GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2021

Brenda O'Toole
Progressive Lifestyles Inc
Suite 11A
6600 Highland Rd
Waterford, MI 48327

RE: License #: AS630067505
Investigation #: 2021A0602015
Lochaven CLF

Dear Ms. O'Toole:

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 (248) 975-5053.

Sincerely,

Cindy Berry, 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 #:	2021A0602015
Complaint Receipt Date:	03/24/2021
Investigation Initiation Date:	03/25/2021
Report Due Date:	05/23/2021
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	Suite 11A 6600 Highland Rd Waterford, MI 48327
Licensee Telephone #:	(248) 666-1365
Administrator:	Brenda O'Toole
Licensee Designee:	Brenda O'Toole
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:	07/05/2019
Expiration Date:	07/04/2021
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per an incident report received on 3/23/2021, Resident A was given another resident's medication.	Yes

III. METHODOLOGY

03/24/2021	Special Investigation Intake 2021A0602015
03/25/2021	Special Investigation Initiated - Telephone Call made to the Office of Recipient Rights.
03/30/2021	Inspection Completed On-site Interviewed staff members, Vickie Joesph, Louise Morris, home manager, Tracy Centers and observed Resident A.
04/27/2021	Exit Conference Message left for the licensee designee informing her of the investigative findings and recommendation of the investigation.

ALLEGATION:

Per an incident report received on 3/23/2021, Resident A was given another resident's medication.

INVESTIGATION:

On 3/24/2021, a complaint was received and assigned for investigation alleging that on 3/23/2021 Resident A was given another resident's medication.

On 3/30/2021, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Tracy Centers, staff members Vickie Joseph and Louise Morris and observed Resident A. Ms. Centers stated resident medications are kept in the staff office in a locked cabinet. Resident snacks are also kept in the staff office. Since the onset of the pandemic and the residents being home all day, their behaviors have changed. They seem to be more demanding and ask for different things at the same time creating a hectic environment. Residents look forward to their snacks and will ask for them while medication is being administered. Ms. Centers stated on 3/23/2021 she received a call from Ms. Joseph informing her that she administered Resident B's medication to Resident A in error. Ms. Centers was in route to the facility and contacted Resident A's doctor upon her arrival. The doctor stated Resident A could

possibly display some signs of irritability and tiredness but should be okay. Ms. Centers was instructed to administer Resident A her regular medications. Resident A did not display any unusual behaviors post ingestion of Resident B's medication.

Ms. Joseph stated she has worked for the company for 7 years and at the Lochaven home for the last 5 years. She said on 3/23/2021 it was a very busy morning. She was in the office preparing to administer medication around 7:15 am. The residents have a daily routine where Resident C comes downstairs first, Resident B comes downstairs second, and Resident A comes downstairs last. On 3/23/2021 Resident C came downstairs first as usual but Resident A came downstairs before Resident B. Ms. Joseph said she had each resident's medication in individual medication cups on the counter in the office. Resident C decided at the last minute that she wanted to go to work. Ms. Joseph stated she needed to get Resident C dressed and her lunch made by 8:15 am and was rushing a bit to get it done. Resident A and Resident B have very few medications in the morning, but both have a nose spray. Ms. Joseph grabbed Resident B's medication from the counter and administered it to Resident A in error as they were both sitting on the counter in the office unlabeled. Ms. Morris came downstairs after showering Resident A, saw the medication on the counter in the office and stated she would administer Resident A her medication. Ms. Joseph informed Ms. Morris she had already administered Resident A's medication to her. She went back into the office and realized she administered Resident B's medication to Resident A. Ms. Joseph immediately called Ms. Centers and informed her of the error. Ms. Centers arrived a few minutes later as she was already on her way to the facility. Resident A's physician was notified, and staff was informed to monitor her for any side effects. Ms. Joseph stated Resident A did not display any side effects from the medication.

Ms. Morris stated she has worked for the company for four years and at the Lochaven home for the last six months. She said on 3/23/2021 after assisting Resident A with her shower (around 7 am) she went into the office and saw two medication cups on the counter. She informed Ms. Joseph that she would administer Resident A her medication. Ms. Joseph informed her she had already administered it to her. Ms. Joseph returned to the office and realized she had administered Resident B's medication to Resident A.

On 3/30/2021, I received and reviewed Resident A and Resident B's medication logs for the month of March 2021. According to the logs, Resident A is prescribed the following am medication, Benztropine 1 mg, Valproic ACD 250/5ML SPY 10 ml, Levothyroxine 25 mcg, Fluticasone 50 mcg 2 sprays in each nostril, Loratadine 10 mg and Fiber-Lax 625 mg. Resident B is prescribed the following am medication, Fluticasone 50 mcg 2 sprays in each nostril and Sertraline 100 mg.

On 3/30/2021, I observed Resident A but was unable to interview her as she is non-verbal and was unable to provide any information regarding the allegation.

On 4/27/2021, I left a message for the licensee designee, Brenda O'Toole for the exit conference informing her of the investigative findings and recommendation of the investigation.

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 specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 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. Joseph and Ms. Morris, I determined that Ms. Joseph prepared the resident's medication ahead of time by removing them from the pharmacy issued containers and placing them in medication cups (unlabeled) and leaving them on the counter in the office before they were ready to be administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the information obtained from Ms. Centers, Ms. Joseph and Ms. Morris, there is sufficient information to determine that Ms. Joseph did in fact administer Resident B's medication to Resident A in error. On 3/23/2021, Resident A received Fluticasone 50 mcg 2 sprays in each nostril and Sertraline 100 mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

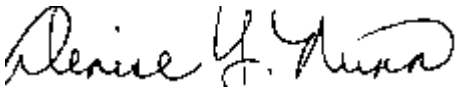
IV. RECOMMENDATION

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

4/27/2021

Cindy Berry — Date
Licensing Consultant

Approved By:



04/28/2021

Denise Y. Nunn — Date
Area Manager