



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 28, 2026

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

RE: License #: AS740015976
Investigation #: 2026A0580049
Thornhill Home

Dear Andrea Bubel:

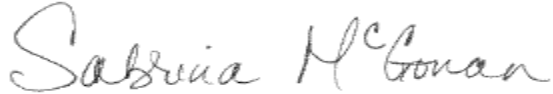
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in cursive script that reads "Sabrina McGowan". The ink is dark and the signature is fluid.

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 #:	AS740015976
Investigation #:	2026A0580049
Complaint Receipt Date:	08/03/2026
Investigation Initiation Date:	08/06/2026
Report Due Date:	10/02/2026
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:	Thornhill Home
Facility Address:	2202 Thornhill Port Huron, MI 48060
Facility Telephone #:	(810) 985-8133
Original Issuance Date:	08/30/1994
License Status:	REGULAR
Effective Date:	02/27/2025
Expiration Date:	02/26/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A experienced a medical emergency during breakfast, and concerns were raised about a delay in seeking emergency medical assistance.	Yes

III. METHODOLOGY

08/03/2026	Special Investigation Intake 2026A0580049
08/03/2026	APS Referral Denied by APS for investigation.
08/06/2026	Special Investigation Initiated - Telephone Call to Recipient Rights, St. Clair County.
08/10/2026	Contact - Telephone call received Call from RR Investigator Henderson.
08/11/2026	Inspection Completed On-site Unannounced onsite.
08/11/2026	Contact - Face to Face Interview with DS Kendall.
08/11/2026	Contact - Face to Face Interview with HM Kathy Davis.
08/12/2026	Contact - Document Received Documents received.
08/26/2026	Contact - Telephone call made Call to Licensee Designee, Andrea Bubel.
09/03/2026	Contact - Document Received Death Certificate Received.
09/21/2026	Contact - Telephone call made Call to Relative Guardian A.
09/21/2026	Contact - Telephone call made

	Call to RR Investigator Henderson.
09/21/2026	Contact - Telephone call made Call to DS Lashay Phillips.
09/23/2026	Contact - Telephone call made Call to DS Jennifer Cserca
09/24/2026	Exit Conference Exit with LD Bubel.

ALLEGATION:

Resident A experienced a medical emergency during breakfast, and concerns were raised about a delay in seeking emergency medical assistance.

INVESTIGATION:

On 08/03/2026, I received a complaint via LARA-BCHS-Complaints. This complaint was denied by Adult Protective Services (APS) for investigation.

On 08/03/2026, I reviewed the Incident Report (IR) received via email on 07/27/2026. The IR states that on 07/26/2026, Staff Jennifer Cserca got Resident A up for the morning, changed his brief and got him dressed. Resident A came out to the dining room table for breakfast. Halfway through breakfast, Resident A's head dropped forward. Staff Cserca came over and asked was Resident A okay. Staff asked co-worker Michelle Kendall to come check on Resident A and upon doing so, Resident A picked up his head and started drinking his juice. Staff Cserca walked over and touched Resident A on the shoulder, and he was cold and clammy. Day shift staff members Celina Flores and Lashay Phillips came in and touched Resident A on the head and shoulder. Day shift contacted the supervisor, then called 911. Resident A was also drooling from the mouth. Resident A was transported to Lake Huron Medical Center by EMS. En route to the hospital Resident A lost his pulse and EMS began CPR. Upon arrival at the hospital Resident A had a heart rate, but still no pulse. The hospital began life saving measures; however, Resident A was unable to be resuscitated. Staff will be trained again in medical emergencies and the procedure to follow if any medical emergency occurs.

On 08/06/2026, I contacted assigned Recipient Rights Investigator, Joselyn Henderson. A voice mail message was left requesting a return call.

On 08/10/2026, I interviewed RR Investigator, Joselyn Henderson. There is concern that staff contacted management as opposed to calling 911, causing a delay in health care. Resident A passed away on the same day.

On 08/11/2026, I conducted an unannounced onsite inspection at Thornhill Home. Contact was made with Direct Staff (DS), Celena Flores. Staff Flores stated that on the day in question, when she arrived at work around 7am the residents were sitting around the breakfast table. When she spoke to Resident A his head was down. When he looked up, he was sweating and did not appear to look okay. Staff Flores then contacted Home Manager (HM), Kathy Davis, who suggested staff call 911. Training verification indicates that DS Flores is current in CPR/1st Aid training, effective 05/2025-05/2027. No CPR was performed because Resident A did not stop breathing.

While onsite residents were observed sitting at the dining room table. These residents were adequately dressed and groomed. No concerns regarding their care were noted.

On 08/11/2026, while onsite, I interviewed DS Michelle Kendall. DS Kendall stated that on the day in question she was in the back preparing another resident for the day. DS Kendall stated that when she observed Resident A with his head down, she inquired with DS Jennifer Cserca if Resident A were okay. DS Cserca was preparing to call HM Davis when Resident A lifted his head up. Resident A ate two bites of food. The day shift came in and then called 911. DS Kendall denied that Resident A had shown any signs of being ill during her overnight shift. Training verification indicates that DS Kendall is current in CPR/1st Aid training, effective 01/31/2025-01/2027. DS Kendall did not initiate CPR because Resident A did not stop breathing while at the home.

On 08/11/2026, while onsite, I interviewed HM Kathy Davis. HM Davis stated that at around 7:02 am she received a call from DS Flores indicating that Resident A did not appear to look well. HM Davis instructed the staff to call 911. HM Davis stated that Resident A is usually talkative and when it's time to eat, he eats. HM Davis stated that she believes that staff should have called 911.

On 08/12/2026 I received a copy of the AFC Assessment Plan for Resident A. The plan indicates that Resident A is able to communicate his needs. Resident A uses a wheelchair for mobility and requires staff assistance with toileting, grooming, personal hygiene and bathing.

On 08/26/2026, I interviewed Licensee Designee (LD) Andrea Bubel regarding the allegations. LD Bubel stated that no staff were disciplined in regard to this incident. Staff will be retrained in handling emergency situations.

On 09/03/2026, I received a copy of the State of Michigan Certificate of Death for Resident A. Resident A was 65 years old. The State of Michigan Certificate of Death records Resident A's date of death to be 07/26/2026. The time of death is listed as 08:02 AM. The cause of death is listed as Probable malignant cardiac arrhythmia and Hypertensive cardiovascular disease. The manner of death is listed as natural. No autopsy was performed.

On 09/21/2026, I interviewed Relative Guardian A. Relative Guardian A stated that she believes that the staff at the home did all they could for Resident A. Relative Guardian A had no concerns regarding the care being provided.

On 09/21/2026, I called RR Investigator Joselyn Henderson. Investigator Henderson responded via email that Recipient Rights investigation is not yet complete.

On 09/21/2026, I interviewed DS Lashay Phillips. DS Phillips stated that she and DS Flores arrived to work together that morning, however, DS Flores made it inside first. As DS Phillips recalled that DS Flores came back outside and stated that they needed to call EMS. DS Phillips inquired as to why and was told about Resident A. Upon entering the house, she observed that Resident A was slumped over. Resident A would not respond to prompts to engage him. DS Phillips stated that Resident A was not his usual self as he normally greets incoming staff excitedly while referencing his cars. DS Phillips stated that she continued to try and engage Resident A while her co-worker called either the home manager or 911, as she is unsure of who was called first. Training verification indicates that DS Phillips is current in CPR/1st Aid training, effective 10/2024-10/2026. No CPR was performed because Resident A did not stop breathing.

On 09/23/2026, I interviewed DS, Jennifer Cserca. DS Cserca recalled that on the day in question she went to get Resident A up for the day at 6:30am. DS Cserca stated that she calls Resident A, friend, and asks if she can perform his daily tasks. DS Cserca stated that she proceeded to ask Resident A if she could change him, get him dressed and get him up for breakfast, and he replied "yes" to all tasks. DS Cserca stated that she transferred Resident A to his wheelchair and then they went to the dining table for breakfast. DS Cserca sat Resident A's breakfast in front of him. DS Cserca stated that Resident A began eating his food when all of a sudden, his head dropped forward. DS Cserca touched Resident A and he was cold and unresponsive for an estimated 30 seconds. DS Cserca then stated to her co-worker, DS Kendall, that they should call 911 because it appears that something is wrong with Resident A. DS Cserca stated that she began searching for her cellphone when DS Flores walked in for her shift. DS Cserca alerted DS Flores to what was happening. DS Flores then called HM Kathy Smith, who told her to call 911. Training verification indicates that DS Cserca is current in CPR/1st Aid training, effective 07/09/2026-07/09/2028. No CPR was performed because Resident A did not stop breathing.

On 09/24/2026, I conducted an exit conference with Licensee Designee, Andrea Bubel. LD Bubel stated that an organization wide training will be scheduled, training staff on emergency protocols. LD Bubel was informed of the findings of this investigation.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	It was alleged that Resident A experienced a medical emergency during breakfast, and concerns were raised about a delay in seeking emergency medical assistance. I reviewed the Incident Report dated 07/26/2026. Direct Staff, Celena Flores, stated that upon arrival at work around 7am she spoke to Resident A, his head was down. When he looked up, he was sweating and did not appear to look ok. Staff Flores then contacted Home Manager, Kathy Davis, who suggested staff call 911. Direct Staff, Michelle Kendall, stated that on the day in question she was in the back of the home preparing another resident for the day. DS Kendall stated that when she saw Resident A with his head down, she inquired with DS Jennifer Cserca if Resident A were ok. DS Cserca was preparing to call HM Davis when Resident A lifted his head up. Resident A ate two bites of food. The day shift came in and then called 911. DS Kendall denied that Resident A had shown any signs of being ill during her overnight shift. Home Manager, Kathy Davis, stated that at around 7:02 am she received a call from DS Flores indicating that Resident A did not appear to look well. HM Davis instructed the staff to call 911. Licensee Designee, Andrea Bubel, stated that staff will be retrained in handling emergency situations. Relative Guardian A stated that she believes that the staff at the home did all they could for Resident A. Relative Guardian A had no concerns regarding the care being provided. Direct Staff, Lashay Phillips, stated that upon arriving to work she observed Resident A was slumped over. Resident A would not respond to prompts to engage him. DS Phillips stated that

	Resident A was not his usual self as he normally greets incoming staff excitedly while referencing his cars. DS Phillips stated that she continued to try and engage Resident A while her co-worker called either the home manager or 911, as she is unsure of who was called first. Direct Staff, Jennifer Cserca, stated that Resident A began eating breakfast when all of a sudden, his head dropped forward. DS Cserca touched Resident A, and he was cold and unresponsive for an estimated 30 seconds. DS Cserca then stated to her co-worker, DS Kendall, that they should call 911 because it appears that something is wrong with Resident A. DS Cserca stated that she began searching for her cellphone when DS Flores walked in for her shift. DS Cserca alerted DS Flores to what was happening. DS Flores then called HM Kathy Smith, who told her to call 911. Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, 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

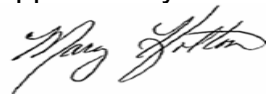
Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.



Sabrina McGowan
Licensing Consultant

September 24, 2026
Date

Approved By:



Mary E. Holton
Area Manager

September 28, 2026
Date