GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30, 2022

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

RE: License #: AS500411266
Investigation #: 2022A0617024
Progressions 22133 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 #:	AS500411266
Investigation #:	2022A0617024
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 22133 21 Mile
Facility Address:	22133 21 Mile Road Macomb, MI 48044
Facility Telephone #:	(248) 913-7600
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?
Resident A went to the hospital with an unexplained injury to his scrotum.	**Yes**
Resident B has been physically abused by staff Gabby Williams.	**No**

III. METHODOLOGY

07/15/2022	Special Investigation Intake 2022A0617024
07/15/2022	Special Investigation Initiated - Letter Email sent to Licensee Designee Ms. Waynick
07/18/2022	Contact - Document Received I received and reviewed the following: Resident Registry, Resident ID forms for all residents, staff schedule for June and July 2022, List of Staff with job titles and phone numbers, Resident file for Resident A and B, and Incident reports for Resident A.
07/20/2022	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed staff Deborah Rand, Rhonda Weston and Resident A. Resident B was not at the facility at the time of the onsite.
08/23/2022	Contact - Telephone call made TC with Mr. Kenebrew
08/23/2022	Contact - Telephone call made TC with Ms. Sayva.
08/23/2022	Contact - Face to Face I interviewed Resident B fact to face at the FIC housing facility.
08/24/2022	Contact - Telephone call made TC with Ms. Williams
08/24/2022	Exit Conference I held an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation.

ALLEGATION:

- **Resident A went to the hospital with an unexplained injury to his scrotum.**
- **Resident B has been physically abused by staff Gabby Williams.**

INVESTIGATION:

On 07/15/22, I received two complaints regarding the Progressions 22091 21 Mile facility. The first complaint stated that Resident A (71) has dementia, hypertension, acid reflux, and a traumatic brain injury. Resident A had skin missing off one of his testicles. Resident A is not able to say how it happened due to confusion. The facility staff noticed Resident A had bright red blood on his testicle but had no recent falls or injuries they were aware of. Resident A is a chronic masturbator. Resident A is still at Henry Ford. There is no discharge date. The plan is to return to the group home as Resident A's guardian was contacted and had no safety concerns.

The second complaint indicated that the home manager, Gabby, has pulled Resident B's hair, pushed her into the shower, and pushed her into her room. Gabby forces Resident B to take two showers a day because she tells Resident B "she stinks". The facility withholds Resident B's cellphone from her so she cannot make calls. Since the mistreatment began, the staff has told Resident B that her guardian does not believe anything she is saying. It is believed these comments were made as a scare tactic. Other staff has witnessed the mistreatments and does not do anything. There was a recent incident, exact date unknown, where Gabby snatched a water bottle out of Resident B's hand and water spilled every. She forced Resident B to shower and then made her clean up the spilled water afterwards. Additionally, Resident B's family purchased a 12-pack of pop for Resident B and the staff proceeded to dump out nine of the cans when Laurie left. Resident B is afraid to go back to the group home.

On 07/18/22, I received and reviewed the following: Resident Registry, Resident ID forms for all residents, staff schedule for June and July 2022, List of Staff with job titles and phone numbers, Resident file for Resident A and B, and Incident reports for Resident A. According to the incident report dated 7/12/22, staff went into Resident A's room to assist him with a shower when they noticed blood coming from his penis area. Staff immediately contacted emergency services. According to the medical documents from Henry Ford Hospital, Resident A was seen on 07/12/22 for injury to scrotum, initial encounter, and avulsion of skin.

On 07/20/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Deborah Rand, Rhonda Weston and Resident A. Resident B was not at the facility at the time of the onsite.

When I arrived at the facility, I rang the doorbell, but no one answered. I saw residents sitting in the living room of the home, but I did not see staff. The front door was unlocked, I opened the door and called out for staff. The residents stated that staff had

went next door to the affiliated licensed AFC. I walked throughout the home checking for staff, but I did not find anyone. After several minutes I observed an individual sitting outside in the backyard with their back to the inside of the home. I went outside and observed the individual with earbuds in her ears and it appeared she was playing a game on her phone. After several attempts to get her attention, she turned around and identified herself as Ms. Deborah Rand. Ms. Rand stated that she had to step outside to make an important call to DTE. Regarding Resident A's injury, Ms. Rand stated that she is unaware of how it occurred. According to Ms. Rand she was not working the day of the injury, but she is aware that Resident A is a routine masturbator, and he often uses foreign objects such as tissue rolls, gloves, etc. Resident A masturbates daily.

During the onsite investigation, I interviewed staff Rhonda Weston. Ms. Weston stated that she was working on the day of Resident A's injury. Ms. Weston was giving another resident a shower around 9:30 am. When she was finished, she went into Resident A's room to prepare him for his shower. When she opened his door, he was in the process of leaving his room, but he only had his briefs on. When Ms. Weston looked down, she seen a pool of blood on the floor and there was blood running down Resident A's leg from his briefs. When Ms. Weston examined Resident A, she observed that he had blood all over his genitals and the skin was off his scrotum to the point she could see the flesh. She cleaned him up the best she could until EMS arrived and took Resident A to the Henry Ford Hospital. Ms. Weston stated that Resident A could not say how the injury happened.

During the onsite investigation, I interviewed Resident A. Resident A had issues effectively communicating due to his disabilities, but he did state that there was a lot of blood and he thought he was going to die from his injuries.

With regards to Resident B, Ms. Rand stated that she was working on the day of the alleged incident. According to Ms. Rand, The home manager Gabrielle Williams was also working that day and she attempted to give Resident B a shower. Ms. Rand heard Ms. Williams tell Resident B multiple times "don't put your hands on me". After Resident B's shower, she sat on the couch, and everything appeared to be normal. There was not any further incident. Ms. Rand is unaware of staff pouring out any of Resident B's pop or water. Ms. Rand also stated that she has never witnessed or aware of Resident B taking two baths in a day.

With regards to Resident B, Ms. Weston stated that she never witnessed any abuse or altercation between Resident B and Ms. Williams. According to Ms. Weston, Resident B has hygiene issues, and she is supposed to take a bath daily. Resident B will often lie and say that she took a shower but, she only went into the shower and wet her hair. Staff then will redirect her to take a proper shower. Resident A has a bad body odor from improper hygiene practices.

On 08/23/22, I interviewed Resident B's guardian Corey Kenebrew. Mr. Kenebrew does not believe the allegations as Resident B has a history of lying and manipulative behavior. Mr. Kenebrew believes that Resident B is making up the situation to

manipulate her way into moving back home with her mother which is not an option currently. Mr. Kenebrew stated that he has no concerns about the facility, and he has other clients in the home. Mr. Kenebrew stated that Resident B no longer resides at the facility as she has transferred to FIC Housing.

On 08/23/22, I interviewed Ms. Susan Savaya who is the program manager of FIC Housing. Ms. Savaya stated that Resident B has bad hygiene and must be redirected daily to take a proper shower. Resident B has a strong body odor that requires her clothing, and bedding to be washed more than once a week. Resident B has demonstrated behavioral aggression when redirected to do something that she does not want to do.

On 08/23/22, I interviewed Resident B fact to face at the FIC housing facility. Resident B stated that Ms. Williams got mad at her because she was sitting on the couch drinking water. Ms. Williams grabbed the cup of water out of Resident B's hand and poured it onto the floor. Ms. Williams then forced Resident B to take a shower. Ms. Williams pushed Resident B into the bathroom, pulled her hair and physically showered Resident B. After forcing Resident B to take a shower, Ms. Williams forced Resident B to mop up the water that Ms. Williams poured on the floor. Resident B asked to use her cell phone, but staff told her that she could not call her boyfriend, she could only call the approved list of people from her guardian. Resident B was upset and called her mother to pick her up. She has not gone back to the facility since. Resident B stated that she loves her new placement as she is now living with old friends at the facility.

On 08/24/22, I interviewed the Home Manager Gabrielle Williams. Ms. Williams stated that with regards to Resident B, on the day of the alleged incident, Resident B and staff were having a disagreement about Resident B showering. Staff told Resident B to take a shower and she went into the bathroom and in under 3 minutes she came out still smelling of a strong negative body odor. Ms. Williams redirected Resident B and told her to take a proper shower. Resident B swung and hit Ms. Williams. Ms. Williams told Resident B, "do not touch me, I do not touch you so do not touch me". Resident B took a proper shower and Ms. Williams observed her shower. When Resident B was finished, Ms. Williams then washed Resident B's hair. Once the shower was complete, Ms. Williams combed and blow-dried Resident B's hair. Ms. Williams educated Resident B on the importance of proper hygiene. That same day, Resident B was drinking water and spilled some on the floor. Ms. Williams told Resident B to clean it up since she made the spill. With regards to Resident B's cell phone, Ms. Williams stated that per the guardian, Resident B is only allowed to have her phone between the hours of 5pm and 9pm. Also, per her guardian, Resident B was not allowed to call her boyfriend due to being inappropriate with him.

On 08/24/22, I held an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation. Mrs. Waynick understood the findings of the investigations and stated that she would provide a corrective action plan once the report was received.

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, the Progressions facility failed to protect and properly care for Resident A. Resident A was left unsupervised in his room and sustained a substantial injury to his scrotum that required him to be taken to the hospital. According to the medical documents from Henry Ford Hospital, Resident A was seen on 07/12/22 for injury to scrotum, initial encounter and avulsion of skin.
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 upon the information gathered through my investigation, there is sufficient information to conclude that the facility violated this rule. During my unannounced onsite investigation, I observed staff Ms. Rand sitting outside with her back to the residents while wearing earbuds in her ears and it appeared she was playing a game on her phone. The residents were left unattended and unsupervised in the home during the time staff, Ms. Rand was outside using her phone.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(a) Use any form of punishment **(b) Use any fomr of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based upon the information gathered through my investigation, there is insufficient information to conclude that the facility violated this rule. Ms. Williams denies physically touching Resident B other than washing her hair during a shower. No other staff witnessed or observed any abuse or mistreatment to Resident B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

08/24/22

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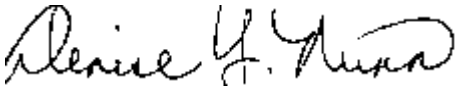
Eric Johnson Date
Licensing Consultant

Approved By:



08/30/2022

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Denise Y. Nunn Date
Area Manager