GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

April 28, 2026

RE: License #: AS520281606
Investigation #: 2026A0873009 - Lakeside

Dear Ms. 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.
- 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

License #:	AS520281606
Investigation #:	2026A0873009
Complaint Receipt Date:	03/06/2026
Investigation Initiation Date:	03/06/2026
Report Due Date:	05/05/2026
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Licensee Designee:	Melissa Rood
Name of Facility:	Lakeside
Facility Address:	49 Airfield Road Gwinn, MI 49841-9097
Facility Telephone #:	(906) 346-6235
Original Issuance Date:	05/05/2006
License Status:	REGULAR
Effective Date:	11/27/2024
Expiration Date:	11/26/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
Resident A was given the wrong medication, leading to hospitalization.	Yes
Additional Findings	No

III. METHODOLOGY

03/06/2026	Special Investigation Intake 2026A0873009
03/06/2026	Special Investigation Initiated - Telephone Referred to APS
03/06/2026	APS Referral Referred to APS
03/20/2026	Inspection Completed On-site
03/20/2026	Contact - Face to Face Interviews with employees
04/28/2026	Exit Conference with LD Rood

ALLEGATION:

Resident A was given the wrong medication, leading to hospitalization.

INVESTIGATION:

On 3/6/26, I received an incident report from Bay Human Services regional manager Rebecca Stivers explaining a medication error at the facility. Employee Jennifer DeForge accidently gave Resident A another resident's medication. The facility contacted Ms. Stivers and then contacted poison control. Resident A began experiencing sweating and dizziness and was taken to the hospital. Resident A was put under observation there until he came back to baseline functioning and was discharged.

On 3/20/26, I interviewed Ms. Stivers at the facility. After the error occurred, the facility contacted poison control and were told to observe Resident A and look for any indications that he was having a reaction to the medication. Resident A began to show side effects of the medication such as dizziness and sweating. The facility

contacted poison control a second time and were told to take Resident A to the hospital. Approximately 2 hours after hospital admission, Resident A seemed back to normal and was discharged.

On 3/20/26, I interviewed Ms. DeForge at the facility. During lunch Ms. DeForge took two different resident medications to the table where several residents were sitting. Resident A started coughing and choking on his food. Ms. DeForge had the medication crushed in applesauce in a spoon in her hand. Before she realized what happened, Resident A had leaned over and at the applesauce and medication out of the spoon.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Ms. DeForge admitted to accidentally administering the wrong medication to Resident A leading to his hospitalization for severe side-effects.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/28/26, I explained the findings of this report to licensee designee Melissa Rood. She told me she'd have the corrective action plan to me soon and thanked me.

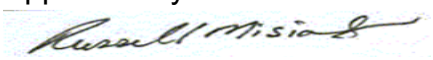
IV. RECOMMENDATION

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

4/25/26

Garrett Peters — Date
Licensing Consultant

Approved By:



4/29/26

Russell B. Misiak — Date
Area Manager