GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Kathryn Simpson
Progressive Lifestyles Inc
1370 North Oakland Blvd
Suite 150
Waterford, MI 48327

RE: License #: AS630012724
Investigation #: 2025A0991012
Oakwood AIS/MR Group Home

Dear Kathryn Simpson:

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) 972-9136.

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

I. IDENTIFYING INFORMATION

License #:	AS630012724
Investigation #:	2025A0991012
Complaint Receipt Date:	03/03/2025
Investigation Initiation Date:	03/04/2025
Report Due Date:	05/02/2025
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	1370 North Oakland Blvd Suite 150 Waterford, MI 48327
Licensee Telephone #:	(248) 742-1378
Licensee Designee:	Kathryn Simpson
Name of Facility:	Oakwood AIS/MR Group Home
Facility Address:	832 W Oakwood Oxford, MI 48371
Facility Telephone #:	(248) 820-9274
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	06/06/2023
Expiration Date:	06/05/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 2/28/2025, Resident A had bruising around his right shoulder, under his clavicle and under his neck.	Yes

III. METHODOLOGY

03/03/2025	Special Investigation Intake 2025A0991012
03/03/2025	APS Referral Received from Adult Protective Services (APS)
03/04/2025	Special Investigation Initiated - Telephone Call to assigned Adult Protective Services (APS) worker, Jordan Walker
03/04/2025	Referral - Recipient Rights Sent to Office or Recipient Rights (ORR)
03/04/2025	Contact - Document Received Picture of Resident A's injuries
03/04/2025	Contact - Telephone call made Call to ORR worker, Rishon Kimble- not opening for investigation
03/04/2025	Contact - Telephone call made To program director, Kathryn Simpson
03/05/2025	Contact - Document Received Received individual plan of service, crisis plan, staff schedule
03/06/2025	Contact - Telephone call made To home manager, Nakia Stanley
03/07/2025	Contact - Telephone call made Left Message for Trinity Health social worker
03/07/2025	Contact - Telephone call made Left message for guardian

03/07/2025	Contact - Document Received Received incident report, prescription for Hoyer lift
03/11/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager, staff, and observed residents
03/12/2025	Contact - Telephone call made Left message for Trinity Health social worker
03/13/2025	Contact - Telephone call made To direct care worker- Donisha Johnson- voicemail not set up
03/13/2025	Contact - Telephone call made To direct care worker, Erica Jackson
03/13/2025	Contact - Telephone call received From direct care worker, Donisha Johnson
03/13/2025	Contact - Telephone call made Left message for direct care worker, Destanie Martin
04/01/2025	Contact - Telephone call received From APS worker, Jordan Walker- not substantiating abuse
04/16/2025	Contact - Telephone call made To home manager, Nakia Stanley
04/16/2025	Contact - Document Received Hospital discharge paperwork, in-service training form
04/17/2025	Exit Conference Via telephone with licensee designee

ALLEGATION:

On 2/28/2025, Resident A had bruising around his right shoulder, under his clavicle and under his neck.

INVESTIGATION:

On 03/03/25, I received a complaint from Adult Protective Services (APS), alleging that on 02/28/25, Resident A was found to have bruising around his right shoulder, under his clavicle, and under his neck. The bruising was not present on 02/27/25. Resident A is currently at Trinty Health Oakland Hospital. I initiated my investigation on 03/04/25 by

contacting the assigned APS worker, Jordan Walker. I received and reviewed a picture of Resident A's injuries. His right arm is in a sling. There was extensive purplish/red bruising around his collarbone. On 03/04/25, I made a referral to the Office of Recipient Rights (ORR). I spoke with ORR worker, Rishon Kimble. Ms. Kimble stated that the complaint was not opened for investigation by ORR, as there were no allegations of abuse. Resident A was found to have a compression fracture, which is not typically caused by abuse. Ms. Kimble stated that staff observed the bruising around his shoulder and had him sent to the hospital. Resident A is non-verbal and cannot report what happened. Staff did not witness a fall and do not have any explanation for the bruising.

On 03/04/25, I interviewed the Progressive Lifestyles program director, Kathryn Simpson. Ms. Simpson stated that she interviewed staff at the home regarding Resident A's injuries. None of the staff know what happened and they are adamant that Resident A did not fall. Staff stated that they would not have been able to pick Resident A up from the ground if he had fallen. Ms. Simpson confirmed that Resident A is non-verbal and does not ambulate. He is wheelchair-bound or stays in his bed. Resident A wears briefs and is fed through a PEG tube. Staff roll Resident A in bed to change his briefs. She stated that Resident A does have osteoporosis. It was reported to Ms. Simpson that Resident A broke his collarbone and part of his back. Resident A's guardian stated that they were compression fractures. Resident A is not mobile and requires a Hoyer lift for transfers. The Hoyer lift in the home is currently broken, so Resident A requires a two-person assist per his individual plan of service (IPOS). Ms. Simpson stated that they got a prescription for the Hoyer lift to be repaired on 02/06/25, but it is still not fixed. They followed up with Resident A's case manager, but she had not submitted the request for the Hoyer lift repair. Ms. Simpson stated that staff told her Resident A was not transferred from his bed on Thursday, 02/27/25, which was the day before he went to the hospital. Staff told Ms. Simpson that they did not get Resident A out of bed or change his shirt that day. He was only repositioned in bed. On Wednesday, 02/26/25, staff got Resident A out of bed and showered him. He appeared to be fine, and nobody reported any injuries at that time. On the morning of Friday, 02/28/25, the home manager lifted Resident A's arm to help change and reposition him. She saw bruising on Resident A's arm and neck. Ms. Simpson stated that all staff are aware that Resident A requires a Hoyer lift or a two-person assist. There are always at least two staff on shift. When staff are first hired, they complete hands-on training and shadow an experienced staff person, who shows them how to transfer, change, and reposition the residents.

On 03/06/25, I interviewed the home manager, Nakia Stanley, via telephone. Ms. Stanley stated that she has worked in the home for over two years. On Friday morning, 02/28/25, direct care worker, Destanie Martin, asked her to assist in hooking up Resident A's feeding pump. She went to Resident A's bedroom to assist with his feeding and noticed that he needed to be repositioned and changed. Resident A did not appear to be in clean clothes on Friday morning, as his shirt had dry skin on it. He was not positioned properly, as he was not pulled up or centered in his bed. When she went

to lift Resident A's arm to take his shirt off, she noticed that he had a long bruise from the bottom of his arm up to his shoulder blade. The top of Resident A's shoulder was swollen and there was bruising and swelling around his collarbone. Resident A did not appear to be in pain when she initially walked into the room, but when she lifted Resident A's arm, she could tell that he was in pain. When Ms. Stanley asked Destanie Martin what happened, Ms. Martin stated that she did not see any bruising on Resident A and it was not there the day before. She stated that Resident A had been very vocal throughout the day and night on Thursday. Ms. Martin called the other staff who worked with her on Thursday, Melissa Model, to see if she noticed anything. Ms. Model stated that she did not see any bruising on Resident A during her Thursday shift.

Ms. Stanley stated that she called the emergency pager and then called 911 to have Resident A transported to the hospital. She also notified Resident A's guardian. Resident A was transported to Trinity Hospital in Pontiac. Direct care worker, Erica Jackson, followed the ambulance to the hospital. Ms. Jackson told Ms. Stanley that they initially x-rayed the wrong arm. The hospital did a second round of x-rays and found that Resident A had a compression fracture on his spine and shoulder. She stated that none of the staff know what happened to Resident A. They do not have any ideas as to how the injury occurred. Ms. Stanley stated that Resident A was last transferred from his bed on Wednesday afternoon or evening when he was showered. Donisha Johnson, Erica Jackson, and Donna Parkin were working at that time. Donna Parkin and Donisha Johnson initially transferred Resident A to the shower bed. Donisha Johnson did not feel comfortable transferring Resident A back to his bed, so they asked Erica Jackson for assistance. Erica Jackson and Donna Parkin transferred Resident A from the shower bed to the bed.

Ms. Stanley stated that all staff are trained on how to properly transfer Resident A. Resident A requires a two-person assist if the Hoyer lift cannot be used. Ms. Stanley stated that they normally use the Hoyer lift for transfers, but it had been broken for about three to four weeks. She contacted Resident A's case manager, Mackenzie Weaver, regarding the Hoyer lift, but it had not yet been repaired or replaced. Ms. Stanley stated that Resident A was not transferred out of bed at all on Thursday, 02/27/25. She stated that it is not typical for Resident A to stay in bed for the whole day, but they were trying not to lift him unnecessarily due to the Hoyer lift being broken. She was not sure if Resident A's clothes were changed on Thursday. She stated that staff typically change Resident A's shirt throughout the day, as he has secretions and slobs, which makes his shirt wet. Staff are supposed to change Resident A's briefs and reposition him as least every two hours. They also check his feeding tube site, as there have been issues with leakage. Staff are supposed to document their checks in the log. Ms. Stanley stated that one staff can roll and change Resident A, but they usually have two staff provide assistance. They use the bed pads under Resident A to roll him and pull him up. She stated that they have to manually move Resident A in order to change his shirt, as he is not able to provide any assistance. All staff have been shown how to transfer and change Resident A. None of the staff have said that they were having issues with regards to repositioning, changing, or transferring Resident A. Ms. Stanley

stated that she did not believe any staff intentionally hurt Resident A, but she was concerned that nobody noticed the bruising.

I received and reviewed a copy of an incident report completed by the home manager, Nakia Stanley, dated 02/28/25. The information in the incident report is consistent with the information that Ms. Stanley provided during my interview with her.

I received and reviewed a copy of the staff log dated 01/22/25, which notes that Resident A's Hoyer lift is broken. The note states that Resident A is a two-person lift only. I received and reviewed an email sent by the home manager, Nakia Stanley, to Resident A's Easter Seals case manager, Mackenzie Weaver, on 02/06/25, with a prescription for a Hoyer lift dated 02/05/25 from McLaren Oakland Lake Orion Family Medicine.

I received and reviewed a copy of Resident A's individual plan of service (IPOS) and crisis prevention and safeguard plan effective 05/01/24. The crisis plan notes that Resident A is totally dependent on caregivers for all ADLs (activities of daily living) and requires a Hoyer lift to transfer. If unable to use the Hoyer lift, caregivers are to use a two-person transfer. Resident A also uses a wheelchair. The plan notes that the lift should be used daily due to total dependence for all transfers and pressure relief. Caregivers are to follow daily directions for lift maintenance to ensure proper functioning. The IPOS notes that caregivers are to contact the OT (occupational therapist) if problems exist with equipment- being torn, broken, or not functioning properly. The plan states that Resident A should be repositioned at least every two hours and his skin should be examined each time a position is changed, or at least every four hours. Resident A's IPOS notes that Resident A leans heavily over to the left side due to his scoliosis and asymmetrical skeletal development.

On 03/11/25, I conducted an unannounced onsite inspection at Oakwood AIS/MR Group Home. I interviewed direct care worker, Melissa Model. Ms. Model stated that she has worked at the home for approximately one year. She stated that she was working a 24-hour shift on Thursday, 02/27/25, until Friday, 02/28/25. She stated that she was doing transport on Friday morning and did not check on Resident A, as she was getting everyone else up. She stated that she did not notice any bruising or injuries on Resident A during her shift on Thursday, 02/27/25. They did not get Resident A out of bed on Thursday, as the Hoyer lift was broken. She stated that they have not been getting Resident A out of bed since January, due to not being able to use the Hoyer lift. She stated that they did change his belly band and t-shirt on Thursday. Resident A is not able to assist when staff change him. He has limited mobility on one side and his arm is stiff. Staff slowly pull his shirt up and over each arm. She did not notice any bruising on Resident A. Resident A did not appear to be in any pain on Thursday and nothing out of the ordinary happened during the shift. Ms. Model stated that she received a call from Destanie Martin on Friday morning. Ms. Martin told her that they found marks or bruises on Resident A. She told Ms. Martin that she did not know what happened. Ms. Model stated that she did not believe the injuries occurred during her

shift. She stated that somebody might have pulled up too hard when they were changing Resident A. Ms. Model stated that they checked and changed Resident A every two hours throughout her shift on Thursday. She always has another staff assist her when changing Resident A. She stated that she is not sure why she did not see any bruises on Resident A during her shift on Thursday, but she did not look over his whole body. Ms. Model stated that she was trained on how to properly transfer and change Resident A. Staff observe an experienced staff person during their first few days on the job. When they are comfortable, they begin providing hands on care. Ms. Model did not believe that anyone intentionally harmed or physically abused Resident A.

On 03/11/25, I interviewed direct care worker, Donna Parkin. Ms. Parkin stated that she has worked in the home since the beginning of November. She stated that she worked a 24-hour shift from 2:00pm on Tuesday, 02/25/25, until 6:00pm on Wednesday, 02/26/25. She worked on Thursday, 02/27/25, from 9:00am-5:00pm. She stated that on Wednesday, 02/26/25, Resident A was showered. Ms. Parkin stated that she was training Donisha Johnson, as Ms. Johnson had never showered Resident A before. They brought the shower bed into Resident A's room to transfer him from his bed to the shower bed. Ms. Parkin stated that Ms. Johnson did not feel comfortable transferring Resident A, so she went and got Erica Jackson to assist her. She stated that they were able to transfer Resident A to the shower bed without any issues. Ms. Parkin lifted Resident A's upper body and Ms. Jackson lifted his legs. She did not believe the injury occurred at that time. Ms. Parkin stated that Erica Jackson and Donisha Johnson transferred Resident A back to his bed following his shower on Wednesday. Ms. Parkin stated that staff told her Resident A slept through the night on Wednesday. She worked during the day on Thursday, but she was running transport and picked up staff, so she was out of the home for most of the day. Ms. Parkin stated that Resident A stayed in bed all day on Thursday. His belly band and shirt were changed on Thursday. She was not aware of anything out of the ordinary happening on Thursday. She stated that she did not observe any marks or bruises on Resident A during her shifts from 02/25/25-02/27/25, and he was not showing any signs of pain. She did not believe that Resident A was dropped, because staff would not be able to lift Resident A from the floor, as Resident A is heavy. Ms. Parkin stated that staff are trained on how to properly change and transfer Resident A. She stated that Resident A is stiff and one of his arms is fixated and does not move much. She did not believe that any staff intentionally caused harm to Resident A. She did not know how Resident A sustained his injuries.

During the onsite inspection, I reviewed the electronic staff logs where staff document if they have repositioned and checked Resident A. Staff were not consistently charting their checks and repositioning of Resident A. Charting was not completed for the midnight shift on 02/25/25. There was no charting completed from 02/26/25 until 10:00am on 02/27/28. Destanie Martin charted that she repositioned Resident A every two hours from 10:00am-10:00pm on 02/27/28. Melissa Model charted that she repositioned Resident A every two hours from 12:00am-8:00am on 02/28/25.

On 03/13/25, I interviewed direct care worker, Erica Jackson, via telephone. Ms. Jackson stated that she has worked in the home for almost two years. Ms. Jackson stated that she was working from 2:00pm on Wednesday, 02/26/25, until 9:00am on Thursday, 02/27/25. Nothing out of the ordinary happened during her shift. She stated that they usually use a Hoyer lift to transfer Resident A, but it was broken, so he requires a two-person assist. The Hoyer lift had been broken for more than a few weeks. Resident A was showered on Wednesday, 02/26/25. Ms. Jackson stated that Donisha Johnson and Donna Parkin showered Resident A. They called her in after the shower to assist with getting Resident A back into his bed from the shower bed. Ms. Jackson stated that Donisha Johnson did not feel comfortable lifting Resident A from the shower bed to his bed. They did not have any issues transferring Resident A back to his bed. Ms. Jackson lifted Resident A's legs and Ms. Parkin lifted Resident A under his arms. She stated that Resident A was not dropped. Ms. Jackson stated that they would have needed to call 911 if Resident A was dropped, because they would not be able to lift him from the floor. Resident A stayed in bed for the rest of her shift. He was checked every 15 minutes and changed every two hours. She stated that they changed Resident A's shirt on Thursday morning, and she did not observe any marks, bruises, or redness. Resident A did not appear to be in any pain and was not making any noises other than his usual sounds. There were no signs that he was in pain. Ms. Jackson stated that she came back to the home Friday morning. She stated that staff were discussing Resident A's injuries when she came on shift. She stated that she was giving another resident a shower when EMS (emergency medical services) came to the home. She followed behind the ambulance to accompany Resident A to the hospital. She stated that they initially x-rayed the wrong side, but after doing a second x-ray, it was discovered that Resident A's right shoulder was fractured. Ms. Jackson stated that she has no idea how Resident A was injured. She does not think anyone intentionally harmed Resident A and did not have any concerns about staff in the home. She stated that she was trained by seasoned staff on how to properly transfer and change Resident A.

On 03/13/25, I interviewed direct care worker, Donisha Johnson, via telephone. Ms. Johnson stated that she has worked in the home for four months. She was working from 2:00pm on Wednesday, 02/26/25, until 10:00am on Thursday, 02/27/25. Ms. Johnson stated that Resident A was showered on Wednesday, 02/26/25. He is normally transferred with the Hoyer lift, but the Hoyer lift was broken, so he required a two-person assist. Ms. Johnson stated that she was assisting Donna Parkin with transferring Resident A onto the shower bed. Ms. Parkin had Resident A's upper body, but she did not think Resident A was positioned properly, so they went and got Erica Jackson to assist with the transfer. Donna Parkin lifted Resident A's upper body, and Erica Jackson lifted his feet. Ms. Johnson stated that she and Donna Parkin showered Resident A. Resident A was calm during his shower and did not appear to be uncomfortable. He did not have any marks, bruises, or swelling. Ms. Parkin was going home directly after showering Resident A, so Erica Jackson took over caring for Resident A so that she could do his medications and feeding. Ms. Johnson stated that Erica Jackson transferred Resident A back to his bed from the shower bed on her own. She stated that

Erica Jackson is very experienced with Resident A. Ms. Johson stated that she did not lift Resident A at all on Wednesday, but she repositioned him in bed after dinner. She did not see any problems or issues. She stated that Resident A will let you know if there is an issue. He will yell or pull out his feeding tube. Resident A slept through the night on Wednesday. She did not change Resident A's clothes before she left on Thursday morning. Ms. Johnson was then off work until 03/02/25. Ms. Johnson stated that she has no idea what happened to Resident A. She did not believe Resident A was dropped, as staff would not be able to lift him from the ground. She stated that they would have to call 911 if that happened. Ms. Johnson stated that there are always two or three people on shift, but nobody knows what happened to Resident A.

On 04/01/25, I interviewed the assigned APS worker, Jordan Walker. Mr. Walker stated that he would not be substantiating abuse or neglect. The hospital indicated that Resident A's injuries were compression injuries, which could have happened at any time. There was no evidence of abuse. Resident A returned to the home following his discharge from the hospital. Resident A's guardian did not have any concerns about Resident A returning to the home.

On 04/16/25, I interviewed the home manager, Nakia Stanley, via telephone. Ms. Stanley stated that Resident A is doing well since returning to the home on 03/13/25. The occupational therapist came to the home and trained staff on how to properly position and transfer Resident A. A new Hoyer lift was delivered to the home, and staff are using it to transfer Resident A. Resident A's follow-up appointments have been scheduled.

I received and reviewed Resident A's after visit summary from Trinity Health. It notes that Resident A was hospitalized from 02/28/25-03/13/25 for a compression fracture of the L4 vertebra, sequela and a right humeral fracture. A compression fracture happens when the front part of a spinal bone breaks and collapses. A fall or other accident can cause it. A minor injury or moving the wrong way can cause a break if one has thin or brittle bones (osteoporosis). Resident A was referred for home health services upon discharge, including skilled nursing and occupational therapy.

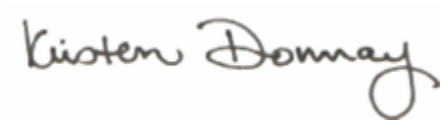
I received and reviewed an in-service/training record dated 03/19/25, which notes that the occupational therapist (OT) from Trinity Health completed a visit on 03/19/25. It notes that Resident A is a 61-year-old male with CP (Cerebral Palsy) spasticity. He was diagnosed with a fractured head of his right humerus and a compression fracture. Resident A's right upper extremity is spastic and contracted long term. He has osteoporosis and scoliosis. The OT demonstrated proper positioning, use of adaptive technology, self-care, and dressings to the home manager, Nakia Stanley. Ms. Stanley demonstrated these techniques independently. No further OT was recommended, as all instructions were completed. The other staff in the home signed the in-service training record to indicate that they were trained in these areas as well.

On 04/17/25, I conducted an exit conference via telephone with the licensee designee, Kathryn Simpson. Ms. Simpson stated that she would submit a corrective action plan to address the violations identified during the investigation.

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 information gathered through my investigation, there is sufficient information to conclude that Resident A's personal needs, including safety and protection, were not attended to at all times. Resident A was hospitalized from 02/28/25-03/13/25 for a compression fracture of the L4 vertebra and a right humeral fracture. Resident A is nonverbal and he is bed/wheelchair bound. He is completely dependent on staff for his activities of daily living, transfers, and repositioning. None of the staff in the home could provide an explanation as to how Resident A's injuries occurred. Resident A's Hoyer lift had been broken since 01/22/25 and staff were utilizing a two-person assist to transfer Resident A. Staff last transferred Resident A from his bed to give him a shower on 02/26/25. My interviews with staff provided inconsistent information with regards to who transferred Resident A to and from the shower bed, including direct care worker, Donisha Johnson, reporting that Erica Jackson transferred Resident A back to bed on her own. Staff did not consistently document in the log when they checked and repositioned Resident A on 02/25/25 and 02/26/25. The home manager, Nakia Stanley, stated that Resident A was not positioned properly, and his shirt appeared soiled when she went into his room on the morning of 02/28/25. She observed bruising on Resident A when she went to change his shirt, but none of the other staff reported seeing the injuries or knowing how they occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

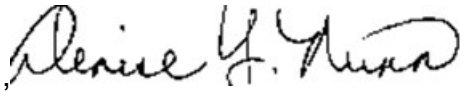
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



04/17/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



05/20/2025

Denise Y. Nunn Date
Area Manager