GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2022

Kathleen Swantek
Blue Water Developmental Housing, Inc.
1600 Gratiot, Ste 1
Marysville, MI 48040

RE: License #: AS500396887
Investigation #: 2022A0604007
Nottingham

Dear Mrs. Swantek:

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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500396887
Investigation #:	2022A0604007
Complaint Receipt Date:	01/13/2022
Investigation Initiation Date:	01/13/2022
Report Due Date:	03/14/2022
Licensee Name:	Blue Water Developmental Housing, Inc.
Licensee Address:	Ste 1 - 1600 Gratiot Marysville, MI 48040
Licensee Telephone #:	(810) 388-1200
Administrator:	Kathleen Swantek
Licensee Designee:	Kathleen Swantek
Name of Facility:	Nottingham
Facility Address:	80525 Belle River Road Memphis, MI 48041
Facility Telephone #:	(810) 392-2524
Original Issuance Date:	03/12/2019
License Status:	REGULAR
Effective Date:	09/12/2021
Expiration Date:	09/11/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was throwing and breaking things. Staff Kassondra Behn told Jennifer Guzek to give Resident A, Resident B's Lorazepam 2 mg to calm him down. Ms. Guzek passed the medication to Resident A.	Yes

III. METHODOLOGY

01/13/2022	Special Investigation Intake 2022A0604007
01/13/2022	APS Referral Referral made to Adult Protective Services (APS). Assigned to Emily Poley.
01/13/2022	Special Investigation Initiated - Telephone TC to APS
01/14/2022	Contact- Document Sent Email to and from Andrea Peters. Received email from Andrea Peters with staff phone numbers and resident medication logs.
01/19/2022	Contact - Document Received Email from Emily Poley. Sent return email.
01/24/2022	Contact - Document Received Email from Emily Poley re: Resident A's guardian.
01/25/2022	Contact - Document Sent Email to and from Andrea Peters.
01/25/2022	Contact - Document Sent Email to and from Emily Poley. Emailed Resident A's guardian's information.
01/27/2022	Contact - Document Received Email to and from Emily Poley from APS. She cannot get ahold of staff Jennifer. She will be substantiating.

01/27/2022	Contact - Document Sent Email to and from Andrea Peters. Jennifer is still working for Blue Water Developmental Housing. Confirmed phone number 586-242-2524.
01/27/2022	Contact - Telephone call made TC to Jennifer Guzek. Unable to leave message.
03/04/2022	Contact - Document Sent Email to and from Emily Poley. Complaint has been substantiated.
03/09/2022	Contact - Telephone call made TC to Jennifer Guzek. Unable to leave message.
03/09/2022	Contact- Telephone call made TC to Emily Link
03/09/2022	Exit Conference Completed exit conference by email from Licensee Designee, Kathy Swantek.

ALLEGATION:

Resident A was throwing and breaking things. Staff Kasondra Behn told Jennifer Guzek to give Resident A, Resident B's Lorazepam 2 mg to calm him down. Ms. Guzek passed the medication to Resident A.

INVESTIGATION:

On 01/12/2022, I received two incident reports from Division Director, Andrea Peters. I reviewed incident reported dated 01/11/2022 completed by Staff, Emily Link. The report stated, “(Resident A) was having a rough day and was throwing and breaking things. Kassy (Kassandra Behn) said to give him someone else’s PRN to calm him down so Jennifer popped another resident’s meds and gave it to (Resident A). It was a Lorazepam 2 mg”. Report indicated that Andrea Peters was contacted, resident’s vitals were taken and the doctor’s office was contacted.

On 01/12/2022, I sent an email to Andrea Peters regarding incident. Ms. Peters stated that Macomb County Recipient Rights has been contacted and is also completing an administrative review. Ms. Peters stated that they are being told conflicting stories from the three staff that were present on what was given and if it was intentional. On 01/13/2022, I opened a special investigation regarding incident.

On 01/14/2022, I completed an unannounced onsite investigation at the Nottingham Home. I interviewed Home Manager, Kassandra Behn and observed Resident A. Ms. Behn stated that she recently started working at the home in December 2021. She stated that she cannot log into the electronic medication administration system because she is waiting on her username and password. She can pass medications using paper medication administrator record. She stated that on 01/11/2022 Resident A wanted to throw away a sandwich and seemed irritated. The Assistant Manager, Jennifer Guzek, was also present. Resident A went to his room and they heard a lot of noise. They found that his roommate's television was broken and the DVD player was removed from wall outlet. They redirected Resident A out of his room and tried to get him to do a puzzle or listen to music. Andrea Peters was contacted, and she said to write an incident report about the television. Resident A then began knocking stuff over in the living room. Resident A repeats words but cannot verbalize what is wrong. At 3:00 pm Staff Emily Link arrived. Resident A had thrown a lamp in living room and flipped over a table. Ms. Guzek asked if she could give Resident A a PRN. Ms. Behn stated that she agreed but was not sure that he had one. Ms. Link was finishing giving another resident a shower. Ms. Guzek said that she could not find PRN. She then looked in medication cabinet and said she found Resident A's Diazepam. Ms. Behn stated that she never saw the medication passed. She stated that she left her shift and got a call two hours later stating that someone else's medication was passed to Resident A. Ms. Guzek said she found Resident A's Diazepam, however, he was given Resident B's Lorazepam. Ms. Behn stated that medication counts confirmed the Lorazepam was given because there were 14 instead of 15 pills after incident. The medication was not logged. During the onsite investigation, Ms. Behn provided a written statement that she had previously written regarding incident.

On 01/14/2022, I received copies of Resident A and Resident B's November 2021, December 2021 and January 2022 medication logs by email from Andrea Peters. Resident B's January 2022 medication log indicates that he is prescribed Lorazepam 2 mg PRN. There were no initials indicating that the medication had been administered as a PRN in January 2022. Resident A's medication log does not indicate that he is prescribed Lorazepam as a PRN.

On 03/04/2022, APS Worker Emily Poley confirmed that the complaint regarding Nottingham Home was substantiated. The APS investigation has been closed.

On 01/27/2022 and 03/09/2022, I attempted to interview Staff, Jennifer Guzek, by phone. I was unable to leave messages at the number provided.

On 03/09/2022, I interviewed Staff, Emily Link, by phone. She stated that she is no longer working at the Nottingham home. Ms. Link stated that on day of incident she walked in for her normal shift and Resident A was having a bad day. He was breaking

things which was unusual for him. However, he recently had a medication change which may have affected behavior. Ms. Link stated that the new home manger, Kassandra, authorized assistant manager, Jennifer, to pass someone else's medication to Resident A. She stated that the assistant manager claims she gave Resident A his own medication. Ms. Link stated that she checked medication drawer after Kassandra and Jennifer left the home and saw that Resident B's Ativan (Lorazepam) was missing. He had a full pack prior to the incident and medication was not initiated for on log. Ms. Link contacted Area Director, Andrea Peters, to repot incident. Ms. Link stated that she is 100 percent sure manager told Jennifer to give Resident A another resident's medication and assistant manager said, "ok".

I completed an exit conference with Licensee Designee, Kathy Swantek, on 03/09/2022. I informed her of the violations found and that a copy of the special investigation report would be mailed once approved. I also informed her that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: Complete an individual medication log that contains all of the following information: **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to the Home Manager, Kassandra Behn and Staff, Emily Link, Resident B was missing a Lorazepam from pill pack after incident on 01/11/2022. It is believed the medication was given to Resident A by Staff, Jennifer Guzek. There are no initials on the medication log to confirm the medication was administered despite it missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Staff Emily Link stated that Home Manager, Kassandra Behn told Staff, Jennifer Guzek, to give Resident A another resident's PRN. Ms. Behn denies this, however, the medication was missing from the pill pack after this incident and it was not documented on the medication log. Resident A was apparently administered the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**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: **(c) Restrain a resident's movement by binding or tying or through he use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Ms. Behn and Ms. Link stated that Resident A was throwing and breaking things on 01/11/2022. Ms. Link heard Ms. Behn tell Ms. Guzek to give Resident A another resident's PRN in response to his behavior. Ms. Behn denies telling Ms. Guzek to pass Lorazepam to Resident A, however, the medication was passed to Resident A to calm him down as he was throwing and breaking things in the home. Ms. Behn told Ms. Guzek she could give Resident A a PRN if he had one, however, she was not sure if he did.
CONCLUSION:	**VIOLATION ESTABLISHED**

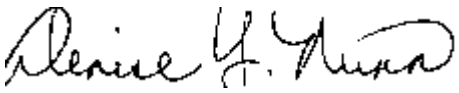
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change in the license status.

03/09/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



03/30/2022

Denise Y. Nunn — Date
Area Manager