GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2024

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

RE: License #: AS090391446
Investigation #: 2024A0623001
Bangor

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.
- 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,

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090391446
Investigation #:	2024A0623001
Complaint Receipt Date:	06/03/2024
Investigation Initiation Date:	06/05/2024
Report Due Date:	08/02/2024
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:	Bangor
Facility Address:	3501 Bangor Rd. Bay City, MI 48706
Facility Telephone #:	(989) 846-9631
Original Issuance Date:	03/14/2018
License Status:	REGULAR
Effective Date:	09/14/2022
Expiration Date:	09/13/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has 2nd degree burns from a rice sock used on his abdomen.	Yes

III. METHODOLOGY

06/03/2024	Special Investigation Intake 2024A0623001
06/05/2024	APS Referral
06/05/2024	Special Investigation Initiated - Letter
06/07/2024	Contact - Telephone call received Phone call received from Recipient Rights
06/07/2024	Contact - Telephone call received Voicemail received from Bay County Recipient Rights Melissa Prusi
06/12/2024	Inspection Completed On-site Special Investigation
06/14/2024	Contact - Telephone call made Phone call to APS worker Julie Anderson
06/24/2024	Contact - Telephone call made Phone call to Ladd Veitengruber RN.
06/24/2024	Contact - Telephone call made Phone call to Home Manager Dawn Richter
06/24/2024	Contact - Document Received AFC
06/27/2024	Contact - Telephone call made Phone call to guardian
06/27/2024	Contact - Telephone call made Phone interview of AFC staff Stephanie Majdecki.

07/15/2024	Inspection Completed-BCAL Sub. Compliance
07/15/2024	Exit Conference Exit Conference with Administrator Tammy Unger.
07/24/2024	Contact – Telephone call made Phone call to Home Manager Dawn Richter

ALLEGATION: Resident A has 2nd degree burns from a rice sock used on his abdomen.

INVESTIGATION: On 6/7/24, I contacted Recipient Rights (RR) associate Melissa Prusi. RR Melissa Prusi stated that they will be substantiating due to the unacceptable use of a rice sock as it is an unapproved treatment for Resident A's constipation.

On 6/12/24, I conducted an unannounced onsite inspection of Bangor Adult Foster Care facility. I interviewed Assistant Home Manager Rachel Daugherty and direct care staff Lindsey Rolstan.

Rachel Daugherty and Lindsey Rolstan confirmed that they observed burn-like areas on Resident A's abdomen on 5/28/24 and completed an Incident Report. R.N. LADD Veitengruber was notified by the staff of Resident A's wound and later came to the home and provided treatment. They were unaware of a heated rick sock being used on Resident A. They were aware that Resident A has a treatment plan in place to address constipation concerns.

The Incident Report indicated upon the start of the 1st shift staff Rachel and Lindsey assisted Resident A with personal care and observed the inflammation on the lower abdomen area. Corrective measures included contacting the nurse and following instructions to monitor the area. R.N. Ladd Veitengruber began treatment in the facility on 5/28/24 using Xeroform Petrolatum wound dressing and monitoring the site.

According to observation and Resident A's Assessment Plan he is immobile from the shoulder's down, non-verbal and relies on his staff and family to keep him physically safe. Resident A's treatment for constipation included Milk of Magnesia, Miralax, Suppositories and Enema. On 6/12/24, I observed Resident A had a large bandage covering his lower abdomen. I observed that Resident A appeared clean, dressed appropriately and staff appeared attentive to his specialized needs.

On 6/14/24, I contacted APS worker Julie Anderson and was informed that they will be substantiating their case due to the injury sustained.

On 6/24/24, I contacted home care nurse Ladd Veitengruber R.N. Ladd Veitengruber confirmed he observed what he in his 12 years of home care experience as a 2nd degree burn on the lower abdomen of Resident A. Skin Care Audits completed. Follow up with Resident A the area is healed and will continue to be monitored.

On 6/24/24, I contacted Bangor Home Manager (HM) Dawn Richter. HM Richter stated that she has addressed staff at a recent staff meeting to use only approved treatments.

On 6/27/24, I contacted Resident A's guardian regarding the incident. The guardian stated that they were made aware of the incident, informed of the treatment plan and they have no concerns regarding the care provided in the home. The guardian expressed that this was an isolated incident and Resident A is well cared for and safe in the home.

On 6/29/24, I contacted direct care staff Stephanie Majdecki. Stephanie Majdecki confirmed that they had used the rice sock without permission, had not used it before and it is not an approved treatment for Resident A. Stephanie Majdecki stated that they made the rice sock themselves, and used it when she couldn't get a call back from the nurse regarding Resident A's constipation. Stephanie Majdecki stated that she has used a rice sock heated in the microwave before, however it was applied to her children and not a resident. Stephanie Majdecki stated that going forward she will not use any treatment that has not been approved.

On 7/15/24, I conducted an exit conference with Administrator Tammy Unger after multiple attempts to contact Licensee Designee (LD) James Pilot. I discussed the results of my investigation and explained which rule violation I am substantiating. Tammy Unger agreed and stated that she and LD Pilot were aware of the incident and will complete and submit a corrective action plan upon the receipt of my investigation report.

On 7/24/24 I contacted Home Manager (HM) Dawn Richter regarding the incident. HM Richter stated that the direct care staff responsible for the injury to Resident A was terminated on 7/1/24.

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:	On 5/28/24 Resident A was observed to have a burn on his lower abdomen which was confirmed to be 2nd degree by Ladd Veitengruber R.N. Direct care staff Stephanie Majdecki confirmed using a rice sock she made and heated it in the microwave on Resident A. Resident A is immobile from the shoulder's down and non-verbal, so they were unable to express discomfort or physically dislodge the rice sock. This was not an approved treatment and it caused injury. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

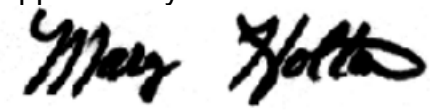
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, no change in the license status is recommended.

7/24/24

Cynthia Badour — Date
Licensing Consultant

Approved By:



7/25/24

Mary E. Holton — Date
Area Manager