STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 14, 2024

Vonda Willey
Blue Water Developmental Housing, Inc.
Bldg. 1
1362 River Rd.
St. Clair, MI 48079

RE: License #: AS740012986
Investigation #: 2024A0580034
Stoneybrook Home

Dear Vonda Willey:

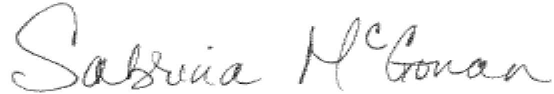
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740012986
Investigation #:	2024A0580034
Complaint Receipt Date:	05/09/2024
Investigation Initiation Date:	05/13/2024
Report Due Date:	07/08/2024
Licensee Name:	Blue Water Developmental Housing, Inc.
Licensee Address:	Bldg. 1 1362 River Rd. St. Clair, MI 48079
Licensee Telephone #:	(810) 388-1200
Administrator:	Vonda Willey
Licensee Designee:	Vonda Willey
Name of Facility:	Stoneybrook Home
Facility Address:	3087 Stoneybrook Port Huron, MI 48060
Facility Telephone #:	(810) 982-6167
Original Issuance Date:	05/23/1980
License Status:	REGULAR
Effective Date:	08/03/2023
Expiration Date:	08/02/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident had a fall and it was not reported.	No
There was a medication error and Resident A was taken to the hospital.	Yes

III. METHODOLOGY

05/09/2024	Special Investigation Intake 2024A0580034
05/13/2024	Special Investigation Initiated - Telephone Call to Recipient rights, St. Clair Co.
05/15/2024	Inspection Completed On-site Unannounced onsite inspection.
05/15/2024	Contact - Face to Face Interview with staff, Amy Shue.
05/16/2024	Contact - Document Received Email from Tracy Duncan, RR Investigator.
05/16/2024	APS Referral Referral to APS.
05/21/2024	Contact - Document Received Documents requested received via email.
05/30/2024	Contact - Telephone call made Call to Relative Guardian A.
06/03/2024	Contact - Document Received Documents received fax via Relative Guardian A.

06/11/2024	Contact - Document Sent Email to Tracy Duncan, RR Investigator.
06/12/2024	Exit Conference Exit conference with the licensee designee, Vonda Willey.
06/14/2024	Contact - Telephone call made Call to Relative Guardian A.

ALLEGATION:

. Resident had a fall and it was not reported.

INVESTIGATION:

On 05/09/2024, I received a complaint via BCAL Online Complaints.

On 05/13/2024, I placed a call Sandy O'Neill, Recipient Rights (RR) Director in St, Clair County, who confirmed that the complaint alleging the same allegations has been received by their office. There is a concern that Resident A fell or received an injury of some sort to his hand, that was not reported. Resident A did receive Occupational Therapy on 04/29/2024 and no injury was noted. Resident A is deaf and requires an interpreter. Resident A is a long-time resident of the home and there have been no prior concerns. Resident A has been moved to a new home within the same corporation.

On 05/15/2024, I conducted an unannounced onsite inspection at Stoneybrook Home. Contact was made with the Assistant home Manager, Tammie Kulka and Direct Staff, Amy Shue. Assistant home Manager, Kulka stated that she had no observation of Resident A falling or hurting his hand, however, his guardian reports that there is a bruise on his hand. Staff Shue denied Resident A has had a fall that was not reported.

Two residents were observed while in the home. Both were sitting at the kitchen table doing activities. Both were adequately dressed and groomed. They appeared to be receiving proper care.

On 05/16/2024, I received an email message from Tracey Duncan, assigned RR Investigator in St. Clair County. Investigator Duncan shared that she was able to interview Resident A along with the assistance of an interpreter. Both his case manager and the interpreter stated that Resident A is an accurate reporter of information, especially with yes and no questions. Resident A indicated he did not fall but started to fall and caught himself, hurting his thumb. Resident A also indicated the incident happened in the kitchen area (not during any mealtimes) and there were no staff present and/or other people. Resident A did not inform any staff that it occurred. Resident A also indicated that his thumb/hand did not bleed and was not swollen.

On 05/16/2024, I made a complaint to Adult Protective Services (APS), sharing the allegations alleged in the complaint.

On 05/21/2024, I received a copy of the AFC Assessment Plan for Resident A. The plan indicates that Resident A is not able to understand verbal communication. He is deaf and uses American Sign Language (ASL). The plan also indicates that he requires assistance with feeding, bathing, grooming, personal hygiene, and walking/mobility. The plan does not describe how these needs will be met. This plan is signed by Relative Guardian A on 12/20/2023 and Licensee Designee, Vonda Willey, on 12/29/2023.

On 05/30/2024, I spoke with Relative Guardian A, who stated that while she is not sure that Resident A had a fall, he is deaf and uses his hands to communicate, so it is possible that he may have hit the wall with his hand. However, based on her observation of his walker and his glasses, which were both bent on the same side as the injured thumb, it appears he had some sort of injury/fall. When hospitalized, Resident A was diagnosed with cellulitis and needed surgery. Relative Guardian A also added that she has requested to his case manager that Resident A be moved from that home several times, with no success. However, she insisted that Resident A be moved immediately after this incident. Relative Guardian A stated that she is aware that Resident A has been moved to another home within the same corporation, however, she will accept what she can at this time as long as he did not have to return to Stonybrook Home.

On 06/03/2024, I received a copy of the McLaren Port Huron Emergency Department notes for Resident A. Resident A was admitted to the hospital on 05/06/2024 due to an overdose. On 05/10/2024 Resident A presented with a left thumb I & D for an acute thumb abscess. Surgery was performed and included an incision and drainage of the left thumb abscess. The left thumb nail plate was also removed.

On 06/11/2024, I sent an email to Tracy Duncan, RR Investigator. Investigator Duncan indicated that there was no substantiation related to the alleged fall, due to no evidence that Resident A had actually fallen and/or injured his hand/thumb in the home.

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:	It was alleged that Resident A had a fall and it was not reported. Assistant Home Manager, Tammie Kulka stated that she had no observation of Resident A falling or hurting his hand. Staff Amy Shue denied Resident A has had a fall that was not reported. Resident A indicated he did not fall but started to fall and caught himself, hurting his thumb. Resident A also indicated the incident happened in the kitchen area (not during any mealtimes) and there were no staff present and/or other people. Resident A did not inform any staff that it occurred. Resident A also indicated that his thumb/hand did not bleed and was not swollen. Relative Guardian A stated that while she is not sure that Resident A had a fall, he is deaf and uses his hands to communicate, so it is possible that he may have hit the wall with his hand. The McLaren Port Huron Emergency Department notes for Resident A indicate that on 05/10/2024 surgery for Resident A was performed and included an incision and drainage of the left thumb abscess. The left thumb nail plate was also removed. RR Investigator Tracy Duncan indicated that there was no substantiation due to no evidence that Resident A had actually fallen and/or injured his hand/thumb in the home. Based on the interviews conducted with manager Kulka, staff, Amy Shue, Resident A, Relative Guardian A, RR Investigator Tracy Duncan, a review of the McLaren Port Huron Emergency Department notes, and the AFC Assessment Plan for Resident A, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was a medication error and Resident A was taken to the hospital.

INVESTIGATION:

On 05/13/2024, I placed a call to Sandy O'Neill, RR Director in St, Clair County, who confirmed that the complaint alleging the same allegations has been received by their office. Director O' Neill shared that staff Amy Shue admitted to a medication error, which resulted in Resident A being sent to the Emergency Room (ER).

On 05/15/2024, while onsite, Manager Tammy Kulka stated that Resident A was given the wrong medication and sent to the hospital as a directive after speaking with his physician. Documents were requested.

On 05/15/2024, while onsite, I spoke with staff, Amy Shue, who recalled that on the day in question, Resident A and Resident B switched seats at the table. She went to prepare the meds and she guesses that due to routine, she'd prepared the medication for Resident B, however due to Resident A being in the seat Resident B normally sits in, she gave Resident A Resident B's medication by mistake. She realized her error after he'd taken the medication.

On 05/21/2024, I received a copy of the Incident and Medication Error Report requested. The incident report dated 05/06/2024 indicates that staff Amy Shue was passing 5:00pm medication. Normally residents sit in routine seats at the table, today Resident A sat in a different seat. When passing medication, staff Amy Shue ended up giving Resident A another resident's 5:00pm medications. Staff called EMS, Resident A's guardian, the residential director and home manager were all notified. Staff stayed with Resident A monitoring home until EMS arrived. Staff took proper documents and met at McLaren Hospital. Guardian A was present and did not authorize staff to obtain information or stay.

The Medication Error Report maintained by the home indicates that Resident A was given Amitiza, 8MCG-3 capsules, Lorazepam 0.5MG-1 tab, Lamotrigine 200MG-1 ½ tabs, Clozapine 100MG-3 tabs, Banophen 25MG-1 tab, Fenofibrate 145MG-1 tab.

On 05/30/2024, I spoke with Relative Guardian A, who stated that because of the medication error, the hospital was not sure that Resident A would pull through. The hospital began inquiring if he has a Do Not Resuscitate (DNR) Order. He was aspirating and it developed into aspirational pneumonia. Resident A was hospitalized for approximately 1 week. He slowly came out of it and he's a lucky guy to still be alive.

On 06/03/2024, I received a copy of the McLaren Port Huron Emergency Department notes for Resident A, dated 05/06/2024, with the chief complaint being an overdose. The notes indicate that Resident A, who stays at a group home, was accidentally given his roommates medication. Since then, Resident A has become more and more obtunded and altered. Resident A is non-responsive, only to painful stimuli. According to EMS who were called to the group home, Resident A was vomiting because staff were trying to feed him, even though he was more obtunded than baseline. Resident A was not responding to EMS and brought to the hospital immediately. Resident A was

assessed as having Acute hypoxemic respiratory failure suspect secondary to aspiration.

On 06/13/2024, RR Investigator Tracy Duncan indicated that she substantiated the medication error.

On 06/14/2024, I placed a follow up call to Relative Guardian A regarding Resident A's current health status. Relative Guardian A stated that Resident A does not have any follow-up medical treatments relating to the overdose. Resident A is doing fine and much happier in his current placement, which appears to be a good fit at this time.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that there was a medication error and Resident A was taken to the hospital. Manager, Tammy Kulka, stated that Resident A was given the wrong medication and sent to the hospital as a directive after speaking with his physician. Staff, Amy Shue, stated that Resident A and Resident B switched seats at the table and due to routine, she gave Resident A Resident B's medication by mistake. The incident report dated 05/06/2024 was reviewed. The Medication Error Report maintained by the home indicates that Resident A was given Amitiza, 8MCG-3 capsules, Lorazepam 0.5MG-1 tab, Lamotrigine 200MG-1 ½ tabs, Clozapine 100MG-3 tabs, Banophen 25MG-1 tab, Fenofibrate 145MG-1 tab. Relative Guardian A stated that because of the medication error, the hospital was not sure that Resident A would pull through. He was aspirating and it developed into aspirational pneumonia. Resident A was hospitalized for approximately 1 week. The McLaren Port Huron Emergency Department notes for Resident A, dated 05/06/2024, indicate that the chief complaint is an overdose. Resident A was assessed as having Acute hypoxemic respiratory failure suspect secondary to aspiration.

	RR Investigator Tracy Duncan indicated that she substantiated the medication error. Based on the interviews conducted with manager Kulka, staff, Amy Shue, Resident A, Relative Guardian A, RR Investigator Tracy Duncan, a review of the Incident Report dated 05/06/2024, the Medication Error Report, and the McLaren Port Huron Emergency Department notes for Resident A, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/21/2024, I received a copy of the AFC Assessment Plan for Resident A. The plan also indicates that he requires assistance with feeding, bathing, grooming, personal hygiene, and walking/mobility. The plan does not describe how these needs will be met. This plan is signed by Relative Guardian A on 12/20/2023 and Licensee Designee, Vonda Willey, on 12/29/2023.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on a review of the AFC Assessment Plan for Resident A, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/12/2024, I conducted an exit conference with the licensee designee, Vonda Willey. LD Willey was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

June 14, 2024

Sabrina McGowan Date
Licensing Consultant

Approved By:

June 14, 2024

Mary E.. Holton Date
Area Manager