GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2023

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

RE: License #:	AS090084054
Investigation #:	2023A0123042
	Brookwood CLF

Dear Mr. Pilot:

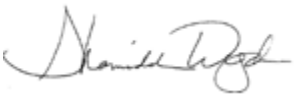
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090084054
Investigation #:	2023A0123042
Complaint Receipt Date:	05/09/2023
Investigation Initiation Date:	05/09/2023
Report Due Date:	07/08/2023
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:	Brookwood CLF
Facility Address:	909 Murphy St. Bay City, MI 48706
Facility Telephone #:	(989) 686-1999
Original Issuance Date:	12/01/1998
License Status:	REGULAR
Effective Date:	05/17/2022
Expiration Date:	05/16/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/02/23, staff Linda Reid was assigned to Resident A. When Resident A demanded to leave her bed, Staff Reid used an ARJO lift to place Resident A on a comforter that was on the floor. Resident A remained in this position from 4:30 pm until 9:00 pm. On 05/03/23, bruises were discovered on Resident A's knees. It is believed these bruises came from the 05/02/23 incident. Staff Reid has additionally been very mean to Resident A and made statements to her such as "you shouldn't be here".	Yes
Additional Findings	Yes

III. METHODOLOGY

05/09/2023	Special Investigation Intake 2023A0123042
05/09/2023	APS Referral Information received regarding APS referral.
05/09/2023	Special Investigation Initiated - Telephone I spoke with adult protective services worker John Jones.
05/10/2023	Contact - Telephone call received I received a call from Guardian 1.
05/10/2023	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
05/18/2023	Contact - Document Received Requested documentation received via email.
06/02/2023	Contact - Telephone call made I attempted to contact staff Linda Reid. Her phone was not in service.
06/02/2023	Contact - Telephone call made I spoke with Melissa Prusi of recipient rights.
06/02/2023	Contact - Telephone call made I interviewed staff Shayla Niernberg via phone.
06/08/2023	Contact - Telephone call made

	I made a second attempt to contact staff Linda Reid. Her phone was not in service.
06/09/2023	Inspection Completed On-site I conducted a follow-up on-site to interview Resident B.
06/14/2023	Exit Conference I spoke with administrator Tammy Unger via phone.

ALLEGATION: On 05/02/23, staff Linda Reid was assigned to Resident A. When Resident A demanded to leave her bed, Staff Reid used an ARJO lift to place Resident A on a comforter that was on the floor. Resident A remained in this position from 4:30 pm until 9:00 pm. On 05/03/23, bruises were discovered on Resident A's knees. It is believed these bruises came from the 05/02/23 incident. Staff Reid has additionally been very mean to Resident A and made statements to her such as "you shouldn't be here".

INVESTIGATION: On 05/08/2023, I receive a copy of an *AFC Licensing Division-Incident/Accident* Report via email dated for 05/02/2023 stating that a second shift staff person (Shayla Niernberg) witnessed Resident A ask staff Linda Reid a couple of times if she could get up, and Staff Reid told Resident A no. The incident report further states that Staff Reid put Resident A on the floor using an ARJO lift onto a blanket, instead of her wheelchair. Resident A was not wearing any pants, and Resident A ripped her brief off. Resident A laid on the floor with only a shirt until 9:00 pm on a blanket and a pillow, with no covers.

On 05/09/2023, I spoke with adult protective services investigator John Jones. He stated that Resident A lacks capacity, cannot be interviewed. Resident A uses an ARJO lift. Staff Linda Reid transferred Resident A to the floor instead of to her wheelchair. Resident A got small bruises from moving around on the floor. Staff Reid is currently suspended. Resident A has a public guardian. Resident A has dementia and has a history of yelling and being argumentative.

On 05/10/2023, I received a phone call from Resident A's public guardian. I asked Guardian 1 if she had any concerns regarding Resident A's care. Guardian 1 stated that she spoke with adult protective services yesterday and received an incident report about the incident today via email. She stated that prior to this there were no issues of concern. She stated that she is not aware of whether Resident A bruises easily.

On 05/10/2023, I conducted an unannounced on-site visit at the facility. I interviewed staff Kaylee Crowl. She stated that Resident A is currently recovering from pneumonia. She stated she heard that Resident A did not eat dinner (which is served between 5:00 pm and 6:00 pm) the day of the incident because of staff Linda Reid. She stated that Staff Reid is currently off the schedule. She denied having any knowledge of any previous mistreatment and did not see the bruises on Resident A

knees. She stated that she worked first shift on the day of the incident. Staff Crowl stated that Resident A has dementia and does yell. She stated that Resident A will let you know when she wants to get up though. She stated that Resident A's verbal communication is limited.

During this on-site I obtained a copy of Resident A's *Assessment Plan for AFC Residents* completed in December 2022. The assessment plan notes that Resident A needs full assistance with all of her personal care, and that she uses a wheelchair for mobility, and an ARJO lift. Her *Health Care Appraisal* also notes that she uses a wheelchair. Physician authorizations were also obtained for both her wheelchair and ARJO lift.

On 05/10/2023, I made face to face contact with Resident A. She was observed at the dining room table sitting in a wheelchair. She appeared hard of hearing, and per Staff Crowl, Resident A was recovering from pneumonia. Resident A was not interviewed due to limited verbal communication skills. During this on-site, all six residents were seen to be clean and appropriately dressed.

On 06/02/2023, and 06/08/2023, I made attempted phone calls to staff Linda Reid. Her phone appeared to be out of service.

On 06/02/2023, I spoke with recipient rights investigator Melissa Prusi via phone. She stated that she interviewed Resident A and Resident B, who is Resident A's roommate. She stated that Resident A did not really want to speak about the incident, speaking about 30 seconds to a minute and then became upset. Ms. Prusi stated that Resident B is very capable of saying what happened. She stated that staff Shayla Niernberg worked that day as well, and had observed Resident A on the floor, and reported the incident the next day. Staff Niernberg reported that Staff Reid was talking rudely to Resident A.

On 06/02/2023, I made a call to staff Shayla Niernberg. She stated that she worked second shift on 05/02/2023. It was a normal shift, and she was doing outings that day. She stated that Resident A was in bed at the start of the shift screaming to get up. Staff Reid told Resident A no. Staff Reid took the ARJO Lift and put Resident A on the floor with a comforter and a pillow, and Resident A was left there for hours until bedtime. It was around 4:0 pm to 4:30 pm, before dinner when Resident A was put on the floor. Staff Niernberg stated that she had been in and out doing outings but had walked past Resident A's room and saw her on the floor. She stated that Resident A had bruising on both of her knees that covered both kneecaps. She stated that she is not sure if Resident A ate dinner that day. She stated that she does not think Staff Reid did anything for Resident A that day. She stated that prior to this incident, Staff Reid would say verbal remarks toward Resident A. She stated that she thinks Staff Reid snapped, and that on the day of the incident, Staff Reid was mumbling remarks that Resident A could hear. She stated that Staff Reid said that Resident A "*shouldn't be here*" and needs to be in another home, among other comments. Staff Nirenberg stated that Resident A was yelling all day that day, and

things got progressively worse. She stated that Resident A was laying on the floor naked, because she had ripped her brief off due to being angry. She stated that Resident A also had pneumonia at that time.

On 06/09/2023, I conducted a follow-up on-site at the facility to interview Resident B, Resident A's roommate. Resident B stated that she saw staff Linda Reid put Resident A on the floor. Resident A did not have on a brief and was half naked and exposed. Resident B stated that she did not think this was right. Resident A also had pneumonia at the time. Resident B stated that Resident A had asked for dinner. Staff Reid refused to let Resident A eat. Resident B stated that she felt bad for Resident A and wanted to feed Resident A herself and get her up from the floor. Resident B stated that Resident A does not remember much. She stated that she thinks Resident A wanted to sit in her recliner chair, but Staff Reid put Resident A on the floor instead. She stated that Staff Reid is always mean to Resident A and would call Resident A hateful names like "*stupid*" and "*retarded*." Resident B stated that Resident A was on the floor until about midnight, and ended up with bruises on her knees because Resident A was trying to get up, but Staff Reid would not let her.

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:	Guardian 1 reported that she was informed of the incident via an incident report. She denied having any concerns prior to this incident. Staff Shayla Niernberg reported that Staff Reid left Resident A on the floor with a comforter and pillow, refused to get Resident A up from the floor, and that Resident A ended up with bruising on her knees. Staff Nirenberg also reported that Staff Reid made mean statements toward Resident A. Resident B was interviewed and reported witnessing Staff Reid put Resident A on the floor, and made mean statements towards Resident A. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

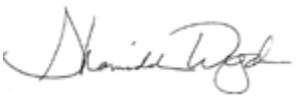
INVESTIGATION: On 05/10/2023, I conducted an unannounced on-site visit at the facility. I requested a copy of Resident A's *Assessment Plan for AFC Residents*. The assessment plan did not have her bath seat, gait belt, hospital bed noted in the assessment plan. Copies of the physician authorizations were obtained on at this on-site for each of the assistive devices.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	On 05/10/2023, I obtained a copy of Resident A's assessment plan. Her bath seat, gait belt, and hospital bed were not specified in her assessment plan. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/14/2023, I conducted an exit conference with administrator and designated person Tammy Unger via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

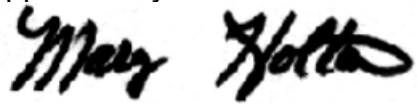
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



06/14/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



06/16/2023

Mary E. Holton Date
Area Manager