GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

Meaghan Hall
Progressive Lifestyles Inc
Suite 11A
6600 Highland Rd
Waterford, MI 48327

RE: License #: AS630408166
Investigation #: 2022A0605044
E Maple Rd

Dear Ms. Hall:

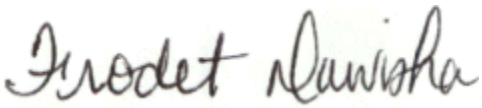
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630408166
Investigation #:	2022A0605044
Complaint Receipt Date:	09/09/2022
Investigation Initiation Date:	09/12/2022
Report Due Date:	11/08/2022
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	Suite 11A 6600 Highland Rd Waterford, MI 48327
Licensee Telephone #:	(248) 666-1365
Administrator:	Kathryn Simpson
Licensee Designee:	Meaghan Hall
Name of Facility:	E Maple Rd
Facility Address:	230 E Maple Rd Milford, MI 48381
Facility Telephone #:	(248) 820-9274
Original Issuance Date:	05/10/2022
License Status:	TEMPORARY
Effective Date:	05/10/2022
Expiration Date:	11/09/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 09/05/2022, Resident A was upset screaming that she "was supposed to go somewhere". After Assistant Home Manager (AHM), Elizabeth Holey, was unsuccessful in attempting to redirect Resident A, Resident A pushed AHM and AHM fell to the ground. Resident A tripped over AHM, and Resident A began screaming "she pushed me, she tackled me".	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2022	Special Investigation Intake 2022A0605044
09/12/2022	APS Referral Adult Protective Services (APS) denied referral.
09/12/2022	Special Investigation Initiated - Letter I emailed Oakland County Office of Recipient Rights (ORR) Katie Garcia who is investigating these allegations.
09/12/2022	Contact - Document Received Email from ORR Katie Garcia.
09/13/2022	Inspection Completed On-site I conducted an unannounced on-site investigation and interviewed direct care staff (DCS) Kathryn Stewart and observed Residents B, C, and D.
09/13/2022	Contact - Telephone call made Interviewed licensee Kathryn Simpson regarding allegations.
09/13/2022	Contact - Face to Face Interviewed Resident A and the Director of Vocational Services at the Learning Enrichment Center regarding the allegations.
09/27/2022	Contact - Document Sent Email to ORR Katie Garcia.
09/28/2022	Contact - Document Received Email received from ORR Katie Garcia.

09/28/2022	Contact - Telephone call made Interviewed the assistant HM Elizabeth Holey regarding the allegations.
09/28/2022	Contact - Telephone call made Left message for licensee designee Meaghan Hall.
09/28/2022	Contact - Document Sent Email sent to licensee designee Meaghan Hall.
10/11/2022	Exit Conference Conducted exit conference via telephone with licensee designee Meaghan Hall with my findings.

ALLEGATION:

On 09/05/2022, Resident A was upset screaming that she "was supposed to go somewhere". After Assistant Home Manager (AHM), Elizabeth Holey, was unsuccessful in attempting to redirect Resident A, Resident A pushed AHM and AHM fell to the ground. Resident A tripped over AHM, and Resident A began screaming "she pushed me, she tackled me".

INVESTIGATION:

On 09/09/2022, intake # 190062 was assigned for investigation. Adult Protective Services (APS) made the referral but will not be investigating. I initiated this investigation by emailing the referral to Oakland County Office of Recipient Rights (ORR) worker Kathleen Garcia.

On 09/12/2022, I contacted ORR worker Ms. Garcia who stated that she received the incident report (IR) from E. Maple Rd. Home and the incident report is very clear and consistent with the verbal testimony from the staff, that Resident A pushed the assistant home manager (AHM) Elizabeth Holey to the floor and that Resident A tripped over Ms. Holey and fell on top of Ms. Holey. Ms. Holey never pushed Resident A. Ms. Garcia stated she will not be substantiating her case.

On 09/12/2022, I received the IR dated 09/05/2022 at 8:30PM regarding the incident. The IR stated that Resident A was upset stating, she was supposed to go somewhere. AHM Elizabeth Holey tried to redirect her, but Resident A continued to yell. AHM went to walk away, and Resident A pushed AHM to the ground. Resident A took a step forward and tripped over AHM landing onto AHM on the floor. Direct Care Staff (DCS) Manasseh Mihelcich (Mary) went to help Resident A up off AHM. Mary checked Resident A for injuries and there were no marks found at the time. Resident A was redirected to her room to calm her down.

On 09/13/2022, I conducted an unannounced on-site investigation and interviewed direct care staff (DCS) Kathryn Stewart and observed Residents B, C, and D. Resident A was not present as she was at Learning Enrichment Center located in Novi. I attempted to interview Residents B, C, and D, regarding the allegations but they were unable to carry a conversation or provide any information regarding the incident.
I interviewed Ms. Stewart regarding the allegations. Ms. Stewart has been employed with Progressive Lifestyles for six years. She works all shifts. Ms. Stewart was not present during the incident on 09/05/2022. Ms. Stewart stated she heard that Resident A fell on top of the assistant home manager Elizabeth Holey. Ms. Stewart stated that is all she heard and that she does not believe that Ms. Holey pushed Resident A because, “Elizabeth would never put her hands on any resident.” Ms. Stewart stated she does not have any other information to provide.

The home manager (HM) Destiny Ranbarger called while I was at this home. I interviewed the HM via telephone regarding the allegations. The HM stated she was not present on 09/05/2022 when the incident occurred between Resident A and the AHM as the HM was off. The AHM told the HM that Resident A was having a behavior, the AHM tried to redirect, but it was not working. The AHM turned around to walk away to give Resident A sometime and that is when Resident A pushed the AHM to the floor. Then Resident A took a step forward and tripped over the AHM falling on top of the AHM. There was a direct care staff (DCS) present, Manasseh Mihelcich who goes by Mary was present. Mary helped Resident A up off the floor and then Mary checked Resident A all over and there were no injuries. The HM stated that the AHM did sustain injuries, bruises to both knees. The HM stated that the AHM would never push a resident or put her hands on a resident.

On 09/13/2022, I interviewed Resident A face-to-face at the Learning Enrichment Center in Novi. Resident A initially did not want to be interviewed but agreed to in the presence of the Director of Vocational Services, Jen Carpen. Resident A stated, “she says I fell on top of her. She put me to the ground and hurt my head.” Resident A stated that “she,” is the AHM Elizabeth Holey. Resident A stated, “I was disobeying her, then I pushed her, and she fell to the floor.” Resident A then stated, “I think Liz (Elizabeth Holey) is a liar.” When asked to provide more information, Resident A was unable to. Resident A then stopped talking and wanted to get up and leave. I concluded the interview.

I interviewed Ms. Carpen regarding the allegations. Ms. Carpen stated that Resident A never reported any incident to her regarding the AHM Elizabeth Holey. However, the AHM reported to Ms. Carpen last week that Resident A was having behavioral issues as Resident A was “snatching boxes and throwing them at staff.” The AHM told Ms. Carpen that Resident A pushed her. Ms. Carpen stated she has never observed any injuries on Resident A. Ms. Carpen stated that, “Resident A changes her mind often. One minute she says something and the next minute it’s something different.” Ms. Carpen stated Resident A is not consistent with her stories at times. Ms. Carpen stated she has no concerns about E. Maple Rd. home.

On 09/28/2022, I interviewed the AHM Elizabeth Holey via telephone regarding the allegations. Ms. Holey stated that on 09/05/2022, Resident A had been sleeping all day. Around 8:00PM, Resident A got off the phone after speaking with her mother. The AHM stated it was a good phone conversation between Resident A and her mother. The AHM then passed Resident A her 8PM medications and then Resident A returned to her bedroom. Around 8:30PM, Resident A came out of her bedroom screaming, saying “I’m not supposed to be here. I’m not supposed to be here.” The AHM tried to redirect Resident A, but Resident A was escalating so as the AHM tried to walk away, Resident A pushed the AHM down. The AHM stated, “Next thing I know is that Resident A was on top of me on the floor.” The AHM stated she never pushed Resident A nor did she put her hands on Resident A. The AHM stated she asked DCS Mary, “What happened?” Mary told the AHM that,” Resident A tripped over you and then landed on top of you.” Mary then helped Resident A up and checked Resident A for injuries and there were no injuries. The AHM stated once she saw Mary help Resident A up, the AHM went into the office and checked herself. The AHM stated both of her knees were bruised. The AHM stated she Resident A pushed her, the AHM fell onto both hands and knees to brace herself and that how she sustained the bruising. The AHM stated that Resident A’s mental health has been declining within the last year where Resident A now requires more care.

On 09/28/2022, I interviewed licensee designee Meaghan Hall regarding the allegations via telephone. Ms. Hall stated she is very familiar with Resident A and that Resident A “has been struggling a bit and is challenging at times where Resident A quires extra support.” Resident A has been showing signs of confusion and with the confusion, Resident A’s stories do not make sense. She has digressed with the amount of engagement at E. Maple Rd. Resident A refuses to go to workshop or do any activities at home. She does not want to take showers or do anything anymore. On 09/05/2022, Resident A had a behavior after the AHM passed Resident A’s 8PM medications. The AHM tried to redirect Resident A but Resident A stated, “No,” that she was not going to calm down and then Resident A became more elevated with the AHM. The AHM wanted to give Resident A some space, so the AHM went to walk away and that is when Resident A pushed the AHM to the floor. Then Resident A tried to take a step and tripped over the AHM falling on top of her onto the floor. Mary, the DCS who was present helped Resident A up and checked Resident A for any injuries, which Resident A did not have any. Ms. Hall stated that the AHM was injured as she had bruising on both knees. Ms. Hall stated that she heard from the HM that Resident A told the HM that “Liz pushed me.” Ms. Hall stated the AHM would never push a resident or put her hands on a resident. She stated that Resident A tripping on top of the AHM was an accident.

On 10/04/2022, I interviewed DCS Manasseh Mihelcich (Mary) via telephone regarding the allegations. Mary stated she was present on 09/05/2022 during the incident with Resident A. Mary was folding blankets in the living room when Resident A came out of her bedroom, was very anxious and kept saying, “I’m not supposed to be here. I’m supposed to go somewhere!” The AHM Elizabeth Holey tried to redirect Resident A, but Resident A was escalating and continued to scream, “I’m not supposed to be here!” The AHM told Resident A that she does not have to be anywhere right now and that it was

time for bed. Resident A was not being redirected so the AHM turned around to walk away and Mary saw Resident A push the AHM who fell to the floor. The Mary stated she saw Resident A take a step forward and then tripped over the AHM and fell on top of the AHM. Mary stated she helped Resident A up from on top of the AHM and checked Resident A for injuries. Mary stated that Resident A was not injured. Mary stated that Resident A then told Mary, “Liz pushed me.” Mary told Resident A, “Liz did not push you. You tripped over her and fell on top of her.” Mary stated she took Resident A back to her bedroom, passed her a PRN medication and stayed with Resident A in her bedroom until she calmed down. Mary stated that the AHM sustained bruising to both knees because of Resident A pushing her to the floor.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on my investigation, AHM Elizabeth Holey did not use any form of physical force towards Resident A. On 09/05/2022, Resident A was yelling and screaming. The AHM tried to redirect Resident A, but that was not working. The AHM then turned around to walk away and Resident A pushed the AHM onto the floor. Then Resident A took a step forward and tripped and landed on AHM on the floor. Resident A did not sustain any injuries, but the AHM had bruising on both knees. AHM and DCS Mary who was present both denied that AHM pushed Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the unannounced on-site investigation on 09/05/2022, I observed the garage door opened and Resident B sitting on the leather recliner covered with a blanket. There were no staff present. Resident B saw me and began walking towards me. Resident B was somewhat verbal, but unable to carry a conversation. I called out to staff as the door leading to the inside of the open was left wide opened, but there was not answer by staff. I walked to the front door with Resident B following me. I knocked several times, but no answer. I looked inside the window and observed a staff member later

identified as DCS Kathryn Stewart assisting Resident C onto her wheelchair. Ms. Stewart opened the door and stated she was the only DCS on shift. Ms. Stewart stated that she was not aware that Resident B had stepped outside into the garage because Ms. Stewart was helping Resident C in the bathroom. Ms. Stewart stated that Resident C usually sits in the garage, but stated, “staff usually go with her (Resident B).

On 09/13/2022, I contacted one of Progressive Lifestyles licensee designees Kathryn Simpson. Ms. Simpson initially reported that Resident B can be outside in the community by herself, but that Ms. Simpson would review Resident B’s crisis plan and get back to me. Ms. Simpson reviewed Resident B’s crisis plan and stated that Resident B must be supervised when in the community by staff. Ms. Simpson stated she will forward this information to licensee designee Meaghan Hall.

On 09/28/2022, I reviewed Resident B’s crisis plan completed on 09/13/2022 by Macomb-Oakland Regional Center (MORC) and it stated that Resident B should be in visual contact of staff at all times while in the community as Resident B does not always utilize a safe level of awareness and good judgment and due to possible behavioral outbursts.

On 10/11/2022, I conducted the exit conference with licensee designee Meaghan Hall with my findings. Ms. Hall stated she completed an in-service with all staff regarding Resident B’s IPOS/Crisis Plan and that there will be sufficient staff at all times at E. Maple Rd., to meet the needs of Resident B and all the other residents. Ms. Hall will be submitting a corrective action plan.

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 on my investigation, there was insufficient staff on duty at all times for the supervision and protection of Resident B on 09/05/2022. Resident B was observed to be sitting outside in the garage without any staff present. There was only one staff on shift, DCS Kathryn Stewart who was inside the home attending to Resident C who is wheelchair bound.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, Resident B's supervision and protection was not met as written in her assessment plan. According to Resident B's assessment plan dated 09/13/2022 completed by MORC, Resident B should be in visual contact of staff at all times while in the community as Resident B does not always utilize a safe level of awareness and good judgment and due to possible behavioral outbursts. There was only one staff present, DCS Kathryn Stewart who was inside the home attending to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

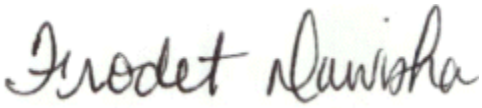
INVESTIGATION:

During the unannounced on-site investigation on 09/13/2022, I observed the garage door opened and the door leading to the inside of the home opened too. There was no standard screen in place during fly season. I observed several flies inside the home.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	During the unannounced on-site investigation on 09/13/2022, I observed the garage door opened and the door leading to the inside of the home opened too. There was no standard screen. I observed flies inside the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

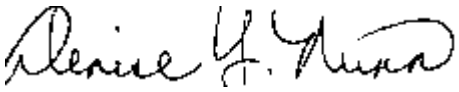
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



10/12/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:



10/12/2022

Denise Y. Nunn Date
Area Manager