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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2022

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

RE: License #: AS500409309
Investigation #: 2023A0465003
County Manor

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.
- 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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500409309
Investigation #:	2023A0465003
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/13/2022
Report Due Date:	12/10/2022
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:	County Manor
Facility Address:	53880 County Line Rd. New Baltimore, MI 48047
Facility Telephone #:	(586) 725-0829
Original Issuance Date:	03/09/2022
License Status:	REGULAR
Effective Date:	09/09/2022
Expiration Date:	09/08/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct Care Staff, Michael Egan and Payton Jurn, are not trained to pass medication.	Yes
The facility does not have an emergency bag in the vehicle.	No

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A0465003
10/12/2022	Contact - Document Received Facility documents received via email
10/13/2022	Special Investigation Initiated - Telephone I spoke to Complainant via telephone
10/25/2022	Contact - Document Received Facility documents received via email
10/27/2022	Inspection Completed On-site I conducted an onsite investigation. I reviewed resident records, conducted a walkthrough of the facility, observed the emergency bag, and interviewed direct care staff, Payton Jurn. All six residents are non-verbal and unable to be interviewed for this investigation.
11/01/2022	Contact - Document Received Facility documents received via email
11/21/2022	Contact - Document Received Facility documents received via email
11/21/2022	Contact - Telephone call made I spoke to Guardian A1 via telephone
11/29/2022	Contact - Telephone call made I spoke to Guardian B1 via telephone
12/01/2022	Contact - Telephone call made I spoke to direct care staff, Davellshia Christian via telephone

12/02/2022	Contact - Telephone call made I interviewed ex-direct care staff, Melissa Roberts, via telephone
12/05/2022	Contact - Telephone call made I spoke to direct care staff, Lacrecia Tyson, via telephone
12/05/2022	Contact - Telephone call made I interviewed ex-direct care staff, Marcia Watson, via telephone
12/05/2022	Contact - Telephone call made I interviewed direct care staff, Michael Egan via telephone
12/05/2022	Contact - Telephone call made I spoke to direct care staff, Laura Lee Counterman, via telephone
12/05/2022	Exit Conference I conducted an Exit Conference with Vonda Willey and Andrea Peters, via telephone

ALLEGATION:

Direct Care Staff, Michael Egan and Payton Jurn are not trained to pass medication.

INVESTIGATION:

On 10/11/2022, a complaint was received, alleging that direct care staff, Michael Egan, and Payton Jurn, are not trained to pass resident medication. The complaint stated that Mr. Egan has failed his medication training twice and is still administering medication to residents.

On 10/13/2022, I spoke to Complainant via telephone. Complainant confirmed that the information contained in the complaint is accurate.

On 10/27/2022, I conducted an onsite investigation at the facility. I conducted a walkthrough of the facility, reviewed resident files, employee training records and staff schedules, interviewed direct care staff, Payton Jurn. At the time of my onsite investigation, there were six residents residing in the home. All six residents are non-verbal and were unable to be interviewed for this investigation. I observed all the residents to be appropriately dressed and with adequate hygiene.

I reviewed the *Assessment Plans for AFC Residents* for Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F. According to the *Assessment Plans for AFC Residents*, all six residents require medication administration assistance by direct care staff.

At the time of my onsite investigation, there were ten direct care staff employed by the facility. I reviewed the employee training records, which documented the hire dates and medication training dates for all employees. The *Macomb County Community Mental Health Training Logs* confirmed nine direct care staff, including Ms. Payton, successfully completed medication training as part of their new hire training. The *Macomb County Community Mental Health Training Logs* stated that Payton Jurn was hired on 8/19/2021, completed medication training on 1/13/2022 and successfully completed medication refresher training on 10/26/2022. The *Macomb County Community Mental Health Training Logs* stated that Mr. Egan was hired on 11/20/2001, completed medication training on 7/13/2013 and has failed refresher medication training two times in 2022 and is scheduled to retake medication training on 12/6/2022.

I reviewed the Staff Schedules for August 2022, September 2022, October 2022, and November 2022, and determined that Mr. Egan was working alone at the facility on the following dates and times:

8/5/2022 from 11:00pm – 8/6/2022 at 7:00am
8/7/2022 from 11:00pm – 8/8/2022 at 7:00am
8/12/2022 from 11:00pm – 8/13/2022 at 7:00am
8/14/2022 from 11:00pm – 8/15/2022 at 7:00am
8/19/2022 from 11:00pm – 8/20/2022 at 7:00am
8/21/2022 from 11:00pm – 8/22/2022 at 7:00am
8/26/2022 from 11:00pm – 8/27/2022 at 7:00am
8/28/2022 from 11:00pm – 8/29/2022 at 7:00am
9/2/2022 from 11:00pm – 9/3/2022 at 7:00am
9/4/2022 from 11:00pm – 9/5/2022 at 7:00am
9/9/2022 from 11:00pm – 9/10/2022 at 7:00am
9/10/2022 from 11:00pm – 9/11/2022 at 7:00am
9/16/2022 from 11:00pm – 9/17/2022 at 7:00am
9/17/2022 from 11:00pm – 9/18/2022 at 7:00am
9/18/2022 from 11:00pm – 9/19/2022 at 7:00am
9/23/2022 from 11:00pm – 9/24/2022 at 7:00am
9/25/2022 from 11:00pm – 9/26/2022 at 7:00am
9/30/2022 from 11:00pm – 10/1/2022 at 7:00am
10/1/2022 from 11:00pm – 10/2/2022 at 7:00am
10/8/2022 from 11:00pm – 10/9/2022 at 7:00am
10/15/2022 from 11:00pm – 10/16/2022 at 7:00am
10/26/2022 from 11:00pm – 10/27/2022 at 7:00am
11/5/2022 from 11:00pm – 11/6/2022 at 7:00am

I interviewed direct care staff, Payton Jurn, who stated that she has worked at the facility for one year. Ms. Jurn stated, “There are six residents living here. They are all non-verbal. The residents are well-cared for. I am trained to pass medication. Mr. Egan is not medication-trained and cannot administer medication to residents as of now. But

there is always someone working that can administer medication. I have no knowledge of a time when there was not a staff on duty trained in medication administration."

On 11/21/2022, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I believe staff are providing good care to Resident A. My only concern is the high turnover rate of staff. Resident A is pretty easy going and easy to care for. I do not have medication concerns."

On 11/29/2022, I spoke to Guardian B1 via telephone. Guardian B1 stated, "I have not had any concerns with the medication administration being provided to Resident B. I don't have any in-depth knowledge of what goes on in the home, but I believe he is being well-cared for."

On 12/1/2022, I spoke to direct care staff, Davellshia Christian, via telephone. Ms. Christian stated that she has been working at the facility for two months. Ms. Christian stated, "I am not trained to pass medication yet. I will complete my training on 12/27/2022. Because I can't pass medication, I am always working with someone that can pass medication. But there have been two times that I was scheduled to work with Mr. Egan, and he also cannot pass medications. So, we had to call direct care staff, Emily Link, to come into the facility to pass the medications. I am not aware of any other times that this has happened."

On 12/2/2022, I interviewed ex-direct care staff, Melissa Roberts, via telephone. Ms. Roberts stated that she worked at the facility from June of 2022 to November 2022. Ms. Roberts stated, "I am trained to pass medication and was trained to pass medications before I was left alone with residents. However, I know Mr. Egan was not trained in medication administration and was being left alone with residents. I am not sure what the plan was to ensure that residents would receive medication if needed while Mr. Egan was working. I no longer work at the facility and am unsure if he is still working alone."

On 12/5/2022, I spoke to direct care staff, Lacrecia Tyson, via telephone. Ms. Tyson stated that she has worked at the facility for eight months. Ms. Tyson stated, "There has been an issue with staff working alone in the facility that are not trained and able to administer medications. When a staff is working that cannot administer medications, the residents have to wait until the next staff come on shift, in order to receive their medications. In some cases, management will ask for the next staff on-duty to come in early for their shift, in order to pass medications. It has been challenging and a lot of this has to do with being short-staffed and not having enough employees that are medication trained."

On 12/5/2022, I interviewed ex-direct care staff, Marcia Watson, via telephone. Ms. Watson stated that she worked at the facility from December 2018 to November 2022. Ms. Watson stated, "I was trained and able to administer medications to residents. I know Mr. Egan as not trained and approved to pass medications because he failed his last two medication trainings. Sometimes, management did have Mr. Egan scheduled to

work alone, mostly midnight shifts. And if a resident needed medication during the time that Mr. Egan was working, he could not pass the medication. So, the residents had to wait until the next staff came on duty to administer the medication to them."

On 12/5/2022, I interviewed direct care staff, Michael Egan via telephone. Mr. Egan stated that he has worked at the facility for one year but has worked for the corporation for 21 years. Mr. Egan stated, "I am not currently trained to pass medication because I have not successfully passed a medication training since 2013. I have taken the medication training twice in the last few months, but I have failed both trainings. I take a third training tomorrow. 90% of the time that I am working, there is another staff working with me, that is trained and able to administer medication to residents. 10% of the time, I am scheduled to work alone, and there is no one in the facility that is trained and able to administer medication to residents. If a resident needed medication while I was working alone, I would call my supervisor, but this generally doesn't happen. But I would not administer medication to a resident because I am not allowed to. Resident A attends a day program and needs to medication passed to him by 6:00am, but I work until 7am. So, when I am scheduled to work alone, management will have the staff, usually Ms. Link, who is scheduled to work at 7:00am, come in at 5:00am so that she can administer Resident A's medication. I am not aware of anyone else that is not trained and able to administer medications." Mr. Egan acknowledged that when he is the only staff on duty, he cannot administer resident's prescribed medications if needed.

On 12/5/2022, I spoke to direct care staff, Laura Lee Counterman, via telephone. Ms. Counterman stated that she is the home manager for the facility and has been working at the home since May 2022. Ms. Counterman stated, "All of the staff have been trained in medication administration. And there are always two staff on duty, and there is always at least one person working that is trained in medication administration. Mr. Egan is also medication trained and can administer resident medications if needed. Mr. Egan did fail two recent medication training demos and has to retake it a third time. Ms. Link is coming into work at 5:00am to administer resident medications." Ms. Counterman stated that Mr. Egan can administer medication but also acknowledged that he has failed two medication trainings and that she is scheduling Ms. Link to come into work early on the days that Mr. Egan is working, to pass resident medications.

On 12/5/2022, I conducted a telephone conference with licensee designee, Vonda Willey and Division Director, Andrea Peters. Ms. Willey and Ms. Peters acknowledged that there have been times when the staff on duty at the facility are not trained in medication administration. Ms. Willey and Ms. Peters stated that Mr. Egan is not allowed to pass medications as of now due to their Macomb CMH Contract, which stipulates that all direct care staff must recertify and successfully complete medication training every two years in order to administer medications.

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:	According to the *Assessment Plans for AFC Residents*, all six residents require medication administration assistance by direct care staff. According to the *Macomb County Community Mental Health Training Logs* stated that Mr. Egan has failed medication training twice in 2022 and is not currently allowed to administer medication to residents. According to the Staff Schedules, between August 2022 and November 2022, Mr. Egan has worked alone at the facility approximately 23 times. According to Ms. Christian, on two occasions, she and Mr. Egan were scheduled to work together at the facility, and both were not trained to administer medication. Ms. Christian stated that an off-duty staff was called into work to administer the medication. According to Ms. Roberts, Ms. Tyson, Ms. Watson, and Mr. Egan, when Mr. Egan is working alone at the facility, resident medications are not able to be administered. Ms. Roberts, Ms. Tyson, Ms. Watson, and Mr. Egan stated that if the staff on duty cannot administer medication, residents must wait until a staff trained in medication administration arrives onsite at the facility. According to Ms. Willey and Ms. Peters, they are aware that there have been times when the staff on duty at the facility are not trained and able to administer resident medications. Based on the information above, the facility does not have sufficient staff on duty at all times to administer prescribed medication to residents, as specified in their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have an emergency bag in the vehicle.

INVESTIGATION:

On 10/11/2022, a complaint was received, alleging that the facility does not have an emergency bag in the vehicle at all times. The complaint stated that the emergency bags are being taken from the facility to be shared with other licensed adult foster care homes.

On 10/27/2022, I conducted an onsite investigation at the facility. I conducted an inspection of the facility. I observed two emergency bags onsite at the facility. I observed one large emergency bag in the vehicle parked in the driveway of the facility. I observed a second emergency bag in the hallway closet, inside the facility.

During the onsite investigation, I interviewed Ms. Jurn, who stated, “I am familiar with the emergency bags, and I have never observed the bags to be gone or missing. I am not aware of this ever happening.”

On 12/1/2022, I interviewed Ms. Christian via telephone. Ms. Christian stated, “I am aware of the emergency/first aid bag. I am not aware of any issues related to the emergency/first aid bag being taken away from the home or missing for any period of time.”

On 12/5/2022, I spoke to Ms. Tyson, via telephone. Ms. Tyson stated, “The emergency/first aid bag is always available in the home and vehicle at all times. I have never seen it leave the home. It’s always here. I don’t believe this allegation is true.”

On 12/5/2022, I interviewed Mr. Egan via telephone. Mr. Egan stated, “I know where the emergency/first aid bags are kept. I have never noticed the bags to be missing or gone from the home or vehicle.”

On 12/5/2022, I spoke to Ms. Counterman, via telephone. Ms. Counterman stated, “The emergency/first aid bags are always here in the home and in the vehicle, available for use if needed. The emergency bags have never left the home as far as I know.”

On 12/5/2022, I conducted an exit conference with licensee designee, Vonda Willey and Division Director, Andrea Peters. Ms. Willey and Ms. Peters are in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14319	**Resident transportation.**
	When a home provides transportation for a resident, the licensee shall assure all of the following: **(b) That a vehicle carries a basic first aid kit.**
ANALYSIS:	On 10/27/2022, I conducted an onsite investigation at the facility and observed two emergency bags at the home. I observed one large emergency bag in the vehicle parked in the driveway of the facility. I observed a second emergency bag in the hallway closet, inside the facility. According to Ms. Jurn, Ms. Christian, Ms. Tyson, Mr. Egan and Ms. Counterman, the emergency/first aid bags are always in the home and vehicle, available for use if needed. Ms. Jurn, Ms. Christian, Ms. Tyson, Mr. Egan and Ms. Counterman denied knowledge of a time when the emergency/first aid bags were missing from the home. Based on the information above, there is not sufficient information to confirm that the facility does not have the required emergency/first aid bag available at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Stephanie Gonzalez

12/7/2022

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Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

12/08/2022

_____

Denise Y. Nunn — Date
Area Manager