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 #:	2023A0123025
	Eunice Hayes Home

Dear Mrs. Willey:

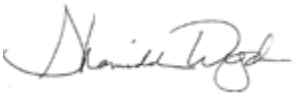
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0123025
Complaint Receipt Date:	02/16/2023
Investigation Initiation Date:	02/17/2023
Report Due Date:	04/17/2023
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?
On 2/09/23, staff Ryan Stapleton was verbally and physically aggressive toward Resident A. Staff Stapleton told Resident A he had to go to bed and stated, “we are not doing this every night.” Staff Stapleton then kicked the foot of the recliner chair to lower it. Staff Stapleton grabbed Resident A by the arm. Staff Stapleton took Resident A to his room and intentionally pushed him into the wall. There is a dent on the wall from Resident A being pushed by Staff Stapleton.	Yes

III. METHODOLOGY

02/16/2023	Special Investigation Intake 2023A0123025
02/16/2023	APS Referral Information received regarding APS referral.
02/17/2023	Special Investigation Initiated - Telephone AFC Consultant, Susan Hutchinson contacted the home manager, Troy McFarlane requesting information related to this complaint
03/03/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
03/07/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Kimberly Sanchez.
03/07/2023	Contact - Telephone call made I interviewed staff Ryan Stapleton via phone.
03/08/2023	Contact - Telephone call received I interviewed staff Kimberly Sanchez via phone.
03/08/2023	Contact - Telephone call made I interviewed Resident A via FaceTime.
03/13/2023	Contact- Telephone call made I left a voicemail requesting a return call from Resident A’s case manager.
03/15/2023	Exit Conference

	I conducted an exit conference with the licensee designee.
03/15/2023	Contact- Telephone call made I left a voicemail requesting a return call from Guardian 1.
03/15/2023	Contact-Telephone call received I received a voicemail from Guardian 1.
03/15/2023	Contact- Telephone call made I spoke with Guardian 1 and Relative 1.

ALLEGATION: On 2/09/23 staff Ryan Stapleton was verbally and physically aggressive toward Resident A. Staff Stapleton told Resident A he had to go to bed and stated, "we are not doing this every night." Staff Stapleton then kicked the foot of the recliner chair to lower it. Staff Stapleton grabbed Resident A by the arm. Staff Stapleton took Resident A to his room and intentionally pushed him into the wall. There is a dent on the wall from Resident A being pushed by Staff Stapleton.

INVESTIGATION: On 02/15/2023, I received an *Incident/Accident Report* signed on 02/15/2023, detailing an incident that occurred on 02/09/2023. The incident report states that Resident A and Staff Kimberly Sanchez were spoken with, and Resident A reported that Staff Ryan Stapleton told him to go to bed, and also pushed him while Resident A was walking down the hallway. Staff Sanchez reported hearing a thud but did not witness anything due to counting medication at the time. Staff Stapleton told Staff Sanchez that Resident A had fallen in the hallway. The home supervisor informed Staff Stapleton that this is Resident A's home, and he does not have a bedtime. The corrective measures taken were noted to be filing a recipient rights complaint and checking Resident A for injuries.

On 03/03/2023, I conducted an unannounced on-site at the facility. I interviewed home manager Troy McFarlane. He stated that the alleged incident occurred on a night shift, and staff Ryan Stapleton is currently suspended. He stated that Resident A said he was told by Staff Stapleton to go to bed, and while walking down the hallway, Staff Stapleton pushed him. The other staff person, staff Kimberly Sanchez only heard a thump. Staff Stapleton told Staff Sanchez that Resident A fell. Staff McFarlane stated that it is hard to say what really happened. He stated that Resident A did not have any marks or bruises. During this on-site, Staff McFarlane pointed out indentations in the wall that he was told were not there prior to this alleged incident.

During this on-site, Resident A was not at the home, as he was on an outing with staff.

I obtained copies of Resident A's documentation during this on-site including his St. Clair Community Mental Health (CMH) *Adult Residential Licensing- Resident Assessment for Reimbursement* form, and *Health Care Appraisal*. On 03/06/2023, I

received a copy of his *Assessment Plan for AFC Residents (*dated 01/02/2023*)* via fax. His documentation from CMH under *Section II- Behavior or Cognitive Care Needs* (page four) states that Resident A can become agitated in crowded situations or during transitions. On page three of the documentation it states Resident A "*needs assistance with managing emotions at times as he becomes overwhelmed. He is very social*." His *Health Care Appraisal* dated for 01/19/2023 states that he is fully ambulatory. His documentation does not note that he is a fall risk, nor does he use any special equipment (cane, walker, etc.).

On 03/07/2023, I interviewed staff Ryan Stapleton via phone. He denied the allegations. Staff Stapleton stated that his shift started at 11:00 pm. Resident A was in the living room, and he asked Resident A to go to bed because he had program/school the next morning. Resident A said no. He stated that he tried to hand Resident A his blanket, and Resident A yelled "don't touch me. Don't touch my stuff." Staff Stapleton stated that he was still in the living room, and Resident A was in the hallway. He stated that he heard a thump like Resident A kicked the wall or punched it. Staff Stapleton stated that the next morning, Staff Sanchez told him that Resident A was really upset with him (Staff Stapleton). He stated that Resident A gets upset when you ask him to do things. He stated that Resident A threatened to break his teeth. He stated that Resident A has not lived in the facility long. He stated that he has never had something like this come up in the three years he's been working at the facility. When asked if he wrote down notes in the staff communication log or Resident A's chart notes about the incident, he said no.

On 03/08/2023, I interviewed staff Kimberly Sanchez via phone. Staff Sanchez stated she did not witness much. She stated that she saw Staff Stapleton in the living room bickering with Resident A about going to bed. Resident A did not want to. Staff Stapleton pushed the footrest of Resident A's recliner chair down while Resident A was sitting in the chair. She stated that she heard a noise from the hallway, then Staff Stapleton came in the dining room where she was and said that Resident A fell. She stated that at that time she was doing medication counts. She stated that it is not normal for Resident A to fall, and that she does not believe that Resident A just fell. She stated that Resident A got really upset. She stated that she heard Resident A say either "you hit me" or "you pushed me" right after hearing the thud. She stated that this is not the first time Staff Stapleton has complained about Resident A going to bed, and that it happened last weekend as well. She stated that she told Staff Stapleton to leave Resident A alone. She stated that Resident A stays up late on nights he does not have to get up for school. She stated that on the next morning when she took Resident A his medication, Resident A instantly started complaining about Staff Stapleton saying Staff Stapleton was mean, that he hurt him. She stated that she looked for marks and bruising but did not see any. She stated that at the time the incident occurred, the other residents were all in bed.

On 03/08/2023, I interviewed Resident A via FaceTime. Resident A stated that Staff Stapleton threw him against the wall and the hallway closet door. He stated that Staff Stapleton made him cry and made him really sad. He stated that his shoulder

area hurt afterward. He stated that Staff Stapleton got angry when he (Resident A) was sitting in his recliner chair. Resident A stated that he was minding his own business. Resident A stated that he was “really ticked off.” He stated that Staff Stapleton has never done that before. He stated that this incident happened in the evening time while on his way to bed. Resident A described that Staff Stapleton pushed him down the hallway towards his room, and during this call, he pointed out on the wall, spots he was pushed into. During this FaceTime call, I asked Resident A to show me where in the hallway Staff Stapleton pushed him. Resident A pointed to two areas that were the same spots that Staff McFarlen pointed out during my unannounced on-site on 03/03/2023. He stated that Staff Stapleton did push his recliner chair down and took his cup. He denied that he went to school the next day. He stated that Staff Stapleton tried to force him to go to sleep.

On 03/15/2023, I spoke with Guardian 1 and Relative 1 via phone. Guardian 1 stated that Resident A told her that Staff Stapleton pushed him from the back, while making him go to bed, to get out of his (Staff Stapleton’s) way. Relative 1 stated that he spoke with Resident A who had told him his shoulder hurt, then he found out that Resident A had been sitting in his recliner chair. Staff Stapleton took his foot and pushed down on the footrest, then Staff Stapleton grabbed Resident A’s arm and pulled him up. He stated that then Staff Stapleton pushed Resident A all of the way down to his room. He stated that Resident A would not have said “don’t hit me” or “don’t push me” if it didn’t happen.

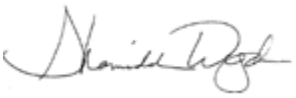
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	An incident report dated for 02/09/2023 states that Resident A reported that Staff Stapleton told him to go to bed, and also pushed him as he was walking down the hallway. The incident report notes that supervision informed Staff Stapleton that this is Resident A’s home, and he does not have a bedtime. Staff Kimberly Sanchez reported hearing a thud, and right afterwards heard Resident A yell out either “you pushed me” or “you hit me.” Staff Sanchez stated that Staff Stapleton pushed down the footrest of Resident A’s recliner, and that

	Staff Stapleton has complained twice about Resident A going to bed. She stated that she told Staff Stapleton to leave Resident A alone. Staff Sanchez did not observe Resident A being pushed. Staff Stapleton denied the allegations. He reported that he heard a thump that sounded like Resident A either punched or kicked the wall. Resident A stated that Staff Stapleton tried to force him to go to bed and threw him against the wall several times. He also reported that Staff Stapleton pushed the footrest of the recliner chair down that he was sitting in and took his cup. He reported that his shoulder hurt. Guardian 1 and Relative 1 stated that Resident A told them that Staff Stapleton pushed Resident A to his room. Relative 1 stated that Resident A told him that Staff Stapleton grabbed him by the arm and pushed his footrest on his recliner chair down as well, and that his shoulder hurt. Staff McFarlane and Resident A pointed out on the walls during their interviews where the indentations were where Resident A was pushed. There is a preponderance of evidence to substantiate a rule violation in regard to mistreatment from Staff Stapleton toward Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

IV. RECOMMENDATION

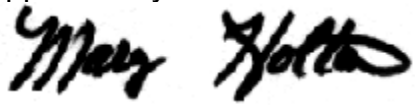
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



03/17/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



03/17/2023

Mary E. Holton Date
Area Manager