STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

July 25, 2017

John Williams
Progressive Lifestyles Inc.
Suite 11A
6600 Highland Rd
Waterford, MI 48327

RE: License #: AS630067505
Investigation #: **2017A0602015**
Lochaven CLF

Dear Mr. Williams:

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.

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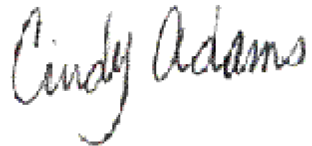
www.michigan.gov/lara • 517-335-1980

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) 975-5053.

Sincerely,



Cindy Adams, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630067505
Investigation #:	2017A0602015
Complaint Receipt Date:	04/27/2017
Investigation Initiation Date:	05/01/2017
Report Due Date:	06/26/2017
Licensee Name:	Progressive Lifestyles Inc.
Licensee Address:	Suite 11A 6600 Highland Rd Waterford, MI 48327
Licensee Telephone #:	(248) 563-5390
Administrator:	John Williams
Licensee Designee:	John Williams
Name of Facility:	Lochaven CLF
Facility Address:	556 Lochaven Waterford, MI 48327
Facility Telephone #:	(248) 682-6396
Original Issuance Date:	11/16/1995
License **Status:**	REGULAR
Effective Date:	07/05/2015
Expiration Date:	07/04/2017
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who has a history of self-injurious behaviors, was able to get into an unlocked medication cabinet located in the staff office and took 10 Tylenol tablets. The door to the office was supposed to be locked.	Yes

III. METHODOLOGY

04/27/2017	Special Investigation Intake 2017A0602015
05/01/2017	Special Investigation Initiated - Telephone Email sent to the assigned Recipient Rights worker, Kevin Motyka.
05/04/2017	Inspection Completed On-site Interviewed the home manager, Tracy Centers, Resident A and staff member Vickie Joseph.
05/15/2017	Contact – Telephone call made Message left for staff member Samantha Dugas.
06/26/2017	Contact – Telephone call made Message left for staff member Samantha Dugas.
06/27/2017	Contact – Telephone call made Message left for staff member Samantha Dugas.
06/27/2017	Exit Conference Message left for the licensee designee, John Williams
06/27/2017	Contact – Document sent Email sent to Mr. Williams.

ALLEGATION:

Resident A, who has a history of self-injurious behaviors, was able to get into an unlocked medication cabinet located in the staff office and took 10 Tylenol tablets. The door to the office was supposed to be locked.

INVESTIGATION:

On 4/27/2017 a complaint was made and assigned for investigation alleging that Resident A got into an unlocked medication cabinet and took 10 Tylenol tablets.

On 5/1/2017 I made an on-site investigation and interviewed the home manager, Tracy Centers, the Director of Progressive Lifestyles, Kathryn Simpson, staff member Vickie Joseph and Resident A. Recipient Rights worker, Kevin Motyka also participated.

Ms. Centers stated when she arrived to work on Monday, 4/24/2017, there was an incident report on her desk that had been written on Friday, 4/21/2017 by staff member Samantha Dugas. Ms. Centers said the incident report documented that Resident A was seen coming out of the staff office (where the medications are kept) and had approximately 10 Tylenol tablets in her pocket. Ms. Centers stated the on-call supervisor should have been contacted immediately and notified of the situation but this did not occur. She stated that Resident A should have been taken to the hospital immediately as a precautionary measure in case she ingested any medication but this did not occur either. Ms. Centers took Resident A to Huron Valley-Sinai Hospital Emergency Department on 4/24/2017. Resident A had lab work completed and her acetaminophen levels were noted as normal. Ms. Centers stated there are two keys for the medication cabinet that are kept in locked boxes. One locked box is located just outside the staff office and the other is kept inside the staff office. Each box requires that a code be entered in order to obtain the key. The box that is located outside of the staff office is used in case of emergencies only. Staff are required to lock the medication cabinet when they are done administering medications and place the key back in the locked box. The facility has two medication cabinets – one for standing medication orders and one for regular medication. Both cabinets utilize the same key for entry.

Ms. Simpson stated as a result of Ms. Dugas not following proper procedures, she was demoted from a weekend supervisor to a direct care worker and was in-serviced on the proper safeguards for residents effective 4/24/2017. Ms. Dugas said it is clearly stated in Resident A's Individual Plan of Service – IPOS that staff must have eye contact with her while in the common areas of the home but Ms. Dugas failed to adhere to this.

Ms. Joseph stated she was upstairs with Resident B and did not witness the actual incident. She heard what sounded like a chair fall over, some banging around and voices but was unable to hear what was being said. Ms. Joseph stated she went downstairs and saw that one of the dining room chairs was flipped over, the dining room table was at a slant and Resident A was in her bedroom. She asked Ms. Dugas if everything was OK and if she needed help with anything. Ms. Joseph stated the only information Ms. Dugas provided to her was that Resident A had gotten into the office.

Resident A was unable to recall specific dates but said she pulled on the office door and it was not locked so she entered. She said when she got into the office she twisted the lock on the medication cabinet and it opened. She stated that she took the pills, put

some in her pocket and swallowed some of them. Ms. Dugas was in the basement and when she came upstairs Resident A was standing in the kitchen. She took the pills out of her pocket and showed them to Ms. Dugas. Resident A stated Ms. Dugas did not see her take any of the pills and she did not tell her that she had taken any. Ms. Dugas took the pills from her and she became angry. She said she flipped over a dining room chair and pushed the dining room table before going to her room.

On 4/27/2017, I reviewed Resident A's IPOS, discharge paperwork from Huron Valley-Sinai Hospital Emergency Department dated 4/24/2017, Health Care Chronological notes dated 4/24/2017 and 4/28/2017, In-service/training record for staff dated 4/24/2017 and incident report dated 4/21/2017. Resident A's IPOS indicates that she should be within eyesight of staff at all times while in the common areas of the home (living room, kitchen and dining area). The emergency department paperwork indicates that Resident A was seen by a physician on 4/24/2017. The health care chronological notes dated 4/24/2017 indicate that Ms. Centers transported Resident A to Huron Valley-Sinai Hospital on this date. Her blood levels were tested for acetaminophen and found to be normal. Resident A was seen by her primary care physician on 4/28/2017 as a follow up and there were no concerns noted. I also reviewed the in-service/training that was conducted by Ms. Simpson. All staff were in-services on the proper safeguards that staff must adhere to with regards to the residents while in the home. The incident report that was written by Ms. Dugas documented that she was in the basement doing laundry and staff member, Vickie Joseph was upstairs with another resident. When Ms. Dugas returned from the basement, Resident A was seen coming out of the staff office. Ms. Dugas checked her pockets and found approximately 10 Tylenol tablets in her pocket. Ms. Dugas failed to lock the staff office and the medication cabinet that is located in the staff office.

On 6/27/2017 I left a voicemail message for the licensee designee, John Williams. I also sent Mr. Williams an email on this same date informing him of the investigative findings and recommendation of this investigation. I informed Mr. Williams that Kathryn Simpson already provided documentation of compliance. However, a corrective action plan is required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled

	Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information obtained from Ms. Centers, Ms. Simpson, Ms. Joseph and Resident A, the staff office and medication cabinet were left unlocked. As a result, Resident A was able to retrieve several Tylenol tablets. Resident A ingested some of the pills but did not know how many.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on the information obtained from Ms. Centers and Ms. Simpson, Ms. Dugas failed to follow Resident A's safeguards as outlined in her IPOS. According to Resident A's IPOS, she should be within eyesight of staff while in the common area of the home. Ms. Dugas went into the basement (leaving Resident A unsupervised in the common area of the home) without informing Ms. Joseph who was the other staff on shift. Resident A was able to retrieve Tylenol tablets from the unlocked medication cabinet and ingest an unknown amount. Although Resident A did not inform Ms. Dugas that she had taken some of the pills, Ms. Dugas did not notify the on-call supervisor nor did she seek medical attention.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

6/27/2017

Cindy Adams Date
Licensing Consultant

Approved By:

07/25/2017

Denise Y. Nunn Date
Area Manager