GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 1, 2022

Vonda Willey
Blue Water Developmental Housing, Inc.
Ste 1
1600 Gratiot
Marysville, MI 48040

RE: License #:	AS740013018
Investigation #:	2023A0123001
	Eunice Hayes Home

Dear Mrs. Willey:

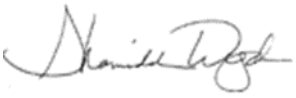
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS740013018
Investigation #:	2023A0123001
Complaint Receipt Date:	09/29/2022
Investigation Initiation Date:	09/30/2022
Report Due Date:	10/29/2022
Licensee Name:	Blue Water Developmental Housing, Inc.
Licensee Address:	Ste 1 1600 Gratiot Marysville, MI 48040
Licensee Telephone #:	(810) 388-1200
Administrator:	Vonda Willey
Licensee Designee:	Vonda Willey
Name of Facility:	Eunice Hayes Home
Facility Address:	4291 Peck Road Port Huron, MI 48060
Facility Telephone #:	(810) 984-4083
Original Issuance Date:	11/07/1985
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was kicked out of the group home due to his aggressive behaviors. Resident A is at McLaren Hospital and has been medically cleared for discharge. At this time, Resident A has nowhere to go.	Yes

III. METHODOLOGY

09/29/2022	Special Investigation Intake 2023A0123001
09/29/2022	APS Referral Information received regarding APS referral.
09/29/2022	Contact - Document Received Incident reports and Resident A's discharge notice received via email.
09/30/2022	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
10/18/2022	Contact - Telephone call made I left a voicemail requesting a return call from Guardian 1.
10/18/2022	Contact - Document Sent I sent a follow-up email to Andrea Bubel requesting a return call.
10/18/2022	Contact - Telephone call made I left a message requesting a return call from McLaren Port Huron patient advocate Joshua Koehn.
10/18/2022	Contact - Telephone call received I spoke with Ms. Bubel via phone.
10/18/2022	Contact - Telephone call received I spoke with Mr. Koehn from McLaren Port Huron via phone.
10/18/2022	Contact - Telephone call made I made a follow-up call to CMH placement coordinator Ms. Allen. I left a voicemail requesting a return call.

10/18/2022	Contact - Telephone call received I received a voicemail follow-up from Mr. Koehn.
10/19/2022	Contact - Telephone call received I spoke with Ms. Allen from CMH via phone.
10/28/2022	Contact- Telephone call made I made a second attempted call to Guardian 1. There was no answer.
10/28/2022	Contact- Telephone call received I spoke with Guardian 1 via phone.
10/28/2022	Contact- Telephone call made I made a call to Resident A's case manager Cheyenne Johnston via phone. I left a voicemail requesting a return call.
10/28/2022	Contact- Telephone call received I spoke with case manager Cheyenne Johnston via phone.
11/01/2022	Exit Conference I spoke with licensee designee Vonda Willey.

ALLEGATION: Resident A was kicked out of the group home due to his aggressive behaviors. Resident A is at McLaren Hospital and has been medically cleared for discharge. At this time, Resident A has nowhere to go.

INVESTIGATION: On 09/29/2022, I received seven incident reports via email. The first incident report dated for 09/29/2022 at 7:45 am states that Resident A choked staff Tammy Norman. Staff Norman received several scratches and welts. 911 was called, the police arrived and transported Resident A to McLaren Hospital. The incident report states that Resident A was given an emergency discharge from the facility. An incident report dated 09/28/2022 at 8:00 pm states that Resident A choked a staff person, Lyndsay Wood, which caused the staff to cough and vomit. Other staff intervened by physically releasing his grip and redirecting him. A third incident report dated 09/28/2022 at 5:40 pm notes that Resident A scratched another resident's neck and began to choke the other resident. Staff intervened and redirected Resident A out of the living room. A fourth incident report dated for 09/28/2022 at 5:10 pm notes that Resident A began choking another resident that was sitting in the living room watching television. Staff intervened. A fifth incident report dated 09/28/2022 again at 5:10 pm notes that Resident A began choking staff Ericka Colden while she was in the medication room. Staff Colden used disengagement skills, and other staff redirected Resident A. On 09/28/2022, at 11:30 am, an incident report notes that Resident A choked the home supervisor, breaking his necklace, while on the back deck. A seventh incident report for the same date and time notes that Resident A choked staff Tammy Norman and tore her t-shirt.

Each incident report notes that staff tried to verbally ask Resident A to release his grip and that disengagement skills were used to stop him from choking others. The corrective measures were that Resident A has been given an emergency discharge notice.

On 09/30/2022, I conducted an unannounced on-site visit at the facility. I interviewed home manager Troy McFarlane and residential services division director Andrea Bubel. Ms. Bubel and Mr. McFarlane stated that Resident A was choking other residents and had choked a staff person to the point of vomiting, scratches, and marks. Resident A is still at the hospital and has not been released. They stated that had Resident A been released yesterday, he would have come back to the facility, and that Resident A may be undergoing a psychological evaluation.

On 09/30/2022, during the unannounced on-site visit, I interviewed community mental health clinical case managers Ryan Gladfelter and Ellen Drowns, and case manager/placement coordinator Katherine Allen. Ms. Drowns stated that she saw that Resident A went to the hospital, and that Resident A has a “nice firm grip.” Mr. Gladfelter stated that he received an email about Resident A assaulting Resident B from Staff McFarlane. He stated that he did not mention it to Resident B because he did not want to trigger Resident B. He stated that Resident A grabs to get attention. Ms. Allen stated that she used to be Resident A’s case manager, and that this behavior is out of character for him. She stated that another facility conducted an interview regarding placement for Resident A, and that they are looking for an out of county placement for him. Mr. Gladfelter stated that if Resident A was medically discharged with nowhere to go, is because the facility is not accepting him back. During this interview, Ms. Allen referred to an email that stated that a hospital nurse requested a phone conference regarding Resident A being medically cleared and ready for discharge, and that someone said in the email chain that Blue Water gave an emergency discharge notice, and that Resident A cannot be discharged back to the home. Ms. Allen stated that no one from CMH gave the order to leave Resident A at the hospital. They reported that it is not normal to have a hospital as the discharge plan, but in the last couple of months hospitals have been working with them.

On 10/18/2022, I spoke with Ms. Bubel via phone. She stated that Resident A was taken by police to the hospital on 09/29/2022 at about 7:00 am. She stated that the hospital did not discharge Resident A within those 24 hours, and had they, the facility would have taken him back. She stated that community mental health did not update them on Resident A until after the discharge notice date. She stated that multiple residents were being choked by Resident A, and that Resident A choked a staff member to the point of vomiting. She stated that CMH agreed with the discharge. She stated that Resident A was in the hospital prior to being admitted to Eunice Hayes Home.

On 10/18/2022, I spoke with Joshua Koehn, McClaren Port Huron’s patient advocate. He stated that Resident A left the hospital on 10/07/2022 and was

admitted on 09/29/2022. I asked Mr. Koehn if Resident A was medically ready for discharge prior to 10/07/2022. He stated that he will review Resident A's chart and call back. Mr. Koehn called back and left a voicemail stating that he did some looking into Resident A's record, and also spoke with a CMH hospital liaison. He stated that the hospital was trying to get Resident A back to his AFC home, but the home refused to take Resident A back. He stated that Resident A had to sit there at the hospital until a new placement was found for him.

On 10/19/2022, I spoke with CMH placement coordinator Katherine Allen via phone. She stated that Resident A was placed at a facility in Lapeer, MI. She stated that Resident A was admitted to the facility on 09/26/2022. She stated that Resident A was placed in the facility from a hospital, and the facility put him back in the hospital, and refused to take him back, per a doctor at the hospital. She stated that Resident A did have to stay at the hospital until a new placement was found.

On 10/28/2022, I spoke with Guardian 1 via phone. Guardian 1 denied having any concerns but stated that the discharge was abrupt and surprising. He stated that Resident A got aggressive, so he understands. He stated that Resident A was in the hospital for maybe a couple of weeks and was in the hospital until a new placement was found for him. He stated that he had received a call from who he believes was the director of the Blue Water Developmental Housing, Inc. informing him they would not be welcoming Resident A back to Eunice Hayes. He stated that Resident A only resided at the facility for about four days.

On 10/28/2022, I spoke with Resident A's community mental health case manager Cheyenne Johnston via phone. She stated that when she returned from vacation on 10/03/2022, she found out that Resident A was in the hospital. She stated that Resident A resided at the facility from 09/26/2022 through 09/29/2022. She stated that Resident A left the hospital on 10/07/2022. She stated that she is not familiar with the staff in the home, and that her co-worker Ellen Drowns noted that Resident A was struggling a bit. She stated that Eunice Hayes is a behavioral home. She stated that this was not Resident A's normal behavior and that he was not placed in behavioral homes before being placed in this facility.

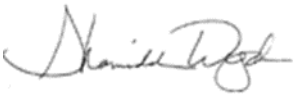
APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local**

	community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	On 10/18/2022, I spoke with Joshua Koehn, McClaren Hospital Port Huron's patient advocate. He reported that the hospital was trying to get Resident A back to his AFC home, but the home refused to take Resident A back. He stated that Resident A had to sit there at the hospital until a new placement was found for him. He reported that Resident A left the hospital on 10/07/2022. On 10/19/2022, CMH Placement coordinator Katherine Allen reported that per a doctor from McLaren Port Huron Hospital reported that the hospital was trying to get Resident A back to the facility, but the home refused to take him back, and Resident A had to stay at the hospital until a new placement was found for him. On 10/28/2022, I spoke with both Guardian 1 via phone who stated that he was informed that the facility would not take Resident A back, and that Resident A was in the hospital until placement was found for him. The facility issued a 24-hour discharge notice to Resident A on 09/29/2022. He was at the hospital between 09/29/2022 and 10/07/2022, until a new AFC placement was found for him, but was reportedly medically ready for discharge prior to 10/07/2022. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/01/2022, I conducted an exit conference with licensee designee Vonda Willey via phone. I informed of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6)



11/01/2022

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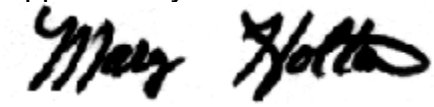
Shamidah Wyden Date
Licensing Consultant

Approved By:



11/01/2022

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Mary E. Holton Date
Area Manager