GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2024

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

RE: License #:	AS090084054
Investigation #:	2024A0872030
	Brookwood CLF

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.
- 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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090084054
Investigation #:	2024A0872030
Complaint Receipt Date:	04/02/2024
Investigation Initiation Date:	04/03/2024
Report Due Date:	06/01/2024
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:	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 3/18/24, the facility would not allow Resident A to return after spending the weekend with her guardian. The home sent a certified discharge letter to Resident A on 03/15/24. Resident A was not given a proper discharge notice.	Yes

III. METHODOLOGY

04/02/2024	Special Investigation Intake 2024A0872030
04/02/2024	APS Referral This complaint was referred by APS. Sarah Labarge is the APS worker
04/03/2024	Contact - Telephone call made I spoke to APS Worker, Sarah Labarge about this complaint
04/03/2024	Contact - Document Received I received documents from APS Labarge
04/03/2024	Special Investigation Initiated - Telephone
04/04/2024	Inspection Completed On-site Unannounced
04/05/2024	Contact - Document Sent I emailed the administrator and the home manager requesting information related to this complaint
04/14/2024	Contact - Document Received AFC documentation received
05/03/2024	Contact - Telephone call made I interviewed Guardian A1
05/03/2024	Exit Conference I conducted an exit conference with the licensee designee, James Pilot
05/03/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 3/18/24, the facility would not allow Resident A to return after spending the weekend with her guardian. The home sent a certified discharge letter to Resident A on 03/15/24. Resident A was not given a proper discharge notice.

INVESTIGATION: On 04/03/24, I spoke to Adult Protective Services (APS) Worker, Sarah LaBarge via telephone. According to APS LaBarge, Resident A was admitted to Brookwood CLF AFC home in February 2024. On 03/14/24, Guardian A1 took Resident A to an appointment and then decided to take Resident A home with her for the weekend. Guardian A1 made arrangements with the facility and let them know that she would be bringing Resident A back to the facility on 03/18/24. On 03/29/24, APS LaBarge spoke to Guardian A1 who stated that when she went to return Resident A to Brookwood CLF AFC, she was told that Resident A could not return. Guardian A1 told APS LaBarge that the facility issued Resident A a 3-day notice of eviction from the facility. Currently, Resident A is staying with Guardian A1 until a new placement can be found.

On 04/04/24, I conducted an unannounced onsite inspection of Brookwood CLF AFC. I interviewed the home manager (HM), Karie Duff and observed two residents who appeared to be clean, dressed appropriately, and were being appropriately supervised by staff. HM Duff confirmed that Resident A resided at this facility until 03/18/24. According to HM Duff, Resident A was admitted to this facility on 02/21/24. While a resident of the facility, Guardian A1 was uncooperative with staff and medical appointments for Resident A. Therefore, management provided Resident A with a 3-day discharge notice. HM Duff said the notice was issued to Resident A and Guardian A1 on 03/14/24 and Guardian A1 did not try to bring Resident A back to the AFC home after receiving the notice.

On 04/08/24, I received AFC paperwork related to this complaint from the administrator (AD), Tammy Unger. In the email, AD Unger stated that their residential director, Tabatha Barnes was asked to give a 3-day notice to Resident A by Bay Arenac Behavioral Health because they were going to be moving her to another AFC home. I reviewed a letter dated 03/15/24 signed by the administrator, Tammy Unger, addressed to Guardian A1. According to the letter, Bay Human Services issued Resident A a 3-day discharge notice because “the home is unable to provide safe medical care due to the lack of cooperation from the guardian. Medical concerns and issues are unable to be addressed. Phone calls are not returned, appointments are cancelled by the guardian.”

According to Resident A’s Health Care Appraisal dated 02/20/24, she is diagnosed with bipolar disorder, post-traumatic stress disorder, and intellectual disabilities.

On 05/03/24, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that Resident A resided at Brookwood CLF for less than one month. She said that on 03/14/24, she took Resident A to an appointment and told AFC staff that she would be taking Resident A home with her for the weekend, bringing her back to the AFC on 03/18/24. On 03/15/24 at 4:45pm, she received a voicemail message from Tabatha

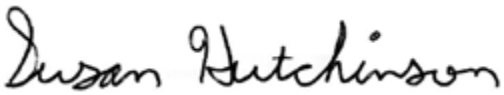
Barnes telling her that Resident A has been issued a discharge notice. On 03/19/24, Guardian A1 received a certified letter from Tammy Unger, COO/Administrator of Bay Human Services Inc. stating that Resident A was being discharged from Brookwood CLF effective 03/18/24. According to Guardian A1, Resident A has been residing with her since that time while Resident A's case manager looks for a new AFC placement for her.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	On 03/14/24, Guardian A1 took Resident A to an appointment and then notified AFC staff that she would be taking Resident A home with her, returning her to the AFC home on 03/18/24. On 03/15/24, Guardian A1 received a voice mail message telling her that Resident A was being discharged from Brookwood CLF. On 03/18/24, Guardian A1 received a written 3-day discharge notice for Resident A, telling her that Resident A was being discharged from Brookwood CLF. Guardian A1 and Resident A were never given a 30-day discharge notice as required by this rule. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/03/24, I conducted an exit conference with the licensee designee, James Pilot. I discussed the results of my investigation and explained which rule violation I am substantiating. I told LD Pilot that once my report is approved, I will send him a copy, requesting a corrective action plan. LD Pilot agreed.

IV. RECOMMENDATION

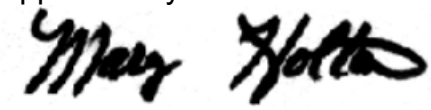
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



May 8, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 8, 2024

Mary E. Holton Area Manager	Date