GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2025

Gavin Aikens
Neulife Rehabilitation of Michigan, Inc.
Suite 102
36975 Utica Road
Clinton Township, MI 48036

RE: License #: AS500411266
Investigation #: 2025A0617002
Progressions 22133 21 Mile

Dear Mr. Aikens:

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 #:	2025A0617002
Complaint Receipt Date:	12/17/2024
Investigation Initiation Date:	12/18/2024
Report Due Date:	02/15/2025
Licensee Name:	Neulife Rehabilitation of Michigan, Inc.
Licensee Address:	Suite 102 - 36975 Utica Road Clinton Township, MI 48036
Licensee Telephone #:	(586) 817-2593
Administrator:	Gavin Aikens
Licensee Designee:	Gavin Aikens
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:	REGULAR
Effective Date:	01/01/2023
Expiration Date:	12/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are neglected and not changed in a timely manner	Yes

III. METHODOLOGY

12/17/2024	Special Investigation Intake 2025A0617002
12/18/2024	Special Investigation Initiated - On Site Initiated SI with an unannounced onsite investigation
12/18/2024	Inspection Completed On-site I conducted an unannounced onsite investigation at the Progressions 22133 21 Mile facility. I interviewed staff Janiya Woodland, Brianca McCaa, Brenyal Hatter, Director of Clinical Services Marisa Gonzalez, Licensee Designee Gavin Aikens, Resident A and Resident B.
01/31/2025	Exit Conference I conducted an exit conference with licensee designee Gavin Aikens to discuss the findings of this report. Mr. Aiken was not available, and a message was left for him.

ALLEGATION:

Residents are neglected and not changed in a timely manner

INVESTIGATION:

On 12/17/24, I received a complaint regarding the Progressions 22133 21 Mile. According to the complaint, there is retaliation against individuals that voice concerns. Residents are left neglected and not changed in timely manner. Staff sleeps during shifts, Understaffed, house is uncleaned, smells of urine, and not enough food in the home.

On 12/18/24, I conducted an unannounced onsite investigation at the Progressions 22133 21 Mile facility. I interviewed staff Janiya Woodland, Brianca McCaa, Brenyal Hatter, Director of Clinical Services Marisa Gonzalez, licensee designee Gavin Aikens, Resident A and Resident B.

According to Ms. Woodland, Resident A has complained that the night staff does not check on her regularly to see if she needs a brief change. Ms. Woodland stated that residents are supposed to be checked on every two hours, but the facility is understaffed and that causes issues. There is supposed to be two staff during the day and one at night but there are a lot of call offs which leaves one staff to have to cover the whole facility. Ms. Woodland stated that there is too much work for one staff member to do alone in addition to providing adequate supervision. Ms. Woodland stated that she is scheduled to be the only staff member on shift from 3pm to 7pm today. Ms. Woodland stated that she is concerned because during the time that she will be alone, she will have to cook dinner, feed, clean, toilet and supervised the residents all at the same time. In addition to those tasks, staff are expected to shower residents, clean the home and do laundry. There are six residents in the home and one resident is bedbound and unable to feed or toilet herself. According to Ms. Woodland, some of the residents leave the facility during the day for program but all residents are back by 4pm and dinner is served at 5pm. According to Ms. Woodland, the home is often dirty during the day because day shift staff are spread thin and don't always have time. With regards to food in the home, management provides groceries as needed. Ms. Woodland stated that there is always food in the home but sometimes there isn't enough food for everyone to receive adequate portions. Today she is making pepper steak and there is only enough food for two people.

During the onsite investigation, I observed the facility menus and the food being prepared matched the items listed on the menu. I observed that the home had a lot of food available for residents including can goods, fresh fruits and vegetables, and a variety of frozen meats. However, I also observed that there was only one pack of steak for dinner, which is not enough to feed six residents adequately. I also observed that the home was clean, organized and did not smell of urine. During the onsite investigation, I reviewed several resident files, and multiple residents require assistance with toileting.

According to Ms. Hatter, the facility is short staffed and there have been times where she was the only staff member working a shift. Ms. Hatter stated that two staff members should be enough to properly care for the residents, but some staff don't get as much done as others. Ms. Hatter believes that having more staff would improve resident care and supervision. Ms. Hatter stated that when the facility is short staffed, Resident A and Resident C has to wait to be toileted or changed. Ms. Hatter stated that due to the extensive needs of the residents, more care is required. According to Ms. Hatter, the home is not dirty often, but it depends on who is working, how many are working and how busy staff are that day. The home is supposed to be cleaned each shift but that is hard to do when the facility is short staffed. Ms. Hatter stated that there is sufficient amount of food in the home for the residents.

According to Resident A, staff are getting better at changing her and checking on her but there were issues. Resident A stated that the issues isn't just with night staff, some day shift staff will make her wait to go to the bathroom because they are busy. Resident A stated that she has a hard time holding her bladder and doesn't like to wait. Resident A stated that the home is never dirty or smell bad. With regards to food, Resident A

stated that she never gets enough to eat because the portions are very small. The facility offers substitutions but it's just a peanut butter and jelly sandwiches. Resident A believes that the facility needs more staff.

According to Resident B, the homes provide adequate amount of food. The home is always clean, and she has no issues to report.

According to Mr. Aikens, he is aware of the concerns and is actively working to resolve the issues.

According to Ms. Gonzalez, management has instructed staff to conduct resident checks every hour instead of every two hours. However, Ms. Gonzalez stated that those checks do not include brief/bathroom checks. Ms. Gonzalez also stated that management has increased the number of notifications for staff in effort to keep them on task. Ms. Gonzales stated that the facility is restructuring staffing patterns to increase management for staff. Ms. Gonzalez doesn't believe the facility is short staffed, but the current staff is not using their time wisely and effectively. Ms. Gonzalez stated that the facility is looking to hire more qualified staff.

During the onsite investigation, I reviewed the staff schedule and the schedule was inaccurate. According to the schedule Ethelynn Sanford was supposed to work from 7am to 7pm, but she was not onsite. Ms. Hatter was not listed on the schedule, but she was working as a floater staff between this facility and their affiliated facility next door. Ms. McCaa was not listed on the schedule either, but I observed her at the facility. According to Mr. Aikens, she worked from 7am to 11am.

On 01/31/25, I conducted an exit conference with licensee designee Gavin Aikens to discuss the findings of this report. Mr. Aiken was not available, and a message was left for him.

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 there is sufficient information to conclude that the facility has violated this rule. According to staff Ms. Woodland, Ms. Hatter, licensee designee Mr. Aikens and Resident A, residents are not being taken to the restroom nor their briefs changed in a timely manner. Resident A stated that she struggles with holding her bladder and there are times that she is forced to while she

	waits for staff assistance. Staff stated they are understaffed and that often caused delays in providing care for the residents.
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:	Based upon the information gathered through my investigation, there is there is sufficient information to conclude that the facility has violated this rule. According to staff Ms. Woodland, Ms. Hatter, licensee designee Mr. Aikens and Resident A, residents are not being taken to the restroom nor their briefs changed in a timely manner. Resident A stated that she struggles with holding her bladder and there are times that she is forced to while she waits for staff assistance. Staff states that they are understaffed and they often caused delays in providing care for the residents. Ms. Woodland stated that she is concerned with being the only staff member on shift because during the time that she will be alone, she has to cook dinner, feed, clean, toilet and supervised the residents all at the same time. In addition to those tasks, staff are expected to shower residents, clean the home and do laundry. There are six residents in the home and one resident is bedbound and unable to feed or toilet herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.**

	(e) Any scheduling changes.
ANALYSIS:	During the onsite investigation, I reviewed the staff schedule and the schedule was inaccurate. According to the schedule, Ethelynn Sanford was supposed to work from 7am to 7pm, but she was not onsite. Ms. Hatter was not listed on the schedule, but she was working as a floater staff between this facility and their affiliated facility next door. Ms. McCaa was not listed on the schedule, but I observed her at the facility. According to Mr. Aikens, she worked from 7am to 11am.
CONCLUSION:	**VIOLATION ESTABLISHED**

***--p-0APPLICABLE RULE**	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered through my interviews, documentation reviews and onsite investigation, the facility did have the appropriate amount of food. I observed the refrigerator and freezer to be fully stocked with groceries. The home also had several cabinets with can goods and other foods. The home was well supplied with food. However, during the onsite investigation I observed that there was only one pack of steak for dinner, which is not enough to feed six residents adequately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During the onsite investigation, I observed the home to be clean and there were no concerns to report. The home did not have a foul smell or odor. Residents reported that the home is clean and they had no concerns to report.
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.

02/03/25

Eric Johnson Date
Licensing Consultant

Approved By:

02/10/2025

Denise Y. Nunn Date
Area Manager