GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

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

RE: License #: AS500411266
Investigation #: 2025A0617008
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

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

I. IDENTIFYING INFORMATION

License #:	AS500411266
Investigation #:	2025A0617008
Complaint Receipt Date:	03/21/2025
Investigation Initiation Date:	03/21/2025
Report Due Date:	05/20/2025
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:	01/01/2025
Expiration Date:	12/31/2026
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has not seen her doctor or had her injections, causing hospitalization.	Yes

III. METHODOLOGY

03/21/2025	Special Investigation Intake 2025A0617008
03/21/2025	Special Investigation Initiated - Telephone TC to Licensee Designee
03/26/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the Progressions 22133 21 Mile facility. I interviewed staff Debra Rand, Beatrice Bessiake, Medical coordinator Lana Bey-Wright and Executive Director Stephan Stasiw. Resident A was hospitalized at the time of the onsite investigation.
03/26/2025	Contact - Telephone call made TC to Resident A Guardian
05/07/2025	Contact - Telephone call made TC with Resident A Guardian
05/07/2025	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:

Resident A has not seen her doctor or had her injections, causing hospitalization.

INVESTIGATION:

On 03/21/25, I received a complaint regarding the Progressions 22133 21 Mile facility. The complaint stated that one of the residents has not seen her doctor or had her injections, which cause her to go crazy and end up in the hospital.

On 03/26/25, I conducted an unannounced onsite investigation at the Progressions 22133 21 Mile facility. I interviewed staff Debra Rand, Beatrice Bessiake, Medical coordinator Lana Bey-Wright and Executive Director Stephan Stasiw. Resident A was hospitalized at the time of the onsite investigation.

According to Ms. Rand, Resident A receives a Haloperidol injection monthly at her doctor's office for her mental health disability. Ms. Rand stated that Resident A was currently hospitalized for a psychiatric evaluation due to having a mental health breakdown. Ms. Rand stated that Resident A has been very difficult and combative over the last six months.

According to medial coordinator Lana Bey-Wright, Resident A receives a Haloperidol injection once a month at the doctor's office. Ms. Bey-Wright stated that Resident A received her last shot on November 23, 2024. Ms. Bey-Wright stated that she did not find out that Resident A missed multiple appointments until February 2025. She stated that when she found out, she contacted Resident A's doctor to schedule an appointment. The earliest appointment that the doctor had available was 3/19/25. According to Ms. Bey-Wright, on the day of the appointment, Resident A was very combative and was refusing to go to the doctor. The facility contacted Resident A's guardian to see if she could encourage Resident A to go to cooperate and go to the doctor. Resident A was still being very combative, and EMS was called. Resident A was then admitted to the hospital for a psychological evaluation. Resident A remains hospitalized at the time of the onsite investigation. Ms. Bey-Wright stated that the Medication logs show that Resident A received her injection in December 2024, but that appointment was missed but staff still signed the log anyway. Ms. Bey-Wright could not provide an explanation as to why Resident A missed her injections for three consecutive months.

I conducted a mediation audit, and I observed that Resident A last received her Haloperidol injection on November 23, 2024. The following errors were found for Resident A Medication logs:

November 2024
- Glucerna Liquid Vanilla- not initialed /given on 11/10 (2pm), 11/11 (2pm), 11/22 (2pm), 11/30 (2pm)
- Levothyroxine tab 75mcg- not initialed/given on 11/3, 11/10, 11/17, 11/24

December 2024
- Aripiprazole tab 30mg- not initialed/ given on 12/26
- B Complex not initialed / given on 12/26
- Calcium Carbona TE tab 600mg not initialed/ given on 12/26
- Escitalopram tab 10mg not initialed/ given on 12/26
- Ferrous Sulf tab 325mg not initialed/ given on 12/26
- Fluticasone SPR 50mcg not initialed/ given on 12/26
- Glucerna Liquid Vanilla- not initialed /given on 12/16 (2pm), 12/19 (2pm), 12/26 (7am and 2pm), 12/30 (2pm)
- Haloperidol injection – was signed on 12/23 but the appointment was missed, and Resident A did not receive the injection.
- Haloperidol tab 10mg not initialed/ given on 12/26
- Levothyroxine 75mcg not initialed/ given on 12/8, 12/15, 12/22, 12/26, 12/29
- Loratadine tab 10mg not initialed/ given on 12/26
- Omeprazole cap 20mg not initialed/ given on 12/26
- Thera-M tab not initialed/ given on 12/26
- Vitamin D3 not initialed/ given on 12/26

January 2025
- Calcium Carbonate tab 600mg not initialed/ given on 1/13 (8pm)
- Glucerna Liquid Vanilla- not initialed /given on 01/2 (2pm), 01/9 (2pm), 01/13 (8pm)
- Haloperidol Injection- not initialed /given for the month of January 2025
- Levothyroxine 75mcg not initialed/ given on 01/5, 01/12, 01/19, 1/26

February 2025
- Glucerna Liquid Vanilla- not initialed /given on 02/1 (2pm), 2/2 (2pm), 02/23 (2pm)
- Haloperidol Injection- not initialed /given for the month of February 2025
- Levothyroxine 75mcg not initialed/ given on 2/2, 2/9, 2/16, 2/23

According to Executive Director Stephan Stasiw, Resident A had appointments scheduled for her injections on 12/20/24 and 1/8/25 but both appointments were missed. Mr. Stasiw was not aware of why the appointments were missed.

On 05/07/25, I interviewed Resident A's guardian. According to Resident A's guardian, on 03/19/25, the facility called her to talk with Resident A to try and calm her and convince her to go to the doctor for her appointment. Resident A's guardian stated that she was unsuccessful, and Resident A became even more agitated. Her

guardian requested that EMS be contacted. According to Resident A's guardian, Resident A was admitted to the hospital on 3/19/25 until 4/8/25. Resident A's guardian stated that she routinely participated in monthly meetings with the facility, and they never notified her that Resident A had missed her injections for several months. She stated that she was aware that Resident A missed her December appointment but was unaware about January and February's missed appointments. Resident A's guardian stated that she moved Resident A from the facility due to the lack of adequate care she was receiving. Resident A's last day in the facility was 3/19/25. Resident A's guardian stated that she is missing her social security card, Medicaid card and Medicare card that the facility cannot find. In addition, Resident A's guardian stated that the facility promised to reimburse Resident A for the $7,000+ that was stolen from her by a facility employee in 2023 (SIR# 2023A0617016) but has failed to do so.

On 05/07/25, 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 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the information gathered through my investigation, there is there is sufficient information to conclude that the facility has violated this rule. Resident A is prescribed Haloperidol injections 100mg/ml once a month to be given at her doctor's office. The facility did not schedule and take Resident A to receive her injections in December 2024, January 2025, February 2025 and March 2025. The facility could not provide an explanation as to why Resident A did not receive the injections.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based upon the information gathered through my investigation, there is there is sufficient information to conclude that the facility has violated this rule. I conducted a mediation audit, and I observed that Resident A last received her Haloperidol injection on November 23, 2024. The following errors were found for Resident A Medication logs: <u>November 2024</u> - Glucerna Liquid Vanilla- not initialed /given on 11/10 (2pm), 11/11 (2pm), 11/22 (2pm), 11/30 (2pm) - Levothyroxine tab 75mcg- not initialed/given on 11/3, 11/10, 11/17, 11/24 <u>December 2024</u> - Aripiprazole tab 30mg- not initialed/ given on 12/26 - B Complex not initialed / given on 12/26 - Calcium Carbona TE tab 600mg not initialed/ given on 12/26 - Escitalopram tab 10mg not initialed/ given on 12/26 - Ferrous Sulf tab 325mg not initialed/ given on 12/26 - Fluticasone SPR 50mcg not initialed/ given on 12/26 - Glucerna Liquid Vanilla- not initialed /given on 12/16 (2pm), 12/19 (2pm), 12/26 (7am and 2pm), 12/30 (2pm) - Haloperidol injection – was signed on 12/23 but the appointment was missed, and Resident A did not receive the injection. - Haloperidol tab 10mg not initialed/ given on 12/26 - Levothyroxine 75mcg not initialed/ given on 12/8, 12/15, 12/22, 12/26, 12/29 - Loratadine tab 10mg not initialed/ given on 12/26 - Omeprazole cap 20mg not initialed/ given on 12/26 - Thera-M tab not initialed/ given on 12/26 - Vitamin D3 not initialed/ given on 12/26 <u>January 2025</u> - Calcium Carbonate tab 600mg not initialed/ given on 1/13 (8pm) - Glucerna Liquid Vanilla- not initialed /given on 01/2 (2pm), 01/9 (2pm), 01/13 (8pm) - Haloperidol Injection- not initialed /given for the month of January 2025

	- Levothyroxine 75mcg not initialed/ given on 01/5, 01/12, 01/19, 1/26 <u>February 2025</u> - Glucerna Liquid Vanilla- not initialed /given on 02/1 (2pm), 2/2 (2pm), 02/23 (2pm) - Haloperidol Injection- not initialed /given for the month of February 2025 - Levothyroxine 75mcg not initialed/ given on 2/2, 2/9, 2/16, 2/23 The facility did not schedule and take Resident A to receive her injections in December 2024, January 2025, and February 2025. According to Ms. Bey-Wright, she was not aware that Resident A missed those appointments until February 2025 and at that time she reached out to Resident A's doctor. Therefore, Resident A missed her medication for 3 months before the facility contacted her doctor.
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.

05/07/25

Eric Johnson Date
Licensing Consultant

Approved By:

For 06/05/2025

Denise Y. Nunn Date
Area Manager