GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 31, 2026

Matthew Scharich
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090084054
Investigation #:	2026A0123045
	Brookwood CLF

Dear Matthew Scharich:

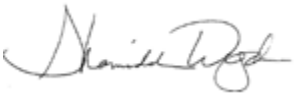
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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

License #:	AS090084054
Investigation #:	2026A0123045
Complaint Receipt Date:	07/13/2026
Investigation Initiation Date:	07/14/2026
Report Due Date:	09/11/2026
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	3463 Deep River Rd P.O. Box 741 Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Melissa Rood
Licensee Designee:	Matthew Scharich
Name of Facility:	Brookwood CLF
Facility Address:	909 Murphy St. Bay City, MI 48706
Facility Telephone #:	(989) 686-1999
Original Issuance Date:	12/01/1998
License Status:	REGULAR
Effective Date:	05/17/2026
Expiration Date:	05/16/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/05/2026, staff LaToya Young was asleep during her shift.	Yes
Staff Young has refused to help Resident B with showering.	No

III. METHODOLOGY

07/13/2026	Special Investigation Intake 2026A0123045
07/14/2026	Special Investigation Initiated – Telephone- I spoke with recipient rights officer Angela Wend.
07/15/2026	Inspection Completed On-site- I conducted an unannounced on-site at the facility.
07/31/2026	Contact - Telephone call made- I made a follow-up call to the facility. I interviewed Resident B.
07/31/2026	Contact - Telephone call made- I interviewed staff LaToya Young.
08/05/2026	Contact - Telephone call made- I interviewed staff Julie Bohnow.
08/18/2026	APS Referral- APS referral completed.
08/20/2026	Contact- Telephone call made- Follow-up interview with staff LaToya Young via phone.
08/20/2026	Contact- Document Sent- I requested documentation from the facility.
08/21/2026	Contact- Document Received- Requested documentation received.
08/21/2026	Contact- Telephone call made- FaceTime call with Resident B.
08/24/2026	Exit Conference- I spoke with LD Matthew Scharich.

ALLEGATION:

- **On 07/05/2026, staff LaToya Young was asleep during her shift.**
- **Staff Young has refused to help Resident B with showering.**

INVESTIGATION: On 07/10/2026, the Bureau of Community and Health Systems received the allegations noted above. The complaint notes that Staff LaToya Young did not feed breakfast to Resident A and Resident B. The residents did receive their breakfast from another staff person on shift. Staff Young refused to assist Resident B while Resident B was showering.

On 07/14/2026, I spoke with recipient rights officer Angela Wend via phone. Angela Wend stated that she spoke with Resident A and Resident B who reported that the allegations were true. Staff Julie Bohnow was also present on shift. Staff LaToya Young was asleep on a recliner chair under a blanket. Staff Bohnow was passing medications at the time. She stated that both residents reported they tried to awaken staff to assist them with breakfast. Resident B also mentioned that Staff Young has refused to assist Resident B with shaving her armpits in the shower. Resident B does not feel safe to do so due to having "*shakes*" (i.e. tremors).

On 07/15/2026, I conducted an unannounced on-site at the facility. I interviewed home manager Karie Duff and Resident A. Resident B was not present. During this on-site, I observed several other residents throughout the facility. They appeared clean and appropriately dressed.

During this on-site, I interviewed home manager Karie Duff. Staff Duff stated that Staff Young's employment has been terminated due to unrelated reasons. She stated that Resident B was instructed to let staff know when she is going to shower so staff can assist her. She states that sometimes Resident B does not tell staff when she is getting in the shower. She stated that Staff Young reported that Resident A did ask for breakfast, and Staff Young told Resident A she needed to get her blood sugar levels checked and medication prior to eating. Staff Duff stated that this was at 5:30 am that Resident A requested breakfast, and the medication pass is scheduled for 6:00 am. She stated that according to the medication order, Resident A has to wait 20 minutes before eating.

During this on-site, I interviewed Resident A. Resident A stated that she was at the dining room table waiting for breakfast and had already had her insulin shot administered. Resident A asked Staff Young for food, and Staff Young never responded. Resident A stated Staff Young was in a recliner covered up under a blanket. Resident A stated she has trouble reading, so she asked staff Julie Bohnow what was on the menu for breakfast. Staff Bohnow told Resident A to ask Staff Young because she was passing medications, and Staff Young was responsible for fixing breakfast. Resident A stated Staff Bohnow asked her if she woke Staff Young up, Resident A replied that she tried to. Then Staff Bohnow instructed Resident A to fix herself a bowl of cereal due to Resident A's blood sugar being low and shaking.

Resident A stated that she can fix her own cereal, and Staff Bohnow was still passing medications. Resident A stated after Staff Young woke up, Staff Young said she would make breakfast. Resident A told Staff Young she had cereal already. Staff Young got upset at Resident A for eating the cereal before Staff Young could make breakfast. Resident A stated that Resident B was not a part of this situation, and that Resident B was still asleep at the time Resident A ate the cereal. Resident A stated that she did not tap Staff Young awake because she did not want Staff Young to get upset with her. She stated that there was another incident where Staff Young was upset with her (Resident A) for being in the kitchen. Staff Young told Resident A that the kitchen was for staff only, and Resident A was only getting a glass of tap water. Resident A also stated that Staff Young got snappy with her over unwashed dishes that were not Resident A's dishes, as Resident A had already washed her own dishes. Resident A stated that breakfast is served when you wake up, but she has to wait 20 minutes after her medication to eat. Resident A stated that Resident B (her roommate) goes into the bathroom and does not tell staff that she is getting into the shower. Resident B will come out of the bathroom, and you can tell Resident B's hair would still need to be washed. Resident A stated that she will tell Resident B to let staff know she is getting in the shower, and Resident B will say, "*I'm fine*." Resident A stated that Resident B does not ask for things and will just do things without asking (i.e. take showers, grab snacks.)

On 07/16/2026, I received requested documentation from the facility. Resident A's medication administration records (MAR) for July 2026 notes that Resident A receives Novolog INJ FLEXPEN daily (Inject subcutaneous per sliding scale before meals) and Novolog INJ FLEXPEN (100 unit/ML; inject 4 units subcutaneous twice daily at breakfast and lunch; check blood sugar prior to dose and add additional units per sliding scale onto dose if needed). The MAR notes that staff Julie Bohnow passed Resident A this medication for 6:00 am on 07/05/2026.

A copy of Resident A's *Assessment Plan for AFC Residents* dated 06/16/2026 notes that staff dispenses Resident A's medication. For *Eating/Feeding* it notes that Resident A is diabetic and staff will cook the meals needed and follow dietary instructions. The assessment plan notes Resident A is on a special diet.

A copy of Resident B's *Assessment Plan for AFC Residents* dated 02/19/2026 notes that staff assist Resident B with washing hair and reminders for washing her body in the shower. Resident B's *Individual Plan of Service* dated 03/05/2026 notes that staff are to "*teach, role model, provide hand over hand assistance and/or assist as needed to support [Resident B] participating in washing her hair and hands daily. This will help increase [Resident B's] independent living skills. Home staff will assist [Resident B] with this goal daily and document participation and refusals daily as they occur*."

On 07/31/2026, I made a follow-up call to the facility. I interviewed Resident B. Resident B stated that staff Latoya Young never refused her any food, or to feed Resident B. Resident B reported not knowing if Staff Young refused anyone else their

breakfast. Resident B stated that she personally never saw Staff Young sleeping. Resident B stated that Staff Young would not help her with washing her hair, after telling Staff Young that she was getting in the shower. She stated that Staff Young just said "*okay*" and never came to the bathroom. Resident B stated that she does not remember what day or month this happened.

On 07/31/2026, I interviewed staff LaToya Young via phone. Staff Young denied the allegations. She stated that she was told she was fired due to not completing training videos. She denied sleeping. She stated that she was told that what she does on her breaks is up to her. She stated that other staff sleep during their shifts. Staff Young stated she received a warning about sleeping once, and never did it again. She stated that she received the warning before 07/05/2026. Staff Young stated that Resident B follows Resident A. Both residents are independent. Resident A got upset that she (Staff Young) asked Resident A to wash a bowl, and Resident A made a complaint that Staff Young was on shift asleep. She denied not fixing the residents breakfast because she was asleep. She stated the allegations are not true.

On 08/05/2026, I interviewed staff Julie Bohnow via phone. Staff Bohnow stated that on 07/05/2026, staff LaToya Young was asleep. Resident A attempted to wake up Staff Young. Staff Bohnow reported personally witnessing Staff Young asleep in the front living room. Staff Young was supposed to be the one to fix breakfast, as Staff Bohnow was passing medication. Resident A had received her morning diabetic medication. Staff Bohnow stated that Staff Young was terminated due to falling asleep while doing online job training. Staff Bohnow stated that she could not stop to get Resident A breakfast due to being in the middle of medication passing. She stated that after she finished passing medication, she got Resident A some breakfast. Staff Bohnow stated that Resident B is sneaky and does not tell staff when Resident B gets in the shower. Staff Bohnow stated Resident B attempted this same behavior last night, and she (Staff Bohnow) had to redirect Resident B. Staff Bohnow stated she does not believe Staff Young refused to assist Resident B in the shower. Staff Young was just rude with how she would say things. She stated that Staff Young told the residents that they are "*full grown women who need to get up and do their own dishes.*"

On 08/20/2026, I made a follow-up call to staff LaToya Young. She denied the allegation that she refused to help Resident B with showering. She stated that is not true. She stated that Resident B would get in the shower without telling staff, and by the time staff knew Resident B was already out of the shower. She stated that some of the staff and staff Karie Duff gave Resident B the impression she could shower independently. She stated that Staff Duff said both Resident A and Resident B are independent. She stated that she was told to read their assessment plans and individual plans of services but did not read them all. She stated that she did not sign she read Resident A's assessment plan because Resident A was a new resident. She stated that Resident B would tell staff she washed her hair, and her hair was clean. She stated she also washed Resident B's hair, and it was not greasy or unclean.

On 08/20/2026, I received requested documentation regarding Resident A's special diet. A *Medical Appointment Progress Note* dated 07/27/2026 notes Resident A received medical care on this date and was diagnosed with non-infectious pancolitis. Resident A was instructed to eat a soft diet for two to three days, then a high fiber diet. A *Professional Order* dated 07/25/2025, staff notes that a nurse ordered Resident A be on a BRAT diet. A *Bay-Arenac Behavioral Health Nutrition Treatment Plan Addendum II* dated 07/30/2026, extensively details foods to avoid to promote healing from Pancolitis and GERD.

On 08/21/206, I made a call to the facility, and conducted a FaceTime call with Resident B, and manager Dawn Richter. Resident B stated that things are going well. Staff have been helping Resident B wash her hair. Resident B reported receiving assistance with hair washing last night. Resident B appeared clean and appropriately dressed. No issues were noted.

Bay Human Services, Inc. has a *Sleeping on Duty* policy that notes the following:

"Sleeping on duty is strictly prohibited. Giving the appearance of sleeping on company premises is not permitted. Secluding oneself for the purpose of sleeping may result in immediate termination. Sleeping on duty is strictly prohibited unless special work situations are involved and prior approval has been granted, ie: travel."

On 08/24/2026, I conducted an exit conference with licensee designee Matt Scharich. I informed LD Scharich of the findings and conclusions. LD Scharich confirmed that the Bay Human Services policy for sleeping on duty is still in effect.

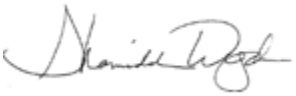
APPLICABLE RULE	
R 400.701	**Required personnel policies.**
	(1) A licensee shall have all the following written policies and procedures: **(b) Resident care related prohibited practices.**
ANALYSIS:	On 07/15/2025, I conducted an unannounced on-site at the facility. Resident A reported that on 07/15/2026 at breakfast time, Staff LaToya Young was asleep at the time Resident A needed breakfast. On 07/31/2026, I interviewed staff LaToya Young. She denied the allegations. Staff Young reported receiving a warning about sleeping once, and never did it again. She stated that she received the warning before 07/15/2026. On 08/05/2026, I interviewed staff Julie Bohnow who reported witnessing Staff LaToya Young asleep during her shift.

	There is a preponderance of evidence to substantiate a rule violation regarding staff LaToya Young who was reportedly witnessed sleeping while on duty on 07/15/2026. Bay Human Services Inc. has a policy against staff sleeping while on duty. Per the policy, sleeping on duty is strictly prohibited.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	On 07/15/2025, I conducted an unannounced on-site at the facility. Resident A stated that Resident B (Resident A's roommate) goes into the bathroom and does not tell staff that she is getting into the shower. On 07/16/2026, I received requested documentation from the facility. Resident B's *Individual Plan of Service* dated 03/05/2026 notes that staff are to "*teach, role model, provide hand over hand assistance and/or assist as needed to support [Resident A] participating in washing her hair and hands daily.* On 07/31/2026, I interviewed staff LaToya Young. She denied the allegation that she refused to help Resident B with showering. On 07/31/2026, I made a follow-up call to the facility. I interviewed Resident B who reported that Staff Young refused to assist Resident B with showering. On 08/05/2026, I interviewed staff Julie Bohnow who reported Resident B does not inform staff when Resident B is going to take a shower. There is not a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action, I recommend continuation of the AFC small group home license (capacity 3-6).



08/31/2026

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:

 for 8/31/2026

_____

Mary E Holton Date
Area Manager