GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

May 1, 2025

RE: License #: AS520382182
Investigation #: 2025A0873012
Bay View

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.

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520382182
Investigation #:	2025A0873012
Complaint Receipt Date:	03/20/2025
Investigation Initiation Date:	03/24/2025
Report Due Date:	05/19/2025
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd , Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	James Pilot
Licensee Designee:	Melissa Rood
Name of Facility:	Bay View
Facility Address:	83 W. M-35, Gwinn, MI 49841
Facility Telephone #:	(906) 346-2219
Original Issuance Date:	08/18/2016
License Status:	REGULAR
Effective Date:	02/18/2025
Expiration Date:	02/17/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION

	Violation Established?
Staff was sleeping, resulting in Resident A's hospitalization.	No
Additional Findings	Yes

III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A0873012
03/24/2025	Special Investigation Initiated - Letter Email to APS/open case
03/24/2025	APS Referral Referred by APS
04/02/2025	Inspection Completed On-site
04/02/2025	Contact - Face to Face Interviews with Ms. Larson and Ms. Frossoehme
04/02/2025	Contact - Document Received Incident report received
04/14/2025	Inspection Completed On-site
04/14/2025	Contact - Face to Face Interview with Ms. Snay
05/01/2025	Contact - Telephone call made Interview with Ms. Wixtrom
05/01/2025	Inspection Completed-BCAL Sub. Compliance
05/12/2025	Exit Conference With Melissa Rood

ALLEGATION:

Staff was sleeping, resulting in Resident A's hospitalization.

INVESTIGATION:

On 3/21/25, I received a complaint regarding Resident A's hospitalization. Staff at the home may have been sleeping on the job, leading to Resident A's condition deteriorating, requiring hospitalization.

On 4/2/25, I interviewed home manager Patti Larson at the facility. Ms. Larson came to the facility at approximately 7:00am on 3/18/25 and observed Resident A unresponsive on the couch. Resident A regularly slept on the couch. Resident A had a history of subclinical seizures. Emergency medical services (EMS) were called and Resident A was transported to the hospital. Ms. Larson had no evidence that staff Brittany Snay slept on the job.

On 4/2/25, I interviewed staff Ashley Grossoehme at the facility. Ms. Grossoehme arrived at the facility at approximately 7:15am on 3/18/25. EMS arrived at the same time. The day before, Resident A's behavior was difficult. In the morning he was loud and aggressive but by lunch he mellowed out. By evening Resident A was lying on the couch. Staff called Ms. Larson to come and check on him and take vitals, all of which were normal. Breathing was normal. When staff attempted to take Resident A's blood pressure, he pulled away from them. Ms. Grossoehme has never known staff Snay to sleep on the job.

On 4/2/25, I reviewed the incident report. The report read that on 3/17/25, Ms. Larson checked Resident A's vitals which were in a good range. Ms. Larson told the night shift to continue monitoring Resident A and call EMS if his condition changed. No changes were noticed throughout the shift. Morning staff reported that Resident A had two seizures between 6:40am and 7:00am. Resident A's breathing had changed and when his vitals were taken it was noted that his oxygen levels were at 70% and his pulse was 123 beats per minute. Ms. Larson called EMS at 7:14am. When EMS arrived, Resident A had a third seizure. EMS transported Resident A to the hospital where he is currently in the ICU, in a coma with respiratory failure.

On 4/14/25, I interviewed staff member Brittany Snay at the facility. On 3/17/25, Ms. Snay left the facility at approximately 10:00pm. During that shift Resident A was acting irrationally and refused medications, including seizure medications. Resident A's vitals were consistent throughout the shift. Ms. Snay arrived back at the facility approximately 6:00am on 3/18/25 and noticed Resident A's breathing was different. Ms. Snay asked the night shift about Resident A's breathing and they reported to her it was fine. Resident A had two seizures between 6:00am and 7:00am. Because of the condition of Resident A, staff called Ms. Larson to come to the facility. Ms. Snay denied sleeping while working at the facility.

On 5/1/25, I interviewed Upper Peninsula Health System resident nurse care manager June Wixtrom over the telephone. When Resident A arrived at the hospital he was non-responsive. Resident A was put on a ventilator. During his entire time at the hospital he was having repeated subclinical seizures. Resident A was not responsive during his time at the hospital and has since been transferred to a facility in lower Michigan, still in a coma and on a ventilator.

APPLICABLE RULE	
R 400.14206	**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 care agreement and assessment plan.
ANALYSIS:	I found no evidence that staff member Brittany Snay was sleeping while on duty.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 4/2/25, I reviewed the incident report from 3/18/25. Staff member Snay, after arriving for her shift at 6am, noticed Resident A’s breathing had changed and he was having seizures. Ms. Larson arrived at the facility at 7:00am and reported Resident A’s oxygen to be at 70% with an elevated pulse. EMS was contacted at 7:15am.

On 4/14/25, I interviewed staff Snay at the facility. Ms. Larson was contacted and asked to come to the facility at 7am because Resident A’s breathing had changed and he was having seizures.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Staff noticed Resident A was having seizures and his breathing had changed. Instead of contacting EMS, staff called home manager Larson to come and check on him. Given the circumstances of the situation staff should have obtained emergency care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/12/25, I explained the findings of this report to licensee designee Melissa Rood. She reported that not calling EMS in that type of situation is against their company policy as well.

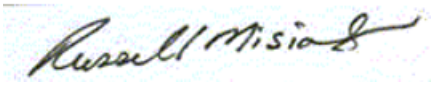
IV. RECOMMENDATION

Contingent upon receipt of an appropriate corrective action plan, I recommend no changes to the status of this license.

5/1/25

Garrett Peters Date
Licensing Consultant

Approved By:



5/1/25

Russell B. Misiak Date
Area Manager