GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2026

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

RE: License #: AS090391446
Investigation #: 2026A0572052
Bangor

Dear Matt 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.
- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090391446
Investigation #:	2026A0572052
Complaint Receipt Date:	08/31/2026
Investigation Initiation Date:	09/02/2026
Report Due Date:	10/30/2026
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Melissa Rood
Licensee Designee:	Matt Scharich
Name of Facility:	Bangor
Facility Address:	3501 Bangor Rd Bay City, MI 48706
Facility Telephone #:	(989) 684-8019
Original Issuance Date:	03/14/2018
License Status:	REGULAR
Effective Date:	09/14/2026
Expiration Date:	09/13/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's wheelchair tipped backward during van transport, causing him to hit his head and require medical evaluation.	Yes

III. METHODOLOGY

08/31/2026	Special Investigation Intake 2026A0572052
09/02/2026	Special Investigation Initiated - On Site Home Manager, Becky Coyer; Resident B, Resident C and Resident A.
10/07/2026	Contact - Telephone call made Ex-Staff, Karie Duff.
10/08/2026	Inspection Completed-BCAL Sub. Compliance
10/08/2026	APS Referral An APS Referral was made.
10/08/2026	Exit Conference Licensee Designee, Matt Scharich

ALLEGATION:
Resident A's wheelchair tipped backward during van transport, causing him to hit his head and require medical evaluation.

INVESTIGATION:
On 08/31/2026, the local licensing office received a complaint for investigation. Recipient Rights made a referral to licensing for further investigation.

On 09/02/2026, I made an unannounced onsite at Bangor located in Bay County Michigan. Interviewed were, Home Manager, Becky Coyer; Resident B, Resident C and Resident A. Staff, Karie Duff was not working today.

On 09/02/2026, I interviewed Home Manager, Becky Coyer regarding the allegation. Becky Coyer says that Karie Duff has worked for the company for approximately 10 years and was a former Home Manager for another home within the company but recently stepped down to a Direct Support Professional (DSP). Karie Duff was

trained in how to fasten wheelchairs in the van on her 1st day at Bangor. During the incident, the residents were going on an outing. Resident A's wheelchair wasn't fully secured, causing him to fall backwards, hitting his head. Karie Duff pulled over on the side of the road, called staff that were at the home. Karie Duff then fastened Resident A and brought him back home, before leaving again to transport him to the Emergency Room. The incident caused Resident A to receive a goose egg on the side of his head.

On 09/02/2026, I received the Van Policy for Bangor. It indicates the standards, procedures and responsibilities and it also outlines steps on how to secure a resident with a wheelchair in the van.

On 09/02/2026, I interviewed Resident B regarding the allegation. Resident B indicated that the staff took off too fast and it caused Resident A to flip backwards. Resident B shouted, "Oh no, he flipped back!" to the staff when Resident A fell backwards. Him and another resident helped lift Resident A back up, as Resident A's foot was stuck in between the seat. Resident B said that he told staff, Karie Duff that it looked as if she only locked his back wheels and not the front ones. Resident B indicated that they didn't go far. They only went as far as the house next door from their home. Karie Duff locked Resident A in, took the residents back home and then transported Resident A to the emergency room. Resident B said he heard it when Resident A hit his head and said that the staff person is a very fast driver.

On 09/02/2026, I interviewed Resident C regarding the allegation. Resident C heard a loud, "Boom" when the incident occurred. She was sitting in the front seat and saw that Resident A had fallen backwards in his wheelchair. Resident C says that Staff, Karie Duff was driving too fast and his seat was not locked in. When he hit his head, he was yelling, "Help me, help me!"

On 09/02/2026, I interviewed Resident A regarding the allegation. Resident A informed that he thinks that he was not locked in all the way, which caused him to fall backwards. Resident A denied that Staff, Karie Duff was driving too fast. Resident A believes that he hit his head. Resident A is unsure who helped him up.

On 09/02/2026, I reviewed the Incident Report which indicates that on 08/27/2026, Karie Duff was backing out of driveway when Resident A's wheelchair fell backwards, causing Resident A to hit head. The Corrective Measures is for staff to make sure that Resident A's wheelchair is buckled in before pulling off and everyone in van must also be secure while in the van. The Action Taken was Resident A was taken to the hospital for a scan and sent home.

On 10/07/2026, I interviewed Ex-Staff, Karie Duff regarding the allegation. Kaire Duff informed that she had just backed out of the driveway, she put it in drive, and as soon as she accelerated, Resident A's wheelchair tipped backwards. She stopped the van, helped Resident A back up and secured him in the van. She eventually transported Resident A to the ER and indicated that a bruise on the back of his head

appeared the next day. Karie Duff had been with the company for 10 years working in a different home and had stepped down to a DSP. She explained that the van was different from the van at the other home. She explained that she was never trained on that van and had asked the Home Manager to train her after the incident had occurred but never received the training. Karie Duff denied driving fast and said she only made it to in front of the next-door neighbor's house when the incident occurred. Karie Duff stated that she thought he was fully secure. Karie Duff was no longer allowed to transport residents in wheelchairs, up until she ended her employment with the company.

On 10/08/2026, I made a referral to Adult Protective Services (APS). The allegations of this investigation were shared.

On 10/08/2026, I held an exit conference with Licensee Designee, Matt Scharich regarding the results of the special investigation. Matt Scharich did not have any issues, concerns or anything to add regarding the results of the special investigation.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the interviews of the home manager, residents and former staff, there is enough evidence to establish a violation of licensing rules. Staff were leaving the home to take some of the residents on an outing when Resident A's wheelchair fell backwards, causing him to sustain a head injury. All that was interviewed indicated that this incident did occur.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

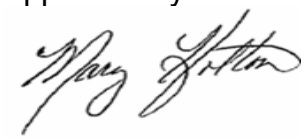
I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 3-6).



10/08/2026

Anthony Humphrey — Date
Licensing Consultant

Approved By:



10/08/2026

Mary E. Holton — Date
Area Manager