



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 7, 2024

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

RE: License #:	AL090084487
Investigation #:	2024A0123055
	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,

A handwritten signature in dark ink, appearing to read 'Shamidah Wyden', written in a cursive style.

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**

<b>License #:</b>	AL090084487
<b>Investigation #:</b>	2024A0123055
<b>Complaint Receipt Date:</b>	08/16/2024
<b>Investigation Initiation Date:</b>	08/20/2024
<b>Report Due Date:</b>	10/15/2024
<b>Licensee Name:</b>	Bay Valley Adult Foster Care Inc.
<b>Licensee Address:</b>	5113 Reinhardt Lane Bay City, MI 48706
<b>Licensee Telephone #:</b>	(989) 450-8769
<b>Administrator:</b>	Karen Barry
<b>Licensee Designee:</b>	Karen Barry
<b>Name of Facility:</b>	Bay Valley AFC Inc.
<b>Facility Address:</b>	5113 Reinhardt Lane Bay City, MI 48706
<b>Facility Telephone #:</b>	(989) 450-8769
<b>Original Issuance Date:</b>	01/07/1999
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/09/2023
<b>Expiration Date:</b>	05/08/2025
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	Violation Established?
Resident A has lived in the AFC home for six months and has had multiple hospitalizations since living there. Resident A was not hospitalized prior to moving to the facility. Staff are not able to provide appropriate care to Resident A.	No
On 08/15/2024, there were dirty dishes, and trash in Resident A's bedroom. Resident A's carpet was dirty.	No
There is a staff person that appears to be under the influence of drugs while working.	No
It is unknown how often the residents are being bathed.	Yes
There is a concern residents are declining from malnutrition.	No
There are 40 residents in the facility.	No

## III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A0123055
08/20/2024	APS Referral Information received regarding APS referral.
08/20/2024	Special Investigation Initiated - Telephone I spoke with adult protective services investigator Bethany Hornbacher via phone.
08/27/2024	Inspection Completed On-site I conducted an unannounced on-site.
09/24/2024	Inspection Completed On-site I conducted an unannounced follow-up at the facility.
10/02/2024	Contact- Telephone call made I interviewed staff Amanda Chatman.
10/03/2024	Exit Conference I spoke with Shawn Pnacek via phone.

10/04/2024	Contact- Document Received I received requested documentation.
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**ALLEGATION:** Resident A has lived in the AFC home for six months and has had multiple hospitalizations since living there. Resident A was not hospitalized prior to moving to the facility. Staff are not able to provide appropriate care to Resident A.

**INVESTIGATION:** On 08/20/2024, I spoke with adult protective services investigator Bethany Hornbacher via phone. Bethan Hornbacher stated that she conducted an on-site yesterday and interviewed Resident A. Resident A had no complaints. Bethan Hornbacher stated that Resident A reported that when they ring the call button for assistance, staff may not come right away if they are helping others. Staff are nice, and Resident A denied having any personal care concerns, stating that it was just a personal health issue. Resident A denied being in the hospital multiple times. Resident A receives physical therapy through McLaren.

On 08/27/2024, I conducted an unannounced on-site at the facility. Resident A was interviewed. Resident A stated that they went to the hospital a few days due to having a health issue. Resident A stated that it was a personal health issue, nothing to do with the staff. Resident A stated that the cause of their health issue hasn't been found, but they haven't had the same symptoms since. Resident A stated that the staff have been good to them.

On 09/24/2024, I conducted an unannounced follow-up on-site visit at the facility. I interviewed staff Jennifer Homminga. Staff Homminga stated that she recently returned to working at the facility a couple weeks ago. She stated that Resident A was in the hospital one time, then went to rehab for a couple of weeks. She stated that Resident A had A-Fib issues and had physical therapy services that are now over.

During this investigation, I observed Resident A's *AFC-Resident Information and Identification Record*, and it notes that Resident A moved into the facility on 01/19/2024.

On 09/27/2024, I spoke with co-corporate director Shawn Pnacek via phone. Shawn Pnacek stated that there is no record of multiple hospitalizations for Resident A.

On 10/02/2024, I interviewed staff Amanda Chatman. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. Staff Chatman stated that she personally knew Resident A prior to working in the facility. Staff Chatman stated that Resident A did not go to the hospital during the time Staff Chatman was working in the facility. Staff Chatman stated that Resident A had just returned from one hospital stay just prior to her working there. Staff Chatman stated that Resident A was receiving appropriate personal care during her time at the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.15301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<p><b>(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:</b></p> <p><b>(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.</b></p>
<b>ANALYSIS:</b>	<p>On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A. Resident A denied being hospitalized multiple times and denied having any concerns regarding personal care.</p> <p>On 09/24/2024, I interviewed staff Jennifer Homminga. She confirmed that Resident A was hospitalized once. On 09/27/2024, I spoke with Shawn Pnacek who stated that there is no record of multiple hospitalizations for Resident A.</p> <p>On 10/02/2024, I interviewed staff Amanda Chatman. She denied the allegations.</p> <p>There is no preponderance of evidence to substantiate a rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** On 08/15/2024, there were dirty dishes, and trash in Resident A's bedroom. Resident A's carpet was dirty.

**INVESTIGATION:** On 08/20/2024, I spoke with adult protective services investigator Bethany Hornbacher via phone. Bethany Hornbacher stated that there was nothing wrong with Resident A's room. The carpet is dated, but not dirty. There was nothing on the floor. Bethany Hornbacher stated that the owner of the facility, Shawn Pnacek, stated that they were replacing the carpet soon. Bethany Hornbacher stated that during her on-site, staff were vacuuming and mopping.

On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D.

Resident A stated that the facility is always clean, and they have never seen any dirt. Resident A denied having dirty dishes in their bedroom. Resident A stated that they take their medication with apple sauce, and the staff takes the apple sauce dish away when finished. Resident A denied eating their meals in the room and denied having dirty carpet. Resident A stated that the staff vacuums regularly and keeps the carpet clean.

The interview with Resident A was conducted in Resident A's bedroom. The bedroom appeared clean, orderly, and the carpet appeared clean as well. There were no dirty dishes or trash in the room. No issues were noted. Resident A appeared clean and appropriately dressed.

Resident B was interviewed. Resident B stated that the facility is never dirty, and Resident B denied any concerns about their carpet being dirty. Resident B stated that there is new carpeting in their room and staff vacuums regularly. Resident B's bedroom was observed during this interview. It was clean. No issues were noted.

Resident C was interviewed. Resident C denied that there are any dirty dishes left in their bedroom. Resident C's bedroom was observed to be clean and tidy. No issues were noted.

Resident D was interviewed. Resident D denied any concerns about the cleanliness of the facility. Resident D's bedroom was observed during this interview and appeared clean and tidy. No issues were noted.

On 09/24/2024, I conducted an unannounced follow-up on-site visit at the facility. The home appeared clean. No issues were noted. The carpeting in the hallways was observed to have been replaced with hardwood flooring.

On 10/02/2024, I interviewed staff Amanda Chatman. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. She denied that Resident A's bedroom floor was dirty. She stated that Resident A would eat apple sauce with their medication, and the only dish that would be in the room would be the apple sauce dish. Staff Chatman denied that any dirty dishes and trash were in the room.

<b>APPLICABLE RULE</b>	
<b>R 400.15403</b>	<b>Maintenance of premises.</b>
	<b>(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.</b>
<b>ANALYSIS:</b>	On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and

	<p>Resident D. They denied the allegations and reported no issues about the cleanliness of the facility. Resident A stated that their room is always clean.</p> <p>Resident A's bedroom was observed during this on-site, and it was clean. No issues were noted.</p> <p>On 09/24/2024, I conducted an unannounced follow-up visit and noted no issues with the facility's flooring or trash and dirty dishes.</p> <p>On 10/02/2024, I interviewed staff Amanda Chatman. She denied the allegations.</p> <p>There is no preponderance of evidence to substantiate a rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** There is a staff person that appears to be under the influence of drugs while working.

**INVESTIGATION:** On 08/20/2024, I spoke with adult protective services investigator Bethany Hornbacher via phone. She stated that staff Mandy appears to be super bubbly, and positive. Staff Mandy denied using drugs.

On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D.

Resident A denied having any knowledge of staff using drugs.

Resident B was interviewed and stated that they thought one staff may have been on drugs, but that staff person no longer works in the facility. Resident B stated that the staff person seemed "spacey."

Resident C was interviewed. Resident C denied having any concerns about any staff being drunk or on drugs.

Resident D was interviewed and denied having any concerns about staff being high (under the influence) or drunk.

On 09/27/2024, I spoke with co-corporate director Shawn Pnacek via phone. Shawn Pnacek stated there was suspicion of alcohol use, but there was no definitive proof. Shawn Pnacek stated that staff Amanda Chatman was let go due to not being a good fit for the facility.

On 10/02/2024, I interviewed staff Amanda Chatman via phone. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. Staff Chatman denied the allegations. Staff Chatman stated that there was one time that she was sick, and manager Sherri Colberg refused to let her go home once, until after she threw up. Staff Chatman stated that this was the only day it could have appeared that way. Staff Chatman denied ever being impaired while working and stated that this allegation was a lie.

<b>APPLICABLE RULE</b>	
<b>R 400.15204</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(2) Direct care staff shall possess all of the following qualifications:</b> <b>(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.</b>
<b>ANALYSIS:</b>	<p>On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D. They denied having any knowledge of any staff using drugs.</p> <p>On 09/27/2024, I spoke with co-corporate director Shawn Pnacek via phone. Shawn Pnacek stated there was suspicion of alcohol use, but there was no definitive proof.</p> <p>On 10/02/2024, I interviewed staff Amanda Chatman via phone. Staff Chatman denied the allegations.</p> <p>There is no preponderance of evidence to substantiate a rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** It is unknown how often the residents are being bathed.

**INVESTIGATION:** On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D.

Resident A stated that they receive two showers a week minimum, and the bed sheets are changed weekly.

Resident B stated that they personally receive one shower a week if lucky. Resident B stated they were not showered last week. When old staff were still working, Resident B stated that they would get two showers a week. Resident B stated that they have been using hospital bath wipes to stay clean.

Resident C was interviewed. Resident C stated that they are supposed to get two showers per week. Sometimes a shower is missed in a week, so they go to the bathroom and wash themselves up.

Resident D was interviewed and stated that they are independent with showering.

On 09/24/2024, I conducted an unannounced follow-up on-site. I interviewed staff Jennifer Homminga. Staff Homminga stated that she recently returned to working at the facility a couple weeks ago. Staff Homminga stated that there were a lot of residents who complained about not getting a bath, and named five residents including Resident A and Resident B.

During this on-site, I reviewed the *Assessment Plan for AFC Residents*. Resident A's assessment plan dated, 01/19/2024, notes that Resident A requires assistance with bathing for getting in/out the tub, washing their body and hair. Resident B's assessment plan, dated 03/10/2024, notes that Resident B needs assistance getting safely in and out of the shower, and assistance with washing/drying as needed. Resident C's assessment plan dated 04/19/2024, notes that Resident C requires assistance with getting in/out the shower, washing hair, back, and feet to knees. Resident D's assessment plan dated 09/20/2023, has yes checked for needing assistance with bathing, but no details were noted. All other personal care tasks were checked no. There were about ten other resident assessment plans that were reviewed that noted the residents each needed assistance with bathing.

On 09/27/2024, I interviewed co-corporate director Shawn Pnacek via phone. Shawn Pnacek stated that Resident B and Resident C had complaints regarding not getting staff assistance with bathing, and the issue was addressed with staff on the same day.

On 10/02/2024, I interviewed staff Amanda Chatman via phone. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. Staff Chatman stated that residents were going without baths. There were times that showers were missed because of staffing issues. Staff Chatman stated that staff could not cook meals and provide bathing assistance at the same time. Staff Chatman stated that manager Sherri Colberg was present during those times but was not helping staff provide personal care.

<b>APPLICABLE RULE</b>	
<b>R 400.15314</b>	<b>Resident hygiene.</b>
	<b>(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.</b>
<b>ANALYSIS:</b>	On 08/27/2024, I conducted an unannounced on-site at the

	<p>facility. I interviewed Resident A, Resident B, Resident C, and Resident D.</p> <p>Resident A stated that they receive at least two showers a week. Resident B reported that they have not been getting showered at least weekly. Resident C stated that they have missed getting a shower, so they have to wash themselves up.</p> <p>On 09/24/2024, I interviewed staff Jennifer Homminga. Staff Homminga stated that upon her return to working at the facility, multiple residents complained about not getting bathed.</p> <p>On 09/27/2024, I interviewed Shawn Pnacek who stated that Resident B and Resident C complained to him about staff not assisting them with bathing, and he addressed the issue with staff the same day.</p> <p>On 10/02/2024, staff Amanda Chatman was interviewed and stated that there were residents that were going without getting bathed due to staffing issues.</p> <p>There is a preponderance of evidence to substantiate a rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:** There is a concern residents are declining from malnutrition.

**INVESTIGATION:** On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D.

Resident A stated that the facility serves really good food. Three meals are served daily.

Resident B stated that they receive enough food to eat. Three meals are served daily.

Resident C stated that they sit in the dining room for all three meals and that they get enough to eat.

Resident D stated that they get enough to eat and that three meals per day are served.

On 09/24/2024, I conducted a follow-up visit and reviewed weight records for 16 residents. The documentation was not indicative of a drastic decline in weight loss

across the residents' weight records. I observed the menu's posted on the refrigerator during this visit for July, August, September, and October 2024. A variety of different food options were listed daily. Substitutions were noted as well.

*Assessment Plans for AFC Residents* were reviewed as well for 16 residents. There was only two assessment plans that indicated that a resident required assistance sometimes with eating/feeding.

On 09/27/2024, I interviewed co-corporate director Shawn Pnacek via phone. Shawn Pnacek stated that the facility has never had a shortage of food. They recently purchased more food to have an extra stock.

On 10/02/2024, I interviewed staff Amanda Chatman via phone. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. Staff Chatman stated that during her time working in the facility, residents were served three meals a day and snacks. Staff Chatman stated that she regularly cooked meals, and there were no residents who were malnourished. Staff Chatman stated that residents could feed themselves. The residents with dementia would need help at times if they were not eating enough or were picking at their food.

<b>APPLICABLE RULE</b>	
<b>R 400.15313</b>	<b>Resident nutrition.</b>
	<b>(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.</b>
<b>ANALYSIS:</b>	<p>On 08/27/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D. They each reported that they receive three meals a day, and that they get enough to eat.</p> <p>During the course of this investigation, weight records and the facility's menus were reviewed. Assessment plans for the residents indicated that majority of the residents do not require assistance with eating/feeding.</p> <p>On 09/27/2024, I interviewed co-corporate director Shawn Pnacek via phone. He stated that the facility has never had a shortage of food.</p> <p>On 10/02/2024, I interviewed staff Amanda Chatman. She stated that during her time at the facility, residents were served three meals a day, and snacks.</p>

	There is no preponderance of evidence to substantiate a rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** There are 40 residents in the facility.

**INVESTIGATION:** On 08/20/2024, I spoke with adult protective services investigator Bethany Hornbacher via phone. Bethany Hornbacher stated that the facility has 20 beds, not 40.

On 09/24/2024, I conducted an unannounced follow-up on-site at the facility. There were 16 resident bedrooms throughout the facility. I visually observed nine residents. They appeared clean and appropriately dressed. The facility is physically not large enough to hold 40 residents.

On 10/02/2024, I interviewed staff Amanda Chatman via phone. Staff Chatman stated that she no longer works in the facility but worked for a few months between July 2024 and September 2024 on 1<sup>st</sup> shift. Staff Chatman stated that while working in the facility there were 20 residents in the facility when she first started, and by there were about 16 residents when she left.

On 10/04/2024, I received a copy of the facility's *Resident Register* that lists 17 residents currently residing in the facility.

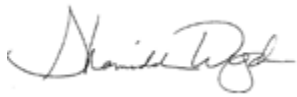
<b>APPLICABLE RULE</b>	
<b>R 400.15105</b>	<b>Licensed capacity.</b>
	<b>(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.</b>
<b>ANALYSIS:</b>	<p>On 09/24/2024, I conducted an unannounced on-site. I physically observed 16 bedrooms in the facility, and nine of the residents.</p> <p>On 10/02/2024, I interviewed staff Amanda Chatman who stated that 20 or less residents resided in the facility while she worked there.</p>

	<p>On 10/04/2024, I reviewed the <i>Resident Register</i> that lists there's 17 residents residing in the facility.</p> <p>There is no preponderance of evidence to substantiate a rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 10/04/2024, I conducted an exit conference with co-corporate director Shawn Pnacek via phone. I informed him of the findings and conclusions.

#### IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 13-20).

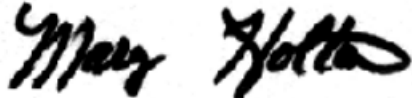


10/04/2024

Shamidah Wyden  
Licensing Consultant

Date

Approved By:



10/07/2024

Mary E. Holton  
Area Manager

Date