GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

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

RE: License #:	AS740013018
Investigation #:	2024A0123002
	Eunice Hayes Home

Dear Vonda Willey:

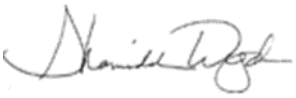
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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 #:	2024A0123002
Complaint Receipt Date:	10/25/2023
Investigation Initiation Date:	10/25/2023
Report Due Date:	12/24/2023
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:	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 is being assaulted by Resident B. Staff are neglecting to take action to protect Resident A and other residents in the home. On 9/30/2023, Resident A went to McLaren Hospital after he was struck in the forehead by Resident B. Resident A's forehead was lacerated which resulted in Resident A receiving glue treatment at the hospital. Resident B hits and punches people in the home. Staff and management know this is an issue with Resident B but are failing to protect other residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/25/2023	Special Investigation Intake 2024A0123002
10/25/2023	APS Referral Information received regarding APS referral.
10/25/2023	Special Investigation Initiated - Telephone I spoke with APS investigator Dan Schave via phone.
10/31/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility. I interviewed staff and residents.
11/01/2023	Contact - Document Received Requested documentation received via email from the facility.
11/08/2023	Contact - Telephone call received I received a voicemail from licensee designee Vonda Willey.
11/09/2023	Contact - Telephone call made I left a voicemail for Vonda Willey.
11/13/2023	Contact - Telephone call received I spoke with Vonda Willey and Andrea Bubel via phone.
11/13/2023	Contact- Telephone call received I received a voicemail from Vonda Willey.

11/20/2023	Contact - Telephone call made I spoke with Resident A's Guardian 1 via phone.
12/04/2023	Exit Conference I conducted an exit conference with licensee designee Vonda Willey via phone.
12/04/2023	Contact- Document Received Requested documentation received via email.
12/11/2023	Contact- Document Received Received requested documentation via email.

ALLEGATION: Resident A is being assaulted by Resident B. Staff are neglecting to take action to protect Resident A and other residents in the home. On 9/30/2023, Resident A went to McLaren Hospital after he was struck in the forehead by Resident B. Resident A's forehead was lacerated which resulted in Resident A receiving glue treatment at the hospital. Resident B hits and punches people in the home. Staff and management know this is an issue with Resident B but are failing to protect other residents.

INVESTIGATION: On 10/25/2023, I spoke with adult protective services investigator Dan Schave via phone. He stated that Resident B took a cast iron paper towel holder to Resident A's head. Resident B has resided in the home since March 2023. Resident B is very highly behavioral. Resident B sneaks into other residents' rooms at night to physically assault them. Resident B is assaulting staff as well. Another resident will flip tables in the home when Resident B triggers the other residents' behaviors. Law enforcement calls have been made on Resident B. To dated, there has been no 30-day discharge notice issued to Resident B.

On 10/31/2023, I conducted an unannounced on-site at the facility. I interviewed residents and staff. The interviews are as follows:

I interviewed Resident D. Resident D stated that Resident B breaks things that belongs to others, and that Resident B has hurt Resident D by hitting Resident D in the face. Resident D stated that his glasses were bent as a result of being hit. Resident D stated that Resident B hit Resident A, Resident A's face was bloody, and Resident A had to go to the hospital. Resident D stated that he did not witness the incident between Resident A and Resident B.

During this on-site, I observed Resident A sitting at the facility's dining room table. Resident A is non-verbal and could not be interviewed. Resident A appeared clean and appropriately dressed.

I interviewed staff Michelle Kindle. Staff Kindle stated that things are so bad that Resident A's Guardian 1 shows up every day and stays for hours. Staff Kindle stated that she believes Resident B is targeting Resident A because Resident A is non-verbal and cannot defend himself. Resident B hit Resident A with a metal paper towel holder. Resident A did not realize how bad he was injured. The incident occurred in the kitchen. Staff Kindle stated that she ran behind Resident A as Resident A ran away, and she saw that he was bleeding. Staff called the police. The police and EMT's looked at Resident A's injury and didn't think Resident A needed stitches. Guardian 1 came and took Resident A to the emergency room, and Resident A ended up getting stitches.

I interviewed staff Erica Colden, medication coordinator. Staff Colden stated that before Resident B threw the paper towel holder at Resident A, Resident B was in the garage having a behavior. Staff Colden stated that she was keeping an eye on Resident B, then stepped away to take a call. Resident B entered the home, was having a behavior still, threw the paper towel holder, and then began punching residents sitting at the table. Guardian 1 put a non-locking against egress door lock on Resident A's bedroom door to prevent Resident B from entering his room. Resident C, Resident B's roommate, has expressed being afraid of Resident B.

I interviewed Resident C. Resident C stated that she does not like Resident B. Resident B hits Resident C, and Resident B hits the walls. Resident C stated that she wants a different roommate or room, as Resident C does not feel safe sharing a room with Resident B. Resident C stated that she was last physically hit by Resident B last week. Resident B punches Resident C in her legs and arms. Resident C stated that Resident B hit Resident A with a paper towel holder, and Resident C witnessed this incident firsthand. She stated that the paper towel holder hit Resident A in the forehead. Resident C stated that Resident A also hit her twice on the same day Resident A was hit with the paper towel holder. Resident B attacks staff. Staff redirects the other residents to their rooms to try and keep them safe from Resident B.

I interviewed Resident B. Resident B stated that she has been living in the home for a couple of months. Resident B stated that she punches staff but stated that she gets along with everyone. Resident B stated that she threw a paper towel holder at Resident A.

On 10/31/2023, during the unannounced on-site inspection, I obtained requested documentation.

Resident B's *Assessment Plan for AFC Residents* dated 03/24/2023 under *Controls Aggressive Behavior* notes "*Home & School staff assist as needed*" and yes is checked for *Gets Along With Others*.

A copy of Resident A's McLaren Port Huron discharge paperwork was obtained. The paperwork notes that on 09/30/2023, Resident A was seen for a forehead laceration.

On 11/01/2023, I received requested documentation via email from the facility. An *AFC Licensing Division- Incident/Accident Report* dated 09/30/2023 at 12:15 pm in summary, states that Resident A was eating lunch at the table when a housemate (Resident B) came from the garage having a behavior. Resident B threw an iron paper towel holder at Resident A, striking Resident A in the forehead. Resident A got up and ran to the bathroom. A staff person observed that Resident A's face was covered in blood. Staff cleaned Resident A's face, applied Neosporin and a band aid. Resident A was transported to McLaren for medical treatment. The corrective measures taken to remedy and/or prevent recurrence box was left blank.

On 11/01/2023, I received additional incident reports dated 09/20/2023, 09/21/2023 and 09/30/2023. The incident reports for 09/20/2023 and 09/21/2023 details highly behavioral incidents Resident B had including property damage and physical assault toward staff, and staff interventions were documented to include verbally calming Resident B, giving her a PRN, a bath, redirecting, and calling management. The 09/30/2023 incident report is regarding Resident E being highly behavioral. Resident E flipped furniture in the home, punched a hole in the wall, etc. Staff and two residents locked themselves in a bedroom. 911 was called, and staff did not exit the bedroom until the police arrived at the home.

Another incident report dated 09/30/2023 for Resident B, in summary states that Resident B was in the garage having a behavior kicking and punching the facility's van. Staff made attempts to redirect Resident B to a safer location within the facility. Resident B continued the behavior, staff backed off, and left the door open to visibly see Resident B. The house phone rang. Resident B came in the home continuing her behavior in the kitchen banging on countertops, etc. Resident B then grabbed the paper towel holder, tried to throw it at staff, it missed and hit Resident A in the forehead. Staff called 911 and applied a high-level holding technique for several minutes until Resident B calmed down enough to go low level hold, to no holding. Resident B then went back into the garage to wait for the police and EMS.

On 11/13/2023, I received a phone call from licensee designee Vonda Willey, and manager Andrea Bubel. During this call I was informed of the following:
There was a 30-day notice issued to Resident B last Thursday (11/09/2023). There was an incident over this past weekend where Resident D was assaulted by Resident B resulting in Resident D having to seek emergency medical treatment (stitches in Resident D's head). Resident B's father, Guardian 2 may be a possible placement. Guardian 2 and Guardian 3 are experiencing conflict with one another about where Resident B should be placed. Resident B did not have a one-on-one staff and has resided in the facility since March 2023. Resident B has damaged the facility's van as well as two staff person's vehicles, plus numerous house repairs that have been done to the facility. Resident B is currently in the hospital for a psychological evaluation since yesterday. Resident D's glasses were broken last week by Resident B. There was about a 30-day period where Resident B's behavior was fine.

On 11/13/2023, I received a voicemail from licensee designee Vonda Willey. She stated that a 24-hour discharge notice was issued for Resident B. She stated that Guardian 2 advised that he was at the hospital to pick Resident B up, and Guardian 2 will be picking up Resident B's belongings. Resident B has been discharged from the facility.

On 11/20/2023, I interviewed Resident A's Guardian 1 via phone. Guardian 1 stated that Resident B has moved out of the home. Resident A, who is non-verbal, is now moving to another facility. Resident B hit Resident A with a paper towel holder. At the time, the home's supervisor as well as the EMTs that responded to the home said that Resident A did not need medical care. Two staff persons transported Resident A to the hospital. Resident A ended up getting his wound glued closed. Resident B walked into Resident A's room and scratched Resident A's face after the incident with the paper towel holder. Resident B has broken the facility's van mirrors, bashed a staff person's rear car window with her fist, and damaged the facility's mailbox. Guardian 1 stated that she would go to the facility in the evening time so Resident B would not assault Resident A. Guardian 1 stated that she slept overnight once at the facility. Guardian 1 stated that Resident B knew what she was doing. There would only be two staff on the floor. Guardian 1 stated that she expressed her concerns about this, because staff would have to watch Resident B as well as cook, etc. Guardian 1 stated that Resident B would also punch Resident C while Resident C was sleeping and flash her private area at Resident C. Guardian 1 stated that she did not care for how things were handled.

On 12/04/2023, I received a copy of Resident B's *St. Clair County Community Mental Health Individual Plan of Service* (IPOS) dated 09/27/2023. In Resident B's IPOS it states that when Resident B is agitated, staff should *"follow OT recommendations below with sensory seeking interventions"* and "*If OT interventions are not working, re-direct [Resident B] to another room." The IPOS goes into detail about a "sensory diet"* that includes a "*variety of activities and options*" such as deep pressure/joint compressions, movement activities/tools, oral simulation, providing a calming area, transitional techniques, fidget handheld items, noise reducing headphones, etc. There does not appear to be any mention of staff interventions when Resident B is physically aggressive towards others.

On 12/11/2023, I received a copy of an *AFC Licensing Division Incident/Accident Report* dated 11/12/2023 regarding Resident D having to seek medical attention after being assaulted by Resident B. The incident report states *"[Resident D] and [Resident B] were in the living room and began arguing. [Resident B] got up from her seat and attacked [Resident D] but stopped when staff told her too. Then, [Resident B] calmly walked into the kitchen, grabbed a plastic cup that was sitting on the counter and threw it at [Resident D] immediately splitting his head and starting a fight between them. Staff escorted [Resident D] into the kitchen and treated him while watching [Resident B] as she sat in the living room. Staff verbally calmed them down and called EMS and police to treat [Resident D] and [Resident B]."* McLaren

Port Huron is noted at the hospital. The *corrective measures taken to remedy and/or prevent recurrence* box was left blank.

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 10/31/2023, I conducted an unannounced on-site at the facility and interviewed staff and residents. Resident D stated that Resident B was physically aggressive towards others in the home, and that Resident B injured Resident A. Staff Kindle was interviewed and confirmed that Resident B physically assaulted Resident A. Staff Colden confirmed the assault on Resident A from Resident B and reported that Guardian 1 put a non-locking against egress door lock on Resident A's bedroom to prevent Resident B from assaulting Resident A. Resident C stated that Resident B assaulted Resident A, as well as Resident C and staff. Resident B confirmed that she assaulted Resident A. Resident A's McClaren discharge paperwork confirms Resident A suffered a laceration to his forehead. Licensee Designee Vonda Willey reported that Resident D was assaulted by Resident B, resulting in Resident D also having to go receive medical treatment and stitches. Guardian 1 was interviewed and reported that she had to spend extended time at the facility to ensure Resident A's safety from Resident B. Resident A's assessment plan and IPOS did not appear to address how staff were to handle Resident B's escalated behaviors, and how to keep others safe from Resident B's physical aggression.

	Incident reports reviewed during the course of the investigation notes that staff on more than one occasion backed off situations where a resident was highly behavioral, and the behaviors escalated leading to physical harm and/or damage to the facility. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/31/2023, I conducted an unannounced on-site at the facility. I obtained a copy of Resident B's *Assessment Plan for AFC Residents* dated 03/24/2023. The assessment plan only included Guardian 3's signature. There was no licensee designee or responsible agency signature noted.

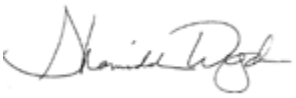
On 12/04/2023, I received an email from Andrea Bubel, residential services division director who confirmed that there was only one signature for Resident B's assessment plan.

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:	During the course of this investigation, I requested a copy of Resident B's assessment plan. On 10/31/2023, I obtained a copy. The assessment plan did not have all of the appropriate signatures noted. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/04/2023 I conducted an exit conference with licensee designee Vonda Willey. I informed her of the findings and conclusions.

IV. RECOMMENDATION

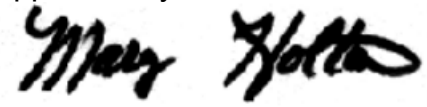
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



12/11/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



12/11/2023

Mary E Holton Date
Area Manager