient rights investigator Bridget Hayes. The recording is a conversation between Resident A and staff Kelsea Smith captured via voice recording. The recording goes as follows:

Resident A: *No, you wouldn't.*
Staff Smith: *Yes, I would. [Resident A], stop!*
Resident A: *No, you would not.*
Staff Smith: *[Resident A]! Enough! Holy fuck.*
Resident A: *No, you wouldn't.*
Staff Smith: *Go to your room or something. Stop arguing.*
Resident A: *I don't like you.*
Staff Smith: *I don't like you either. At least not right now, I don't. Arguing over nothing.*
Resident A: *Fuck you.*
At this point, you can hear another resident, Resident A, and staff talking about the outside temperature and it being cold outside.
Staff Smith: *Okay, you rage baiter.*
Staff Smith: *[Resident A]!! Go outside!*
Resident A: *You go outside.*

Staff Smith: *I will! I'll meet you out there. I'll freaking pull you into the street.*
Resident A: *Why don't you kiss my ass.*
Staff Smith*: I would if it was clean.*
Staff Smith: *God!*

On 03/10/2026, I conducted an on-site at the facility. I tried to interview Resident A. Resident A refused to be interviewed stating *"I don't want to talk to her. I'm tired."* Resident A was observed lying in bed.

During this on-site, I interviewed staff Kinsey Sanders. Staff Sanders stated that on 02/22/2026, she started recording during lunch time. Resident A was at the table, calm and relaxed, joking. Staff Kelsea Smith got agitated with Resident A and started yelling at Resident A. Staff Sanders stated that Resident A never yelled at Staff Smith. She stated sometimes Staff Smith can get snippy with other staff, but not the residents. Staff Sanders stated Staff Smith is currently suspended. She stated that Staff Smith was yelling at Resident A prior to Staff Sanders recording the interaction. Staff Sanders stated that staff Kelsea Smith threatened Resident A with calling the home manager, so Resident A would no longer be able to live in the facility, and that when she decided to start recording. She stated that Staff Smith called Resident A a "*rage baiter*" and told Resident A to "*kiss her ass.*"

On 03/18/2026, I requested and received requested documentation via email. I received a copy of Resident A's Bay Arenac Behavioral Health Authority *Positive Support Plan* dated 04/17/2025. It notes that Resident A listed targeted behaviors include physical aggression and verbal aggression. In the plan it notes that staff are to stay calm with Resident A. Staff are not to argue, lecture, or try to prove they are right. The plan tells staff to pay attention to their tone of voice and try to use a calm, pleasant tone. It also notes that if Resident A is becoming verbally or physically aggressive toward staff or other residents, calmly yet firmly tell Resident A to stop. If Resident A stops, the plan notes to praise Resident A and continue interactions. If Resident A does not stop, staff are to let Resident A know they are going to give Resident A some space and let Resident A know he can come to staff when he is ready to talk.

On 03/31/2026, I made a call to home manager Kelsey Schairer. Staff Schairer stated that staff Kelsea Smith told another staff member that she (Staff Schairer) told Staff Smith that it is okay to tell a resident to shut up. Staff Schairer stated that this is not true. She stated that Staff Smith was fired. Staff Smith denied saying what she said to Resident A, even after being told by recipient rights there was a recording of it. Staff Schairer state that it is 100% Staff Smith's voice in the recording. Staff Schairer stated that Resident A does not remember Staff Smith. Staff Schairer stated that she showed a photo of Staff Smith to Resident A, and Resident A still did not remember Staff Smith.

On 03/31/2026, I interviewed staff Kelsea Smith via phone. Staff Smith stated she guessed someone had a recording of her saying things. Staff Smith told Resident A

to go outside to smoke a cigarette. Staff Smith stated that either Staff Kinsey Sanders or staff Cassandra Latter made the recording to get her in trouble. Staff Smith stated that Staff Sanders or Staff Latter were also speaking rudely. Staff Smith stated that a co-worker called Resident A a "*rage-baiter*" and all she did was agree with the co-worker. After I read the transcript of the recording to Staff Smith, Staff Smith stated that the recording was "*just diabolical*," and denied remembering this conversation with Resident A.

On 03/31/2026, I interviewed staff Cassandra Latter. Staff Latter stated that she did not like the tone which Staff Kelsea Smith would use with Resident A. Staff Smith was too stern, and in her opinion, there were easy situations where Staff Smith could have ignored things instead of responding. Staff Latter stated that it was only in situations where Resident A was inappropriate that Staff Smith was too stern. Staff Latter stated that Staff Smith could have changed her tone, because she would speak to Resident A, as if Resident A was a child.

On 04/08/2026, I interviewed staff Catrina Heslewood. Staff Heslewood stated that she has not personally witnessed any concerning behavior from staff towards residents. Staff Heslewood stated that Resident A expressed inappropriate behavior prior to a medication change. Staff Heslewood stated that she heard through hearsay that Resident A was not being aggressive when the alleged incident occurred. Staff Heslewood stated that she has witnessed staff Kelsea Smith get aggressive with Resident A verbally, when Resident A was aggressive towards Staff Smith. Resident A would say nasty aggressive things towards women, and Staff Smith would match Resident A's aggressiveness.

On 04/08/2026, I interviewed assistant home manager Jenna Santoyl. Staff Santoyl stated that she did not work with staff Kelsea Smith often, just a couple days a month. Staff Santoyl stated that Staff Smith would tell residents what to do instead of giving them options. Staff Santoyl stated that Staff Smith would direct the residents' day to benefit herself. Staff Santoyl denied witnessing any concerning interactions between Resident A and Staff Smith. Staff Santoyl stated that she has not heard any direct complaints from residents about Staff Smith. Staff Santoyl stated that she heard the voice recording and it was Staff Smith's voice.

On 04/09/2026, I interviewed Resident A via phone. Resident A denied remembering what staff Kelsea Smith said, but that they were going back and forth arguing. Resident A stated that Staff Smith argued with him a lot and told him to "*get my ass outdoors*."

On 04/09/2026, I interviewed Resident B. Resident B stated that he does not remember staff names well. Staff showed Resident B a photo of staff Kelsea Smith during this call. Resident B then stated that Staff Smith talked to them and braided his hair. Resident B stated that Staff Smith was nice, and he cannot say anything bad about her.

On 04/10/2026, I conducted an exit conference with licensee designee Joe Pilot. I informed LD Pilot of the findings and conclusions. LD Pilot was unsure of Staff Smith's current employment status, and stated he'd follow up with a corrective action plan.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 02/27/2026, I received a voice recording from recipient rights investigator of an interaction between Resident A and staff Kelsea Smith. The recording appears to capture Staff Smith speaking inappropriately towards Resident A. On 03/10/2026, I conducted an unannounced on-site at the facility. Resident A refused to be interviewed. A follow-up phone call was made to the facility on 04/09/2026. Resident A stated that he and Staff Smith were arguing back and forth and stated that Staff Smith told him to "*get my ass outdoors*." On 03/10/2026, I interviewed staff Kinsey Sanders who stated that she recorded the interaction between Resident A and staff Kelsea Smith. She stated that Staff Smith was yelling at Resident A prior to the recording being made. On 03/18/2026, I obtained a copy of Resident A's *Positive Support Plan* which outlines how staff are supposed to interact with Resident A. In the plan it notes that staff are to stay calm with Resident A. Staff are not to argue, lecture, or try to prove they are right. The plan tells staff to pay attention to their tone of voice and try to use a calm, pleasant tone. On 03/31/2026, I made a call to home manager Kelsey Schairer. Staff Schairer stated that it is 100% Staff Smith's voice in the recording. On 03/31/2026, I interviewed staff Kelsea Smith via phone. She denied the allegations. On 03/31/2026, I interviewed staff Cassandra Latter. Staff Latter did not witness the alleged incident but stated she did not like the tone which Staff Smith would use with Resident A and stated that Staff Smith was too stern.

	On 04/08/2026, I interviewed assistant manager Jenna Santoyl. She stated that she heard the voice recording and it was Staff Smith's voice. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Kelsea Smith reported slept while on shift on 02/22/2026.

INVESTIGATION: On 03/31/2026, I made a follow-up call to staff Kinsey Sanders. Staff Sanders stated that she witnessed staff Kelsea Smith sleeping from about 6:00 am to 8:00 am on 02/22/2026. She stated that the shift was from 6:00 am to 6:00 pm. She stated that Staff Sanders has done this previously about five or six times. She stated that staff Cassandra Latter may have witnessed this as well.

On 03/31/2026, I made a call to home manager Kelsey Schairer. Staff Schairer stated that no staff have directly reported any allegations of staff sleeping. She stated that Staff Kelsea Smith started working at the facility in July 2025. Staff Schairer stated that she started in August 2025. She stated she remembers that the previous home manager sent Staff Smith home for sleeping at work. She stated that the residents have not said anything about staff sleeping.

On 03/31/2026, I interviewed staff Kelsea Smith via phone. Staff Smith denied that she was sleeping during her shift. Staff Smith stated that a lot of staff will doze off during their shift, then "*come to*."

On 03/31/2026, I interviewed staff Cassandra Latter via phone. Staff Latter stated that she witnessed staff Kelsea Smith sleeping on shift quite a bit. Staff Latter stated that Staff Smith would fall asleep in the recliner chair. Staff Latter stated that Staff Smith has also left her shift early before at least an hour and a half early at least twice. Staff Latter stated that she takes care of the residents as if they are family and would not want Staff Smith caring for her family.

On 04/08/2026, I sent an email to administrator Melissa Rood confirming that the Bay Human Services Personnel Policy Manual dated 06/01/2019 is the current version of the policy manual. The policy manual states on page 25:

"*Sleeping on duty is strictly prohibited. Giving the appearance of sleeping on company premises is not permitted. Secluding oneself for the purpose of sleeping may result in immediate termination. Sleeping on duty is strictly prohibited unless special work situations are involved and prior approval has been granted, ie: travel*."

On 04/08/2026, I interviewed staff Catrina Heslewood via phone. Staff Heslewood stated that she has seen a newer staff nod off, and other staff she's witnessed

sleeping no longer work in the facility. Staff Heslewood denied witnessing staff Kelsea Smith sleep because they worked opposite shifts. Staff Heslewood stated that she never heard anyone complain about it. Staff Heslewood stated that when she was on shift working with Staff Smith in the past, there was no issue with sleeping.

On 04/08/2026, I interviewed assistant home manager Jenna Santoyl. Staff Santoyl stated that she heard complaints of staff Kelsea Smith sleeping, but she was unsure if Staff Smith was written up for it, as it was possibly hearsay. Staff Santoyl stated that she is aware there were incidents of it prior to her (Staff Santoyl) working in the home.

On 04/08/2026, I interviewed Resident A via phone. Resident A stated that he has seen staff Kelsea Smith sleeping on shift before. Resident A stated that Staff Smith was sleeping on the couch. Resident A stated that two staff work each shift, and there was another staff present in the home.

On 04/09/2026, I interviewed Resident B. Resident B stated that he has never seen staff sleeping.

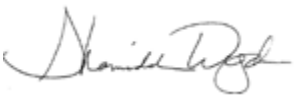
On 04/10/2026, I conducted an exit conference with licensee designee Joe Pilot. I informed LD Pilot of the findings and conclusions. LD Pilot was unsure of Staff Smith's current employment status, and stated he'd follow up with a corrective action plan.

APPLICABLE RULE	
R 400.701	**Required personnel policies.**
	(1) A licensee shall have all the following written policies and procedures: **(b) Resident care related prohibited practices.**
ANALYSIS:	On 03/31/2026, I made a follow-up call to staff Kinsey Sanders. She stated that staff Kelsea Smith was asleep on 02/22/2026 between 6:00 am and 8:00 am. On 03/31/2026, I made a call to home manager Kelsey Schairer. She stated she remembers that the previous home manager sent Staff Smith home for sleeping at work. She stated that the residents have not said anything about staff sleeping. On 03/31/2026, I interviewed staff Kelsea Smith via phone. She denied that she was sleeping during her shift. She stated that a lot of staff will doze off during their shift, then "*come to*." On 04/08/2026, I sent an email to administrator Melissa Rood confirming that the Bay Human Services Personnel Policy

	Manual dated 06/01/2019 is the current version of the policy manual. The policy prohibits sleeping while staff are on duty. On 03/31/2026, I interviewed staff Cassandra Latter. She stated that she witnessed staff Kelsea Smith sleeping on shift quite a bit. On 04/08/2026, I interviewed assistant home manager Jenna Santoyl. Staff Santoyl stated that she heard complaints of staff Kelsea Smith sleeping, but she was unsure if Staff Smith was written up for it, as it was possibly hearsay. She stated that she is aware there were incidents of it prior to her (Staff Santoyl) working in the home. On 04/08/2026, I interviewed Resident A via phone. Resident A stated that he has seen staff Kelsea Smith sleeping on shift before. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of the acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



04/13/2026

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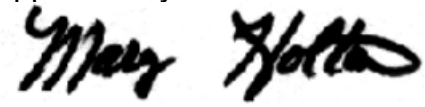
Shamidah Wyden Date
Licensing Consultant

Approved By:



04/13/2026

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Mary E. Holton Date
Area Manager