GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 9, 2023

Ashley Jennings
Progressive Lifestyles Inc.
1370 North Oakland Blvd
Suite 150
Waterford, MI 48327

RE: License #: AS630408166
Investigation #: 2024A0991001
E Maple Rd

Dear Ashley Jennings:

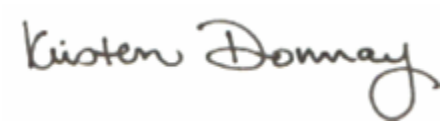
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630408166
Investigation #:	2024A0991001
Complaint Receipt Date:	10/10/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/09/2023
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	1370 North Oakland Blvd Suite 150 Waterford, MI 48327
Licensee Telephone #:	(248) 742-1378
Licensee Designee:	Ashley Jennings
Name of Facility:	E Maple Rd
Facility Address:	2301 E Maple Rd Milford, MI 48381
Facility Telephone #:	(248) 820-9274
Original Issuance Date:	05/10/2022
License Status:	REGULAR
Effective Date:	11/10/2022
Expiration Date:	11/09/2024
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has been verbally and physically abused by staff at the group home for the last three to six months. Staff push Resident A with their forearms into her chest and neck. They pin her in the bathroom and sit on her. Staff pinch her face and throw her on the bed. Staff have threatened to lock Resident A in the garage.	No
On 10/01/23, direct care worker, Jessica Combs, forcefully pulled Resident A into the house by her purse strap.	Yes

III. METHODOLOGY

10/10/2023	Special Investigation Intake 2024A0991001
10/10/2023	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
10/10/2023	APS Referral Received from Adult Protective Services (APS), assigned to APS worker, Bradley Edwards
10/10/2023	Referral - Recipient Rights Call to Katie Garcia, assigned ORR worker
10/11/2023	Contact - Document Received Email from Katie Garcia with incident reports, plan of service, and additional allegations
10/18/2023	Contact - Telephone call made Interviewed home manager, Destiny Ranbarger
10/18/2023	Contact - Telephone call made Interviewed direct care worker, Tabitha McIntyre
10/18/2023	Contact - Telephone call made Interviewed direct care worker, Jessica Combs
10/18/2023	Contact - Telephone call made Interviewed direct care worker, Kathryn Stewart
10/18/2023	Contact - Telephone call made Interviewed direct care worker, Kiersten Celcer

10/24/2023	Contact - Document Received Email from APS worker, Bradley Edwards
10/24/2023	Contact - Document Received Email from direct care worker, Katie Garcia
11/01/2023	Contact - Telephone call made To home manager, Destiny Ranbarger
11/07/2023	Inspection Completed On-site Unannounced onsite inspection, interviewed residents and home manager
11/08/2023	Exit Conference Via telephone with licensee designee, Ashley Jennings

ALLEGATION:

- **Resident A has been verbally and physically abused by staff at the group home for the last three to six months. Staff push Resident A with their forearms into her chest and neck. They pin her in the bathroom and sit on her. Staff pinch her face and throw her on the bed. Staff have threatened to lock Resident A in the garage.**
- **On 10/01/23, direct care worker, Jessica Combs, forcefully pulled Resident A into the house by her purse strap.**

INVESTIGATION:

On 10/10/23, I received a complaint alleging that for the past three to six months, Resident A has been verbally and physically abused at the group home. The allegations stated that staff members, Destiny, Jessica, Liz, Raquel, and Kiersten push Resident A with their forearms into her chest and neck. The staff pin Resident A down in the bathroom and sit on her. They pinch Resident A in the face and throw her down on the bed. Resident A was observed with bruises to her arms approximately one month ago. Staff yell at Resident A and say, "kiss my ass and suck my D." Staff have threatened to lock Resident A in the garage. There are no injuries or bruises on Resident A currently. Resident A is having angry outbursts and is fearful of returning to the group home. I initiated my investigation on 10/10/23 by contacting the assigned Adult Protective Services (APS) worker, Bradley Edwards, and the assigned Office of Recipient Rights worker, Katie Garcia.

On 10/11/23, I received additional allegations from the assigned ORR worker, Katie Garcia, alleging that on 10/01/23 staff, Jessica Combs, forcefully pulled Resident A into the house by her purse when Resident A was pacing on the driveway and refusing to enter the home.

On 10/18/23, the assigned ORR worker, Katie Garcia, and I conducted phone interviews with the staff from the E Maple Rd. Home. We interviewed the home manager, Destiny Ranbarger, and direct care workers, Jessica Combs, Tabitha McIntyre, Kathryn Stewart, and Kiersten Celcer. All of the staff who were interviewed denied being physically or verbally abusive toward Resident A. They denied witnessing or hearing about Resident A being physically abused. They had no knowledge of Resident A being pushed in the chest and neck, being pinned down in the bathroom, being thrown on the bed, or being threatened to be locked in the garage. They never heard staff yell at Resident A or tell her to “kiss my ass and suck my D.”

The home manager, Destiny Ranbarger, stated that she has been working with Resident A for seven years. Resident A has a history of twisting things around. She gave an example of when Resident A was sleeping on the couch and staff asked her if she wanted help taking her shoes off so she could get comfortable. Resident A agreed, but later told her mom that staff forced her to remove her shoes. Ms. Ranbarger stated that Resident A wants to be with her mom, and she knows that if she tells her mom that staff are treating her poorly, then her mom will take her home. Ms. Ranbarger stated that there was an incident with staff, Raquel, a few weeks ago. Resident A threw her phone and was approaching Raquel. Raquel picked up the phone and placed it on the counter. Raquel put her arms up in a protective or blocking manner as Resident A was coming at her, and Resident A walked into her. Ms. Ranbarger stated that Resident A previously made allegations that Kiersten pushed her on the bed, but another staff was present, and Kiersten left the room immediately after Resident A started saying that she pushed her. Ms. Ranbarger stated that Resident A makes a lot of allegations and perceives things to be happening that did not happen. Ms. Ranbarger stated that the allegation of staff pinching her cheeks most likely stemmed from her. She used to lovingly pinch Resident A’s cheeks and tell her she was cute. Resident A was okay with this until one time she told Ms. Ranbarger not to do that, so Ms. Ranbarger never did it again. She stated that she has not done this for several months. Ms. Ranbarger stated that she never heard staff cussing at Resident A. Resident A might have overheard staff’s personal conversations, but it was not directed at Resident A. She stated that it is not likely that staff pinned her in the bathroom, as the bathroom that Resident A uses is very tiny. She also stated that there are three doors in the garage, and it would be impossible to lock Resident A in the garage.

Direct care worker, Kiersten Celcer, stated that Resident A previously made allegations that she pushed her onto the bed. Ms. Celcer stated that it is an everyday thing for Resident A to make these types of allegations. She denied ever being physically aggressive towards Resident A, and she stated that she never pushed Resident A onto the bed. Ms. Celcer stated that Resident A was upset after returning home from a visit with her mom. She put her hand out, Resident A took her hand, and they walked to her room. Ms. Celcer was helping Resident A take her shoes off when Resident A said, “You pushed me on the bed.” Ms. Celcer stated that she immediately left the room. It is common for Resident A to make accusations and allegations against staff. She stated that she has a great relationship with Resident A, but when Resident A does not want to

be in the home, she will make allegations. Ms. Celcer stated that another staff, Tabitha, was present during the incident.

Direct care worker, Tabitha McIntyre, stated that she was present when Resident A made allegations about staff, Kiersten Celcer, pushing her on the bed. Resident A had just returned from a visit with her mom. Kiersten offered her a hand and asked her to come into her bedroom and take a few minutes to cool down since she was upset. Resident A walked with Kiersten into her room, then turned around and said, “Why are you pushing me? Why are you shoving me?” Ms. McIntyre stated that Kiersten never pushed or shoved Resident A. She was only using verbal prompts. Ms. McIntyre stated that Resident A loves Kiersten and typically looks to Kiersten for comfort. She has never seen Kiersten push or put her hands on Resident A.

On 10/24/23, I received an email from the assigned APS worker, Bradley Edwards. Mr. Edwards met with Resident A and her guardian at the guardian’s home on 10/10/23. Resident A was very hesitant to speak with APS. Resident A stated that she was just not comfortable with APS at this time. Resident A’s guardian explained her concerns with the staff from that home and stated that she was aware of what was reported. Resident A’s guardian stated that these things normally happen on the weekends because that's when the certain staff work and that is why she calls Resident A every Monday. Resident A’s guardian stated that she has previously made complaints about the home. The staff get better after she makes a report, but eventually it is back to the same stuff. Resident A’s guardian asked Resident A if she could speak to APS to provide some information. Resident A then stated that she is pushed to the ground, pushed onto her bed, and grabbed by her face. Resident A stated that Jessica grabbed her by her purse strap and pulled her into the home and she had a rug burn on her neck from it. APS asked Resident A when the last time was that she has had any marks or bruises, and she stated that she does not know. Resident A stated that she does not have any bruises right now. Resident A stated that staff also threaten her by saying that they are going to put her in the garage. Resident A began to cry and stated that she did not want to go back to the home, and she is done talking about it. Resident A’s guardian stated that they are having a meeting at the home to discuss a plan moving forward. Resident A’s guardian stated that she is going to keep Resident A at home with her for now and will start to look for other housing options.

On 10/24/23, I received an email from the assigned ORR worker, Katie Garcia. Ms. Garcia stated that she spoke with Resident A’s supports coordinator, Jamie Spring, from Open Arms/MORC. Ms. Spring stated that it is common for Resident A to fabricate stories about staff because she wants to go back home to mom. Ms. Spring denied having any concerns regarding Resident A’s care with any of the staff.

On 10/18/23, I interviewed the home manager, Destiny Ranbarger, regarding the additional allegations of Jessica pulling Resident A into the home by her purse on 10/01/23. Ms. Ranbarger stated that she was not working when the incident occurred, but she received a phone call from staff, Tabitha McIntyre, around midnight. Ms. McIntyre told her that Jessica Combs pulled up to the home while Resident A was in the

road. Ms. Combs jumped out of her truck, grabbed Resident A by her crossbody purse, and pulled her up the driveway by her purse strap. Ms. McIntyre reported that Jessica pulled Resident A in a mean way, and she was telling her that she is not safe and she did not know why she was playing in the road. Ms. McIntyre reported to Ms. Ranbarger that Resident A's hands were purple that evening from holding onto her purse. Ms. Ranbarger did not observe any injuries on Resident A's hands the following day. She stated that there was a small red mark on Resident A's neck, but it could have been a bug bite. Ms. Ranbarger stated that following this incident, Jessica Combs was removed from the schedule. She has been signed up for recipient rights and gentle teaching training. Ms. Ranbarger stated that Resident A paces in the driveway or the road after she returns home from visits with her mom, because she does not want to go back into the home. This is a fairly new behavior that is being addressed in her plan of service. Staff were doing visual checks every five minutes and prompting her every fifteen minutes when she was only pacing on the driveway. After she started going into the road, her person-centered plan (PCP) was updated to state that she should be in visual sight at all times. Ms. Ranbarger stated that staff will stand in the garage and try to give Resident A space. They do not pressure her too much to come into the home. If cars are leaving the driveway, staff will have to block Resident A from trying to stand behind the cars as they are leaving.

On 10/18/23, I interviewed direct care worker, Tabitha McIntyre. Ms. McIntyre stated that on 10/01/23, Resident A was being dropped off at the home by her mom following a visit. Resident A was refusing to get out of the car, so they were following her care plan and prompting her to leave the car every 15 minutes. After about two hours, Resident A's mom got tired of waiting, so she "assisted" Resident A out of the car and left. Resident A then began pacing on the driveway and went into the road trying to stop vehicles. Ms. McIntyre stated that they blocked the path to the road using their bodies, so Resident A would not be in danger. They called the emergency pager after 30 minutes of Resident A trying to go into the road. They continued to follow her plan and were prompting her by asking if she wanted a snack or wanted to use the bathroom. Resident A still refused to go into the house, so they contacted the emergency pager again for the crisis team to get involved. They called Jessica Combs, who was coming in for her shift soon, to let her know to be careful when she was pulling up to the home. Ms. McIntyre stated that Ms. Combs called and cancelled the crisis team before she arrived at the home. When Ms. Combs arrived at the home, Resident A was standing at towards the middle/end of the driveway. She was not in danger of being hit by a car in the road. Ms. Combs got out of her car, grabbed the strap of Resident A's crossbody purse and used it as leverage to pull her into the garage. Ms. McIntyre stated that Resident A and Ms. Combs were both pulling on the purse strap, which was made of rope. The palm of Resident A's hand in between her thumb and index finger was purple from grabbing the strap of the purse as Ms. Combs pulled on it. Ms. McIntyre stated that she was standing behind Resident A during the altercation, as she was concerned the purse might break and Resident A would fall backwards. She stated that she was worried about Resident A's safety and wanted to catch her if she fell. Ms. McIntyre told Ms. Combs, "You can't do that," and Ms. Combs stated, "I know." Ms. McIntyre immediately texted the home manager, Destiny Ranbarger, and called her shortly

thereafter to tell her the whole situation. Ms. McIntyre stated that the whole situation could have been avoided if Ms. Combs had not cancelled the crisis team and if she had followed the steps in Resident A's plan like they had been doing prior to Ms. Combs arriving at the home. Ms. McIntyre stated that Kathryn Stewart was also on shift and witnessed the incident. The other residents were inside the home sleeping.

On 10/18/23, I interviewed direct care worker, Kathryn Stewart. Ms. Stewart stated that she was working with Tabitha McIntyre on 10/01/23. Resident A was pacing in the driveway and was trying to go in the road. They were trying to convince Resident A to come in for hours. She wanted to go home with her mom, so they tried to redirect her and used the tools that they had been taught from her plan. It was dark outside, so they contacted the emergency pager and Ms. McIntyre continued to supervise and redirect Resident A. They called Jessica Combs to tell her to be careful when she pulled up to the home, since Resident A was outside. Ms. Combs cancelled the pager and told them that she could handle it. When she arrived at the home, she jumped out of her truck, took hold of the purse that Resident A was wearing, and dragged her up the driveway into the house by her purse strap. Ms. McIntyre was standing behind Resident A, because she thought Resident A was going to fall. The other residents were in the home sleeping. Ms. Stewart stated that they told Ms. Combs to stop, and Ms. McIntyre told her that she was going to report her. Ms. Stewart stated that she worked the rest of the midnight shift with Ms. Combs. Resident A was upset and stayed on the couch for most of the night. She did not observe any marks or bruises on Resident A when she checked a few hours later.

On 10/18/23, I interviewed direct care worker, Jessica Combs. Ms. Combs stated that she worked on 10/01/23 from 11:00pm-7:00am. She was working earlier in the day, and picked up the midnight shift because they were short staffed. She stated that the staff who were on shift in the afternoon had been contacting her about Resident A being in the road and they stated that they called the pager. Ms. Combs spoke to the on-call supervisor on her way to the home and asked them to give her a chance to get Resident A into the home, because she thought she could handle it. Ms. Combs stated that when she pulled up to the house, Resident A was at the end of the driveway. She started to pull into the driveway and parked with half of her truck still in the road. Ms. Combs stated that she "guided" Resident A into the house with the string of her purse. Ms. Combs then stated that she "pulled" Resident A into the house by the string of her purse. Resident A was holding the purse strap with her hand and was pulling back to stay outside. Ms. Combs stated that she just slipped into doing what she felt she needed to do. It was 11:00pm at night, pitch black outside, and there are construction vehicles that come down the road. Resident A was unsafe in her eyes. Ms. Combs stated that nobody told her to stop at the time. She stated, "I got told after the fact that I fucked up." She stated that she knows she did the wrong thing by grabbing her purse and dragging her into the house. She should have let the crisis team handle the situation. Ms. Combs stated that she was transferred to a different home after the incident, and she was written up. Ms. Combs stated that Resident A's crisis plan had changed so many times that she was not sure what it said to do when she was refusing to come into the home. She stated that she did not try any other interventions with

Resident A before she pulled her into the house, because she already tried talking to her on the phone during her drive to the home, and Resident A was not responsive. Ms. Combs stated that she feels Resident A's mom is a trigger for a lot of her behaviors, and Resident A should have been dropped off at the home earlier.

I reviewed a copy of Resident A's individual plan of service (IPOS) and crisis prevention and safeguard plan effective 07/01/2023. I noted the following relevant information: Resident A's IPOS indicates that she has high anxiety when transitioning in and out of her home. She exhibits a high amount of anxiety at home with any change in the routine or transition (housemates coming home, mealtimes, showering, housemates showering/going to bed), she is experiencing volatile emotional mood swings - crying one minute and yelling another. Resident A is having difficulty focusing on reality and what her daily routine used to/should look like. Resident A will refuse to shower, complete hygiene activities, change her clothing and is unable to make a decision. Resident A's anxiety results in pacing the home, sidewalk and driveway, crying, yelling, walking out of the home, physically striking out at her housemates and caregivers and dramatic mood swings.

The IPOS indicates that caregivers should all use gentle teaching interactions when working with Resident A. They should convey calmness, and that care about and value her. They should validate her feelings, enjoy activities together, and remember to provide a safe environment where Resident A can relax, express herself, and feel valued. The plan also notes that caregivers should administer positive reinforcement to Resident A throughout the day, offering feedback for compliance or any acceptable behaviors. When providing directives to Resident A, caregivers should utilize a gentle approach and a calm voice. They should avoid arguments and dialogue about the task if she is being stubborn. Caregivers should not use a harsh/directive tone of voice as this may cause her to become even more defensive and uncooperative, and it was noted that she tends to "do the opposite."

The crisis plan indicates that when in the community with home caregivers, Resident A should be within close enough proximity to provide for her safety. Resident A is fully able to get in/out of a vehicle. Caregivers should not be "assisting" her. They can offer her their hand, but should not be pulling her out or pushing her in. If she refuses to get in or get out, caregivers need to give her space and time. They should remain where they can observe her and provide support as needed. Caregivers should verbally engage with her at least every 15 minutes. When Resident A is outside in the front yard/driveway, staff should visually check on Resident A every 5 minutes. Caregivers should not pressure Resident A to come into the garage or house, just provide monitoring.

On 11/07/23, I conducted an unannounced onsite inspection at E Maple Rd. Home. I interviewed Resident B, Resident C, Resident D, and Resident E. None of the residents had any information about staff being mean or hurting Resident A. None of the residents had any information about staff swearing at Resident A or threatening her. Resident D stated that she does not like living in the home and wants to move out. She stated that

sometimes staff are mean. She could not provide any examples of staff being mean or give a reason as to why she wants to move out. During the onsite inspection, the home manager, Destiny Ranbarger, stated that Resident A was not planning on returning to the home. She stated that direct care worker, Jessica Combs, was moved to another home and has not worked any additional shifts at the E. Maple Rd. Home.

On 11/08/23, I conducted an exit conference via telephone with the licensee designee, Ashley Jennings. Ms. Jennings stated that Jessica Combs received written discipline and was transferred to another home. Ms. Combs will also be signed up to retake recipient rights training. Ms. Jennings confirmed that Resident A would not be returning to the E Maple Rd home. She did not have any additional information regarding the investigation and stated that they would submit a corrective action plan to address the violations.

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 investigation, there is sufficient information to conclude that direct care worker, Jessica Combs, did not follow Resident A's plan of service when she dragged Resident A into the house by her purse strap on 10/01/23. Ms. Combs stated that Resident A's crisis plan had changed so many times that she was not sure what it said to do when Resident A was refusing to come into the home. She stated that she did not try any other interventions with Resident A before she pulled her into the house, because she already tried talking to her on the phone during her drive to the home, and Resident A was not responsive. The other staff on shift were attempting to follow Resident A's plan of service and had contacted the on-call crisis team when Ms. Combs arrived at the home and intervened by dragging Resident A into the home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0605044 dated 10/12/2022; CAP dated 10/26/2022**

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff were physically abusive towards Resident A. Resident A reported to Adult Protective Services that staff pushed her to the ground, pushed her onto the bed, and grabbed her by her face. However, none of the staff or residents who were interviewed had any knowledge of staff being physically abusive towards Resident A by pushing her or grabbing her face. There is sufficient information to conclude that staff, Jessica Combs, used physical force other than physical restraint when she pulled Resident A into the house by her purse strap on 10/01/23. This incident was observed by the direct care workers on shift, Tabitha McIntrye and Kathryn Stewart. Ms. Combs also admitted that she pulled Resident A into the house by her purse because she was concerned for her safety, as it was dark outside and Resident A was refusing to go into the home. The staff who observed the incident stated that Resident A was not in immediate danger of being hit by a car when Ms. Combs pulled her into the house.
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: (f) Subject a resident to any of the following: (ii) Verbal abuse. (iv) Threats.

ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff were verbally abusive or made threats towards Resident A. Resident A stated that staff threaten her by saying that they are going to put her in the garage. None of the staff or residents who were interviewed had any knowledge of staff threatening Resident A. The staff denied yelling or swearing at Resident A and did not have any knowledge of anyone saying, "kiss my ass and suck my D."
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

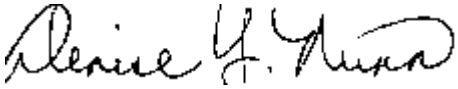
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

11/08/2023

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



11/09/2023

_____

Denise Y. Nunn Date
Area Manager