GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2026

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

RE: License #: AS500409309
Investigation #: 2026A0990016
County Manor

Dear Ms. Bubel:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 972-9136.

Sincerely,

L. Reed

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
3044 W Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500409309
Investigation #:	2026A0990016
Complaint Receipt Date:	04/22/2026
Investigation Initiation Date:	04/22/2026
Report Due Date:	06/21/2026
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:	County Manor
Facility Address:	53880 County Line Rd. New Baltimore, MI 48047
Facility Telephone #:	(586) 725-0829
Original Issuance Date:	03/09/2022

License Status:	REGULAR
Effective Date:	09/09/2024
Expiration Date:	09/08/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A, who has a history of choking from overeating, required CPR and hospitalization after another choking incident, raising concerns about supervision.	Yes

III. METHODOLOGY

04/22/2026	Special Investigation Intake 2026A0990016
04/22/2026	APS referral Initiated at intake.
04/22/2026	Special Investigation Initiated - Letter Email to Andrea Bubel, licensee designee. Requested resident and employee records.
04/23/2026	Contact - Document Received Received emails from Ms. Bubel with resident and employee records
04/23/2026	Contact - Face to Face Completed unannounced onsite investigation at County Manor. Interviewed Home Manager, Lauralee Counterman and Residential Services Division Director Melissa Brandimore.

04/24/2026	Contact - Document Sent Email to Ms. Bubel confirming receipt of documents and informing her that the special investigation was being re-assigned. Email from Ms. Bubel indicating she will send any additional documents to Ms. Reed.
04/27/2026	Contact - Document Received I received emails from Ms. Bubel.
05/06/2026	Contact – Telephone call received I conducted a phone interview with Jose Garci, Adult Protective Services (APS) investigator.
05/11/2026	Contact - Document Sent I emailed Ms. Bubel requesting additional documents.
05/11/2026	Contact - Document Sent I emailed Ms. Bubel requesting Incident Reports for Resident A that involved choking incidents for the years 2024-2026.
05/12/2026	Contact- Telephone call made I called Detective Rea from New Baltimore Police Department. I left a detailed message and sent an email. Detective Rea returned the call.
06/18/2026	Contact - Document Received I reviewed Charles Hartwig's employee record and Resident A's resident record.
06/18/2026	Contact - Document Sent I emailed Ms. Bubel with follow-up questions.
06/18/2026	Contact - Document Sent I emailed direct care staff Charles Hartwig. No response to date.
06/18/2026	Contact - Document Sent I emailed Office of Recipient Rights (ORR) investigator Susan Feld. I inquired about the status of the investigation. Ms. Feld responded.
06/18/2026	Contact- Telephone call to I conducted a phone interview with direct care staff Robin Hughes.

06/22/2026	Contact – Document Received I received an email from Ms. Bubel. I replied with additional questions.
06/22/2026	Contact – Telephone I conducted a phone interview with Tiffany Terenzi, Supports Coordinator/Easter Seals.
06/22/2026	Contact- Document Sent I requested additional documents from Ms. Bubel. I reviewed Resident A's Medical Appointment Record and IPOS training logs.
06/23/2026	Contact- Document Received I received direct care staff Rachel Johnson employee record.
06/23/2023	Contact – Document Sent I emailed direct care staff Rachel Johnson requesting a call back for a phone interview. Received call back and conducted phone interview.
06/23/2026	Contact- Document Received I received the Clinical Swallowing evaluation from Easter Seals from Ms. Terenzi.
06/26/2026	Exit conference I conducted an exit conference with Ms. Bubel.

ALLEGATION:

Resident A, who has a history of choking from overeating, required CPR and hospitalization after another choking incident, raising concerns about supervision.

INVESTIGATION:

On 04/23/2026, I conducted an unannounced onsite investigation at County Manor. I interviewed Residential Services Division Director Melissa Brandimore. Ms. Brandimore, who stated that she was not present when the choking incident occurred. She did go out to the home that evening around 6:30 PM-7:00 PM. Resident A was already at the hospital when she arrived. Ms. Brandimore stated that all staff have completed written statements which can be provided for licensing. Susan Feld from the Office of Recipient Rights (ORR) is investigating, and they had a meeting today. Ms. Brandimore stated

that there were three staff on shift when the incident occurred: Rachel Johnson, Robin Hughes, and Charles Hartwig. The assistant manager, Rachel Johnson, was making dinner. The new employee, Ms. Hughes, was reading the Individual Plan of Services (IPOS) at the kitchen table. Ms. Johnson asked Mr. Hartwig to keep an eye on Resident A while she was making dinner. Resident A reached the counter and grabbed a hamburger bun with a little bit of hamburger. She indicated Resident A tried to grab food twice. The second time he grabbed food, he went out the back door. She was told that Mr. Hartwig did not react. Resident A then came back inside, and staff noticed he was already turning blue. Ms. Johnson told Ms. Hughes to call 911. Ms. Johnson turned off the stove and started performing the Heimlich maneuver with 911 on the phone. She asked Mr. Hartwig for help, and he refused. He said he did not think he could assist and that he was tired and walked away. She believed he had worked at home since February 2026. She stated that Mr. Hartwig then came back and started performing CPR on Resident A despite the dispatcher's instructions to do the Heimlich maneuver. Ms. Johnson yelled at him to stop, and the dispatcher told them to try laying Resident A down to do the Heimlich maneuver. Police, EMS, and the fire department then arrived and took over. All three staff members have been placed on paid leave pending investigation. She has spoken to Detective Rea from the New Baltimore Police Department, who is investigating- Report #26-3732.

On 04/23/2026, I interviewed Home Manager, Lauralee Counterman. She was not present when the choking incident occurred. She stated that an Adult Protective Services (APS) investigator called the house and said he was closing the case. Ms. Counterman stated that the incident occurred on Friday, 04/17/2026. She left home around 3:00 PM that day. She got a call from staff around 4:15 pm regarding Resident A choking. She was about five minutes away and went straight home. EMS and firetrucks were already there when she arrived. She asked Mr. Hartwig to get the other residents out of the house. Ms. Counterman stated that she immediately started contacting the guardian and MORC. She stated that Resident A has lived at County Manor for five years. His father is his guardian (Relative A). Relative A has health issues and can be difficult to get a hold of due to his illness. Resident A's sister, Relative A1, was going to take over as his guardian and has been the primary contact. Ms. Counterman read text messages she had from Relative A1 providing updates from the hospital and thanking her for the care she provided for her brother. Ms. Counterman stated that Resident A had Pica. He had a choking incident back in September or October 2025 when he got a cinnamon roll that staff had put in the oven. He also had an incident with a grilled cheese sandwich in December 2025 or January 2026. He would also try to take food out of the garbage can, so it had to be secured. She indicated that the pantry had to be locked for Resident A; however, it is no longer required since his death. The fridge is kept locked in the home due to another Resident's IPOS. Ms. Counterman stated that Resident A was "busy" all day on the date of the incident. Mr. Hartwig was supposed to be watching him. He grabbed ½ a hamburger bun and walked outside the back of the house. Other staff reported that Mr. Hartwig just stood there and did nothing when Resident A grabbed the hamburger bun. He came right back in, and Ms. Johnson instantly started Heimlich maneuvering. Staff noticed that his lips were already turning blue. Ms. Johnson asked for help because Resident A was a larger guy, and Mr.

Hartwig said he couldn't because he was too tired. He walked out and then came back and started performing CPR. He was told to stop and walked away again. Dispatch asked them to also try the Heimlich maneuver by laying Resident A down. A police officer arrived and tried the Heimlich maneuver by picking Resident A up and laying him down. EMS then arrived and took over. She stated that Resident A needed to be supervised by staff sitting with him when eating. His food was supposed to be in ½ inch bite size pieces, moist ground. At one point, he was prescribed a thickened and pureed diet; however, the thickened diet was discontinued. There are now five residents in the home. They typically have two staff on shift. I took a picture of the staff schedule.
On 05/06/2026, I conducted a phone interview with Jose Garcia, an Adult Protective Services (APS) investigator. Mr. Garcia stated that the home was negligent in observing Resident A because he choked on a hamburger bun. Resident A came inside the home and walked out with a hamburger bun, and the male staff didn't notice when he took the bun. Resident A came back to the kitchen because he was choking, and there was a female staff member who observed that he was choking and began the Heimlich maneuver. Resident A is a larger guy, and the female staff could not properly do the Heimlich and asked the male staff to assist her, but she refused. Law enforcement said this was not the first time that this resident has choked in this home. The Office of Recipient Rights conducted an interview with the staff. Mr. Garcia provided the detective's phone number, which is through the Baltimore Police Department. The APS investigation was substantiated and closed. Resident A passed away.

On 05/11/2026, I emailed Ms. Bubel and requested Mr. Hartwig's CPR and First aid training certificate. In addition, I requested the following documents for Resident A: IPOS, Crisis & Safeguard Intervention, *Assessment Plan,* and *Health Care Appraisal.* I also requested the staff schedule for April 2026 and the *Resident Register*.

On 05/12/2026, I called Detective Rea from the New Baltimore Police Department. I left a detailed message and sent an email. Detective Rea returned the call. Detective Rea said that there are no criminal charges filed against the staff involved. Detective Rea said that the incident did not meet the definition of reckless neglect due to the passing away of Resident A. There have been prior choking incidents since May 2025. Detective Rea said that he was present for a January 2026 choking incident. Detective Rea said that Ms. Johnson was present during the January 2026 choking incident, but Mr. Hartwig was not.

On 06/18/2026, I emailed Ms. Bubel with follow-up questions as follows: Was a swallow test ever done on Resident A? If so, please send documentation. What is the status of the (ORR) investigation? Have there been any changes in the status of the employees who were present at the time of the choking incident? Can you please send documentation that the staff was trained on Resident A's IPOS? Was Resident A still prescribed Simply Thick?

On 06/22/2026, Ms. Bubel replied to questions via email. Resident A received a swallow study on 11/20/2025. Ms. Bubel attached the Medical Appointment Record and Health Care Chronological (HCCs). Ms. Bubel also attached a copy of the diet script

resulting from the swallow study. Ms. Bubel said that Rachel Johnson and Charles Hartwig were substantiated by Macomb County Community College (MCCMH)/ORR with Neglect 1. Rachel Johnson and Charles Hartwig have been terminated. Ms. Bubel attached Resident A's IPOS training log. Resident A was still prescribed Simply Thick. Ms. Bubel attached a copy of the script.

On 06/18/2026, I reviewed the resident record and Mr. Hartwig's employee record. Mr. Hartwig was hired as direct care staff on 01/13/2026. He worked at three previous adult foster care homes prior to this position. Mr. Hartwig is fully trained with a valid CPR and first aid card dated 03/04/2026 and expires 03/2028. Mr. Hartwig completed a medical exam at hire, and it was documented on the physical exam that Mr. Hartwig "may work without limitation/restrictions". It was noted on the medical exam that the job description was not available, and the determination is based on the description of duties provided by the patient/applicant. Mr. Hartwig had no signs or symptoms of communicable diseases. There were two professional references checked for Mr. Hartwig. One professional reference and one personal reference. Both references were satisfactory. It was noticed that in one of the references, it was noted that Mr. Hartwig's weakness was his eyesight. Mr. Hartwig was employed full-time and his work hours are 12 AM to 11: 59 PM. He signed the employee manual and received/signed his job description.

Resident A has lived in the home for five years. Resident A's IPOS was effective 09/01/2026 through 08/31/2026. The IPOS documents that Resident A's case coordinator/case manager meets with him monthly. Resident A does not attend the day program because of recent health concerns and hospitalizations. Resident A' s last physical exam was completed on 01/31/2026. The home is responsible for monitoring all health-related needs and ensuring 911 is called during all incidents. There were safety precautions outlined in the IPOS to address Resident A's seizures. Resident A requires 24/7 support with ADL's and specialized residential care. Resident A **i**s diagnosed with unspecified affective psychosis with origin specific to childhood, infantile autism, current active pica, and generalized epilepsy. Resident A has a Behavior Treatment Plan Review Committee (BTPRC). The BTPRC action plans are to address Resident A's diagnosis of Pica, and the actions are as follows: Locked trash- The trash can should be locked due to Resident A placing unsafe trash items in his mouth. Staff should keep the trash locked to support health and safety. Locked pantry- Lock in place to support health and safety. Locked fridge/freezer- Lock in place to support health and safety. Resident A should be within eyesight during meal. Snack times are supervised while in the kitchen. Resident A has a long history of food-seeking behaviors during mealtimes. Resident A can be very focused on food and impulsive. Staff should monitor him closely while in the community around food. Resident A has Pica and may try to ingest objects that are not edible. He should be monitored visually and requires visual checks every 15 minutes. When kitchen appliances are in use, staff need to monitor Resident A, who does not possess the necessary safety skills in the kitchen and does not understand potential hazards.

BTPRC approves that staff should ensure all food items are locked and support when food is requested. During food meal preparation, staff would be in the kitchen at all

times. After food is prepared, staff should ensure that all plates, sinks, counter tops, and food preparation devices are cleaned of food/drinks and placed away to ensure their health and safety. Staff should not leave the kitchen unless all food items are secured/locked. No food/drink item at any time should be left unattended by staff. Resident A steals food, and staff can take away unsafe items he tries to ingest; Resident A should be within eyesight during meal/snack times and supervised in the kitchen.

Resident A' s IPOS documents that he requires a swallow evaluation for dysphagia and is prescribed Simply Thick Nectar for drinks 100% of the time. Resident A is non-verbal. The IPOS documents that there have been choking incidents in the home, and the following barriers were identified: Staff did not prepare the diet textures properly, lack of monitoring/supervision of all choking incidents, and lack of following the mealtime guidelines outlined by the speech pathologist. The IPOS meeting was held on 08/05/2026, and the following people were present: Resident A, Lauralee Counterman (home manager), Tiffany Terenzi (Supports Coordinator), and Ashley Labrane (Mental Health Professional). The home manager was in-serviced and will ensure that staff are trained on Resident A's IPOS.

I reviewed eight incident reports. There were two prior incident reports that involved Resident A choking as follows: On 05/01/2025 at 9:45 AM, Resident A took a cinnamon roll out of the oven and stuffed it in his mouth. Resident A's lips turned purple, and he was choking. Resident A took off running to the recreation room, and staff came to administer Heimlich, and he was transported to McLaren Hospital. Direct care staff Rachel Johnon was present during that incident. The second incident occurred on 01/01/2026. Resident A was eating, and his lips turned purple and blue. Resident A was transported to the emergency room.

I review the incident report dated 04/17/2026 that involved the following people: Direct care staff Rachel Johnson, Charles Hartwig, Robin Hughes (trainee), Resident A, and Lauralee Counterman (Home manager). During dinner preparation, Ms. Johnson instructed Mr. Hartwig to monitor Resident A while she prepared plated meals for the residents. At that time, Ms. Johnson was training Ms. Hughes, and she was reviewing IPOS documentation as part of her first shift in the home. Mr. Hartwig did not intervene when Resident A obtained a hamburger bun and placed it in his mouth. Ms. Johnson directed Resident A to sit at the table until he finished eating. Afterward, Ms. Johnson again instructed Mr. Hartwig to monitor Resident A while she completed meal preparation. Resident A subsequently obtained another portion of a hamburger bun and exited briefly through the back door. Mr. Hartwig remained seated and did not follow or intervene. Resident A re-entered the home, and at that time, Ms. Johnson observed that his lips appeared slightly blue. Ms. Johnson immediately turned off the stove and approached Resident A, who was showing signs of respiratory distress and turning blue in the face. Ms. Johnson started doing the Heimlich maneuver, but due to difficulty performing the maneuver alone, she requested Mr. Hartwig to assist. Mr. Hartwig responded that he was unable to assist, saying he was tired and walking away. Ms. Hughes contacted 911 and the home manager. Emergency dispatch instructed staff to

place Resident A on the floor and continue abdominal thrusts in a supine position. Mr. Hartwig briefly returned and began performing CPR instead of abdominal thrusts directly. Ms. Johnson corrected him and continued to perform the Heimlich maneuver independently. EMS arrived 30-40 minutes on site and intervened and transported Resident A to McLaren Macomb Hospital. Advanced life-saving measures were continued at the hospital. After 1 hour and 20 minutes, a faint heartbeat was restored, and Resident A was placed on a ventilator. On 04/19/2026, after several tests, it was found that Resident A had no brain activity. Resident A was removed from the ventilator and passed away at 5:32 PM.

I reviewed the menu for 04/17/2026, and it was documented that the home prepared BBQ pulled pork sandwiches, potatoes, mixed veggies, and mixed fruit cup. It was noted on the menu that Resident A is to be served a ½ plate of high fiber vegetable choice. I reviewed the shopping list, and hamburger buns (1 package/8 buns in a pack) were purchased the week of 04/12/2026-04/18/2026.

On 06/18/2026, I emailed ORR investigator Susan Feld. I inquired about the status of the investigation. Ms. Feld stated that Rachel Johnson and Charles Hartwig were substantiated for Neglect 1.

On 06/18/2026, I conducted a phone interview with direct care staff Robin Hughes. Ms. Hughes said that she was present on the day of the incident, and it was her first day working in the home. She was sitting at the kitchen table reading the residents' IPOS books. Ms. Hughes said that Ms. Johnson ran after Resident A because he had stolen a hamburger bun. Ms. Hughes said that Ms. Johnson went after him, but he had already eaten the bun. Ms. Hughes said that Ms. Johnson told Mr. Hartwig to watch Resident A because she was still preparing the meals. Mr. Hartwig was sitting at the kitchen table with her. Resident A then re-entered the kitchen, took another hamburger bun, and ran out of the room. When Ms. Johnson went after Resident A, he was choking on the hamburger bun. Ms. Hughes said she observed Ms. Johnson trying to relieve Resident A, but he was weighing heavily on her. She yelled for her to call 911. Ms. Hughes said that Ms. Johnson was performing the Heimlich on Resident A and was yelling at Mr. Hartwig to help her. Mr. Hartwig said that he was tired. Ms. Hughes said that Mr. Hartwig eventually tried helping Ms. Johnson, but did not follow instructions. The EMS arrived and took Resident A out to the hospital. Ms. Hughes said that both Ms. Johnson and Mr. Hartwig were terminated.

On 06/22/2026, I conducted a phone interview with Tiffany Terenzi, Supports Coordinator/Easter Seals. Ms. Terenzi was aware of the incident involving Resident A and had nothing further to add. Resident A had a swallow evaluation done by their agency and agreed to send a copy of the evaluation later today. Ms. Terenzi said that she trains the managers on residents' IPOS, and they are responsible for training the staff. Resident A had a behavior support coordinator to address Pica. Ms. Terenzi said that she had never met direct care staff Charles Hartwig, but had met Rachel Johns. Ms. Terenzi said that she was informed that ORR substantiated Ms. Johnson for their investigation because she was cooking dinner too early, and she should not have

directed Mr. Hartwig to supervise Resident A because he did not require one-on-one supervision. Ms. Terenzi said that she had no concerns about Resident A's care prior to the incident and believes it was "an unfortunate accident". Ms. Terenzi said that the home was "busy," but they provide good care. Ms. Terenzi said that Relative A is responsive; it would also be good to interview Relative A1. She agreed to send Relative A1's phone number. She later stated that she did not have Relative A1's phone number. On 06/22/2026, I reviewed Resident A, Medical Appointment Record, and IPOS training logs that were requested from Ms. Bubel. Resident A was seen by Kerri Gonda, Speech and Language Pathologist, for choking evaluation on 11/20/2025. The physical findings were as follows: Impulsive self-feeding, chewing, and wallowing. Residents need a mechanical soft diet and thin liquids. I reviewed the IPOS training logs, and Ms. Johnson was trained in Resident A IPOS on 08/07/2025, and Mr. Hartwig was trained on 02/04/2026.

On 06/23/2026, I received an email from Ms. Bubel. Ms. Bubel attached Ms. Johnson's employee record and the ORR investigative report. Ms. Johnson was hired on 01/21/2022 as direct care staff. There were two satisfactory personal reference checks. Ms. Johnson had no prior adult foster care experience. Ms. Johnson's current job description was Residential Supervisor and was signed, as well as the employee handbook. Ms. Johnson had a valid CPR and First Aid certificate that was issued on 05/31/2026 and expired 05/2026.

I reviewed the ORR investigative report dated 05/22/2026 by Susan Feld. Ms. Feld interviewed Mr. Hartwig on 04/23/2023. Mr. Hartwig was aware that Resident A stole food. Mr. Hartwig admitted that Resident A stole a hamburger bun on 04/17/2026 while Ms. Johnson was preparing dinner. Mr. Hartwig reported that he redirected Resident A to sit at the table and eat the bun. Mr. Hartwig gave Resident A sips of water so he would not choke. Mr. Hartwig reported that Resident A took a second bun, stuffed his mouth, and ran out the back door. Resident A came back inside a minute later and sat down on the loveseat, and shortly thereafter, Mr. Hartwig reported hearing Ms. Johnson yell that Resident A was choking. Mr. Hartwig reported that he immediately went to help, and Ms. Hughes called 911. Mr. Hartwig reported that Ms. Johnson could not lift Resident A to do the Heimlich Maneuver. Mr. Hartwig tried to lift him as well, but could not get a good position. They lowered Resident A to the floor, and Ms. Johnson continued to do abdominal thrusts. Mr. Hartwig noticed that Resident A was still blue, so he started chest compressions to keep his blood flowing. EMS arrived shortly thereafter and took over. Mr. Hartwig denied that Ms. Johnson told him to watch Resident A. The report documented that neither Mr. Hartwig nor Ms. Johson followed Resident A outside after he took the second hamburger bun. The report documents that on 05/06/2026, a State of Michigan Certificate of Death for Resident A was reviewed. Resident A's cause of death is choking. Mr. Hartwig and Ms. Johnson were substantiated for Neglect 1.

On 06/23/2026, I emailed direct care staff Rachel Johnson requesting a call back for a phone interview. Received a call back and conducted a phone interview. Ms. Johnson agreed to a phone interview but stated, "If I can remember". Ms. Johnson was very

emotional during the phone call. Ms. Johnson said that she was preparing dinner on 04/17/2026, and she instructed Mr. Hartwig to watch Resident A because she was preparing dinner. Ms. Johnson said that Resident A took a hamburger bun twice, but the second time, he choked. Ms. Johnson said that when she noticed that he was choking, she began the Heimlich Maneuver and yelled at Ms. Hughes to call 911. Ms. Johnson said that Ms. Hartwig refused to help her, but when he did, he was not following the ER dispatchers' directions and was doing CPR instead of Heimlich. Ms. Johnson said that when they are preparing meals, there is always one staff member watching Resident A because he steals food. Ms. Johnson said that one other time, Resident A choked on a cinnamon roll because someone from a different shift left it in the oven; she was the person who got in trouble because it happened on her shift. Ms. Johnson said that she was trained on Resident A's IPOS. Ms. Johnson was terminated on 05/22/2026 for Neglect 1, which she disagrees with. Ms. Johnson said that she no longer wants to discuss the situation, as it is a tragic experience that she is dealing with personally.

On 06/23/2026, I received the Clinical Swallowing evaluation from Easter Seals from Ms. Terenzi. The evaluation was conducted on 11/20/2025 at 1:15 PM, and those who contributed to the assessment and were present were Rebecca Chartier, medical tech from County Manor, home manager Lauralee Counterman (via phone), Resident A, and Kerri Gonda, speech language pathologist.

Resident A is documented as nonverbal, and all his medications were documented in the evaluation. It was documented that Resident A is recommended at a puree and nectar thick, one-on-one feed diet. Resident A weighed 147 pounds. Resident A has missing teeth. The evaluation documented that strategies for food type for Resident A should be within arm's reach supervision during all oral intake, Resident A's meals are to be set up by caregivers and monitor and assist him as needed. The overall goal is to encourage him to slow down while eating and maintain safety. The report documents that when a meal is in front of Resident A, he is to be offered verbal cues to slow down when necessary. If verbal prompts to slow down are ineffective, staff may put their hand over his dish or gently touch his hand to stop him from feeding himself at a fast pace. Another option is for staff to ration out one bite-sized piece at a time in front of him. Resident A is to be prompted to put utensils down, wipe his mouth, or take a small drink in between bites. If needed, staff may momentarily move dishes out of reach to stop him from feeding himself at a fast pace. Resident A is to use a regular cup and small utensils. It was documented that Resident A eats too fast, overloads utensils, and overloads the mouth.

The clinical findings documented that Resident A is inconsistently able to follow prompts to take small bites in a smaller amount and is ok with the caregiver supporting him during mealtimes. The report documents that he's at risk of choking due to impulsive and risky self-feeding behaviors, and he is within mild severity. Resident A's chewing skills are the biggest safety concern, and how much he tries to eat at one time, contributing factors to swallowing impairment, including risky, impulsive self-feeding, and difficulty following directions. His prognosis is good. It was documented in the report that he has pica as well as dysphasia and esophageal dysphasia. The report

documents that the recommended guidelines are a mechanical soft diet and thin beverages, and the caregivers are to be within arm's reach, line of sight supervision, set up all meals, and monitor him as needed when there is a male in front of him or when he attempts to slow down.

On 06/26/2026, I conducted an exit conference with Ms. Bubel. Ms. Bubel was informed of the recommendation for revocation of the license. I explained the disciplinary process and potential outcomes. Ms. Bubel said that this morning Melissa Brandimore, Regional Director, was terminated as result of this incident and other non-compliance issues. Ms. Bubel said that Ms. Brandimore’s skill set lacked leadership. We discussed the rules that are cited.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon the investigation, there is evidence to support that Resident A was not protected and supervised according to his IPOS, which addresses his diagnosis of Pica and dysphagia. On 04/17/2026, two hamburger buns were taken within minutes apart at the home while direct care staff/supervisor Rachel Johnson was preparing dinner, and Charles Hartwig sat at the kitchen table with a trainee, Robin Hughes. Resident A took the first bun and swallowed it after running out of the kitchen, and then, a few minutes later, took a second bun and ran outside. The staff did not follow him outside. Resident A returned inside the home and was observed to be turning blue by Ms. Johnson. As a result of the choking incident, Resident A passed away on 04/19/2026 at McLaren Macomb Hospital. Resident A should be within eyesight during meals, snack times, and supervised while in the kitchen. Resident A has a long history of food-seeking behaviors during mealtimes. During food meal preparation, staff should ensure their health and safety. There are to be no food/drink items left unattended by staff. Resident A steals food, and staff can take away unsafe items he tries to ingest. Resident A's IPOS documents that there have been choking incidents in the home, and the following barriers were identified: Staff's lack of monitoring/supervision of all choking incidents and lack of following mealtime. There were two prior choking incidents in the home, in which, on 05/01/2025 at 9:45 AM, Resident A took a cinnamon roll out of the oven and stuffed it in his mouth and was hospitalized. The second incident occurred on 01/01/2026. Resident A was eating, and his lips turned purple and blue; he was hospitalized. Resident A had a clinical swallowing evaluation on 11/20/2025, and it was documented that Resident A should have supervision within arm's reach during all oral intakes. This did not occur because Resident A stole a hamburger bun and went outside without supervision. Resident A's meals are to be set up by caregivers and monitored and assisted as needed. The report documents that when a meal is in front of Resident A, he is to be offered verbal cues to slow down when necessary. If verbal prompts to slow down are ineffective, staff may put their hand over his dish or gently touch his hand to stop him from feeding himself at a fast pace. If needed, staff may momentarily move dishes out of reach to stop them from feeding themselves at a fast pace. Resident A eats too fast, overloads utensils, and overloads the mouth. Resident A is at risk for choking due to

	impulsive and risky self-feeding behaviors, and he is within mild severity.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the investigation, there is evidence to support that direct care staff Charles Hartwig could not handle an emergency situation on 04/17/2026 when Resident A choked. According to the incident report, interviews with direct care staff, Rachel Johnson, and Robin Hughes, on the date of the incident, Mr. Hartwig did not intervene when Resident A took the hamburger bun and ran outside. Mr. Hartwig remained seated and did not follow or intervene. Furthermore, when Ms. Johnson became aware that Resident A was choking, she immediately began the Heimlich Maneuver. According to Ms. Johnson and Ms. Hughes, she asked Mr. Hartwig to help, and he refused, stating that he was tired. Mr. Hartwige eventually assisted; however, he began CPR when he was supposed to be doing chest compressions as instructed by ER dispatch. Mr. Hartwig is fully trained, has a valid CPR and First Aid card, and has experience as a direct care staff member. In conclusion, Mr. Hartwig's failure to supervise and monitor Resident A as Ms. Johnson was preparing meals, his lack of supervision of Resident A as he took two hamburger buns, and his refusal and slow response to assist Resident A with experiencing respiratory distress are neglectful. As a result, Resident A passed away on 04/19/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the license.

06/26/2026

LaShonda Reed — Date
Licensing Consultant

Approved By:

For 06/26/2026

Denise Y. Nunn — Date
Area Manager