GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 25, 2022

Janice Hurst
Progressive Residential Services Inc
Suite # 165
6001 N. Adams Road
Bloomfield Hills, MI 48304

RE: License #: AS130359802
Investigation #: 2022A1024035
Homer Road House

Dear Mrs. Hurst:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130359802
Investigation #:	2022A1024035
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/02/2022
Report Due Date:	07/30/2022
Licensee Name:	Progressive Residential Services Inc
Licensee Address:	Suite # 165 6001 N. Adams Road Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 641-7200
Administrator:	Ashambi Guy
Licensee Designee:	Janice Hurst
Name of Facility:	Homer Road House
Facility Address:	19030 Homer Rd. Marshall, MI 49068
Facility Telephone #:	(269) 781-3648
Original Issuance Date:	11/14/2014
License **Status:**	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A went on a home visit with the wrong prescription medication.	No
Resident A has foot pain and is not able to go to doctor.	No

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A1024035
06/02/2022	Special Investigation Initiated – Telephone call with Relative A1
07/01/2022	Inspection Completed On-site with Resident A, direct care staff members Martinaye Garret, Erica White, program manager William Chesney
07/01/2022	Contact - Telephone call made with manager Sabrina Williams
07/05/2022	Contact-Documents Received-*AFC Licensing Division-Accident/Incident Report*
07/22/2022	Exit Conference with licensee designee

ALLEGATION:

Resident A went on a home visit with the wrong prescription medication.

INVESTIGATION:

On 5/31/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A went on a home visit with the wrong prescription medication.

On 6/2/2022, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated Resident A spends the night with her regularly and there was one incident where a direct care staff member put one of Resident A's medication in the wrong bottle labeled during the evening or 'pm' timeframe instead of in the bottle labeled in the morning or 'am' timeframe. Relative A1 stated she ended up speaking to a direct care staff member about this who was able to explain which pill bottle the medication belonged in. The medication in question was prescribed to Resident A however labeled incorrectly. Relative A1 stated she is unable to recall when this incident occurred as Resident A has been living in the home for many years.

Relative A1 stated usually direct care staff members send Resident A's medication packaged properly without any issues.

On 7/1/2022, I conducted an onsite investigation at the facility with direct care staff members Martinaye Garret, Erica White and program manager William Chesney who all stated they have no knowledge of Resident A ever being sent on a home visit with medications not packaged correctly or labeled correctly. Ms. Garret and Ms. White both stated that there have been incidents when Relative A1 has not given Resident A his medication or lost his medication while Resident A was on an overnight visit at her private residence. Ms. Garret, Ms. White and Mr. Chesney all stated Resident A is provided with the appropriate medications when he goes on home visits and packaged correctly. I observed Resident A laying down in his bedroom. Resident A was not able to be interviewed due to his cognitive impairment.

I reviewed Resident A's Medication Administration Record (MAR) for the months of March 2022, April 2022, and May 2022. I also observed Resident A's medications in its original prescription bottles. I found no concerns in my review of these records.

On 7/1/2022, I conducted an interview with home manager Sabrina Williams who stated recently Relative A1 became upset because a direct care staff member reminded Relative A1 to administer Resident A's medications as labeled and to refrain from losing Resident A's medications when Resident A is visiting with her on a home visit as Relative A1 has had issues with losing Resident A's medications in the past. Ms. Williams stated she believes Relative A1 was offended when the direct care staff provided this instruction to her and during this time made a statement to her that an unknown direct care staff member packaged the wrong medication for Resident A during one of his home visits in the past however was not able to articulate any other details about this incident. Ms. Williams stated she has no knowledge of Resident A getting the wrong medication and staff members has routinely prepared and packaged Resident A's medications appropriately for his home visits. Ms. Williams further stated she and direct care staff members go over Resident A's medication with Relative A1 in detail to ensure Relative A1 understands what medications are needed and when they are needed.

On 7/5/2022, I reviewed the facility's AFC Licensing Accident/Incident Report dated 3/5/2022. According to this report, Relative A1 called and stated that she had an emergency because she lost Resident A's medications and stated she did not give Resident A's his medications that was scheduled for 4pm or 6pm. This report stated staff member Sabrina Williams picked up Resident A to pass Resident A his missed medications that were administered at 8pm and brought additional medications that were lost.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on this investigation which included interviews with Relative A1, direct care staff members Martinaye Garret, Erica White, program manager William Chesney, manager Sabrina Williams along with my review of an incident report dated 3/5/2022 and Resident A's MAR there is no evidence to support the allegation Resident A went on a home visit with the wrong prescription medication. Relative A1 stated Resident A visits with her regularly and alleged one incident of an evening medication being placed in a morning medication bottle. However, Relative A1 was not able to recall when this incident took place. Ms. Martinaye, Mr. White, Mr. Chesney and Ms. Williams all stated they have no knowledge of Resident A getting the wrong medication and direct care staff members have routinely prepared and packaged Resident A's medications appropriately for his home visits. It should be noted Ms. Williams stated staff members have asked Relative A to avoid losing Resident A's medications while on a home visit since this has occurred in the past. According to an incident report dated 3/5/2022, Relative A1 lost some of Resident A's medications and failed to pass Resident A's medications that was scheduled for 4pm or 6pm which staff had to intervene to ensure Resident A had his medications. I reviewed Resident A's MAR and prescription bottles and found no concerns. The licensee has assured that Relative A has all the appropriate information, medications, and instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has foot pain and is not able to go to the doctor.

INVESTIGATION:

This complaint also alleged that Resident A has foot pain and is not able to go to the doctor.

On 6/2/2022, I conducted an interview with Relative A1 regarding this allegation who stated that she has taken Resident A to the zoo on more than one occasion and when they walk for over an hour Resident A complains about having pain in his right foot. Relative A1 stated Resident A does not do a lot of walking when he is at the adult foster care facility, therefore he has never complained or showed signs of pain while at the facility. Relative A1 stated she is going to speak with the staff about taking him to be seen by a doctor however she has to work with Resident A's case manager first to get specific paperwork for Resident A in order for him to be seen by a physician.

On 7/1/2022, I conducted an onsite investigation at the facility with direct care staff members Martinaye Garret, Erica White and program manager William Chesney who all stated they have not seen any signs of Resident A having pain in his foot. Ms. Garret, Ms. Ms. White, and Ms. Chesney stated they work regularly with Resident A and he walks without any issues. Ms. White and Ms. Garret both further both stated Resident A was recently seen by a physician and was told that he was flat footed and needed to wear orthopedic shoes.

While at the facility I reviewed Resident A's *Patient Care Summary* dated 6/17/2022. This summary stated Resident A was seen by a physician at Oaklawn. The reason for visit stated patient has been saying his feet hurt. This summary instructed Resident A to return back to the office on 8/24/2022 for follow-up.

On 7/1/2022, I conducted an interview with home manager Sabrina Williams who stated that Resident A has not had any issues with having pain in his foot however Relative A1 recently made the request to take Resident A to be seen by a physician to have his foot examined. Ms. Williams stated Resident A notified her at the end of May 2022 that Resident A complained he had pain in his right foot after walking for over an hour at the zoo. Ms. Williams stated Resident A is nonverbal however would be able to at least point to his foot if he had signs of discomfort. Ms. Williams stated she has not seen any unusual behavior to indicate Resident A was having issues with his foot however took Resident A to see a doctor per Relative A1's request. Ms. Williams stated Relative A1 is working with Resident A's case manager to purchase Resident A orthopedic shoes.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group shall obtain needed care immediately.

ANALYSIS:	Based on this investigation which included interviews with Relative A1, direct care staff members Martinaye Garret, Erica White, program manager William Chesney, manager Sabrina Williams, and review of patient summary dated 6/17/2022 there is no evidence to support the allegation Resident A has foot pain and was not able to go to doctor. Ms. Williams stated although there were no unusual behaviors presented by Resident A per Relative A1's request, she took Resident A to see a physician for his foot and it was determined that Resident A needed orthopedic shoes. Care has been obtained for Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/22/2022, I conducted an exit conference with licensee designee Janice Hurst. I informed Ms. Hurst of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson
Licensing Consultant

7/22/2022
Date

Approved By:

07/25/2022

Dawn N. Timm
Area Manager

Date