STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 7, 2023

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

RE: License #: AS500396887
Investigation #: 2023A0604019
Nottingham

Dear Ms. 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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(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 #:	2023A0604019
Complaint Receipt Date:	04/28/2023
Investigation Initiation Date:	04/28/2023
Report Due Date:	06/27/2023
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:	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?
Staff, Stephanie Rice, took Resident A to a dentist appointment. Resident A was left alone for three hours.	Yes

III. METHODOLOGY

04/28/2023	Special Investigation Intake 2023A0604019
04/28/2023	Special Investigation Initiated - Letter Sent email to Andrea Bubel re: incident report received on 04/27/2023
04/28/2023	Contact - Telephone call received TC from Division Director, Andrea Bubel. Resident was not comfortable with being left alone. Resident left alone for three hours while staff allegedly ran errands.
04/28/2023	Contact - Document Sent Email to and from Andrea Bubel
05/01/2023	Inspection Completed On-site Completed onsite investigation. Interviewed Staff, Rachel Johnson, Amanda Patrick and Resident A.
05/02/2023	Contact - Document Sent Email to Emily Poley.
05/02/2023	Contact - Document Sent Email to Andrea Bubel. Requested Resident A's Individual Plan of Service (IPOS)
05/03/2023	APS Referral Referral made to Adult Protective Services (APS)
05/03/2023	Contact - Document Received Email from Emily Poley. No APS referral received. Sent return email.
05/05/2023	Contact - Document Received Received IPOS from Andrea Bubel by email. Sent return email.

05/10/2023	Contact - Telephone call made TC to Stephanie Rice
05/24/2023	Contact - Document Received Received APS denial letter dated 05/03/2023
06/12/2023	Contact- Telephone call received Received message from Stephanie Rice. I returned call
06/12/2023	Exit Conference Completed exit conference with Licensee Designee, Vonda Willey, by phone.
06/12/2023	Contact- Telephone call received Received message from Stephanie Rice. Returned call
06/12/2023	Contact- Document Received Email from Stephanie Rice with letter attached
06/28/2023	Contact- Document Sent Email to Andrea Bubel and Vonda Wiley. Received return email from Andrea Bubel with staff schedules, staff list, Funds forms, receipts and incident reports.
07/11/2023	Contact- Document Sent Email to Andrea Bubel and Vonda Wiley

ALLEGATION:

Staff, Stephanie Rice, took Resident A to a dentist appointment. Resident A was left alone for three hours.

INVESTIGATION:

On 04/27/2023, I received an incident report by email from Division Director, Andrea Bubel, regarding the Nottingham home. The incident report indicated that on 04/24/2023, Stephanie Rice took (Resident A) to a dentist appointment and left while he was at the appointment. The incident report indicates that Ms. Rice is being put on suspension pending investigation. The corrective measure indicate that staff will not leave residents at appointments alone unless noted in their IPOS.

On 04/28/2023, I received telephone call from Division Director, Andrea Bubel after requesting additional information by email. Ms. Bubel indicated that Resident A was left alone for approximately three hours at appointment while Ms. Rice ran errands. Resident A had stated that he was uncomfortable with being left alone and he was still

left at appointment. Ms. Rice is still on leave pending investigation. I opened a special investigation based on information provided by Ms. Bubel and incident report.

On 05/01/2023, I completed an onsite investigation at the Nottingham home. I interviewed Acting Home Manager, Rachel Johnson, Staff Amanda Patrick and Resident A.

On 05/01/2023, I interviewed Acting Home Manager, Rachel Johnson. She stated that she has worked at the Nottingham home for about one year. She is Acting Home Manager since Stephanie Rice was suspended. She stated that she was on vacation when Resident A was left at the appointment. Ms. Johnson stated that they always stay with residents for the duration of their medical appointments and Resident A should not have been left alone.

On 05/01/2023, I interviewed Staff, Amanda Patrick. She stated that she was working the day incident occurred. Resident A wanted her to take him to an appointment. Ms. Patrick stated that she is the med tech, and she usually takes residents to appointments, however, Ms. Rice stated that day she was going to take Resident A to his appointment for a root canal. Ms. Rice wanted to take him to the appointment and go to the store. Ms. Patrick stated that Resident A asked her to tell Ms. Rice that he was not comfortable going to the appointment by himself. She told Ms. Rice that Resident A did not want to be left alone and that they must stay for duration of appointment with residents. Ms. Patrick stated that the dentist's office called the house and said Resident A was ready to be picked up after his appointment and she text Ms. Rice to let her know. Ms. Patrick believed that Ms. Rice ran errands during Resident A's appointments. She saw Ms. Rice put items she purchased in the house and in her own car.

On 05/01/2023, I interviewed Resident A. He stated that he has lived at the Nottingham home since the end of January 2023, and it is going good. He indicated that he had an appointment for a root canal last Monday. He told Home Manager, Stephanie, that he was not comfortable staying at the appointment by himself. Resident A stated that he had to wait about 45 minutes after his appointment was finished and when the office called the house. Resident A stated that he has never been left at an appointment by himself before.

On 05/10/2023, I interviewed Stephanie Rice by phone. She stated that she took Resident A to his root canal appointment at 11 am. Before the appointment, she made dinner for residents and bought Resident A ear buds. She was told at the appointment, that no one could go back with him during root canal, and it would take about an hour. She indicated that she stayed in the waiting room for an hour and then asked how things were coming along. She talked to the hygienist sometime after 12 pm and they said it was taking longer than expected and was probably going to be another couple of hours. She asked them about what food Resident A could eat after root canal and staff told her that she could go and come back. Ms. Rice stated that she left her contact information and went to the store. She purchased food including garlic bread to go with dinner and sherbet Resident A wanted. Ms. Rice stated that she did not do any personal

shopping. She indicated that after going to the store, she went to pick up other residents from workshop. She then picked up Resident A from his appointment around 2:15 pm and made it back to the house at 2:30 pm in time for Resident A's next appointment.

Ms. Rice stated that Resident A had another appointment at 3:00 pm at the house with his case manager. The meeting was scheduled as she had sent his case manager multiple emails about him needing an updated plan of service and lack of services. Ms. Rice stated that she did not have any missed calls from dentist's office. She stated that when she was on phone with one secretary at the dentist's office, another secretary called the house regarding picking up Resident A as they did not know she was already on the phone. Ms. Rice stated that there has been staffing issues since she has worked at the home. She also indicated that training could be improved and that they were given minimal information.

I reviewed Resident A's IPOS effective date 12/01/2022-11/30/2023. The plan was written while Resident A resided at the Pam McDonald Home. The plan indicates that Resident A is diagnosed with Intellectual disability (intellectual developmental disorder) - Mild, Borderline personality disorder, social anxiety disorder (social phobia), Separation anxiety disorder. He receives MORC behavioral supports. Resident A requires enhanced staffing in order for caregivers to provide direct supervision/close visual contact, but leaving him his personal space. CLS staff also accompanies Resident A to all of his medical and doctor appointments to help monitor his medical care. Transportation to all medical appointments funded by the Department of Human Services (DHS).

On 05/24/2023, I received a letter from APS. The letter dated 05/03/2023 indicated that the APS referral was denied.

I completed an exit conference by phone on 06/12/2023 with Licensee Designee, Vonda Willey. I informed her of the violation found and that a corrective action plan would be requested. I also informed her that a copy of the special investigation report would be mailed once approved. Ms. Willey confirmed that it is their policy for staff to stay with residents for the duration of their medical appointments. She indicated that Home Manager, Stephanie Rice, continues to be suspended.

On 06/28/2023, I requested any incidents reports regarding resident choking as described by Ms. Rice. I received three incident reports from Andrea Bubel dated 02/27/2023, 02/28/2023 and 03/01/2023. The incident reports did not state that the Heimlich maneuver had to be performed, however, indicate that Resident B becomes food obsessive and tries to get food out of kitchen and garbage. He needs to be redirected by staff and can become physically aggressive.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was not provided with appropriate supervision at his dentist appointment. Resident A had an appointment for a root canal on 04/24/2023. On 04/28/2023, Division Director, Andrea Bubel indicated that Resident A was left alone for approximately three hours at appointment while Ms. Rice ran errands. Resident A stated that he told Home Manager, Stephanie, that he was not comfortable staying at the appointment by himself. Resident A stated that he had to wait about 45 minutes after his appointment was finished and office called the house. His IPOS dated 12/01/2022 indicates that staff accompany Resident A to all of his medical and doctor appointments to help monitor his medical care. Home Manager, Stephanie Rice indicated that she stayed at appointment for approximately one hour and then was told by staff at dentist office that she could leave and come back when he was done. Licensee Designee, Vonda Willey, Division Director, Andrea Bubel and Staff, Rachel Johnson and Amanda Patrick all confirmed that staff are supposed to stay with residents for the duration of their medical appointments.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL ALLEGATIONS:

INVESTIGATION:

On 06/12/2023, I received a telephone call from Home Manager, Stephanie Rice, after completing the exit conference. She again stated that there were staffing issues when she worked at the home. She also stated that there were issues with the printer/scanner and she had to request a copy of the license to post in home. Ms. Rice also stated that she believed staff was not using food stamps correctly, however, that she did not report because she was not sure. She believed that Rachel bought Pepsi when none of the residents drink it and stated that she believed staff used their Kroger cards to get Kroger fuel points. Ms. Rice stated that she informed recipient rights that she had a letter written with additional information. I provided Ms. Rice with my email address and stated she could email me letter with her concerns as well. Ms. Rice indicated that she believes people are retaliating against her for bringing up concerns. Ms. Rice emailed copy of her letter on 06/12/2023 that was written to Marissa in Human Resources. Ms.

Rice stated in email that she would like a copy of her letter attached to special investigation. Ms. Rice's letter included concerns regarding lack of support from support coordinator, lack of staffing, resident choking while she was showering another, doing midnight shifts work and rushed training.

On 06/28/2023, I received staff schedules, staff list, Funds Part 2 forms, food receipts and incident reports from Andrea Bubel. I reviewed Funds Part 2 forms and receipts for EBT cards for April 2023 and May 2023. The home is tracking how EBT funds are spent on Funds Part 2 forms and maintaining copies of receipts. Food and drink purchases have been made at Kroger, Sam's Club, Dollar General, Walmart and Meijer. I did not observe any purchases on receipts that appeared to be inappropriate spending.

I reviewed incident reports for Resident B dated 02/27/2023, 02/28/2023 and 03/01/2023. Reports indicate that Resident B is obsessive regarding food and can become aggressive. Staff have notified supports coordinator, redirected and given PRN medication. On 07/11/2023, Director Andrea Bubel indicated that she did not have any incident reports regarding Resident B choking and requiring the Heimlich maneuver.

I also reviewed staff schedules for April 2023, May 2023 and June 2023. The Nottingham home schedules one to two staff per shift. They have two staff scheduled during the week between the hours of 7:00 am- 3:00 pm.

On 07/11/2023, I received email from Director, Andrea Bubel. Ms. Bubel stated that they have not received any complaints or concerns regarding residents EBT cards. She indicated that she has seen residents drinking pop when she has been in the home. Ms. Bubel indicated that their standard staffing schedule is two staff per shift, however, they can have one staff per E-Scores.

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:	There is not enough information to substantiate that the home does not have adequate staffing. There were at least two staff on shift when Resident A was left at dentist appointment. Staff schedules indicate that the home schedules one to two staff per shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident even with the consent of the resident.
ANALYSIS:	There is not enough information to substantiate that staff are misusing residents EBT cards. I reviewed Funds Part 2 forms and receipts for EBT cards for April 2023 and May 2023. The home is tracking how EBT funds are spent on Funds Part 2 forms and maintaining copies of receipts. Food and drink purchases have been made at Kroger, Sam's Club, Dollar General, Walmart and Meijer. Director, Andrea Bubel, stated that they have received any complaints regarding EBT cards being used inappropriately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

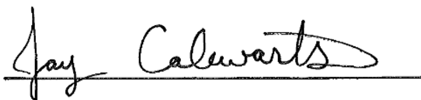
IV. RECOMMENDATION

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

07/20/2023

Kristine Cilluffo Date
Licensing Consultant

Approved By:



For 09/07/2023

Denise Y. Nunn Date
Area Manager