GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2026

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

RE: License #: AS740013022
Investigation #: 2026A0580028
Maple Street Home

Dear Andrea Bubel:

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 #:	AS740013022
Investigation #:	2026A0580028
Complaint Receipt Date:	04/13/2026
Investigation Initiation Date:	04/15/2026
Report Due Date:	06/12/2026
Licensee Name:	Blue Water Developmental Housing, Inc.
Licensee Address:	Bldg. 1 1362 River Rd. St. Clair, MI 48079
Licensee Telephone #:	(810) 388-1200
Administrator:	Andrea Bubel
Licensee Designee:	Andrea Bubel
Name of Facility:	Maple Street Home
Facility Address:	471 Maple Street Algonac, MI 48001
Facility Telephone #:	(810) 794-7220
Original Issuance Date:	09/12/1986
License Status:	REGULAR
Effective Date:	04/06/2025
Expiration Date:	04/05/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff, Stacy Rappa, administered Resident A another resident's medication.	Yes

III. METHODOLOGY

04/13/2026	Special Investigation Intake 2026A0580028
04/13/2026	APS Referral Opened by APS for investigation.
04/15/2026	Special Investigation Initiated - Telephone Call to Cynthia Rhodes, APS.
04/24/2026	Contact - Telephone call made Call to Jocelyn Henderson, Recipient Rights.
04/28/2026	Inspection Completed On-site Unannounced onsite.
04/28/2026	Contact - Face to Face Observation of Resident A.
04/28/2026	Contact - Telephone call made Call to Stacey Rappa, Staff.
04/28/2026	Contact - Document Received Documents received.
05/11/2026	Contact - Document Received Email from RR Investigator Henderson.
05/11/2026	Contact - Telephone call made Call to Relative Guardian A.
05/11/2026	Contact - Document Received Hospital discharge summary rec'd.
05/11/2026	Contact - Document Sent Email to APS Investigator Rhodes.
05/12/2026	Exit Conference Exit Conference with LD Bubel.

ALLEGATION:

Staff, Stacy Rappa, administered Resident A another resident's medication.

INVESTIGATION:

On 04/13/2026, I received a complaint via LARA-BCHS-Complaints. This complaint was opened by Adult Protective Services for investigation.

On 04/15/2026, I interviewed Cynthia Rhodes, assigned APS Investigator. Investigator Rhodes stated that the allegations are true. Staff Stacy Rappa admittedly administered another resident's medication to Resident A. Staff Rappa identified the medication error as soon as it occurred. During her interview with Staff Rappa, she explained that she was in a hurry and probably should have slowed down.

On 04/24/2026, I interviewed Jocelyn Henderson, Recipient Rights (RR) Investigator. Investigator Henderson stated that during her interview with Staff Rappa, she stated that she was rushing due to waking up late for work. Staff Rappa also stated that she did not follow protocol by completing her 3 checks required before passing medication. Resident A was taken to the hospital, accompanied by staff. Relative Guardian A met them at the hospital. The home does not have any discharge instructions related to Resident A's hospital visit. The home assumes the discharge instructions were given to Guardian A.

On 04/28/2026, I conducted an unannounced onsite inspection at Maple Street Home. Contact was made with Angie Miller, Home Manager (HM). HM Miller stated that she was working with Staff Rappa when the medication error occurred. HM Miller recalled that she was in the kitchen preparing breakfast as Staff Rappa was passing medication. As Resident A began putting his medication in his mouth, Staff Rappa quickly realized the error and tried to stop Resident A from swallowing the medication, however, it was too late. Resident A was quickly taken to the hospital where they monitored his heart rate. Resident A was discharged back to the home within a short time frame. HM Miller stated that the error was attributed to a mix up in resident initials. Staff Rappa was written up as a result of the error. Staff Rappa will also repeat medication training, scheduled for 05/07/2026, and will not pass medication until the repeat training is completed.

On 04/28/2026, while onsite I observed 2 residents sitting in the dining room area of the home. Both were adequately dressed and groomed. No concerns regarding their care were noted.

On 04/28/2026, while onsite, I accompanied by HM Miller, observed Resident A while in his room. Resident A is deaf and unable to verbally communicate. Resident A was lying on his bed relaxing. Resident A was adequately clothed and groomed. No concerns regarding his care were noted. HM Miller signaled to Resident A that I was there

checking on him due to the medication error. Resident A gave a thumbs-up when inquiring if he was feeling fine.

On 04/28/2026, I interviewed Direct Staff, Stacy Rappa. Staff Rappa stated that normally she works the afternoon shift, however, in April of this year, she began working mornings. Staff Rappa stated that she woke up late and had been rushing to get to work. Staff Rappa attributes the medication error to the change in her schedule and the fact that she did not do her 3 checks she should have done before pulling the medication. Staff Rappa stated that she has been employed with the corporation for 10 years and has 1 other medication error, several years ago, while working in another of their homes. Staff Rappa confirmed that she was written up as a result of the error and will be re-trained in medication passing.

On 04/28/2026, I received an emailed copy of the documents requested. The AFC Assessment Plan for Resident A indicates that he is hearing impaired. Staff are responsible for administering medications.

The Medication Error Report indicates that Resident A was incorrectly administered Methylphenidate 20mg, Aspirin 81mg, Fluoxetine 40mg, Cetirizine 10mg, and Lamotrigine 150mg.

The Incident Report (IR) dated 04/12/2026 at 8:00am, states that Resident A was given another residents' medication. Staff responsible was identified as Stacy Rappa. Resident A was transported to McLaren Port Huron hospital. Resident A's primary doctor, guardian and Community Mental Health (CMH) were contacted.

On 05/11/2026, I received an email RR Investigator Henderson. RR Investigation Henderson indicated that she has closed her case with a substantiation for Neglect: Class III.

On 05/11/2026, I placed a call to Relative Guardian A. During the interview, Relative Guardian A stated that Resident A has been placed in Blue Water AFC homes for the past 10 years. There have been 3 medications errors throughout this time frame. The previous medication error almost cost Resident A his life. Relative Guardian A stated that she thinks the whole company needs to be retrained in medication passing. Prior to this incident, there have been minor concerns that were able to be addressed by management. Relative Guardian A has requested that CMH find Resident A a new placement. Relative Guardian A agreed to provide a copy of the McLaren Port Huron Discharge instructions that were provided on 04/12/2026.

On 05/11/2026, I received a copy of the McLaren Port Huron Discharge Summary for Resident A. The summary indicates that Resident A visited the hospital on 04/12/2026 for an Abnormal diagnostic test due to an accidental medication error. Resident A's diagnosis was Sinus Tachycardia, a fast heartbeat, in which the heart beats more than 100 times in a minute. Resident A was advised to follow-up with his primary physician within 5-7 days.

On 05/11/2026, I sent an email to APS Investigator Rhodes. I inquired if there was a substantiation as a result of the APS investigation.

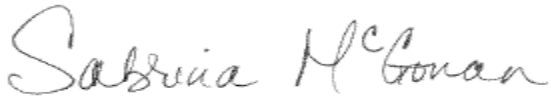
On 05/12/2026, I conducted an exit conference with Licensee Designee (LD), Andrea Bubel. LD Bubel confirmed that Staff Rappa received a written reprimand in her employee file and was not able to administer medication until she was re-trained in medication passing. LD Bubel also stated that all employees complete yearly med pass refresher training. LD Bubel was informed of the findings of this investigation.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that staff, Stacy Rappa, gave Resident A another resident's medication. APS Investigator, Cynthia Rhodes, stated that the allegations are true. Staff, Stacy Rappa admittedly administered another resident's medication to Resident A. RR Investigator, Jocelyn Henderson, stated that during her interview with Staff Rappa, she stated that she did not follow protocol by completing her 3 checks required before passing medication. The investigation established a substantiation for Neglect: Class III. HM, Angie Miller stated that she was working with Staff Rappa when the medication error occurred. Staff Rappa quickly realized the error and tried to stop him from swallowing the medication, however, it was too late. HM Miller stated that the error was attributed to a mix up in resident initials. Resident A is deaf and unable to verbally communicate. Resident A gave a thumbs-up when inquiring if he was feeling fine. The AFC Assessment Plan for Resident A indicates that he is hearing impaired. Staff are responsible for administering The AFC Assessment Plan for Resident A indicates that he is hearing impaired. Staff are responsible for administering medications. The Medication Error Report indicates that Resident A was incorrectly administered Methylphenidate 20mg,

	Aspirin 81mg, Fluoxetine 40mg, Cetirizine 10mg, and Lamotrigine 150mg. The Incident Report (IR) dated 04/12/2026 at 8:00am, states that Resident A was given another resident's medication. Resident A was transported to McLaren Port Huron hospital. The 04/12/2026 McLaren Port Huron Discharge Summary for Resident A indicates that Resident A was diagnosed with Sinus Tachycardia, a fast heartbeat. Relative Guardian A stated that this is Resident A's 3rd medication error throughout this time frame. Prior to this incident, there have been minor concerns that were able to be addressed by management. Relative Guardian A stated that she thinks the whole company needs to be retrained in medication passing. Relative Guardian A has requested that CMH find Resident A a new placement. Based upon my investigation, which consisted of interviews with facility staff members, APS Investigator Cynthia Rhodes, RR Investigator Jocelyn Henderson, Relative Guardian A, and Licensee Andrea Bubel, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

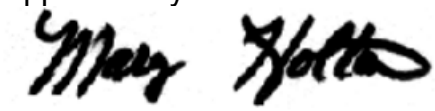
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



May 12, 2026

Sabrina McGowan — Date
Licensing Consultant

Approved By:



May 12, 2026

Mary E. Holton — Date
Area Manager