



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2026

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

RE: License #: AS580418331
Investigation #: 2026A0116041
Rosewood Home

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is fluid and cursive, with the first name "Pandrea" and last name "Robinson" clearly distinguishable.

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
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 #:	AS580418331
Investigation #:	2026A0116041
Complaint Receipt Date:	07/24/2026
Investigation Initiation Date:	07/28/2026
Report Due Date:	09/22/2026
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:	Rosewood Home
Facility Address:	5654 Rosewood Drive Monroe, MI 48161
Facility Telephone #:	(734) 230-2650
Original Issuance Date:	11/19/2024
License Status:	REGULAR
Effective Date:	05/19/2025
Expiration Date:	05/18/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/09/26, staff, Hallie Parsons, administered the wrong medication to Resident A. Resident A tried to tell her that those were not her medications. Ms. Parsons reportedly told Resident A "If you don't take these meds you're going to the psych ward."	Yes

III. METHODOLOGY

07/24/2026	Special Investigation Intake 2026A0116041
07/24/2026	Referral - Recipient Rights Received.
07/24/2026	Contact-Document received Received and reviewed ORR report.
07/28/2026	Special Investigation Initiated - On Site Client care coordinator, Shannon Johnson, Resident C, visually observed Resident B and reviewed Resident B's medication administration record (MAR).
08/10/2026	Contact - Telephone call received Voice message from Ms. Johnson informing me that Resident A was transferred to Stonecrest Center for inpatient psychiatric care.
08/17/2026	Contact - Telephone call made District Manager, Roger Heath.
08/18/2026	Contact - Telephone call made Staff, Hallie Parsons.
08/18/2026	Contact - Telephone call made Marriane Harold, Monroe County Guardian.
08/18/2026	Inspection Completed-BCAL Sub. Compliance
08/26/2026	Contact-Telephone call made Client Care Coordinator, Shannon Johnson
08/26/2026	Inspection Completed On-site Resident A and Ms. Johnson.

08/26/2026	APS Referral Made.
08/28/2026	Exit Conference Licensee designee, Janice Hurst.

ALLEGATION:

On 07/09/26, staff, Hallie Parsons, administered the wrong medication to Resident A. Resident A tried to tell her that those were not her medications. Ms. Parsons reportedly told Resident A “If you don’t take these meds you're going to the psych ward.”

INVESTIGATION:

On 07/24/26, I received and reviewed the investigative report from Monroe County Recipient Rights Investigator, Nina Brennan. Investigator Brennan substantiated the allegations pertaining to the medication error.

On 07/28/26, I conducted an unscheduled onsite inspection and interviewed client care coordinator, Shannon Johnson, reviewed Resident B’s medication administration record (MAR) and interviewed Resident C. Ms. Johnson reported that she was not present when the incident occurred, however, received a call from staff Hallie Parsons, who provided her version of events. Ms. Johnson reported that Ms. Parsons told her that Resident A “grabbed the wrong medications” and reported the cup of medications she ingested belonged to Resident B. Ms. Johnson reported that she contacted staff, Cynthia Plummer, and had her go to the home to transport Resident A to Urgent Care for evaluation. Ms. Johnson reported that Resident A was evaluated and sent home. Ms. Johnson reported she instructed staff to monitor Resident A throughout the night to make sure she did not show any signs of distress. Ms. Johnson reported that Resident A was fine and thankfully did not suffer any ill effects from the medication error.

Ms. Johnson reported on 07/10/26 when she arrived at work, she spoke with Resident A regarding the incident. Resident A told her she did not grab the wrong medication; the medication was given to her by Ms. Parsons. Resident A reported to Ms. Johnson that she told Ms. Parsons several times that the medications she was giving her were not hers and the medication cup had the initials of Resident B. Ms. Johnson reported that Resident A reported that she only took them because Ms. Parsons threatened to send her back to the psych ward if she didn’t take them. Resident A reported she was scared and did not want to go to the psych ward, so she took the medication. Ms. Johnson reported that she believes Resident A and

reported she has been consistent in her reporting of what occurred when she spoke with her guardian and recipient rights.

Ms. Johnson reported that the day after the incident Staff, Hallie Parsons, called off, and is currently on a personal leave. Ms. Johnson reported that if she returns, she will not be allowed to pass medications until she is retrained.

Ms. Johnson reported that on 07/23/26 Resident A started exhibiting some concerning behaviors and was threatening to kill and punch staff and attempted to jump out of the vehicle while it was moving. Ms. Johnson reported that Resident A is currently in the psychiatric ward at ProMedica Hospital and is in a mental crisis. Ms. Johnson reported that she would contact me once she returned home.

I interviewed Resident C and she reported that she likes living in the home and that the staff treat her nicely. Resident C reported that she gets the correct medication and reported being aware of the number of pills she should receive. Resident C reported that the day Ms. Parsons gave Resident A the wrong medications, she was playing around on her cell phone and not paying attention to what she was doing.

I reviewed Resident B's MAR and observed the four p.m. medications Resident A was administered on 07/09/26. Resident A was given Atorvastatin 40mg tablet, Calcium+D3 600-200mg tablet, Carbamazepin 200mg tablet, and Ferrous Sulfate 325mg tablet.

On 08/10/26, Ms. Johnson left a message reporting that Resident A was transferred from ProMedica to Stonecrest Center for continued inpatient psychiatric care.

On 08/17/26, I spoke with district manager, Roger Heath, and he reported that Resident A remains inpatient at Stonecrest and he is unaware when she will be discharged.

On 08/18/26, I interviewed staff Hallie Parsons, and she reported that she does not remember all of the specifics of the incident but denied that she threatened Resident A. Ms. Parsons reported that Resident A grabbed the wrong medication cup. Ms. Parsons reported that she was preparing to give Resident A and B their medication and before she could hand Resident A her medication, she had grabbed Resident B's medication and took it. I informed Ms. Parsons that she should only be preparing and administering one resident's medication at a time. Ms. Parsons agreed and reported that moving forward that is what she will be doing. Ms. Parsons reported that she immediately contacted Ms. Johnson and informed her of the incident. Ms. Parsons reported that staff, Ms. Plummer, came to the home and transported Resident A to urgent care. Ms. Parsons reported Resident A was examined and

released. Ms. Parsons reported she monitored Resident A until she got off at 11:30 p.m. and reported she was fine.

Ms. Parsons reported that she is back at work and is scheduled to complete her medication re-training through Monroe County Community Mental Health Authority on 08/19/26, she also reported that she was written up. Ms. Parsons reported that she is sorry that this happened and she does not want to lose her job.

On 08/18/26, I interviewed, Monroe County Guardian Marrienne Harold. Ms. Harold reported that she is aware of the incident and is thankful that Resident A did not suffer any ill effects from the medication error. Ms. Harold reported that Ms. Johnson called her and told her what happened as well as Resident A. Ms. Harold reported that Resident A is very smart, and she insisted that she told Ms. Parsons that the medications in the cup that she had given her were not hers. Resident A reported she and Ms. Parsons went back and forth about the medications before she eventually took them. Ms. Harold reported that she was surprised that Resident A gave in and took them. Ms. Harold reported that Resident A reported that she took them after Ms. Parsons threatened to send her to the psych ward. Ms. Harold reported that she believes the incident happened as told by Resident A and reported that Resident A has been consistent in her reporting. Ms. Harold reported that Resident A remains inpatient at Stonecrest Center and is still mentally struggling. Ms. Harold reported that she hopes Stonecrest keeps Resident A until she gets back to her baseline.

Ms. Harold reported that the staff at the home overall do a really good job with the residents and she does not have any concerns regarding the care provided in the home.

On 08/26/26, I conducted a scheduled onsite inspection and spoke with Ms. Johnson and attempted to interview Resident A. Ms. Johnson reported that Resident A returned on 08/21/26 and should not have been discharged as she is still in a mental crisis and has slept a total of 6 hours since she has been home. Ms. Johnson reported Resident A's guardian has been to the home daily and took Resident A to Urgent Care on 08/24/26. Ms. Johnson reported that they increased Resident A's trazadone in efforts to help her sleep. Ms. Johnson reported that it has not helped and Resident A is continuing to struggle mentally. Ms. Johnson reported that Resident A has an appointment today to see her psychiatrist, and she hopes they will be able to adjust her medications and hopefully that will stabilize her.

I attempted to interview Resident A but was unable to interview her. She was agitated and yelling and screaming at Ms. Johnson. Resident A then began mumbling and saying things that were unintelligible.

Resident A was interviewed by recipient rights investigator, Nina Brennan on 07/14/26. Investigator Brennan documented the interview in her investigative report dated 07/23/26. Investigator Brennen documented that Resident A reported that Ms.

Parsons gave her another resident's pills. Resident A reported that she told Ms. Parsons immediately that the medications she handed to her were not hers, but Ms. Parsons insisted she take it. Resident A reported Ms. Parsons said, "You take it, or their will be consequences." Resident A elaborated that Ms. Parsons told her she would be taken back to the "psych ward", so she took the medications. Resident A reported she was "scared to death" of going back to the "psych ward" so she just took the medications. Resident A reported that she went to the bathroom to brush her teeth, before bed, when Ms. Parsons came into the bathroom and instructed her to get dressed because she was going to urgent care.

On 08/28/26, I conducted the exit conference with licensee designee, Janice Hurst, and informed her of the findings of the investigation and the rules cited. Ms. Hurst reported an understanding and confirmed that Ms. Parsons had been written up and unable to pass medications until she completed her medication re-training.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the findings of the investigation, which included interviews of client care coordinator, Shannon Johnson, Monroe County Guardian, Marianne Harold, staff, Hallie Parsons, and review of the recipient rights investigative report, there is a preponderance of evidence to substantiate the allegations that staff, Hallie Parsons, gave Resident A Resident B's medication. Resident A and B's medication was not given as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks. (iv) Threats.

ANALYSIS:	Based on the findings of the investigation, which included interviews of client care coordinator, Shannon Johnson, Monroe County Guardian, Marianne Harold, and review of the recipient rights investigative report, there is a preponderance of evidence to substantiate the allegations that staff, Hallie Parsons, threatened Resident A when she attempted to refuse to take medication that she knew and verbalized was not hers.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



08/31/26

Pandrea Robinson
Licensing Consultant

Date

Approved By:



09/02/26

Ardra Hunter
Area Manager

Date