GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 12, 2023

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

RE: License #:	AS060068988
Investigation #:	2024A0123009
	Almont AFC

Dear James Pilot:

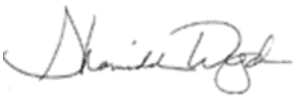
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2024A0123009
Complaint Receipt Date:	11/14/2023
Investigation Initiation Date:	11/15/2023
Report Due Date:	01/13/2024
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:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 10/01/2023, Staff Calandra Scott left staff Ashley Daugherty during a 12-hour shift alone. Residents in the home were left alone with one staff on shift until about 6:30-7:00 am.	Yes

III. METHODOLOGY

11/14/2023	Special Investigation Intake 2024A0123009
11/15/2023	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Melissa Prusi via phone.
11/30/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
12/05/2023	APS Referral APS referral completed.
12/05/2023	Contact - Telephone call made I made an attempted call to staff Calandra Scott. There was no answer, and the voicemail box was full.
12/11/2023	Contact- Telephone call made I made a second attempt to contact staff Calandra Scott. There was no answer.
12/11/2023	Exit Conference I conducted an exit conference with administrator/designated person Tammy Unger via phone.
12/12/2023	Contact- Document Received Requested documentation received via email.

ALLEGATION: On 10/01/2023, Staff Calandra Scott left staff Ashley Daugherty during a 12-hour shift alone. Residents in the home were left alone with one staff on shift until about 6:30-7:00 am.

INVESTIGATION: On 11/15/2023, I spoke with recipient rights investigator Melissa Prusi via phone. She stated that there are at least three residents in the home that require the use of wheelchairs. Two require an ARJO lift and total care. Staff Calandra Scott leaving her shift was considered neglect. Melissa Prusi stated that she interviewed Staff Scott who admitted she left Staff Daugherty alone for six and a half hours. Staff Scott was suspended and did not show up for her next shift. An

incident report was written by the home manager. Five of the residents are either totally dependent or mostly dependent. Staff Scott messaged home manager Tabitha Johnson via Facebook to let her know she was leaving. Staff Scott left the facility that night at around 12:00 am. Staff Daugherty was alone on shift until 6:00 am.

On 11/30/2023, I conducted an unannounced on-site at the facility. I interviewed staff Ashley Daugherty. She stated that on 10/01/2023, she was working with staff Calandra Scott. It was 11:57 pm when Staff Scott left the premises. The 12-hour shift started at 8:00 pm. She stated that prior to this, she and Staff Scott were joking around. Staff Scott then said she was going home and was serious about it. She stated that Staff Scott sent home manager Tabitha Johnson a text message saying, "*I'm dipping*." Staff Daugherty stated that Staff Scott said to her "*may God be with you*" before the door slammed. She stated that Staff Scott told her she was experiences some issues and "*couldn't handle it*." Staff Daugherty stated that five minutes later, she called Staff Johnson. Staff Johnson told Staff Daugherty she would come in to fill in, but Staff Daugherty told Staff Johnson she could handle it. Staff Daugherty stated that the residents were in bed asleep. She denied that any residents require a two-person assist. Two residents regularly require an ARJO lift, and a third on occasion when having issues transferring. She stated that she did not really have a lot of work to do that night. She stated that Staff Scott did not wait for Staff Johnson to respond to her message. She stated that she has never experienced a co-worker walking off the job.

On 11/30/2023, I interviewed staff Tabitha Johnson at the facility. Staff Johnson stated that there were five residents home at the time of the incident. Resident F was on a LOA (leave of absence) that night. Three residents require the use of an ARJO lift. One resident is on hospice. Staff Scott sent Staff Johnson a text message at 11:49 pm. Staff Johnson stated that she responded to the message at 12:13 am, informing Staff Scott that she was sleeping and that she wishes Staff Scott would have called her instead. She stated that she has not heard from Staff Scott since. Staff Johnson stated that when the facility has five or less residents, there have been times where there is only one staff on shift, when there is not much going on. In those instances, they would have someone on standby for any emergencies.

During this on-site, I observed Resident A, Resident, B, Resident C, Resident D, Resident E, and Resident F during this on-site. They were all in the living room and dining room area of the home. They all appeared clean and appropriately dressed.

During this on-site, I obtained an *AFC Licensing Division- Incident/Accident Report* dated for 10/01/2023 at 11:58 am. It states "*During her 12 hour shift 8pm-8 am, Calandra told Ashley she couldn't do this. Told her it was fun and good luck and left. Ashley contacted HM. IR completed due to abandonment*."

During this on-site, I obtained requested documentation for Resident A, Resident B, Resident C, Resident D, and Resident E as they were present in the facility on the night of 10/01/2023.

Assessment Plans for AFC Residents and *Bay Arenac Behavioral Health Plan of Services (IPOS)* were reviewed.

Resident A's assessment plan dated on 07/26/2023 notes that Resident A is non-verbal and utilizes a wheelchair at all times. Resident A also uses an ARJO lift for transfers. Resident A requires total assistance with personal care. Resident A's IPOS notes that Resident A diagnosed with multiple chronic health conditions and is fully dependent on staff for all ADL's (*activities of daily living*) and is unable to respond in emergency situations or fire drills without staff assistance.

Resident B's assessment plan dated 10/03/2023 notes that Resident B uses a wheelchair. Resident B can stand and transfer with staff assistance. Resident B requires assistance with all personal care activities. Resident A's plan of service on page 1 of 10 states *"[Resident B] is much slower in her wheelchair than she has been, historically. She is also more difficult to transfer, often requiring two-people and/or the ARJO lift that is prescribed to her."* On page two it states, "*Almont home practices doing fire drills, and [Resident B] knows how to get to the door and get away from the house in the event of a fire; however, if [Resident B] is laying in bed, home staff would have to get her out of bed and out of the home.*"

Resident C's assessment plan dated 03/23/2023 notes that Resident C can move independently in the community, does not require assistance with walking/mobility, and uses a walker. Resident C's assessment plan indicates the needs for only some verbal reminders for personal care.

Resident D's assessment plan dated 06/23/2023 notes that Resident D can move independently in the community, but for walking/mobility needs staff to hold her hand due to an unsteady gait after standing for too long. Resident D's IPOS indicates that she can utilize public transportation. Resident D requires some assistance with all areas of personal care.

Resident E's assessment plan dated 10/20/2023, notes that Resident E requires full assistance for all personal care. Resident E requires the use of an ARJO lift and wheelchair. Resident E's IPOS dated 02/22/2023 indicates that Resident E has very limited range of motion.

A copy of staff Calandra Scott's *Employee Corrective Action* dated 10/02/2023 notes that Staff Scott received a written warning. It states "*On 10/01/2023, Calandra walker out on her shift without calling manager or assistant manager*." The document is signed by home manager Tabitha Johnson.

On 12/11/2023, and 12/05/2023, I made two attempted/ unsuccessful calls to contact staff Calandra Scott via phone.

On 12/12/2023, I obtained copies of the facility's staff schedules from 09/25/2023 through 12/03/2023. It indicates that there are two caregivers scheduled each shift.

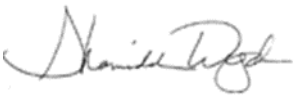
APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 11/15/2023, I spoke with recipient rights investigator Melissa Prusi. She stated that she interviewed staff Calandra Scott who confirmed she abandoned her shift on 10/01/2023, and left Staff Daughtery on shift alone for about six hours. Staff Ashley Daughtery confirmed Staff Scott abandoned her shift and left Staff Daughtery on shift alone. Staff Daughtery informed home manager Tabitha Johnson via phone of Staff Scott leaving work, but informed Staff Johnson she could handle the shift alone. Staff Johnson reported that Staff Scott sent her a text message that she was leaving her shift. She confirmed that there were five residents in the facility the night Staff Scott abandoned her shift. Assessment plans and individual plans of services were reviewed for Resident A, Resident B, Resident C, Resident D, and Resident E. Resident A, Resident B, and Resident E all require full staff assistance with personal care. Resident A, and Resident E require the use of an ARJO lift. Resident B's plan of service indicated that at times, Resident B may require the use of an ARJO lift and/or a two-person assist. On 12/05/2023 and 12/11/2023, I made two unsuccessful attempts to contact staff Calandra Scott by phone. There is a preponderance of evidence to substantiate a rule violation in regard to insufficient staffing on the night of 10/01/2023, and morning of 10/02/2023 due to the documented personal care needs of the residents in the home,

	and staff Calandra Scott abandoning her shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/11/2023, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusion.

IV. RECOMMENDATION

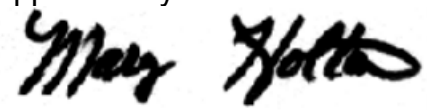
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6.)



12/12/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



12/12/2023

Mary E. Holton Date
Area Manager