GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 17, 2024

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

RE: License #: AM330378865
Investigation #: 2025A1033007
Heritage

Dear Mr. Pilot:

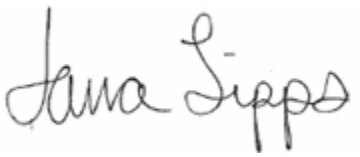
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, 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 #:	AM330378865
Investigation #:	2025A1033007
Complaint Receipt Date:	11/27/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	01/26/2025
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:	Heritage
Facility Address:	4020 Aurelius Road Lansing, MI 48906
Facility Telephone #:	(517) 574-4336
Original Issuance Date:	10/01/2015
License Status:	REGULAR
Effective Date:	12/09/2023
Expiration Date:	12/08/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Cortney Pratt, is providing direct care to residents while she is under the influence of drugs, prescriptions medications, and/or alcohol.	No
Direct care staff, Cortney Pratt, did not provide for Resident A's dignity, respect, and privacy; by taking a video of Resident A while she was laying on the floor at the facility.	Yes

III. METHODOLOGY

11/27/2024	Special Investigation Intake 2025A1033007
12/02/2024	APS Referral- APS, Adult Services Worker, Robert Lindley, assigned.
12/02/2024	Special Investigation Initiated – Letter- Email correspondence with APS Robert Lindley.
12/02/2024	Contact - Telephone call made. Interview conducted with Adult Services Worker, Robert Lindley, via telephone.
12/03/2024	Inspection Completed On-site- Interviews conducted with direct care staff/Home Manager, Tomme Felton, direct care staff/Assistant Home Manager, Dorothy Clark, direct care staff, Meranda Clark. Review of direct care staff, Cortney Pratt, employee file initiated. Review of Resident A's resident record initiated.
12/03/2024	Contact - Face to Face- Meeting with Adult Services Worker, Robert Lindley, at facility to view video recording submitted to APS.
12/03/2024	Contact - Telephone call made- Interview conducted with direct care staff, Renay Smith, via telephone.
12/03/2024	Contact - Telephone call made- Interview conducted with direct care staff, Cortney Pratt, via telephone.
12/03/2024	Contact - Telephone call made- Interview conducted with Citizen 1, via telephone.

12/03/2024	Contact - Telephone call made- Attempt to interview CEI-CMH case manager, Lauren Spencer, via telephone. Voicemail message left, awaiting response.
12/04/2024	Exit Conference- Conducted via telephone with licensee designee, James Pilot, and Administrator, Tammy Unger.
12/12/2024	Contact – Document Received- Email correspondence with CMH-CEI, case manager, Lauren Spencer.

ALLEGATION: Direct care staff, Cortney Pratt, is providing direct care to residents while she is under the influence of drugs, prescriptions medications, and/or alcohol.

INVESTIGATION:

On 11/27/24 I received an online complaint regarding the Heritage adult foster care facility (the facility). The complaint alleged that direct care staff, Cortney Pratt, has been providing resident care while she is under the influence of prescription medications, drugs, and/or alcohol. On 12/2/24 I interviewed Adult Protective Services (APS), Adult Services Worker, Robert Lindley, regarding the allegations. Mr. Lindley reported that he had received these allegations in the form of an APS complaint. He reported that he could not share the referral source of the APS complaint with this licensing consultant. Mr. Lindley also reported he did not interview the APS referral source. Mr. Lindley reported that he did interview Ms. Pratt, via telephone, on 12/2/24, and Ms. Pratt denied these allegations. Mr. Lindley reported that Ms. Pratt reported that she previously had a substance abuse history and has gone through treatment and is currently in recovery. She denied any current substance abuse to Mr. Lindley. Mr. Lindley reported that he made an on-site visit to the facility on 11/25/24 and interviewed direct care staff/home manager, Tomme Felton. Mr. Lindley reported that Mr. Felton stated he had no knowledge of Ms. Pratt coming to work under the influence of drugs, medications, or alcohol. Mr. Lindley reported that Mr. Felton stated the facility does not do drug testing with the direct care staff members unless there is reason to be concerned. He reported no current concerns regarding Ms. Pratt.

On 12/3/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Mr. Felton on this date. Mr. Felton reported that Ms. Pratt has been employed at the facility since 6/24/23. He reported that pre-employment drug testing is not a requirement to work at the facility. He reported that Ms. Pratt has not undergone any drug testing for her job. Mr. Felton reported that Ms. Pratt works third shift (11pm – 7am on weekdays, and 11pm to 11am on weekend days). Mr. Felton reported that the facility is always staffed with at least two direct care staff members per shift. He reported that he has no concerns about Ms. Pratt's performance and has never felt that she has been under the influence of drugs, medications, or

alcohol while working. Mr. Felton reported that he has never received a complaint from another direct care staff member with concerns that Ms. Pratt was under the influence of drugs, medications, or alcohol.

During the on-site investigation on 12/3/24 I interviewed direct care staff/assistant home manager, Dorothy Clark. Ms. Clark reported that she has worked at the facility for just over two years. Ms. Clark reported that she has been assigned to work shifts with Ms. Pratt. Ms. Clark reported that she has never felt Ms. Pratt had been under the influence of drugs, medications, or alcohol, during a shift. Ms. Pratt reported that she has never heard complaints from other direct care staff members that Ms. Pratt was acting as though she was under the influence of drugs, medications, or alcohol.

During the on-site investigation on 12/3/24 I interviewed direct care staff, Meranda Clark. Meranda Clark reported that she has worked at the facility for about two years. She reported that she has worked on some shifts with Ms. Pratt. Meranda Clark reported that she has never suspected Ms. Pratt to be working and providing direct care while under the influence of drugs, alcohol, or prescription medications. Meranda Clark reported that Ms. Pratt is a “really good worker”.

On 12/3/24 I interviewed Ms. Pratt, via telephone. Ms. Pratt reported that she has never provided direct care at the facility while under the influence of drugs, alcohol, or prescription medications.

On 12/3/24 I interviewed direct care staff, Renay Smith, via telephone. Ms. Smith reported that she has worked at the facility for about 1.5 years. She reported that she has no current knowledge of any direct care staff member coming to work under the influence of drugs, alcohol, or prescription medications. Ms. Smith reported that she has not heard any allegations of this nature from any residents, visitors to the facility, or direct care staff members.

On 12/3/24 I interviewed Citizen 1, via telephone. Citizen 1 reported that he previously worked at the facility. He reported that he has worked on shifts with Ms. Pratt. Citizen 1 reported that he has never observed Ms. Pratt to appear to be under the influence of drugs, alcohol, or prescription medications, while providing direct care at the facility.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Based upon interviews conducted with Mr. Lindley, Mr. Felton, Ms. Clark, Meranda Clark, Ms. Pratt, Ms. Smith, & Citizen 1, it can be determined that there is no available evidence Ms. Pratt has been providing direct care to residents of the facility, while under the influence of drugs, Alcohol, or prescription medications. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff, Cortney Pratt, did not provide for Resident A's dignity, respect, and privacy; by taking a video of Resident A while she was laying on the floor at the facility.

INVESTIGATION:

On 11/27/24 I received an online complaint regarding the facility. The complaint alleged that Ms. Pratt used her cell phone to record a video of Resident A laying on the ground moaning and refused to assist Resident A in getting up from the ground. On 12/2/24 I interviewed Mr. Lindley, via telephone. Mr. Lindley reported that the APS Centralized Intake department received a complaint alleging that Ms. Pratt took a video recording of Resident A laying on the ground and Resident A was moaning. Mr. Lindley reported that the alleged video was attached to the APS complaint he received. Mr. Lindley reported that he had viewed the video, and he could not see anyone in the video, except for Resident A. He reported that he could hear a female's voice in the video, but he was unsure who this female was. He reported that Resident A was moaning in the video and the female speaking stated that they were not going to assist Resident A in getting up from the ground. Mr. Lindley reported that he could not share this video with this licensing consultant but would allow this consultant to view the video, in person. Mr. Lindley reported that he made a visit to the facility on 11/25/24 and played the audio of the recording for Mr. Felton. He reported that Mr. Felton identified the female voice in the video as that of Ms. Pratt. Mr. Lindley reported that he interviewed Ms. Pratt, via telephone, on 12/2/24 and Ms. Pratt denied having videoed Resident A at the facility. Mr. Lindley reported that he did not share with Ms. Pratt that he had a video of the alleged incident. Mr. Lindley reported that while he was on-site at the facility on 11/25/24, he interviewed Resident A. He reported that Resident A did not have knowledge of the video. Mr. Lindley reported that the date on the video was 7/9/24.

On 12/3/24 I met Mr. Lindley at the facility to view the video evidence regarding the allegation. Mr. Lindley allowed me to watch the video on his cellular telephone. It was difficult to see the content of the video as the screen was dark. I could see a person laying on the ground and this person was moaning. I could hear another female voice, from off camera, stating to the person on the ground, "We can't lift you, we can't carry you." This female voice was not using a derogatory tone with the individual on the ground. The tone appeared to be matter of fact in context. The

visual quality of the video was difficult for me to determine whether the person on the ground was Resident A, due to the darkened screen.

During the on-site investigation on 12/3/24 I interviewed Mr. Felton about the allegation. Mr. Felton reported that he did hear the audio of the video when Mr. Lindley played the video for him. He reported that he could identify that the female voice in the video was Ms. Pratt. He reported that he could also hear Resident A moaning in the video. He reported that he was certain the noises coming from the resident in the video were from Resident A, even though he was not allowed to visually view the video. Mr. Felton reported that he did not feel Ms. Pratt was treating Resident A in a derogatory or uncaring manner during the video. He reported that Resident A has a history of deciding she does not want to walk and will drop herself to the floor. He reported that Resident A has been tested by physicians to see if this was related to a physical issue or a behavioral issue. Mr. Felton reported that the physicians who have assessed Resident A, believe this to be a behavioral issue. Mr. Felton reported that Resident A can walk, unassisted, but prefers direct care staff to walk with her. He reported she prefers this as this provides her additional attention. Mr. Felton reported that if Resident A does not like the activity, she will drop herself to the ground and sometimes refuse to get back up on her own. Mr. Felton reported that the direct care staff are trained to encourage Resident A to get herself up off from the ground when she exhibits this behavior. Mr. Felton reported that this is what he observed in listening to the audio recording was Ms. Pratt telling the resident that she would not get her off from the floor as the resident needs to be encouraged to help herself back to a standing position. Mr. Felton reported that Ms. Pratt has never been counseled for a resident rights violation and he feels that she is a good employee and very caring with the residents. Mr. Felton reported that he was not aware that this video existed until 11/25/24 when Mr. Lindley brought the video to his attention. Mr. Felton reported that the facility has a no cell phone policy for the direct care staff members, and they are not to use their cell phones during their shifts. Mr. Felton also reported that the facility has a no video or photography policy unless the guardian/responsible person has signed an agreement for the organization to video or photograph a resident for specific purposes.

During the on-site investigation on 12/3/24 I interviewed Ms. Clark. Ms. Clark reported that she is not aware of any video recordings taking place at the facility. She further reported that she has never been made aware that Ms. Pratt took a video of Resident A lying on the ground. Ms. Clark reported that Resident A does have behaviors where she will slide out of her seat and “throw” herself on the ground. Ms. Clark reported that once on the floor, Resident A requires the assistance of either a chair, or two direct care staff members to get up from the ground. She reported that Resident A can pull herself back up to a standing position by using a chair. She reported that one direct care staff member cannot stand Resident A to a standing position due to Resident A’s size. Ms. Clark reported that sometimes when a direct care staff member will attempt to assist Resident A from the floor, Resident A will pinch, hit, slap at the direct care staff member. Ms. Clark

reported that Resident A will moan and grunt at direct care staff when she does not want to get up from the floor.

During the on-site investigation on 12/3/24, I interviewed Meranda Clark. Meranda Clark reported that she has no knowledge of a video recording being taken of Resident A lying on the ground. She reported that Resident A does experience behaviors where she will grunt, stomp her feet, and pretend to lose her balance. She reported that Resident A can ambulate independently but will act out these behaviors for attention. Meranda Clark reported that she has observed Resident A drop herself down to the ground when she did not want to participate in an activity. She reported that when Resident A is on the floor the direct care staff usually bring a chair to her as she can use the chair to pull herself up. Meranda Clark reported that one person cannot get Resident A off from the floor without assistance due to her size. She reported that the facility is always staffed with two direct care staff members. Meranda Clark reported that she has observed Ms. Pratt attempt to help Resident A off from the ground and she has never observed her being rude or uncaring with Resident A.

During the on-site investigation I reviewed the following documents:

- *Michigan Workforce Background Check*, for Ms. Pratt. This document was dated 6/15/23 and identifies that she is eligible for employment.
- *Bay Human Services, Inc. Personnel Manual.* On page 4 of this document, Ms. Pratt signed, on 6/14/23, acknowledging receipt of the manual.
- *Assessment Plan for AFC Residents,* for Resident A, dated 3/29/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *B. Communicates Needs*, it reads, "[Resident A] can sometimes make her needs known through sign or words. Tends to grunt or stomp her feet when she is not understood." Under subsection, *I. Controls Aggressive Behavior*, it reads, "[Resident A] can get slightly physical when she does not get her way, or feels she's not getting enough attention." On page two, under section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, it reads, "[Resident A] can walk independently, but may need assistance at times."
- *Bay Human Services Media Release Form* for Resident A. This document is signed by Guardian A1 and dated 3/30/24. Guardian A1 indicated on this document that Bay Human Services Inc. has permission to take photographs, pictures, digital images, video recordings of Resident A. The document notes that the images can be used for "home use, consumer use, and/or agency use", specifically noting use for newsletters, company website, and company Facebook page.
- Direct care staff schedule for 7/9/24. This document identifies Ms. Pratt and Citizen 1 working on the evening the video of Resident A lying on the ground, was recorded.
- Community Mental Health Clinton/Eaton/Ingham (CMH-CEI), *Medical Visit Form*, for Resident A, dated 1/18/23. Under the section, *Doctor's Orders*, it reads, "Patient seen in clinic due to leg weakness and unwillingness to walk. Physical exam performed. No findings consistent with injury. Patient provided

HEP to improve strength and confidence. Patient to follow up in a month if needed."

- CMH-CEI, *Assessment*, for Resident A, dated 1/16/24. On page four, under the section, *Challenging Behaviors Summary*, it reads, "[Resident A] does have times when she will attempt to hit or kick staff and peers, however, home staff reports they are typically successful in re-directing this behavior. These behaviors continue to happen at a low frequency and intensity, but often vary based upon the individual at the home supporting her or what attention her peers are getting. New support staff are reminded that it takes [Resident A] time to acclimate to new changes and should be cognizant of this when working with her and providing personal care support. [Resident A] generally does not exhibit any form of property damage that would be of concern. She is able to participate in social situations and community setting, with support staff present for guidance and any necessary assistance. [Resident A] can pinch and scratch staff if she is feeling frustrated or doesn't want to participate in a specific task. Staff can attempt to redirect. This does not happen on a regular basis. If this does not work, it is best to let [Resident A] have some time to herself or move away from the task being asked. [Resident A] continues to work on independence in the home, especially so that she is not dependent upon the same staff daily. This has helped increase her own independence and decrease aggression/frustration with staff. No additional paid supports for specific behaviors are needed." On page five, under the section, *Current Abilities Summary*, beginning at sentence four, it reads, "[Resident A] is ambulatory, but walks slowly and only in places she is comfortable with. She often needs staff to help pull her out of chairs or resting situations, but she can stand on her own when she is encouraged to do so. She ambulates within her home, but is often in her wheelchair in the community, as she may refuse to ambulate and/or is unsteady/slowed in public settings." This document is signed by Lauren Spencer, LMSW, MSW, on 1/24/24.
- *PCP/IPOS Inservice Sign in Sheet*, for Resident A, with IPOS Date of 2/1/24. This document was signed by Ms. Pratt on 4/49/24.
- Staff progress notes, for Resident A, dated 7/9/24 with the time of 11pm to 7am, completed by Ms. Pratt, reads, "When staff arrived she was in her chair in the living room. It took both staff members to get her up. Staff got her to the hallway. It took several attempts to get her in to the bathroom. She was showered and the chose to walk down to her bedroom. When morning came staff go her up she started walking down to the bathroom. When she decided to drop to the floor in front of the bathroom door. After she was on the floor, she chose not. Staff continuously tried she chose not."

On 12/3/24, I interviewed Ms. Pratt via telephone. Ms. Pratt reported that she did take a video recording of Resident A on the floor at the facility. She reported that this recording was taken at some point near the "beginning of Summer" of the year 2024. She reported that she took the video because Resident A was on the ground demonstrating a behavior and she wanted to get advice from her manager on how to

handle this behavior. She reported that Resident A was soiled and needed a shower. She reported that the resident dropped to the ground and refused to get up from the ground. Ms. Pratt reported that she was working on this date and time with Citizen 1, and he had to pick up Resident A and carry her to the shower. Ms. Pratt reported that she took the video and sent a copy to Ms. Clark for her review and guidance. Ms. Pratt reported that she did not send the video to any other individual. She reported that she spoke to Ms. Clark, via telephone, on this date and Ms. Clark advised her how to manage Resident A's behavior. Ms. Pratt reported that these are common behaviors for Resident A and the facility is always staffed with two direct care staff members as one direct care staff member cannot assist Resident A off from the ground independently.

On 12/3/24 I interviewed Ms. Smith, via telephone, regarding the allegation. Ms. Smith reported that she has not been made aware of any video taken of Resident A lying on the ground at the facility. Ms. Smith reported that Resident A does have behaviors where she will scratch, punch, slap, and throw herself on the ground. She reported that Resident A is able to ambulate independently but will throw herself to the ground if she does not want to participate in a task. Ms. Smith reported that there are times the direct care staff will need to contact management to have them talk to Resident A, via telephone, to encourage her to get off from the ground because she prefers certain people better than others. Ms. Smith reported that Resident A can recognize Mr. Felton's voice on the telephone and will usually perform tasks for him when requested. Ms. Smith reported that the direct care staff do encourage Resident A to stand herself back up by offering her a chair to pull herself up on. She reported that this is usually better received by Resident A than direct care staff assisting as she can become agitated with that.

On 12/3/24 I interviewed Citizen 1, via telephone, regarding the allegation. Citizen 1 reported that he does not recall an occasion where Ms. Pratt took a video recording of Resident A lying on the ground at the facility. Citizen 1 reported that it is common for Resident A to drop herself to the floor and refuse to stand for direct care staff.

On 12/12/24 I had email communication with CMH-CEI, case manager, Lauren Spencer. Ms. Spencer confirmed that she had been the case manager for Resident A for multiple years up until November 2024. She reported that she did not have any concerns about the care Resident A was receiving at the facility from direct care staff members. Ms. Spencer reported that there was a history with Resident A refusing to walk, dating back "several years". She reported that the direct care staff were diligent about having Resident A seen by physicians to rule out any physical/medical conditions causing her inability/unwillingness to walk. Ms. Spencer reported that any physical concerns had been ruled out and Resident A has regular visits with a psychiatrist through CMH-CEI and it is believed that these refusals to walk are behavioral episodes. Ms. Spencer reported that she has observed the direct care staff providing encouraging words to Resident A in attempts to help her be independent with her ambulating. She further reported that she had never witnessed

Resident A sit on the floor and refuse to get up, but she had received reports of such behaviors.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews conducted with Mr. Lindley, Mr. Felton, Ms. Pratt, Ms. Clark, Meranda Clark, Ms. Spencer, Citizen 1, & Ms. Smith, as well as documentation reviewed from Ms. Pratt's employee file, and Resident A's resident record it can be determined that Ms. Pratt did video Resident A and distribute this video, via cell phone, to other parties without the consent of Guardian A1. Even though, Guardian A1 did sign a Media Release Form on 3/30/24, this document identified the authorization of pictures or videos of Resident A for media purposes. Ms. Pratt acknowledged that she took this video of Resident A to obtain assistance from Ms. Clark with how to manage the behavior that Resident A was exhibiting. She then sent the video via cell phone text message to Ms. Clark. This video was then released to Adult Protective Services by an unknown source, further violating Resident A's right to privacy. I did not find that Ms. Pratt was treating Resident A in a derogatory manner via the care she was providing, but I do find that a privacy violation has occurred. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

12/13/24

Jana Lipps Date
Licensing Consultant

Approved By:

12/17/2024

Dawn N. Timm Date
Area Manager