GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 3, 2024

Janice Hurst
Progressive Residential Services Inc
Suite # 265
6001 N. Adams Road
Bloomfield Hills, MI 48304

RE: License #: AS580015119
Investigation #: 2024A0116044
Borg

Dear Mrs. Hurst:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580015119
Investigation #:	2024A0116044
Complaint Receipt Date:	09/13/2024
Investigation Initiation Date:	09/13/2024
Report Due Date:	11/12/2024
Licensee Name:	Progressive Residential Services Inc
Licensee Address:	Suite # 265 6001 N. Adams Road Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 641-7200
Administrator:	Janice Hurst
Licensee Designee:	Janice Hurst
Name of Facility:	Borg
Facility Address:	1279 Borg Temperance, MI 48182
Facility Telephone #:	(734) 847-4474
Original Issuance Date:	05/18/1993
License Status:	REGULAR
Effective Date:	05/08/2024
Expiration Date:	05/07/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A fell into a crawl space while maintenance workers were at the home working.	Yes

III. METHODOLOGY

09/13/2024	Special Investigation Intake 2024A0116044
09/13/2024	Special Investigation Initiated - Telephone Interviewed assigned adult protective services (APS) investigator, Melissa Jernigan.
09/16/2024	Referral - Recipient Rights Made.
09/17/2024	Inspection Completed On-site Interviewed staff Paula Ivey, reviewed Resident A's individual plan of service (IPOS), visually observed Residents B and C, and observed the crawl space where Resident A fell.
09/25/2024	Contact - Telephone call made Interviewed Nicole Scharf, Resident A's case manager at Monroe County community mental health authority.
09/25/2024	Contact - Telephone call made Interviewed Guardian A 1.
09/25/2024	Contact - Telephone call made Interviewed staff, Amanda Dilts.
09/25/2024	Contact - Telephone call made Interviewed staff, Angie Willcutt.
09/25/2024	Contact - Telephone call made Interviewed staff, Andrew Dilts.
09/27/2024	Inspection Completed-BCAL Sub. Compliance Visually observed Resident A.
10/01/2024	Exit Conference

	With licensee designee, Janice Hurst.

ALLEGATION:

Resident A fell into a crawl space while maintenance workers were at the home working.

INVESTIGATION:

On 09/13/24, I interviewed assigned APS investigator, Melissa Jernigan, and she reported that she is concluding her investigation, and at the present believes that this was a horrible accident and does not believe that Resident A sustained any injuries from the fall.

On 09/17/24, I conducted an unscheduled on-site inspection and interviewed staff, Paula Ivey, visually observed Residents B and C, reviewed Resident A's IPOS and observed the crawl space. Ms. Ivey reported that she was not on shift when the incident occurred but reported that there were three staff on shift when it happened. Ms. Ivey reported that Resident A did sustain some serious injuries from the fall, but reported to date she is doing well. Ms. Ivey reported that Resident A was currently with her father, at a follow up medical appointment, and reported she was not sure when they would be returning to the home.

I visually observed Residents B and C, both were neatly dressed and groomed. Neither resident could be interviewed as they are both non-verbal.

I reviewed Resident A's IPOS dated 04/08/24 and confirmed that she does not require 1:1 staffing, however, the plan documented that the staff at the home are required to provide general supervision ensuring the health and safety of Resident A at all times. I also observed the crawl space that Resident A fell into. The opening to the crawl space is contained in the back of the house in the laundry room. Staff, Ms. Ivey, lifted the crawl space cover and I was able to observe where Resident A fell. I observed a cinder block in the crawl space and Ms. Ivey reported that Resident A hit the cinder block when she fell and that is possibly what caused some of the serious injuries. Ms. Ivey reported that Resident A fractured a rib, sustained a partially collapsed lung as well as some scrapes/abrasions. Ms. Ivey reported that everyone was glad that Resident A did not hit her head on the cinder block as things may have turned out differently.

On 09/25/24, I interviewed Nicole Scharf, Resident A's case manager. Ms. Scharf reported that she was aware of the incident and reported there is no logical reason as to how and why this happened, especially with three staff on shift in the home. Ms. Scharf reported that she is appalled and confused. Ms. Scarf reported her belief that the staff may have been outside and not providing supervision to the residents. Ms. Scharf added that common sense would tell you that if there were maintenance workers in the house, and they inform you that they will be working in the crawl

space, you would think staff would keep all of the residents in the front portion of the home where a watchful eye could be kept on them until the maintenance work was completed.

Ms. Scharf reported that although Resident A does not require 1:1 staffing, the staff is still required to provide general supervision and ensure her health and safety at all times inside and outside of the home.

On 09/25/24, I interviewed Guardian A1, and he reported that Resident A has lived in the home for about two years and has done well. Guardian A1 reported that overall, he has been pleased with the care that the staff provide in the home, and he believes that this is the healthiest and happiest Resident A has been. He further reported cognitively she is improving also. Guardian A 1 reported regarding the fall that he is very upset and stated, “This fall could have cost me my daughter.” Guardian A 1 reported that the incident is unacceptable and that it never should have happened. Guardian A 1 reported that Resident A sustained four fractured ribs, a partially collapsed right lung, bruising to the chest wall as well as scratches and abrasions to her legs. Guardian A 1 reported to date that Resident A is doing well and reported that the staff is managing her pain with medications. Guardian A 1 reported that Resident A is nonverbal and cannot express herself verbally, so it is important for the staff to keep the pain medication in her system. Guardian A 1 reported that he plans to keep Resident A in the home and is hopeful that nothing like this ever happens again.

On 09/25/24, I interviewed staff, Amanda Dilts, and she reported that she was working the 3:00 p.m. to 11:00 p.m. shift on Friday 09/06/24, when the incident occurred. Ms. Dilts reported that she was outside on the front porch on the telephone making a doctor’s appointment for a resident. Ms. Dilts reported that Resident A was outside with her initially and reported that one of the maintenance men informed her that they were going to be working under the house in the crawl space. Ms. Dilts reported that normally when maintenance in working in the crawl space one man is in the crawl space and the other stays out and assists. Ms. Dilts reported thinking if any of the ambulatory residents walked to the laundry room area, either the laundry room door would be closed preventing entry, or the maintenance man above ground would prevent access into the area. Ms. Dilts reported that did not happen and reported that Resident A eventually walked back in house and must have immediately gone to the laundry room where the door was opened and the cover to the crawl space was off, causing her to fall in. Ms. Dilts reported that she heard one of the maintenance men say that someone had fell into the crawl space. Ms. Dilts reported 911 was called and Resident A was transported to the hospital. I asked Ms. Dilts what her/staff practice usually is when any sort of work is being done in the home, as it pertains to the safety/supervision of the residents. Ms. Dilts reported that she would have all of the residents in the kitchen and family room area so that she can keep an eye on them and keep them out of the way of the people who are doing the work. Ms. Dilts reported that all of the other residents were in the living room area on the day of the incident. Ms. Dilts reported that she feels bad for

what happened and reported that the door is now equipped with a door code and signs are posted as a reminder to keep it closed at all times. Ms. Dilts further reported that it was an accident, and that upper management has talked to all of the staff about the incident, and supervision of the residents, especially when others are in the home working.

On 09/25/24, I interviewed staff, Angie Willcutt, and she reported that she worked the 3:00 p.m. to 11:00 p.m. shift on 09/06/24. Ms. Willcutt reported that when she arrived to work the maintenance men were already in the home working in the crawl space. She reported that she went into the kitchen and started to prep and prepare dinner. Ms. Willcutt reported that Resident A was outside with staff, Amanda Dilts, and the other five residents were in the living room with staff, Andrew Dilts. Ms. Willcutt reported that she saw Resident A walk back in the house and reported Ms. Dilts followed shortly after. Ms. Willcutt reported that within seconds of Resident A coming into the home, the maintenance man came to the kitchen area and told her that Resident A had fell into the crawl space. Ms. Willcutt reported that she went to the laundry room and looked in the crawl space and was distraught because Resident A was not moving or responsive and she thought she was dead. Ms. Willcutt reported that 911 was called and Resident A was transported to the hospital. I asked Ms. Willcut what her/staff practice usually is when any sort of work is being done in the home, as it pertains to the safety of the residents. Ms. Willcutt got loud, and responded, “Lady I didn’t do anything wrong, I am done talking to you.” Ms. Willcutt then hung up the phone on me.

On 09/25/24, I interviewed staff, Andrew Dilts, and he reported that he worked the 3:00 p.m. to 11:00 p.m. shift on 09/06/24 and reported that he was in the living room with five of the six residents who reside in the home. He reported that Resident A was outside with staff, Amanda Dilts, and staff Angie Willcutt was in the kitchen preparing dinner. Mr. Dilts reported that everything happened so fast. He reported that he saw Resident A walk in the house, and the next thing he heard was one of the maintenance men telling staff, Angie Willcutt, that Resident A had fallen into the crawl space. Mr. Dilts reported that 911 was called and Resident A was transported to the hospital. I asked Mr. Dilts what his/staff practice usually is when any sort of work is being done in the home, as it pertains to the safety of the residents. Ms. Dilts reported that they try to make sure all of the residents are in one area and reported that on 09/06/24, they all were except for Resident A. He reported that Resident A was also being supervised and was outside with staff, Amanda Dilts, prior to walking back in the home. Mr. Dilts reported that upper management met with him and the other staff who were on shift and sent out a text blast to all the staff regarding the importance of supervision of the residents and the additional safeguards put in place in the home, to prevent something like this from happening again.

On 09/27/24, I conducted a scheduled on-site inspection and visually observed Resident A. Resident A was neatly dressed and groomed and was pacing from the kitchen to the living room. She was moving about well and did not appear to be in pain. Resident A was unable to be interviewed as she is non-verbal.

On 10/01/24, I conducted the exit conference with licensee designee, Janice Hurst. I informed Ms. Hurst of the interview I attempted to complete with her employee, Angie Willcutt, and shared with her the behavior and lack of cooperation shown by her. Ms. Hurst reported that she was aware of what had occurred and reported that it has been addressed. I also informed Ms. Hurst of the findings of the investigation and the specific rule cited. Ms. Hurst reported an understanding and stated that she too had questions as to how this could have happened. Ms. Hurst reported upon receipt of the report she will complete and submit an acceptable corrective action plan.

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 on the findings of the investigation, which included interviews of case manager, Nicole Scharf, Guardian A1, staff, Amanda Dilts, Angie Willcutt, Andrew Dilts, and my review of Resident A's IPOS, I am able to corroborate the allegation. Resident A fell into the crawl space and sustained serious injuries, while there were three staff in the home responsible for her care, protection and supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/02/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

10/03/24

Ardra Hunter
Area Manager

Date