GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Debra Waynick
RDP Rehabilitation, Inc.
51145 Nicolette Dr.
New Baltimore, MI 48047

RE: License #: AS500411264
Investigation #: 2022A0617023
Progressions 22091 21 Mile

Dear Ms. Waynick:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500411264
Investigation #:	2022A0617023
Complaint Receipt Date:	07/15/2022
Investigation Initiation Date:	07/15/2022
Report Due Date:	09/13/2022
Licensee Name:	RDP Rehabilitation, Inc.
Licensee Address:	Suite 102 36975 Utica Road Clinton Township, MI 48036
Licensee Telephone #:	(586) 651-8818
Administrator:	Debra Waynick,
Licensee Designee:	Debra Waynick,
Name of Facility:	Progressions 22091 21 Mile
Facility Address:	22091 21 Mile Road Macomb, MI 48044
Facility Telephone #:	(586) 598-7570
Original Issuance Date:	07/01/2022
License Status:	TEMPORARY
Effective Date:	07/01/2022
Expiration Date:	12/31/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On a daily basis, Resident A wanders away from the facility. The facility is understaffed. They do not have the staffing needed to provide the supervision Resident A needs.	**Yes**

III. METHODOLOGY

07/15/2022	Special Investigation Intake 2022A0617023
07/15/2022	Special Investigation Initiated – Letter Email sent to Licensee Designee Ms. Waynick
07/18/2022	Contact - Document Received Email received from Ms. Waynick. I received and reviewed the following documents: Resident A's assessment plan, Resident A's identification record, staff list with phone numbers, staff schedule for July 2022, and Resident Registry.
07/20/2022	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed home manager Gabriella Williams, staff Deborah Rand, Rhonda Weston and Resident A.
08/03/2022	Exit Conference I attempted to hold an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation, but she was on vacation. I left a voicemail for her.
08/24/2022	Contact – Telephone I spoke with Ms. Waynick to discuss the findings of the investigation.
08/31/2022	Exit Conference I held an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation.

ALLEGATION:

On a daily basis, Resident A wanders away from the facility. The facility is understaffed. They do not have the staffing needed to provide the supervision Resident A needs.

INVESTIGATION:

On 07/15/22, I received a complaint regarding the Progressions 22091 21 Mile facility. The complaint stated that Resident A is diagnosed with advanced dementia with behavioral disturbances, incontinence, mobility issues and has a history of falling. Daily, she wanders away from the facility. The facility is understaffed, as they do not have the staffing needed to provide the supervision Resident A needs. There are concerns for Resident A's safety if she remains at the facility. She might wander off the facility and staff are not available to assist.

On 07/18/22, I received and reviewed the following documents from Ms. Waynick: Resident A's assessment plan, Resident A's Identification record, staff list with phone numbers, staff schedule for July 2022, and Resident Registry. I reviewed the staff schedule for the month of July and there were sufficient staff scheduled to care for the needs of the residents. Per the facility staff schedules, the facility has at least one direct care staff during the day and afternoon shift (waking hours). The facility schedules at least one direct care staff during the evening and midnight shift (normal sleeping hours). According to Resident A's assessment plan, she is diagnosed with advanced dementia with behavioral disturbances. The plan just states to redirect as needed.

On 07/20/22, I conducted an unannounced onsite investigation at the facility. I interviewed Home manager Gabriella Williams, staff Deborah Rand, Rhonda Weston and Resident A. During the onsite investigation I observed the home is equipped with alarms on all the doors and windows of the facility. In addition to the alarms on the doors and windows, the facility has motion detectors at the end of the hallway where Resident A's room is located.

According to Ms. Williams, Resident A has dementia and has walked out of the front door of the home in the past. However, staff have always been aware and have redirected Resident A back into the home safely. The home is equipped with alarms on all the doors and windows of the facility. In addition to the alarms on the doors and windows, the facility has motion detectors at the end of the hallway where Resident A's room is located. This is in place so that staff are alerted when she leaves her room and into the main portion of the home where the front door is located. Ms. Williams stated that there have been several recent incidents of Resident A leaving the facility. On 06/06/22, Resident A experienced a lot of behavioral issues including attempts to leave the home without permission. Staff safely redirected Resident A back into the home. On 06/30/22, the front door alarm went off while staff was in a resident's room changing the

resident's briefs. When staff came out of the room, the front door was open and Resident A was outside in the driveway. Staff safely redirected Resident A back into the home. According to Ms. Williams, she has also assisted with supervising Resident A, while other staff conduct duties.

During the onsite investigation, I interviewed staff Ms. Rand. According to Ms. Rand, on 06/30/22, the front door alarm went off while she was in a resident's room changing the resident's briefs. When Ms. Rand came out of the room, the front door was open and Resident A was outside in the driveway. Ms. Rand safely redirected Resident A back into the home. Resident A was outside for less than two minutes. Ms. Rand stated that Resident A's behavior has become progressively worse over the last several weeks. She is wandering/trying to elope more and is becoming increasingly more difficult to redirect.

During the onsite investigation, I interviewed staff Ms. Weston. According to Ms. Weston, Resident A will often just open the front door and walk out. Staff have to redirect her back into the home. Ms. Weston stated that she has concerns about Resident A's safety as her behaviors have increased recently. Resident A's behaviors include, leaving the home without permission, aggressiveness, combativeness, insubordinate and even violent at times.

During the onsite investigation, I interviewed Resident A. Resident A stated that she likes living in the home. She believes that she sometimes leaves the home without staff permission, but she doesn't know why, and she has a hard time remembering. Resident A stated that she feels safe and secure at the facility as the staff are good to her.

On 08/03/22, I attempted to hold an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation, but she was on vacation. I left a voicemail for her.

On 08/24/22, I spoke with Ms. Waynick to discuss the findings of the investigation. Ms. Waynick stated that she understood the outcome of the investigation and that the facility has added a floater position so that there are two people in the home during the daytime. However, the floater floats between this AFC and the affiliated AFC directly next door.

On 08/31/22, Ms. Wayneck stated that they have added a floater position so that there are two people in the home during the daytime. However, the floater floats between this AFC and the affiliated AFC directly next door. If this home needs assistance with Resident A, and the floater is not currently at this facility, staff will call next door and the floater will come over. The floater position is scheduled from 7am to 11pm. According to Ms. Wayneck the floater position was added around August 1, 2022.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that Resident A was not provided supervision and protection. The home is equipped with alarms on all the doors and windows of the facility. In addition to the alarms on the doors and windows, the facility has motion detectors at the end of the hallway where Resident A's room is located. This is in place so that staff are alerted when she leaves her room and into the main portion of the home where the front door is located. However, these safeguards have not prevented Resident A from leaving the home without permission. Although every time Resident A has left the home without permission, staff have been able to safely retrieve her and redirect her back into the home, there is still great potential for harm while Resident A is out of the home unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Per the facility staff schedules, the facility has at least one direct care staff during the day and afternoon shift (waking hours). The facility schedules at least one direct care staff during the evening and midnight shift (normal sleeping hours). This staffing pattern has not prevented Resident A from leaving the home without permission. Therefore, the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

08/31/2022

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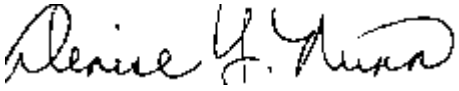
Eric Johnson Date
Licensing Consultant

Approved By:



10/25/2022

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Denise Y. Nunn Date
Area Manager