GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2023

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

RE: License #:	AS740013018
Investigation #:	2023A0123021
	Eunice Hayes Home

Dear Mrs. Willey:

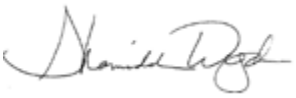
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0123021
Complaint Receipt Date:	01/24/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/25/2023
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 presented at the McLaren ER on 12/31 around 12:30 PM for psychiatric concerns after having a fight with a staff member at her AFC home about a coffee cup. It is unknown if Resident A suffered harm. Resident A has a small abrasion on her forehead that is possibly up to a couple days old. Resident A said she got the abrasion when her head hit a window. Evaluation of Resident A found no psychiatric or medical concerns.	No
Staff Alex Briggins pushed a Resident A down on the couch and said, “You aren’t going anywhere,” and also alleged that staff Ashley Osborne pulled the Resident A’s clothing, trying to prevent Resident A from leaving the home. These incidents were alleged to have occurred during a behavior on 11/19/2022.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2023	Special Investigation Intake 2023A0123021
01/24/2023	APS Referral Information received regarding APS referral.
01/26/2023	Contact - Telephone call made I made an attempted call to Complainant 1. Complainant 1 was not available.
01/26/2023	Contact - Telephone call made I left a voicemail for Resident A's Clinician case manager Ryan Gladfelter requesting a return call.
01/26/2023	Special Investigation Initiated - Telephone I spoke with Resident A's case manager via phone.
01/26/2023	Contact - Telephone call received I received a call from recipient rights investigator Sandy O'Neil.
01/26/2023	Contact - Document Received I received an incident report from Resident A's case manager.
02/02/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.

02/21/2023	Contact - Document Received Requested documentation received from fax.
03/03/2023	Inspection Completed On-site I conducted an unannounced follow-up on-site.
03/06/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Alex Briggins.
03/06/2023	Contact - Telephone call made I spoke with Sandy O'Neil from recipient rights.
03/06/2023	Contact - Telephone call received I interviewed staff Alex Briggins.
03/06/2023	Contact - Telephone call made I left a voicemail for Guardian 1, requesting a return call.
03/06/2023	Contact - Telephone call made I interviewed staff Ashley Osbourne.
03/06/2023	Contact - Telephone call made I spoke with Complainant 1 via phone.
03/06/2023	Contact - Telephone call received I spoke with Guardian 1 via phone.
03/06/2023	Contact- Telephone call made I tried to contact staff Tammy Norman via phone. There was no answer.
03/13/2023	Contact- Telephone call made I tried to contact staff Tammy Norman via phone. There was no answer.
03/13/2023	Contact- Telephone call made I interviewed staff Ericka Colden via phone.
03/14/2023	Contact- Telephone call made I interviewed staff Tameka Wright via phone.
03/15/2023	Exit Conference I conducted an exit conference with licensee designee Vonda Willey.

ALLEGATION: Resident A presented at the McLaren ER on 12/31 around 12:30 PM for psychiatric concerns after having a fight with a staff member at her AFC home about a coffee cup. It is unknown if Resident A suffered harm. Resident A has a small abrasion on her forehead that is possibly up to a couple days old. Resident A said she got the abrasion when her head hit a window. Evaluation of Resident A found no psychiatric or medical concerns.

INVESTIGATION: On 01/26/2023, I made a call to Resident A's clinician case manager Ryan Gladfelter from St. Clair County Community Mental Health. Mr. Gladfelter stated that he was aware Resident A went to the emergency room but was told that she was being physically aggressive, and the police were called because they needed to do a petition. Resident A was sent home. He stated that if he recalls correctly, Resident A hit a wall. He stated that she may have hit her head on a window. He denied having any concerns at this time. He stated that Resident A butts heads with staff Alex Briggins, who is more assertive than Resident A likes. He stated that Resident A gets aggressive quickly and will say staff assaulted her, then later will tell the truth.

On 01/26/2023, I received a copy of a *St. Clair County Community Mental Health Incident Report* from Mr. Gladfelter. The incident report is dated 12/31/2022. The incident report states that Resident A was very agitated and refused to take medication. She escalated, hit another resident then ran outside and pulled her pants down in the driveway. Resident A came back inside screaming, punched, and kicked staff. Resident A then threw a chair at staff and continued swearing and kicking. Resident A punched the medication room window, then got a butter knife from the kitchen, continued hitting, kicking, and spitting, then knocked a staff person to the floor. Staff called management, Guardian 1, and 911. Resident A was transported to McLaren Hospital. She was evaluated and released. The corrective measures were noted to be that supervision will continue to work with Resident A and the i-team to best support Resident A. Her plan will continue to be followed, and 911 will be used as a last resort when she is a danger to herself and others.

On 02/02/2023, I conducted an unannounced on-site visit at the facility. I met with staff Troy McFarlane, and Resident A in the garage. Staff McFarlane stated that the facility currently has positive COVID-19 cases. He stated that he does not recall Resident A going to the hospital at the end of December 2022.

I interviewed Resident A. Resident A appeared clean and appropriately dressed. No visible marks or injuries were noted. She stated that she likes living in the home, but sometimes does not get along with a couple of people. Resident A stated that she went to the hospital because she hit a glass window and got hurt on her head. She denied she received stitches. She stated that she was upset with Staff Briggins and Staff Osbourne because they were telling her what to do in regard to chores. She stated that she hit her bedroom window, and nothing else happened afterwards. She stated that she does not remember fighting over a coffee cup.

On 02/21/2023, I received requested documentation from Staff McFarlane. In the documentation was an incident report from 09/06/2022. The incident report is about Resident A having a behavior because she was upset staff Alex Briggins was making her food for her. After eating dinner, she became assaultive towards staff. She continued on outside having a behavior. Staff were able to get her back in the home, she slammed doors, then she ended up running towards her bedroom window and put her head through it. Management was called. 911 and an ambulance was called. Guardian 1 was notified. A PRN was given, and she was taken to Hurley Medical Center. A CT scan showed there were no injuries. Lake Huron Medical Center discharge documentation dated 09/06/2023 confirms Resident A was seen for an abrasion on her head.

A copy of Resident A's *IPOS* (Individual Plan of Service) *Meeting* report dated 02/28/2022, states that staff in regard to responding to property destruction should "do their best to not attend to the behavior." In responding to her physical aggression it notes that staff should stay clam while blocking physical aggression, attempt to redirect her, and separate themselves and others as needed.

On 03/03/2023, I conducted an on-site follow-up visit at the facility. I spoke with Staff McFarlane. He stated that he does not think Resident A went to the hospital in December 2022. He stated that the incident with the window happened 09/06/2022, and that she only went to the hospital with an injury to her forehead once.

During this on-site, I obtained a copy of Resident A's Assessment Plan for AFC Residents dated 09/23/2022. It states that she needs staff assistance when needed for controlling aggressive behavior, and for exhibiting self-injurious behavior.

On 03/06/2023, I interviewed staff Alex Briggins via phone. He stated that Resident A has put her head through the window in the past. He stated that she will self-harm by beating herself on her arms or head. He stated that she broke her bedroom window, and they ran into her room to see what happened. He stated that Resident A was more worried about breaking the window, than her head. He stated that this incident happened during second shift, and she did not need stiches. He stated that staff are not mistreating Resident A. He stated that he does not remember any argument over a coffee cup.

On 03/06/2023, I interviewed staff Ashley Osbourne via phone. She stated that she was not a staff at the facility on 12/31/2023. She stated that she has been working at a different facility since the end of November 2022. She stated that Resident A self-harms by hitting her head on the wall or punching/beating herself in the face.

On 03/06/2023, I spoke with Complainant 1 via phone. Complainant 1 stated that Resident A reported that there was a fight with staff over hot chocolate. Resident A stated that staff went after her and physically attacked her, and a coffee mug hit her in the face. She had an abrasion at that time. The facility reported that Resident A needed a psych evaluation at that time due to explosive anger. Resident A punches

herself, walls, and windows. Resident A gets frustrated easily and hurts herself. Resident A reported that staff threated to throw a chair at her. Resident A could not be admitted to psych because she did not meet the criteria. Resident A admitted to hitting the wall, but stated staff hit her with a coffee cup. Resident A denied having a headache. Resident A admitted the fight was stupid. Resident A has been to the hospital six times in the last year. In September 2022, she hit her head through a window, and was punching staff trying to run from the facility. Complaint 1 stated that the abrasion appeared to be a slight bump with scratched on it. It was not bleeding but the bump was red.

On 03/06/2023, I interviewed Resident A's father, Guardian 1 via phone. Guardian 1 stated one of the staff brought in their own personal coffee and Resident A demanded staff share it with her. Per Resident A, it became an argument. Guardian 1 stated that he does not remember when this occurred. He stated that he is not aware of the argument being physical, but Resident A threatened staff with a butter knife, and threw chairs. He stated that he did not recall Resident A having an abrasion on her forehead. He stated that at that time, Resident A did say she hit her head on a window. Resident A gets mad over little things. He stated that the facility she used to live in notified him right away of behaviors, but her currently facility notifies him after the fact. He stated that Resident A received medical attention for the one time for putting her head through the window, and at her previous placement, she put her head through the drywall. He stated that if all attention is not on Resident A, she gets upset. He stated that sometimes Resident A tells the truth, and sometimes not.

On 03/13/2023, I interviewed staff Ericka Colden via phone. In regard to the incident that occurred on 12/31/2022, Staff Colden stated the following:

She denied the allegations. Staff had to call law enforcement due to Resident A's behaviors that day. Resident A was throwing things, including chairs. Resident A went outside and pulled her pants down. What set Resident A off was a K-cup. Staff were at the table, and Resident A wanted a cup of coffee. The facility was out of decaffeinated coffee, and Resident A wanted some of her (Staff Colden's) caffeinated coffee K-cups. Resident A went to her room, then came back out and stated that she wanted to kill Staff Colden and that she hated her. Resident A stated it was not nice that staff wasn't sharing. Resident A was offered alternatives because she cannot have caffeinated drinks. Staff were trying to make breakfast at the time, and Resident A was standing in the way, throwing water and chairs. Resident A kept cursing at staff. Resident A told Staff Colden that she was going to get her arrested for not sharing. Resident A punched staff Tammy Norman and staff Tameka Wright. Staff Norman had to talk Resident A back into the house once or twice. Resident A was spitting as well. Guardian 1 was called in addition to the police, and management. Resident A stated that she was going to kill her (Staff Colden) because she wouldn't share the K-Cup. The police made the decision that Resident A needed to go to the hospital. Guardian 1 was upset Resident A acted out over a K-Cup and scolded Resident A about her not being able to drink coffee due to her

pacemaker. Resident A cursed and argued with Guardian 1 and threated to call the police on Guardian 1. Guardian 1 told Resident A this was her last chance. Staff Colden stated that she does not remember Resident A having an abrasion on her forehead. She stated that Resident A has put her head through a window last year. She stated that Resident A bullies staff by threatening them and throwing cups of water at them. She stated that if Resident A had an abrasion, it was self-inflicted. She stated that staff are trained to do CPI with Resident A.

On 03/14/2023, I interviewed staff Tameka Wright via phone. Staff Wright denied the allegations. She stated that Resident A cannot have caffeine, and the incident started over a K-Cup. She stated that the home only buys decaffeinated coffee, and they may have run out and Resident A got upset. She stated that staff can usually calm Resident A down after giving her a PRN medication. She stated that Resident A punched her, kicked, or punched Staff Norman, threw water on staff, and spit in her (Staff Wright's) face. She stated that the police were called because they could not get Resident A to calm down. She stated that the incident (in the past) where Resident A put her head through the window, led to the window being replaced with a non-shattering window. She stated that she thinks the abrasion Resident A had been from bumping her head on a window, and that the abrasion was self-inflicted. She denied that staff fought with Resident A, but that it was Resident A assaulting staff. She stated that Resident A had grabbed a butter knife and acted like she was going to assault staff with it, then acted like she was going to cut herself. Staff Wright stated that the sharp's in the home are locked up.

On 03/15/2023, I spoke with licensee designee Vonda Willey, and residential services division director Andrea Bubel via phone. Mrs. Bubel stated that Resident A's bedroom window was replaced with a non-shattering window. She stated that staff are to do CPI on Resident A if she tries to break a window. She stated that Resident A only had one incident with breaking a window, and that was after she first moved into the home. She stated that there has not been an instance of that behavior since. She stated that she does not recall Resident A having an abrasion on her forehead on or around 12/31/2023.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 01/26/2023, Resident A's case manager Ryan Gladfelter denied having any concerns. He provided an incident report that details that Resident A had a behavior on 12/31/2023, and assaulted staff. She was taken to the hospital due to psychiatric concerns.

	Resident A stated that she did not remember fighting over a coffee cup. Complainant 1 stated that Resident A reported staff physically attacked Resident A, and she had a fight with staff over a drink, and staff hit her with a coffee cup. Resident A presented with an abrasion on her head. Guardian 1 reported that Resident A got upset over staff's personal coffee, and Resident A threatened staff with a butter knife and threw chairs. Guardian 1 did not recall Resident A having an abrasion but stated that Resident A said she hit her head on a window. Staff Colden denied the allegations and stated that Resident A became assaultive towards staff because she could not have a K-Cup. She did not recall Resident A having an abrasion, but stated that if she did, it was self-inflicted. Staff Wright denied the allegations and stated that Resident A became assaultive toward staff because she could not have a K-Cup. She stated that the abrasion was from Resident A bumping her head on a window, and it was self-inflicted. Mrs. Bubel reported that Resident A has not broken a window since she first moved into the facility, and her bedroom window was replaced with a window that does not shatter. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff Alex Briggins pushed a Resident A down on the couch and said, "You aren't going anywhere," and also alleged that staff Ashley Osborne pulled the Resident A's clothing, trying to prevent Resident A from leaving the home. These incidents were alleged to have occurred during a behavior on 11/19/2022.

INVESTIGATION: On 01/26/2023, I received a call from recipient rights investigator Sandy O'Neil via phone. She stated that Resident A alleged that two staff assaulted her. Staff allegedly pushed her on the couch because she tried to elope. She stated that she is investigating whether there was unreasonable force, and that the incident happened on 11/29/2022. She stated that Resident A has many behavior issues.

On 02/02/2023, I conducted an unannounced on-site visit at the facility. I met with staff Troy McFarlane, and Resident A in the garage. Staff McFarlane stated that he is familiar with the allegations from recipient rights. He stated that staff Ashley Osbourne has not worked at the facility for about two months.

I interviewed Resident A. She stated that she likes living in the home, but sometimes does not get along with a couple of people. She stated that she sometimes doesn't get along with staff Alex Briggins but feels safe. She stated that sometimes she did not get along with staff Ashley Osbourne but felt safe once in a while. She stated that Staff Osbourne yelled at her a couple of times, possibly after Christmas time. She stated that Staff Osbourne pulled her clothing while they were outside. She stated that she was trying to run away because Staff Briggins and Staff Osbourne were arguing. She stated that Staff Osbourne pulled on her hard from her side. She stated that Staff Briggins pushed her down on the couch because he was upset, she wanted to go into the kitchen. She stated that staff were cooking dinner at the time. She stated that she told assistant home manager Tammy about it.

During the course of this investigation, a copy of Resident A's *IPOS* (Individual Plan of Service) *Meeting* report dated 02/28/2022 was received. It states that staff can "block" the pathway to exiting the home, but not physically block her movement, staff should provide continuing education as to why she should not elope, and that at least one staff should follow along with her out of the home to monitory for safety.

On 03/06/2023, I made a follow-up call to Ms. O'Neil. She stated that she did not substantiate her case. The staff denied the allegations, and there were no witnesses.

On 03/06/2023, I interviewed staff Alex Briggins via phone. He denied the allegations. He stated that Resident A assaulted Staff Osbourne, and that Resident A will do things to others, and then changes the story around and says that staff did something to her. He denied pushing Resident A. He stated that Resident A fell by the couch, staff went to see if she was okay, and while she was getting up, she said that he pushed her. He stated that she fell while walking toward the wall to punch the wall.

On 03/06/2023, I interviewed staff Ashley Osbourne via phone. She stated that she has been working at a different facility since the end of November 2022. She denied the allegations. She stated that Resident A has a big problem with fibbing, and it is noted in her *Individual Plan of Service.* She denied ever seeing Staff Briggins push Resident A. She denied pulling Resident A's clothing. She stated that staff treats Resident A gently as they are very aware of her past. She stated that when Resident A walks out of the home, staff follow her and talk her into coming back. She stated that CPI is the absolute last resort if Resident A is harming herself or others.

On 03/06/2023, I interviewed Resident A's father, Guardian 1 via phone. Guardian 1 stated Resident A has not said anything about staff pushing her on the couch.

Resident A likes to try to elope and has done so about four or five times. Staff is supposed to follow her. He stated that sometimes Resident A tells the truth, and sometimes not.

On 03/14/2023, I interviewed staff Tameka Wright. She stated that she has not heard of any staff pushing Resident A down or pulling her clothing. She stated that staff talks Resident A into coming back into the home. She stated that they can normally talk Resident A down, and that if she proceeds to leave, staff follow behind Resident A.

APPLICABLE RULE	
R400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Staff Alex Briggins, and staff Ashley Osbourne denied the allegations. There is no preponderance of evidence to substantiate a rule violation. Resident A stated that Staff Osbourne yelled at her and pulled her clothing, and Staff Briggins pushed her down on the couch. Sandy O'Neil of recipient rights stated that she did not substantiate her investigation, as staff denied the allegations and there were no witnesses. Guardian 1 stated that Resident A has not said anything about being pushed. Staff Wright stated that she has not heard of any staff pushing Resident A or pulling her clothing. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION

On 01/26/2023, I received a copy of a *St. Clair County Community Mental Health Incident Report* from Mr. Gladfelter. The incident report is dated 12/31/2022. The incident report states that Resident A was very agitated and refused to take medication. She escalated, hit another resident then ran outside and pulled her pants down in the driveway. Resident A came back inside screaming, punched, and kicked staff. Resident A then threw a chair at staff and continued swearing and kicking. Resident A punched the medication room window, then got a butter knife from the kitchen, continued hitting, kicking, and spitting, then knocked a staff person to the floor. Staff called management, Guardian 1, and 911. Resident A was transported to McLaren Hospital. She was evaluated and released. The corrective measures were noted to be that supervision will continue to work with Resident A and the i-team to best support Resident A. Her plan will continue to be followed, and 911 will be used as a last resort when she is a danger to herself and others.

On 02/02/2023, I conducted an unannounced on-site visit at the facility. I requested documentation, including a copy of the *AFC Licensing Incident/Accident Report*.

On 02/16/2023, requested documentation was received via fax. There was no copy of the *AFC Licensing Incident/Accident Report* for 12/31/2022 included in the fax.

On 03/03/2023, I conducted an on-site at the facility. There was no *AFC Licensing Incident/Accident Report* in Resident A's file for 12/31/2022.

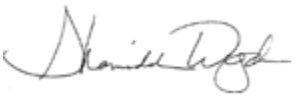
APPLICABLE RULE	
R400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative, and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction of property.**
ANALYSIS:	During the course of this investigation, I requested a copy of the *AFC Licensing Incident/Accident Report* for the

	incident that occurred with Resident A and staff on 12/31/2022. The incident report was not received, nor was it on file at the facility. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/15/2023, I conducted an exit conference with licensee designee Vonda Willey via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

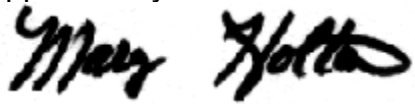
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



03/15/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



03/17/2023

Mary E. Holton Date
Area Manager