GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

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

RE: License #:	AS060068988
Investigation #:	2023A0123009
	Almont AFC

Dear Mr. Pilot:

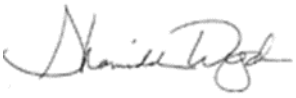
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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

I. IDENTIFYING INFORMATION

License #:	AS060068988
Investigation #:	2023A0123009
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	01/08/2023
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:	Almont AFC
Facility Address:	140 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9648
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
While staff Joe Krystyniak was driving Resident A in the home's wheelchair van, Resident A's wheelchair became unsecured and when they accelerated, Resident A's wheelchair went backward causing Resident A to hit her head on the back of the van. Resident A complained of pain at the time of the incident, and Staff Krystyniak stated he may not have had tighten/secured the straps properly.	Yes

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A0123009
11/10/2022	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
11/15/2022	Contact - Telephone call made I made a call to Resident A's public guardian. I left a voicemail requesting a return call.
11/15/2022	Contact - Telephone call made I interviewed staff Joe Krystyniak via phone.
11/15/2022	Contact - Telephone call received I received a call from Resident A's public guardian.
11/15/2022	APS Referral APS referral made.
11/15/2022	Exit Conference I spoke with administrator Tammy Unger via phone.
11/16/2022	Contact- Document Received I received a copy of Resident A’s updated assessment plan.

ALLEGATION: While staff Joe Krystyniak was driving Resident A in the home's wheelchair van, Resident A's wheelchair became unsecured and when they accelerated, Resident A's wheelchair went backward causing Resident A to hit her head on the back of the van. Resident A complained of pain at the time of the incident, and Staff Krystyniak stated he may not have had tighten/secured the straps properly.

INVESTIGATION: On 11/10/2022, I conducted an unannounced on-site visit at the facility. I spoke with home manager Tabitha Johnson. She stated that staff Joe Krystyniak was with Resident A in the van during an outing when the alleged incident occurred. I requested and received copies of the following documentation from Staff Johnson:

An *AFC Licensing Division- Incident/Accident Report* dated 11/08/2022 states that staff was going down the road, the front straps let loose, and Resident A bumped her head. The action taken by staff was that they did vitals for 30 minutes, up to six hours, and the corrective measures were noted to be to "*check straps and make sure they are hooked up good (looked over the van to make sure all straps were functioning correctly, spoke with [Resident A] and looked her over for any bruises*."

A copy of Resident A's *Head Injury Assessment Record* dated for 11/08/2022 was obtained. The documentation reflects that staff documented Resident A's vital signs, level of consciousness, pupils, behavior, ability to move, and other signs for six hours. There was no notation of any bruising on this documentation.

A copy of Resident A's Health Care Appraisal was obtained. It notes that Resident A uses a wheelchair. It is dated 09/29/2022, and is signed by Jessica Maubray, PAC. A copy of Resident A's physician authorization for her wheelchair was obtained. It is dated for 01/12/2021, as well as an order for her to use a wheelchair seat belt (as needed) which is dated for 02/09/2021.

A copy of Resident A's *Assessment Plan for AFC Residents* dated for 10/05/2021 states that she "*utilizes a wheelchair for all outings with assistance from staff in community*" under *Moves Independently in Community*. It also lists wheelchair use under *Use of Assistive Devices*.

On 11/16/2022, I received an updated copy of Resident A's *Assessment Plan for AFC Residents* dated for 10/03/2022 for which states the same information as the previous assessment plan regarding her wheelchair use.

On 11/10/2022, during this on-site I interviewed Resident A. Resident A stated that she went backwards in the van and hit the back of her head and ear. She stated that she did not have receive medical treatment. She stated that she was not bleeding and denied having a headache. She stated that this was the first time anything like this has happened, and that she was buckled up. She stated that the wheels were strapped, and Staff Krystyniak was driving at the time of the incident.

On 11/11/2022, I received an *AFC Licensing Division- Incident/Accident Report* dated for 11/11/2022 stating that Staff Johnson "*noticed some bruising behind [Resident A's] ear, pulled her hair back to see a large bruise that goes from behind [Resident A's] right ear, towards the middle of the back of her head, and down to her neck*." A skin audit was conducted by Staff Johnson in the bathroom to check for any additional bruising. The corrective measures states that the nurse was contacted and instructed staff to give Tylenol as needed for pain and use a warm compress.

On 11/15/2022, I interviewed staff Joe Krystyniak via phone. He stated that he and Resident A were on an outing and had stopped at a couple of stores. During the trip, Resident A fell backwards. He stated that he is not sure if the wheelchair was strapped securely at the front wheels, and wonders if the straps bounced off somehow. He stated that he remembers strapping all four straps, as there are two in the front, and two in the back. He stated that he also told Resident A to put her brakes on. He stated that Resident A puts her brakes on all of the time. He stated that this is the first time an incident like this had occurred. Staff Krystyniak stated that Resident A said her head hurt at the time. He stated that he immediately notified management and the nurse and was instructed to bring Resident A back to the facility. He stated that he was willing to take her to the ER if needed. He stated that he felt no bumps on her head, and saw no bruising, and a head injury assessment was conducted for Resident A. He stated that a mark was found behind her ear, but he did not observe it himself. He stated that the straps came off the wheelchair wheels, he feels bad, and it is his fault.

On 11/15/2022, I spoke with Resident A's public guardian, Guardian 1 via phone. She stated that she has no concerns regarding Resident A's care. She stated that she did not get an incident report and does not believe she received a call regarding the allegations.

On 11/15/2022, I spoke with administrator Tammy Unger regarding the 11/11/2022 *AFC Licensing Division Incident/Accident Report* and the bruising that was documented. On 11/16/2022, in a follow-up email, Ms. Unger stated that the home manager believes the bruising is from the incident that occurred in the van on 11/08/2022.

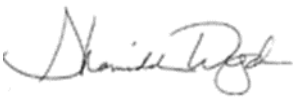
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	An incident report dated 11/08/2022 details an incident where the straps on Resident A's wheelchair came loose and caused her to hit her head in the van.

	Resident A reported that she went backwards in the van and hit the back of her head and her ear. An incident reported dated for 11/11/2022 states that home manager Tabbitha Johnson noted large bruising on Resident A's head and near her ear. Staff Krystyniak stated that Resident A did fall backwards in the van, and he is not sure if the wheelchair was strapped securely at the front wheels, but he remembered strapping all four wheels. Guardian 1 denied having any concerns. There is a preponderance of evidence to substantiate a rule violation in regard to resident safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/15/2022, I conducted an exit conference with administrator and designated person Tammy Unger. I informed her of the findings and conclusion.

IV. RECOMMENDATION

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



11/17/2022

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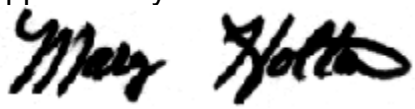
Shamidah Wyden Date
Licensing Consultant

Approved By:



11/17/2022

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Mary E. Holton Date
Area Manager