GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 2, 2023

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

RE: License #: AS630411261
Investigation #: 2023A0612016
Progressions 2104 S Rochester

Dear Ms. Waynick:

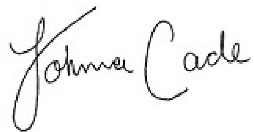
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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,



Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630411261
Investigation #:	2023A0612016
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	03/01/2023
Report Due Date:	04/29/2023
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 2104 S Rochester
Facility Address:	2104 S Rochester Road Rochester Hills, MI 48307
Facility Telephone #:	(248) 608-8553
Original Issuance Date:	07/14/2022
License Status:	REGULAR
Effective Date:	01/14/2023
Expiration Date:	01/13/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 12/12/22, Resident B picked up Resident A's medications and took them.	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A0612016
03/01/2023	Special Investigation Initiated - On Site I completed an unannounced, onsite investigation. I interviewed Program Manager Shamecia Montgomery, Direct Care Staff Yvonne Watson, Direct Care Staff Stephan Cash, and Resident A
03/01/2023	Exit Conference I called licensee designee, Debra Waynick to conduct an exit conference

ALLEGATION:

On 12/12/22, Resident B picked up Resident A's medications and took them.

INVESTIGATION:

On 02/28/23, I received a complaint that alleged on an unknown date a resident picked up another resident's medication and took them. I initiated my investigation on 03/01/23, by completing an unannounced, onsite investigation. I interviewed Program Manager Shamecia Montgomery, Direct Care Staff Yvonne Watson, Direct Care Staff Stephan Cash and Resident A.

On 03/01/23, I interviewed Program Manager Shamecia Montgomery. Ms. Montgomery stated on 12/12/22, at 2:00 pm direct care staff Yvonne Watson was passing medication to Resident A. Resident A usually comes to the kitchen, sits at the table, and staff watch him take his medication. However, on this day, Ms. Watson handed Resident A his medications. Resident A stood up and sat his cup of pills on the ledge in the kitchen while he got himself a glass of water. While his back was turned Resident B came into the kitchen picked up the cup of pills and took them. The medications Resident B took in error were Aspirin 81 mg, Flexeril 10mg, Sod Chlorine tab 1 mg, Vitamin D 2000 units, and Tramadol 50mg. Ms. Montgomery stated she reviewed the cameras to confirm Resident B ingested the medications. Once confirmed she called Resident B's doctor, the pharmacy, and informed Resident B's family of the incident. Resident B's doctor indicated Tramadol may cause Resident B to feel off balance. As such, he should be monitor for safety. Resident B was monitored. He did not experience any side effects or symptoms as a result of the medication he took in error. Resident A's medications were

replaced, and he received them as prescribed. Ms. Montgomery stated Resident B has a traumatic brain injury (TBI). He is a poor source of information and a poor historian. He likely does not remember the incident and he did intentionally take medications that were not prescribed to him.

On 03/01/23, I interviewed Direct Care Staff Yvonne Watson. Ms. Watson started her employment in November 2022. She works morning shift from 7:00 am – 3:00 pm. On 12/12/22, Ms. Watson was administering Resident A his 2:00 pm medications. Ms. Watson stated she put Resident A’s medications into a med cup and gave it to him. Resident A sat the cup of meds on the kitchen counter and went to get himself a glass of water. Resident B came into the kitchen, picked up the cup of medication, and took them. Ms. Watson saw this happen and immediately reported the incident to Ms. Montgomery. Resident A’s medications were replaced, and he received his medication as prescribed. Resident B’s doctor and pharmacy were contacted. They were instructed to monitor him. Ms. Watson stated she monitored Resident B the day the incident occurred and the following day. He did not experience any side effects or symptoms.

During the onsite investigation, completed on 03/01/23, Ms. Watson completed a simulated medication pass. She administered the medications appropriately, using the five rights of medication administration. Ms. Watson acknowledged that she understands when passing medications, she must monitor the resident until they swallowed the medication.

On 03/01/23, I interviewed Direct Care Staff Stephan Cash. Mr. Cash works morning shift from 7:00 am – 3:00 pm. He stated he heard about the medication error however he was not on shift when it occurred. During the onsite investigation, completed on 03/01/23, Mr. Cash completed a simulated medication pass. He administered the medications appropriately, using the five rights of medication administration. Mr. Cash stated the home uses an electronic medication administration record. The system is user friendly and elements the potential for any medication errors.

On 03/01/23, I interviewed Resident A. Resident A stated he takes his medication as prescribed. He remembers when Resident B took his medication by mistake. Resident B did not have any side effects as a result. Resident A stated he received his medication as prescribed.

During the onsite investigation, completed on 03/01/23, I observed the medication cabinet. The cabinet was locked, all medications were stored appropriately. The home uses an electronic medication administration record (MAR). I reviewed the MAR and found no current medication errors. The MAR was thoroughly and appropriately completed for each resident. Both Mr. Cash and Ms. Watson demonstrated their ability to use the electronic MAR appropriately.

On 03/01/23, I called licensee designee, Debra Waynick to conduct an exit conference. There was no answer. I left a voicemail detailing my findings and informing Ms. Waynick that a corrective action plan (CAP) is required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based upon the information gathered through my investigation there is sufficient information to conclude reasonable precautions were not in place to insure that prescription medications were not used by a person other than the resident for whom the medication was prescribed. On 12/12/22, direct care staff, Yvonne Watson gave Resident A his 2:00 pm medications and did not monitor him to assure that he swallowed the pills. Resident A sat the pills on the kitchen counter and Resident B ingested them. Resident B ingested the following medications that were not prescribed to him: Aspirin 81 mg, Flexeril 10mg, Sod Chlorine tab 1 mg, Vitamin D 2000 units, and Tramadol 50mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of this license remain unchanged.

03/02/2023

Johnna Cade Date
Licensing Consultant

Approved By:

03/02/2023

Denise Y. Nunn Date
Area Manager