GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2022

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

RE: License #: AS520281606
Investigation #: 2022A0873010
Lakeside

Dear Mr. Pilot:

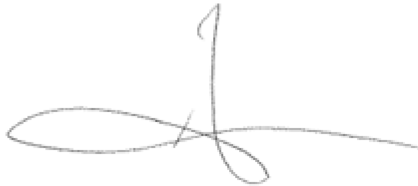
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(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 #:	2022A0873010
Complaint Receipt Date:	09/01/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	10/31/2022
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:	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:	11/27/2020
Expiration Date:	11/26/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 8/24/22, Resident A was sexually assaulted by Resident B.	Yes
On 9/2/22, staff Jamie Helmus physically assaulted Resident A.	No
Additional Findings	No

III. METHODOLOGY

09/01/2022	Special Investigation Intake 2022A0873010
09/02/2022	Contact - Telephone call made Called to set up date to come out to home on 9/6/22 at 1pm
09/02/2022	Special Investigation Initiated - Telephone
09/02/2022	APS Referral Received from APS
09/06/2022	Inspection Completed On-site
09/06/2022	Contact - Face to Face Spoke with Kaitlyn Koval, home manager
09/06/2022	Contact - Face to Face Spoke with Resident B
09/06/2022	Contact - Face to Face Spoke with Donald Eplett
09/06/2022	Contact - Document Received Received IPOS, assessment plan, resident care agreement for both Resident A and B as well as behavior plan for behavior plan for Resident B
09/07/2022	Inspection Completed On-site
09/07/2022	Contact - Face to Face Spoke to Kaitlyn Koval
09/07/2022	Contact - Face to Face Spoke to Kaylee Reader

09/07/2022	Contact - Face to Face Spoke to Jessica Hansen
09/07/2022	Contact - Face to Face Spoke to Jamie Helmus
10/19/2022	Contact - Telephone call made Spoke with Kaitlyn Koval
10/24/2022	Contact – Telephone call made Call to J. Pilot to discuss exit conference. Left voicemail.
10/24/2022	Contact – Telephone call made Spoke to Shelley Haagsma, case manager for Resident A
10/24/2022	Contact – Telephone call made Spoke to Barbara Susorney, guardian for Resident A
10/25/2022	Contact – Telephone call made Spoke to Ms. Koval about behavior plan for resident A
10/26/2022	Exit Conference With Tammy Unger, Administrator

ALLEGATION: On 8/24/22 Resident A was sexually assaulted by Resident B. On 9/2/22 staff Jamie Helmus physically assaulted Resident A.

INVESTIGATION: On 8/31/22 I received a referral from adult protective services worker Brett Blackburn. The referral included notes from his investigation at Lakeside that he had already completed. The notes included an allegation that on 8/24/22 Resident A and Resident B were seen leaving the garage together by staff members of the home. Resident A, mostly non-verbal, gestured to his penis and pointed at Resident B and gave the thumbs up. When asked by staff, Resident B admitted to touching Resident A’s penis. Resident B then apologized to Resident A. Later that day Resident A complained about having pain in his penis. The notes go on to explain that Resident B’s individual plan of service from Pathways CMH indicates that staff should monitor and supervise him during all waking hours for health and safety reasons. Resident B has been caught using the vacuum for sexual purposes. Neither resident currently have one-to-one staffing. APS referred the incident to the Forsyth police department but was told the prosecutor would likely not move forward with the case due to the individuals involved being cognitively impaired.

On Friday 9/2/22 I contacted the home to discuss the allegations. On Tuesday 9/6/22 I conducted on onsite inspection. I spoke with Kaitlyn Koval, home manager. Ms. Koval reported that she was not there at the time the incident occurred, however, she had spoken to Resident B about the incident. Ms. Koval reported that Resident B at first denied that anything happened but upon further questioning he admitted that he had touched Resident A's penis. Ms. Koval told Resident B that what he did was inappropriate. Resident B told Ms. Koval that it was Resident A that "started it." However, Ms. Koval told me that she did not think this incident was consensual because when she spoke to Resident A he was in obvious distress and reported to staff that his penis hurt. Staff inspected Resident A did not see any obvious injury. I was told that this is the first time Resident B has done something like this to another resident.

Also, on 9/2/22 I spoke with Resident B, staff member Kaylee Reader, and staff member Donald Eplett. Resident A is non-verbal, and I did not engage him in conversation. Staff brought me to Resident B's bedroom where he had been laying down. When I walked in Resident B immediately began showing me things in his room and engaging in conversation. However, when I brought up who I was and why I was there, Resident B shut down. I asked him about the allegations against him and how he felt about Resident A, but he denied the incident occurred and no longer would talk to me. Afterwards I spoke briefly with Ms. Reader and Mr. Eplett. Ms. Reader told me that the day of the incident Resident A was distressed about what had happened and believes Resident B touched Resident A inappropriately. Mr. Eplett told me that Resident B likes to get into Resident A's space and believes that Resident A wouldn't make something like this up. Mr. Eplett also believes Resident A was inappropriately touched by Resident B.

I reviewed two incident reports which state that Mr. Eplett and Ms. Reader were in the med room doing the med count. When both staff exited the room, they saw Resident A and another resident exit the garage area. Staff asked what they were doing and were told they weren't doing anything. Resident A then sat at the table and told staff what happened. Because Resident A is mostly non-verbal, they asked him to illustrate what they were doing. Resident A grabbed his penis and pointed at Resident B. Staff then called the home manager to make her aware of the incident and wrote the incident report. Ms. Koval spoke to Resident B about the incident, and he admitted to touching Resident A and apologized. Staff spoke to Rocco Nocera, behavioral analyst, and nurse Monica Wolf about what happened. Mr. Nocera will attempt to get Resident B into a program called The Circles which teaches boundaries and how to abide by them.

I reviewed Resident B's assessment plan and his behavior plan created at Pathways CMH. The assessment plan indicates that Resident B's aggressive and sexual behavior are addressed in his behavior plan. Resident B's behavior plan is dated 8/27/21. Resident B's behavior plan was developed to decrease the extent to which he engages in behavior that places himself or others at imminent risk for harm, while increasing the extent to which he engages in adaptive behaviors. The rationale for

this plan is to, in part, decrease aggression and inappropriate sexual behaviors. The behavior plan promotes the use of personal sex toys, to be provided by Resident B's guardian, to reduce inappropriate sexual behaviors. The report states that Resident B's current masturbatory style poses risk of illness and injury. It also poses predation risks when involving others. These should be minimized by giving him specific objects that may be used, alone, and cleaned regularly to prevent illness risks and injuries. The report also recognizes the potential risk to other vulnerable residents and recommends that Resident B not be allowed to be behind closed doors with other residents and that staff should monitor him while in the home.

On 10/24/22, I interviewed Shelley Haagsma, Resident A's case manager. I discussed the incident with Ms. Haagsma, and it was her opinion that there is no lingering fear or anxiety with Resident A about what occurred. She reported to me that Resident A recently went to UM hospital in Ann Arbor for surgery and was there for several weeks. Ms. Haagsma and Resident A have talked about the even and she reported to me that Resident A still considers Resident B his friend and is happy to be living with him.

On 10/24/22, I interviewed Resident A's guardian, Ms. Susorney, who reported to me that she is a court-appointed guardian and has only been guardian for him for a short time. Ms. Susorney reported to me that she has not yet met Resident A in person and has not yet had any conversations with him.

On 10/25/22, I interviewed Ms. Koval about Resident A's assessment plan as well as his behavior plan. Ms. Koval reported to me that Resident A does not have a behavior plan but that she believes Pathways CMH is currently in the process of developing one. Resident A's assessment plan indicates he has significant needs regarding his activities of daily living, that he communicates through hand gestures and sounds, that he is able to control his sexual behaviors, and that he enjoys living at the home and being around his other roommates and staff.

On 10/26/22, I conducted an exit conference with Tammy Unger, administrator. We discussed the two allegations and I explained for one of them I found a rule violation. She understood and reported to me that they had already discussed putting locks on doors in the home and the garage, where the incident occurred, with Pathways CMH. She is waiting for CMH to get back to her about this. She is aware a corrective action plan will need to be implemented for the substantiated violation.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Resident A and Resident B were alone and unsupervised when Resident B sexually assaulted Resident A. Resident B’s assessment plan and his Pathways CMH behavior plan recognize Resident B’s potential to engage in inappropriate and predatory sexual behaviors and recommends Resident B be monitored and not allowed to be alone, behind closed doors, with other residents.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: On 9/2/22 staff Jamie Helmus physically assaulted Resident A.

INVESTIGATION: On 9/6/22 I received an incident report detailing allegations of a staff member, Jamie Helmus, physically assaulting Resident A. The report explains that on 9/2/22, Kaitlyn Koval, home manager, got back to the home from a ride with two of the home’s residents. When she returned, Mr. Helmus was visibly frustrated with Resident A and reported that Resident A had behavioral issues while Ms. Koval was gone. Ms. Koval sat with Resident A to discuss these behaviors and noticed that he seemed fine at that point. Ms. Koval went to her office. Short afterward, Ms. Koval heard a loud bang and ran upstairs to see what had caused it. She observed Resident A sitting on the floor in the doorway of the laundry room while Mr. Helmus was in front of the cleaning closet attempting to grab cleaning supplies. Mr. Helmus told her that Resident A was trying to grab cleaning supplies and when prompted to stop, he continued and tried to punch Mr. Helmus. While trying to avoid the punch, Mr. Helmus slipped on some water on the ground and fell, which caused the banging sound. Mr. Helmus then went to the bathroom to clean, and Ms. Koval asked Resident A what happened. Resident A started to cry intensely and pointed aggressively down the hallway toward Mr. Helmus and gripped his own arm. Resident A proceeded to perform that motion multiple times and communicated that Mr. Helmus grabbed the front of his shirt around the collar and that he was pulled by Mr. Helmus. Ms. Koval called Jessica Lindgren, the regional manager, to go over the incident and ask what she should do. Ms. Lindgren contacted adult foster care licensing and Ms. Koval contacted recipient rights. Mr. Helmus then had his employment with the home suspended until further notice. No physical injuries were observed on Resident A.

On 9/7/22 I conducted on onsite inspection with Faye Witte from the office of recipient rights. Already at the home was Ms. Lindgren, regional manager for Bay Human Services. While there I was able to conduct face to face interviews with Ms. Koval, Kaylee Reader, staff, Jessica Hansen, assistant manager, Mr. Helmus, and Resident A.

Ms. Koval confirmed what she had written in the incident report. She reported that Resident A grabbed his own arm and shirt to indicate how Mr. Helmus had

physically interacted with him. Ms. Koval reported that the night of the incident she had noticed a status update from Mr. Helmus on Facebook stating that he was going to be looking for a new job. Ms. Koval reported that Mr. Helmus had been employed at the home for about a year and had heard from other staff that Mr. Helmus had mentioned to them that he can be quick to anger and become easily frustrated and that maybe this job was not the best fit for him. Ms. Koval reported that at least one other resident has told her that they don't like it when Mr. Helmus is working at the home.

On 9/7/22, I interviewed Ms. Reader. She reported to me that she was working the date of the incident but did not observe anything. She was not at the house the time of the incident and when she got back Mr. Helmus had reported to her that Resident A's behavior changed. Ms. Reader believes Resident A to be trustworthy and has heard from others that Mr. Helmus has had recipient rights called on him while working at a previous job. Ms. Reader believes Mr. Helmus intentionally provokes behaviors from residents.

On 9/7/22, I interviewed Ms. Hansen who has been working at the home for about a year and a half. Ms. Hansen reported that when she came into work that day Resident A was "shaken up." When asked why, Resident A communicated to Ms. Hansen that Mr. Helmus had gotten physical with him and pulled on his arm and shirt. Ms. Hansen reported that she has seen Resident A cry twice in her time there, both times were about Mr. Helmus. She also reported that Resident A has not wanted Mr. Helmus around since the incident.

On 9/7/22, I interviewed Mr. Helmus. He reported that he has been working in group homes for 14-15 months and that he likes the work because it gives him a sense of purpose. He said that he was surprised the day that he was told he was suspended and did not understand why it was happening. Mr. Helmus reported that the day of the incident Resident A's behaviors escalated and that he threw food across the kitchen and kept taking food out of the refrigerator. Resident A then went into the laundry room and Mr. Helmus tried to redirect him but Resident A started pulling laundry out of the washer/dryer. Mr. Helmus reported Resident A wouldn't let him out of the laundry room at that point and so he put an arm on his back to get out. Resident A then swung at him, Mr. Helmus, pushed him and then fell on the ground. Mr. Helmus denied he was physical with Resident A and was only trying to protect the resident and himself. Mr. Helmus reported he can become frustrated at residents but never acts out on it.

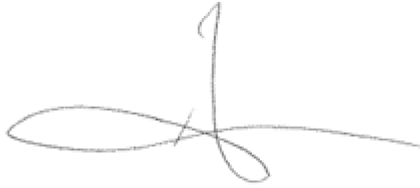
On 9/7/22, I attempted to interview Resident A. He is nonverbal but when asked about different staff members in the house, all his reactions were positive. When Mr. Helmus name was mentioned, Resident A did not react positively and, instead, shook his head. The other resident there at the time was also cognitively impaired and responded when I said "hello," but I did not interview him.

On 10/19/22, I interviewed Ms. Koval to get an update. Mr. Helmus is no longer employed at the home after having been let go.
On 10/26/22, I conducted an exit conference with Tammy Unger, administrator. We discussed the two allegations and I explained for one of them I found a rule violation. She understood and reported to me that they had already discussed putting locks on doors in the home and the garage, where the incident occurred, with Pathways CMH. She is waiting for CMH to get back to her about this. She is aware a corrective action plan will need to be implemented for the substantiated violation.

APPLICABLE RULE	
R 400.14309	**Crisis Intervention.**
	(2) Crisis intervention may be used only for the following reasons: **(a) To provide for self-defense or the defense of others.** **(b) To prevent a resident from harming himself or herself.**
ANALYSIS:	Some type of physical altercation occurred between Mr. Helmus and Resident A. Immediately after it happened, Ms. Koval contacted the regional manager, Ms. Lindgren, and together they contacted recipient rights, licensing, and suspended Mr. Helmus. Mr. Helmus denied being physically inappropriate with Resident A. There is not substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



10/26/2022

Garrett Peters Date
Licensing Consultant

Approved By:

10/26/2022

Mary E. Holton Date
Area Manager