GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 7, 2024

Karen Barry
Bay Valley Adult Foster Care Inc.
5113 Reinhardt Lane
Bay City, MI 48706

RE: License #:	AL090084487
Investigation #:	2024A0123045
	Bay Valley AFC Inc.

Dear Karen Barry:

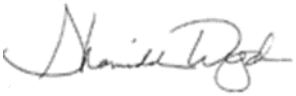
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 E. Genesee Ave.
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 #:	AL090084487
Investigation #:	2024A0123045
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/21/2024
Report Due Date:	08/19/2024
Licensee Name:	Bay Valley Adult Foster Care Inc.
License Address:	5113 Reinhardt Lane Bay City, MI 48706
Licensee Telephone #:	(989) 450-8769
Administrator:	Karen Barry
Licensee Designee:	Karen Barry
Name of Facility:	Bay Valley AFC Inc.
Facility Address:	5113 Reinhardt Lane Bay City, MI 48706
Facility Telephone #:	(989) 450-8769
Original Issuance Date:	01/07/1999
License Status:	REGULAR
Effective Date:	05/09/2023
Expiration Date:	05/08/2025
Capacity:	20

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility is short staffed.	Yes
Resident D did not receive medication timely. A staff person did not know how to administer Resident D with an insulin shot and was instructed on how to do so by Resident D. Staff are not trained on medication administration.	No

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0123045
06/21/2024	APS Referral APS referral completed.
06/21/2024	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
06/24/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
07/19/2024	Contact - Telephone call received I received a voicemail from Complainant 1.
07/19/2024	Contact - Telephone call made I returned a call to Complainant 1.
07/19/2024	Contact - Telephone call made I spoke with APS investigator Julie Anderson.
07/19/2024	Contact - Telephone call made I spoke with staff Sherri Colberg.
07/24/2024	Inspection Completed On-site

	I conducted a follow-up on-site.
07/30/2024	Contact- Telephone call made I spoke with designated person/staff Sherri Colberg.
07/30/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Margaret Kowalczyk.
07/30/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Lisa Smith.
07/30/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Jaime Smith.
07/30/2024	Contact- Telephone call made I made an attempted call to staff Erika Ciszek. The phone was not in service.
08/05/2024	Contact- Document Received Requested documentation received via email.
08/06/2024	Contact- Document Received Requested documentation received via email.
08/06/2024	Contact- Telephone call made I spoke with Staff Sherri Colberg.
08/062024	Exit Conference I spoke with designated person/Staff Sherri Colberg.
08/07/2024	Contact- Telephone call made I attempted to contact staff Margaret Kowalczyk.
08/07/2024	Contact- Telephone call made I attempted to contact staff Lisa Smith.
08/07/2024	Contact- Telephone call made I attempted to contact staff Jaime Smith.
08/07/2024	Contact- Telephone call made I attempted to contact staff Erika Ciszek.

ALLEGATION: The facility is short staffed.

INVESTIGATION: On 06/21/2024, I spoke with Complainant 1 via phone. Individual 1 visited the facility recently and noticed the back door was unlocked. Individual 1 did not know where Resident D's room was, and could not find Resident D. There is a concern about supervision, as Individual 1 was at the facility for a half-hour and did not see a staff person. The facility is understaffed, but the staff there do the best they can. Most of the staff were fired. The residents are not being properly cared for. Complainant 1 stated that the meals served are not nutritional. Resident D misses meals periodically. One day, staff did not ask Resident D if Resident D wanted to eat. Complainant 1 stated that some missed meals are Resident D's fault, but staff does not check on Resident D.

It should be noted that a *BCAL On-Line Complaint* was received on 06/20/2024 stating that the facility had fired 90% of their staff. There are 20 residents who require 24-hour care. The staff do not have time to cook food or administer medications. Residents sit in their wheelchairs all day, resident's do their own laundry, and that it was observed on an unknown day that staff could not be located by a visitor to the home for over 30 minutes.

On 06/24/2024, I conducted an unannounced on-site at the facility. Upon entry to the home, I observed that the entrance door had an audible alarm notifying staff of my entry. I observed 13 residents. Seven residents were sitting in the living room recliners, and others were sitting at the dining room table. Everyone appeared clean and appropriately dressed. No issues were noted. They facility appeared clean and well kept. Three staff were present on shift during this on-site, including a cook. There were no residents sitting in wheelchair that appeared to be unattended to.

On 06/24/2024, I interviewed Resident E. Resident E stated that staffing has not been affected. Resident E stated that staff Sherri Colberg, the new manager has done a great job with the staff she has. She stated that Staff Colberg works hard. Resident E stated that there are three staff on shift during bathing days, and there are never less than two staff on shift. Resident E stated that there were issues with the old staff. Resident E stated "*The troublemakers walked right out of here. They quit.*" Resident E stated that three staff persons all walked off the job because they did not want to work under Staff Colberg, because they would actually have to work. Resident E stated that one of the former staff threated Staff Colberg, and one of the new owners heard it. Resident E stated that the residents spend time in the living room recliner chairs or in the recliners in the sunroom. Resident E stated that staff assist residents throughout the day. Resident E denied seeing anyone sitting in wheelchairs all day. Resident E denied doing their own laundry and stated, "*that is a big lie*." Resident E stated that they have activities such as bingo and arts and crafts weekly. Resident E stated that the back door has always been unlocked, but some doors are always locked. Resident E stated that the doors have alarms notifying staff when someone enters the facility. Resident E stated that the new staff are good staff.

On 06/24/2024, I interviewed Resident D at the facility. Resident D stated that some of the staff quit, and that the facility is short staffed as a result. Resident D stated that there are at least two staff working per shift, sometimes three. Resident D stated that they do not require staff assistance for personal care. Resident D stated that the staff that quit (on 06/17/2024) were the ones working that day. Resident D stated that management scrambled but found coverage. Resident D denied seeing other residents in a wheelchair all day. Resident D stated that residents are usually in the sunroom, living room, or dining room. Resident D stated that staff work 12 to 13 hours shifts. Resident D stated that staff does their laundry, vacuums, and changes their sheets. Resident D stated that Individual 1 came to visit after lunch one day (unknown date), and that is when staff takes their breaks. Individual 1 could not find what room Resident D was in, but there was staff present in the facility. Resident D stated they heard the facility received a delivery that day, and that staff were in the garage because of the delivery. Individual 1 did find Resident D, as Resident D called Individual 1 and directed them to the room. Resident D stated that this complaint is an exaggeration.

On 06/24/2024, I interviewed the new designated licensee designee Sherri Colberg. She denied the allegations. Staff Colberg stated that four staff persons walked out/quit over the course of a couple days or so after Staff Colberg started working at the facility on Monday (06/17/2024). Staff Colberg stated that one of the former staff (Kimberly Ayala) got an attitude after being introduced to the new owners and went to Resident D's room to complain to Resident D. Staff Colberg stated that she was instructed to walk the former staff person out of the facility due to their behavior. Staff Colberg was verbally threatened by the former staff person as well. Staff Colberg stated that she works double shifts to help with coverage. Staff Colberg stated that Resident D complained of their floor being dirty, had Relative 1 steam clean the floor, but Resident D did not ask staff to do it. Staff Colberg stated that there have been no complaints from Relative 1. She denied that residents are doing laundry. Staff Colberg stated that for a visitor to be in the facility for 30 minutes and not see a staff person is an exaggeration. She stated that the staff could have been assisting residents. Staff Colberg stated that there are two staff on each shift. She stated that third shift prepares the meals for first and second shift to warm up. Third shift does the cleaning. Staff Colberg stated that Resident D does not come out of their room, even for meals.

On 06/24/2024, during the unannounced on-site, and during the course of the investigation I reviewed the resident's *Assessment Plans for AFC Residents* for all 20 residents in the home. There were four residents, Resident E, Resident G, Resident H, and Resident B who utilize wheelchairs per their assessment plans, and about 15 residents who utilize walkers. Resident I's assessment plan notes that Resident G loses their sense of whereabouts, and staff have to repeat communication to them. Resident H cannot see well, Resident M has dementia, Resident K has Alzheimer's, Resident G experiences confusion and does not walk, Resident L has vision issues, and Resident B has Parkinson's. The assessment plans reflected that multiple people have physical or health limitations that requires them to have staff assistance with some or most personal care tasks.

On 07/19/2024, I spoke with adult protective services investigator Julie Anderson via phone. Investigator Anderson stated that she did not substantiate her investigation. She stated that Resident D reported having no concerns.

On 07/19/2024, I made a return call to Complaint 1 who left a voicemail. Complainant 1 stated that Resident D was in the hospital. Two days after Resident D got back, Resident D did not receive their medications all day. Resident D asked staff for their medications, and staff responded saying not to worry about it. Complainant 1 stated that when Resident D does not receive their magnesium and sodium, Resident D has to be hospitalized. Complainant 1 stated that bread with a tiny piece of ham was served for lunch the other day. Staff don't vacuum or do things like laundry for the residents.

On 07/24/2024, I conducted a follow-up on-site at the facility. I interviewed Resident D again. Resident D's room appeared to be clean. Resident D stated that there have been no issues since 06/24/2024, the last time Resident D was interviewed. Resident D there are newly hired staff that are being trained. Resident D stated that they have some PRN (as needed) medication that staff will go back to retrieve during medication passing time. Resident D stated that they have an open line of communication with staff, and that Resident D can identify their own medications. Resident D stated that they were doing okay after coming back to the facility after a hospital stay. Resident D stated they are moving out of the facility on 09/01/2024 to move in with family. Resident D stated that they have received their medications on time. Resident D denied having any concerns with the food served. Resident D stated that the meals are balanced, and there is always fruit with every meal. Resident D stated that a variety of meals are provided. Resident D stated that they sometimes do not like what is served, but the facility cannot cook for just one person.

On 07/24/2024, during my follow-up on-site at the facility, I observed the residents present in the home at both dining room tables eating lunch. The lunch, which was a choice of spaghetti with meat balls, or black forest ham sandwiches were observed being served. Fruit cups and chips were options as well. The menu noted that goulash, peas, carrots, and dinner rolls would be served for dinner. The goulash (already cooked) was observed in the refrigerator. The contents of the refrigerator also including fresh fruit (blue berries, grapes, strawberries), etc. The pantry included canned fruit, beans, various other canned goods, cereals. The two refrigerators/freezers were observed to be stocked with frozen meats and bags of frozen vegetables. Canned goods were also observed in the basement on storage shelves. The facility's menus dated 07/22/2024 through 08/04/2024 were observed. There were different foods on the menu including meats, vegetables, and fruit. Substitutions were noted.

During the on-site on 07/24/2024, I spoke with manager Sherri Colberg who stated that she just hired a third shift staff person yesterday. She stated that she has only had third shift partially covered with two staff persons since she started working in the facility (on 06/17/2024), as she was working 12 hour shifts for the first couple of weeks to cover shifts.

On 07/24/2024, I interviewed staff Tonya Rolland at the facility. Staff Rolland denied the allegations. Staff Rolland stated that she has been working in the facility for a year. Staff Rolland stated that she is a trained medication passer. Staff Rolland stated that there are about two to three residents who use wheelchairs depending on the day, but wheelchairs are not used daily. Staff Rolland denied that any residents sit in wheelchairs all day. Staff Rolland stated that there are two staff that work per shift. Staff Rolland stated that there have been no complaints about the food served in the facility. Residents receive three meals per day, and snacks when they want them. Staff Rolland stated that the facility has weekly menu's and they document meal substitutions. Staff Rolland stated that staff does laundry on certain days, and second shift cleans the rooms.

On 07/24/2024, I interviewed Resident F at the facility. Resident F stated that two staff work in the mornings. Resident F stated that the facility has been short staffed but there are at least two staff working, or more. Resident F stated that it has been hard on the staff, but the residents are patient. The food served is very good, and staff are excellent with their quality of work. The food is excellent, Resident F is getting enough to eat, and can get snacks. Resident F stated that they never go away hungry, and balanced meals are served with vegetables and fruits. Resident F stated that staff cleans their room, assists Resident F with personal care, and staff does the laundry. Resident F denied having any issues with their medications. Resident F stated that they are very happy with the cleanliness of the facility and with staff doing their laundry, including ironing. Resident F stated that the facility has visitors who do arts and crafts on certain days, as well as a singer who comes in regularly. Resident F also stated that a piano player visits, and the facility also does bingo. Resident F denied seeing any residents sitting around all day in wheelchairs.

On 07/30/2024, and 08/07/2024, I made attempts to contact staff Margaret Kowalczyk, staff Lisa Smith, staff Jaime Smith, and staff Erika Ciszek via phone. The attempts were unsuccessful.

On 08/06/2024, I spoke to designated person/staff Sherri Colberg. Staff Colberg stated there are currently 20 residents in the home. About eight of the residents have dementia, and there are about four residents who requires assistance transferring from their bed. Staff Colberg stated that there are about six residents who would needs assistance during a fire drill. Staff Colberg stated that she hired a new staff person today, but had to fire three in the past week, but has hired three more. Staff Colberg stated that she only had one staff on third shift last week, as she has to leave at 2:00 am or 3:00 am from the facility to get sleep. Staff Colberg stated that she has been doing a lot of training, interviewing, and firing due to staff not showing up for work.

On 08/06/2024, I conducted an exit conference with designated licensee designee Sherri Colberg. I informed her of the findings and conclusions. Sherri Colberg stated that a new hire will be trained to work on third shift. Right now she has one staff, staff Erika Ciszek working four third shifts a week, and another staff is working three nights a

week. Sherri Colberg stated that her third shift staff are fully trained. Sherri Colberg stated that she is trying to find stable staff and hopes to be fully staffed by next week. On 11/15/2022, I concluded Special Investigation Report #2022A0123059. Rule 400.15206(2) was substantiated in regard to insufficient staffing on third shift based on the residents diagnoses and care needs (i.e. supervision). A corrective action plan dated 12/12/2022 stated that licensee designee Karen Barry was in the process of hiring an additional staff person to work third shift, and that LD Barry would work third shift as needed.

APPLICABLE RULE	
R 400.15206	**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 Fare agreement and assessment plan.
ANALYSIS:	On 06/24/2024, I conducted an unannounced on-site at the facility. I observed three staff on shift, including a cook. I interviewed Resident D and Resident E. Resident E did not express any concerns regarding short staffing. Resident D stated that the facility is short staffed due to several staff quitting but stated that there are at least two to three staff that work on shifts. Resident D did not express any concerns caused by short staffing. During the course of this investigation, I reviewed assessment plans for 20 residents. The assessment plans reflected that multiple people have physical or health limitations that requires them to have staff assistance with some or most personal care tasks. On 07/24/2024, I interviewed staff Tonya Rolland. She denied the allegations. I interviewed Resident F who did not express any concerns regarding short staffing. On 07/24/2024, I spoke with designated person/staff Sherri Colberg who stated that her third shift is only partially covered by two staff, but there is a period of time during third shift when the facility is only staffed with one person. During a follow-up call on 08/06/2024, Staff Colberg reiterated again that third shift is partially covered by one staff person. There is a preponderance of evidence to substantiate a rule violation due to the facility not having sufficient staff based on the current level of personal care needs for the residents residing in

	the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR #2022A0123059 dated 11/15/2022.**

ALLEGATION: Resident D did not receive medication timely. A staff person did not know how to administer Resident D with an insulin shot and was instructed on how to do so by Resident D. Staff are not trained on medication administration.

INVESTIGATION: On 06/21/2024, I spoke with Complainant 1 via phone. Complainant 1 stated that Resident D is insulin dependent, and the staff person administering the medication was not trained. Complainant 1 stated that staff administered medication late to Resident D on 06/18/2024.

On 06/24/2024, I interviewed Resident E. Resident E denied having any issues with the staff who administer their medications. Resident E denied having any issues with the staff who pass medications.

On 06/24/2024, I interviewed Resident D at the facility. Resident D denied having any issues with their medication, just only on the day former staff walked out/quit (on 06/17/2024). Resident D stated that the staff that quit were the ones working that day. Resident D stated that management scrambled but found coverage. Resident D stated that it was only that day that staff was late administering medication. Resident D stated that staff are on top of medication passes any other time. Resident D stated that there was no issue with receiving an insulin injection. Resident D stated that they had to show staff how to put an insulin Libra 2 sensor on their arm. She stated that a former staff person (Jennifer Homminga) was also a nurse, who would apply the sensor. Resident D stated that the sensor is replaced every 14 days.

On 06/24/2024, I interviewed the new designated licensee designee Sherri Colberg. She denied the allegations. Staff Colberg stated that there is more than one trained medication passer. Sherri Colberg denied having a shift where someone was not trained in medication administration.

On 06/24/2024, during the unannounced on-site, Resident D's medication administration records for March through June 2024. No issues were noted. On 08/05/2024, I obtained a copy of Resident D's *Assessment Plan for AFC Residents* dated 01/26/2024 via email. It notes that staff are responsible for administering Resident D's medications.

On 07/24/2024, I interviewed staff Tonya Rolland at the facility. Staff Rolland stated that she has been working in the facility for a year. Staff Rolland stated that she is a trained medication passer. She denied having any knowledge of any staff passing medications without being trained to do so. She stated that the day former staff Kimberly Ayala

walked off the job, she (Staff Rolland) worked that day until 6:00 pm. She stated that at 5:00 pm that day was the last medication pass for her shift. She stated that from what she recalled, Resident D's insulin sensor was working. She denied any knowledge of medications being passed late that day and stated that there is a one-hour window before and after the medication pass time, that medications can still be administered.

On 07/24/2024, I interviewed Resident F at the facility. Resident F denied having any issues with their medication. Resident F reported getting morning and evening medication, and that they are passed timely. Resident F stated that the staff follow's their doctor's instructions and work directly with Resident F's doctor.

On 08/06/2024, I obtained a copies staff medication administration training verification for seven of the facility's staff. Management signed off on medication training for staff Mandie Chapman on 07/17/2024, staff Lisa Smith on 03/22/2024, staff Erika Liszek on 11/20/2022, staff Margaret Kowalczyk on 08/13/2021, staff Nicole Fox on 07/12/2024, staff Tonya Rolland on 06/13/2023, and staff Jaime Smith on 08/03/2012.

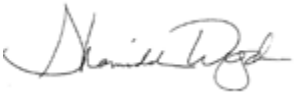
On 08/06/2024, I conducted an exit conference with designated person/licensee designee Sherri Colberg. I informed her of the findings and conclusion.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	On 06/21/2024 Complainant 1 stated that Resident D is insulin dependent, and the staff person administering the medication was not trained. On 06/24/2024, Resident D was interviewed and denied the allegations. Resident D stated that there was no issue with receiving an insulin injection. Resident E and Resident F also denied having any issues with their medications. Staff Sherri Colberg was interviewed and denied the allegations stating that the facility has more than one trained medication passer. On 07/24/2024, I interviewed staff Tonya Rolland. She denied having any knowledge of any staff passing medications without being trained to do so.

	On 08/05/2024, staff Sherri Colberg provided documentation verifying that the facility has multiple staff that are trained in medication administration. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).



08/07/2024

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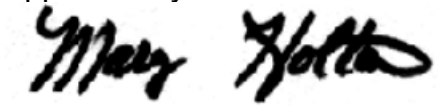
Shamidah Wyden Date
Licensing Consultant

Approved By:



August 7, 2024

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Mary E. Holton Date
Area Manager