GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

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

RE: License #: AS740015319
Investigation #: 2024A0580048
Oak Leaf Dr

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.
- 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 (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 #:	AS740015319
Investigation #:	2024A0580048
Complaint Receipt Date:	08/21/2024
Investigation Initiation Date:	08/23/2024
Report Due Date:	10/20/2024
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:	Oak Leaf Dr
Facility Address:	3405 Oak Leaf Fort Gratiot, MI 48059
Facility Telephone #:	(810) 982-0712
Original Issuance Date:	11/19/1993
License Status:	REGULAR
Effective Date:	06/04/2024
Expiration Date:	06/03/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 8/17/2024, staff, Pam Lawrence grabbed Resident A, twisted his shirt, and hit him in the sternum.	Yes

III. METHODOLOGY

08/21/2024	Special Investigation Intake 2024A0580048
08/21/2024	APS Referral Opened by APS for investigation.
08/23/2024	Special Investigation Initiated - Telephone Call to Dan Schave of APS.
08/28/2024	Inspection Completed On-site Unannounced onsite.
08/30/2024	Contact - Telephone call made Call to Vonda Willey, Licensee Designee.
08/30/2024	Contact - Telephone call made Call to direct staff, Pam Lawrence.
10/07/2024	Contact - Document Received Email from Dan Schave of APS.
10/07/2024	Contact - Telephone call made Call to Cheyenne Johnson, St. Clair County CMH.
10/08/2024	Contact - Telephone call made Call to Denise Cooper, Direct Staff.
10/09/2024	Contact - Telephone call made Call to Wendy Covera, Direct Staff.
10/14/2024	Contact - Telephone call made Call to staff, Dana Brasher.
10/14/2024	Exit Conference Exit conference with LD Vonda Wiley.

ALLEGATION:

On 8/17/2024, staff, Pam Lawrence grabbed Resident A, twisted his shirt, and hit him in the sternum.

INVESTIGATION:

On 08/21/2024, I received a complaint via BCAL Online Complaints.

On 08/23/2024, I placed a call to Dan Schave, assigned Adult Protective Services (APS) investigator, St. Clair County.

On 08/28/2024, I conducted an unannounced onsite inspection. Contact was made with the manager Mary Stone. Manager Stone stated that she was not working on the day in question. Manager Stone stated that Resident A is very aggressive and it was reported that he was having behavioral issues for 8 hours straight. It is manager Stone's understanding that staff Pam Lawrence peeled Resident A off of her. Staff Lawrence has worked for the corporation for 28 years and to her knowledge, there are no prior known allegations made against staff Lawrence's mistreatment of Resident A. No incident report was completed.

While onsite I received a copy of the AFC Assessment Plan for Resident A dated 01/24/2024.The assessment plan indicates that Resident A is unable to communicate his needs. The plan also states that Resident A is unable to control his aggressive behaviors, however, staff are to soothe and help calm Resident A down when displaying aggression.

While onsite I observed Resident A, along with 3 other residents sitting at the dining room table, preparing to eat lunch that was being served. Resident A is nonverbal, however, he along with the other residents, were observed as being adequately dressed and groomed. No concerns in their appearance or behavior were noted. They appeared to be receiving proper care.

On 08/28/2024, while onsite I spoke with staff member on duty, Ashely Cureton, who stated that she was not working on the day of the alleged incident. Staff Cureton has worked with staff Lawrence previously. Staff Cureton stated that while she has witnessed staff Lawrence be stern with Resident A, she has never witnessed her be abusive, aggressive or mean.

On 08/30/2024, I spoke with staff, Pam Lawrence, who recalled that on the day in question Resident A had been going non-stop with his behaviors that day, having gotten out of the home several times and pulling the staffs' hair. Staff Lawrence stated that while she did grab Resident A by the shirt to guide him towards his bedroom, she denied dragging him by his shirt to his room. Staff Lawrence stated that she realized grabbing Resident A's shirt was not a good idea. Staff Lawrence denied poking Resident A in his chest as alleged.

On 09/19/2024, I received an email from Recipient Rights Director in St. Clair County, Sandy O'Neill, who indicated that their office did not substantiate the allegations.

On 10/07/2024, I received an email from Dan Schave of APS, indicating that after speaking with all involved, he will not be substantiating this referral.

On 10/07/2024, I placed a call to Cheyenne Johnson, assigned case manager for Resident A, at St. Clair County Community Mental Health (CMH), who stated that she had not been made aware of the allegations against the staff member in the home. Case Manager Johnson stated that she has not had any concerns with Resident A's care or treatment by staff in the home, nor has she had any complaints.

On 10/08/2024, I placed a call to staff member Denise Cooper, who recalled that she was just arriving to her shift on the day of the alleged incident. Upon arriving, staff Cooper went to the bathroom and did witness the entire incident. Staff Cooper stated she observed staff Lawrence pointing her finger at Resident A's chest. Staff Cooper did not observe staff Lawrence grab Resident A's shirt.

On 10/09/2024, I placed a call to staff, Wendy Covera, who indicated that she did not witness any of the alleged incident, as she arrived to work later that evening, after the alleged incident occurred.

On 10/10/2024, I received a copy of the current St. Clair County CMH Individual Plan of Service (IPOS) created for Resident A. The plan indicates that "A lack of functional communication is often one of the biggest barriers to independence and can frequently result in the demonstration of challenging and/or inappropriate behaviors to communicate wants and needs. To promote Resident A's independence and efficacy in having his wants and needs met, with the primary goal of decreasing his inappropriate/undesirable behaviors (primarily his grabbing of clothing) through increasing desirable communicative behaviors, frequent opportunities should be presented across environments to allow Resident A to choose from multiple options throughout the day."

On 10/14/2024, I spoke with direct staff, Dana Brasher who recalled that on her first day of work, she decided to go in a little early. When she arrived, Staff Lawrence was already in a bad mood, hollering and complaining about the Barney program on TV that Resident A likes to watch. Staff Lawrence grabbed the remote to turn off the TV and said, "Not while I'm working." Resident A continued to pinch and grab at everyone, an obvious indicator that Resident A is upset. Staff Lawrence then took Resident A's tablet away from him, grabbed him by the shirt, twisting it, punched him in the chest and drug him down the hall by his shirt to his room. Staff Brasher stated that staff Denise Cooper observed the entire incident.

On 10/14/2024, I spoke with Vonda Willey, Licensee Designee (LD). LD Willey regarding the rule violation found. LD Willey understood why the licensing rule is being established and agrees to submit a corrective action plan.

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:	It was alleged that on 8/17/2024, staff, Pam Lawrence grabbed Resident A, twisted his shirt, and hit him in the sternum. Home Manager Mary Stone stated that she was not working on the day in question. Staff Lawrence has worked for the corporation for 28 years and to her knowledge, there are no prior known allegations made against staff Lawrence's mistreatment of Resident A. No incident report was completed. The assessment plan indicates that Resident A is unable to communicate his needs. The plan also states that Resident A is unable to control his aggressive behaviors, however, staff are to soothe and help calm Resident A down when displaying aggression. I observed Resident A, along with 3 other residents in the home. They were adequately dressed and groomed. They appeared to be receiving proper care. Staff, Ashely Cureton, stated that she was not working on the day of the alleged incident. Staff Cureton stated that while she has witnessed staff Lawrence be stern with Resident A, she has never witnessed her be abusive, aggressive or mean. Staff, Pam Lawrence, stated that she grabbed Resident A by the shirt to guide him towards his bedroom. Staff Lawrence denied poking Resident A in his chest, as alleged. St. Clair County Recipient Rights Director, Sandy O'Neill, indicated that their office did not substantiate the allegations. APS Investigator, Dan Schave, indicated that after speaking with all involved, he will not be substantiating this referral.

	St. Clair County CMH Case Manager, assigned to Resident A, Cheyenne Johnson, stated that she had not been made aware of the allegations. She has not had any concerns with Resident A's care or treatment by staff in the home Staff, Denise Cooper, recalls witnessing staff Lawrence pointing her finger at Resident A's chest. Staff Cooper did not observe staff Lawrence grab Resident A's shirt. Staff Dana Brasher stated that she observed staff Pam Lawrence grab Resident A by the shirt, twisting it, punched him in the chest and drug him down the hall by his shirt to his room. Based on the interviews conducted and the documents reviewed, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Sabrina McGowan — October 14, 2024

Sabrina McGowan
Licensing Consultant
Date

Approved By:

Mary Holton — October 14, 2024

Mary E. Holton
Area Manager
Date