GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2022

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

RE: License #: AS730287264
Investigation #: 2022A0779045
Glenvale

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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730287264
Investigation #:	2022A0779045
Complaint Receipt Date:	07/13/2022
Investigation Initiation Date:	07/14/2022
Report Due Date:	09/11/2022
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:	James Pilot
Name of Facility:	Glenvale
Facility Address:	7026 Shattuck Saginaw, MI 48603
Facility Telephone #:	(989) 790-2322
Original Issuance Date:	03/01/2007
License **Status:**	REGULAR
Effective Date:	08/31/2021
Expiration Date:	08/30/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/18/22, staff member Teresa Hughes struck Resident A.	Yes

III. METHODOLOGY

07/13/2022	Special Investigation Intake 2022A0779045
07/13/2022	APS Referral Complaint was received from APS.
07/14/2022	Special Investigation Initiated - Telephone Spoke to APS worker, Jessire Ramos.
07/14/2022	Contact - Telephone call made Interview conducted with staff person, Miesha Little.
07/14/2022	Contact - Telephone call made Voicemail message left for staff person, Teresa Hughes.
07/18/2022	Contact - Telephone call made Voicemail message left for staff person, Teresa Hughes.
07/18/2022	Contact - Telephone call made Spoke to recipient rights investigator, Kentera Patterson.
07/18/2022	Contact - Telephone call made Interview conducted with staff person, Caroline Benjamin.
08/10/2022	Inspection Completed On-site
08/24/2022	Exit Conference Conducted with administrator, Tammy Unger.

ALLEGATION:

On 06/18/22, staff member Teresa Hughes struck Resident A.

INVESTIGATION:

On 7/14/22, a phone conversation took place with APS worker, Jessire Ramos, who confirmed that she investigated the same allegations. Ms. Ramos stated that staff person, Miesha Little, witnessed staff person, Teresa Hughes, back hand to hit Resident A across his chest. She stated that Resident A did not sustain any injuries. Ms. Ramos reported that she will be substantiating abuse.

On 7/14/22, a phone interview was conducted with staff person, Miesha Little, who confirmed that she worked on 6/18/22. She stated that she witnessed Ms. Hughes back hand Resident A across his chest. Ms. Little reported that she confronted Ms. Hughes and that Ms. Hughes admitted to her that she hit Resident A. She stated that she checked over Resident A and found him not to have any injuries. Ms. Little stated that no one else was present in the room to witness the incident.

Two attempts were made to contact staff person, Teresa Hughes. One on 7/14/22 and one on 7/18/22 and voicemail messages were left. Ms. Hughes has failed to return either message.

On 7/18/22, a phone conversation took place with recipient rights investigator, Kentera Patterson. She stated that they made multiple attempts to contact Ms. Hughes, but that Ms. Hughes had not been cooperative with their investigation and/or return any of their calls. Ms. Patterson reported that Ms. Little reported to them that she had witnessed Ms. Hughes hit Resident A. She stated that her office will be substantiating that abuse of Resident A did take place.

On 7/18/22, a phone interview was conducted with staff person, Caroline Benjamin, who confirmed that she worked with Ms. Hughes and Ms. Little on 6/18/22. Ms. Benjamin did not witness Ms. Hughes hit Resident A, but did hear Ms. Little confront Ms. Hughes about the incident. Ms. Benjamin stated that later during that shift, Ms. Hughes told her that she “popped” Resident A and that she did not mean to do it.

On 8/10/22, an on-site inspection was conducted and Resident A was viewed. He was viewed to be clean, well groomed and appeared to be doing well. Resident A’s AFC assessment plan was also viewed. The plan stated that Resident A is non-verbal and required full assistance from staff to complete all his activities of daily living.

During the on-site inspection, home manager, Tyrisha Martinez, was interviewed. She stated that Ms. Hughes had already put in her two weeks’ notice before this incident occurred and is no longer working at this home. Ms. Martinez reported that there were

no known issues with Ms. Hughes before this incident. She stated that she has tried to contact Ms. Hughes, but Ms. Hughes will not respond to her calls.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Staff person, Miesha Little, claims that she witnessed staff person, Teresa Hughes, back hand Resident A across his chest on 6/18/22. Staff person, Caroline Benjamin, stated that Ms. Hughes admitted to her that she "popped" Resident A. Ms. Hughes has not responded to several attempts to speak to her about this incident. There is sufficient evidence found to support the allegations that staff person, Teresa Hughes, struck Resident A on 6/18/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/24/22, an exit conference was conducted with administrator, Tammy Unger. She was informed that the result of this investigation warranted a licensing rule violation and that a corrective action plan to address the violation is required.

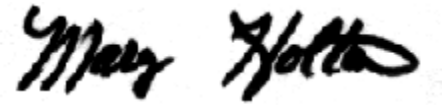
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's home remain unchanged.

8/24/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



08/24/2022

Mary E. Holton Date
Area Manager