



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

October 25, 2022

Debra Waynick  
RDP Rehabilitation, Inc.  
51145 Nicolette Dr.  
New Baltimore, MI 48047

RE: License #: AS500411265  
Investigation #: 2022A0617027  
Progressions 42192 Toddmark

Dear Ms. Waynick:

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.



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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,

A handwritten signature in black ink, appearing to be "EJ".

Eric Johnson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place, Ste 9-100

Detroit, MI 48202

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS500411265
<b>Investigation #:</b>	2022A0617027
<b>Complaint Receipt Date:</b>	07/26/2022
<b>Investigation Initiation Date:</b>	07/27/2022
<b>Report Due Date:</b>	09/24/2022
<b>Licensee Name:</b>	RDP Rehabilitation, Inc.
<b>Licensee Address:</b>	Suite 102 - 36975 Utica Road Clinton Township, MI 48036
<b>Licensee Telephone #:</b>	(586) 651-8818
<b>Administrator:</b>	Debra Waynick
<b>Licensee Designee:</b>	Debra Waynick
<b>Name of Facility:</b>	Progressions 42192 Toddmark
<b>Facility Address:</b>	42192 Toddmark Lane Clinton Township, MI 48038
<b>Facility Telephone #:</b>	(586) 267-5284
<b>Original Issuance Date:</b>	06/29/2022
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	06/29/2022
<b>Expiration Date:</b>	12/28/2022
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
<b>Facility does not have enough staff to cover all shifts.</b>	<b>Yes</b>
<b>There are residents who have their medication pre-packed.</b>	<b>No</b>
<b>Staff are not trained to pass medications.</b>	<b>No</b>

## III. METHODOLOGY

07/26/2022	Special Investigation Intake 2022A0617027
07/27/2022	Special Investigation Initiated - Telephone TC with Licensee Designee Ms. Waynick.
07/27/2022	Contact - Document Sent Email sent to Ms. Waynick
07/28/2022	Contact - Document Received Email received from Ms. Waynick. I received and reviewed the following: Resident Registry, Resident ID forms for all residents, List of Staff with job titles and phone numbers, staff medication trainings, staff schedules for the facilities Progression 42192 Toddmark, Progression 42200 Toddmark and Progression 42196 Toddmark for the month of July 2022.
08/01/2022	Inspection Completed On-site On 08/01/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Gavin Aikens, Kennedy Waelchi, Mercedes Parker and Resident A.
08/16/2022	Contact - Face to Face On 08/16/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Gavin Aikens, Ms. Waynick, Sabrina Brown and Resident E and F.
09/09/2022	Contact - Document Sent Email sent to Ms. Waynick
09/09/2022	Contact - Document Received Email received from Ms. Waynick.

09/09/2022	Exit Conference Held an exit conference with Ms. Waynick
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**ALLEGATION:**

**Facility does not have enough staff to cover all shifts.**

**INVESTIGATION:**

On 07/26/22, I received a complaint regarding the Progression 42192 Toddmark facility. The complaint stated that the facility was recently purchased by a new business, Progressions, within the last 6 months. The new company Progressions does not have enough staff. There is one person to 17 apartments, where residents live. There are three different apartment buildings that are supposed to be individually staffed. The new company makes one person handle each building alone and pass out medication. The one person that works alone pre-packs people's medication for the week. There are about 5-10 people who have their medication pre-packed. There is no way to verify if they are taking their medication or not. There is not a nurse with the company, so there is no one to train new staff with medication. Therefore, the newly hired staff are allowed to pass out medication after a few days of shadowing. There is also no one signing off on their training. Residents go to a game room to play games for entertainment. The building where the game room is located has a broken sliding glass door with no lock. Therefore, anyone can get in and go to any of the apartments inside. This is a security issue.

Progressions 42192 Toddmark is a small group home located in Clinton Township, MI with a capacity of six residents. Progressions 42200 Toddmark is made up of six resident apartments on two floors. In addition to Progressions 42192 Toddmark, the licensee RDP Rehabilitation, Inc. also owns and operates the neighboring AFC facilities Progressions 42196 Toddmark, and Progressions 42200 Toddmark, which are all located in the Canal Luxury Apartment Complex.

On 07/18/22, I received and reviewed the following: Resident Registry, Resident ID forms for all residents, List of Staff with job titles and phone numbers, staff medication trainings, staff schedules for the facilities Progression 42192 Toddmark, Progression 42200 Toddmark and Progression 42196 Toddmark for the month of July 2022.

According to the staff schedule for the facility Progressions 42192, I observed the following dates and times with no staff:

- 7/4 - 11pm to 7am
- 7/8 - 1:22pm to 2:58pm
- 7/20 - 12:55pm to 2:56pm
- 7/22 - 2:35pm to 2:59pm
- 7/25 - 2:03pm to 2:55pm

According to the staff schedule for the facility Progressions 42200, I observed the following dates and times with no staff:

- 7/4 - 3pm to 11pm
- 7/7 - 8pm to 11pm
- 7/9 - 11pm to 7am
- 7/13 - 7pm to 10:55pm
- 7/16 - 7pm to 7am
- 7/17 - 7pm to 11pm
- 7/19 - 7am to 2:55pm
- 7/21 - 3pm to 3:22pm
- 7/24 - 6:33am to 2:50pm
- 7/26 - 4pm to 11pm
- 7/28 - 4pm to 11pm
- 7/29 - 4pm to 11pm
- 7/30 - 4pm to 11pm
- 7/31 - 4pm to 11pm

According to the staff schedule for the facility Progressions 42196, I observed the following dates and times with no staff:

- 7/4 - 11pm to 7am
- 7/6 - 11:07pm to 7am
- 7/7 - 10pm to 7am
- 7/8 - 11:20am to 2:58pm
- 7/10 - 1:16pm to 2:57pm and 11:05pm to 7am
- 7/15 - 5:30am to 7am
- 7/19 - 3:00pm to 3:33pm
- 7/21 - 2pm to 2:57pm
- 7/23 - 7am to 10:10am
- 7/24 - 7am to 8:54am

On 08/01/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Gavin Aikens, Kennedy Waelchi, Mercedes Parker and Resident A.

When I arrived at the facility, I could not gain access inside. The facility is an apartment style facility and there was not a buzzer labeled for the staff office. I buzzed all the apartments and an aid of Resident A let me into the facility. The aid stated that she is a personal one on one staff for Resident A and she is not employed by the facility. She was unsure where staff were located as she and Resident A were in Resident A's apartment with the door closed. I then exited the facility and went next door to the affiliated AFC Progressions 42196 Toddmark. Progressions 42196 Toddmarks staff office is also where the program manager Gavin Aikens office is located. When I arrived

at Progressions 42196 Toddmark, I was greeted by staff Hannah Archer. Ms. Archer stated that Mr. Aikens was in the back in his office. I asked Mr. Aikens if anyone is scheduled to work at Progressions 42192 Toddmark and he stated that Kennedy Waelchi is working but stepped out for lunch. Mr. Aikens stated that he was on his way to that facility to cover but he had to get his lunch first. Therefore, at the time of the onsite investigation, Progressions 42192 Toddmark was unstaffed. According to Mr. Aikens, there is not a time where any of the three facilities are unstaffed nor is there a time where one staff is scheduled to cover multiple buildings.

According to Ms. Archer, when she works, there is always one staff at each building. However, on 07/31/22 there were only two staff to cover all three buildings during the morning shift.

During the onsite investigation, I interviewed staff Mercedes Parker. Ms. Parker stated that there have been multiple times that she had to cover multiple buildings on shift. She recently had to cover multiple buildings on 7/31/22. According to Ms. Parker from 7am to 3pm herself and Ms. Archer had to cover all three buildings. Ms. Archer was also the med passer for all three buildings during that time as well. Ms. Parker stated that the other affiliated Progressions facilities will often pull staff from these three facilities to cover open shifts elsewhere. According to Ms. Parker the midnight shift is most often short staffed.

During the onsite investigation, I interviewed staff Kennedy Waelchi. According to Ms. Waelchi, she has never had to cover multiple buildings. Whenever she works, there is sufficient staffing for all three facilities.

On 08/16/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Gavin Aikens, Ms. Waynick, Sabrina Brown and Resident E and F.

When I arrived at the facility, I could not gain access inside. The facility is an apartment style facility and there was not a buzzer labeled for the staff office. I buzzed all the apartments, but no one let me in. I then went to Progressions 42200 Toddmark and there was no staff there. I went to Progressions 42196 and staff Hannah Archer was present. Ms. Archer said that staff Ms. Brown was at the facility Progressions 42192, but she was in a virtual meeting. Ms. Archer called Ms. Brown to notify her to let me in the facility. I went back to Progressions 42192 and interviewed Ms. Brown. According to Ms. Brown, the facilities are sufficiently staffed, and she has not had to cover multiple buildings. Ms. Brown stated that the staff are expected to complete hourly checks on the residents in their apartments and document. When residents leave the facility, they are expected to sign in and out at one of the three facilities. Residents are also allowed to call one of the offices to notify staff that they are leaving.

During the onsite investigation, I interviewed Resident E. According to Resident E, there are no issues with staffing.

During the onsite investigation, I interviewed Resident F. According to Resident F, staff will come to her apartment and help her if needed. Staff last checked on her sometime the day before. There has never been a time when she needed staff and staff were not available. Staff is always in the building when needed according to Resident F. I observed Resident F's apartment to be dirty and in need of cleaning. Resident F has a cat in her apartment and there were several bowls of water and food on the floor throughout the apartment. The kitchen had several opened cans of cat food that was in need of being discarded.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.</b>
<b>ANALYSIS:</b>	Based on the information gathered through my interviews and documentation reviews, the Progressions facility failed to have adequate staffing to provide 24-hour care and supervision. By only scheduling one to two caregivers to cover three buildings leaves residents unattended. I observed a staff schedule for the month of July 2022. According to the staff schedules, there are a multitude of days that there were insufficient amounts of staff. On 07/04/22, there were no staff at this facility from 11pm to 7am on 07/05/22.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

- **There are residents who have their medication pre-packed.**
- **Staff are not trained to pass medications.**

**INVESTIGATION:**

On 07/18/22, I received and reviewed the medication training for the direct care staff. All direct care staff members medication training were completed. The direct care staff that trainings were reviewed and verified, matched the initials on the resident's medication logs.

During the unannounced onsite investigation on 08/1/22, I conducted medication reviews for Residents B, C and D. No medication errors were observed.



During the unannounced onsite investigation on 08/01/22, I interviewed staff Ms. Parker. According to Ms. Parker, the only medications that are prepacked by staff is when residents are going to be away from the facility at the time of their medication dose.

During the unannounced onsite investigation on 08/01/22, I interviewed staff Ms. Archer. According to Ms. Archer, she takes the medications out of the medication containers which are prepacked and put them into plastic travel bags only if a resident is going to be out of the facility during the time of a medication dose. If the resident is at the facility at the time the medication is required to be given, then the resident must come to Progressions 42196 Toddmark as all three facility medication carts are located in the staff office at Progressions 42196 Toddmark.

During the unannounced onsite investigation on 08/01/22, I interviewed Resident A. Resident A was observed commuting along with her personal one on one aid from her residence at Progressions 42192 Toddmark to Progressions 42196 Toddmark on a walker and with an oxygen tube. I interviewed Resident A and she stated that she had to come all the way to Progressions 42196 Toddmark to receive her PRN pain medication because staff will not bring the medication to her. She was observed crying and in visible pain.

According to Program director Mr. Gavin Aikens, he was instructed by licensee designee Ms. Waynick to have all residents come to Progressions 42196 Toddmark for all medications, no exceptions.

On 08/16/22, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Gavin Aikens, Sabrina Brown licensee designee Ms. Waynick, Resident E and F.

According to Resident F, she must go over to Progressions 42196 Toddmark to receive her medications. Resident F utilizes a walker while she walks, and it is often difficult for her to travel between buildings for medications. Resident F stated that her medications are only prepacked when she is going to be away from the facility during the time her medications are due to be passed. According to Resident F, she normally has no issues with her medication but approximately two weeks ago, she needed a prn for pain and the internet was down. Therefore, staff told her she could not receive her medication because they did not have access to her Medication Administration Record (MARS) as it is all electronic.

According to Ms. Archer, there was a day a few weeks ago that the internet was down around 9pm and staff did not have access to Residents MARS. Therefore, staff was unable to administer Resident F's prn pain medication. Ms. Archer is unaware of backup plan or procedure if the internet goes down.

According to Mr. Aikens and Ms. Waynick, in the event that the internet goes down, the facilities should have paper copies of the MARs for staff use. Neither could produce copies of the paper MARS at the time of the onsite investigation on 08/16/22.

On 09/09/22, I held an exit conference with licensee designee Debra Waynick to inform her the findings of the investigation. Mrs. Waynick understood the findings of the investigations and stated that she would provide a corrective action plan once the report was received.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.</b>
<b>ANALYSIS:</b>	Based on the information gathered through my interviews and documentation reviews, the facility complied with this rule. Staff and residents stated that staff only takes the medications out of the medication containers which are prepacked and put them into plastic travel bags when a resident is going to be out of the facility during the time of a medication dose.
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(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: (a) Be trained in the proper handling and administration of medication.</b>

<b>ANALYSIS:</b>	Based on the information gathered through my interviews and documentation reviews, the facility complied with this rule. I received and reviewed the medication training for the direct care staff. All direct care staff members medication training were completed. The direct care staff that trainings were reviewed and verified, matched the initials on the resident's medication logs.
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**IV. RECOMMENDATION**

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



9/9/22

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Eric Johnson  
Licensing Consultant

Date

Approved By:



10/25/2022

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Denise Y. Nunn  
Area Manager

Date