GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 12, 2022

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

RE: License #: AS630012724
Investigation #: 2023A0991006
Oakwood AIS/MR Group Home

Dear Ms. 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) 975-5053.

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 #:	2023A0991006
Complaint Receipt Date:	11/30/2022
Investigation Initiation Date:	11/30/2022
Report Due Date:	01/29/2023
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	1370 North Oakland Blvd. Suite 150 Waterford, MI 48327
Licensee Telephone #:	(248) 666-1365
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:	06/06/2021
Expiration Date:	06/05/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 11/28/22, the home manager, Nakia Stanley, passed another resident's medications to Resident A.	Yes

III. METHODOLOGY

11/30/2022	Special Investigation Intake 2023A0991006
11/30/2022	Special Investigation Initiated - Telephone Call to Rishon Kimble- Office of Recipient Rights (ORR)
11/30/2022	Referral - Recipient Rights Referred to Oakland County Office of Recipient Rights
12/02/2022	Contact - Telephone call made To home manager, Nakia Stanley
12/05/2022	Contact - Telephone call received From ORR worker, Rishon Kimble
12/08/2022	Inspection Completed On-site Unannounced onsite inspection
12/08/2022	Contact - Document Received Medication records, staff training/in-service verification, health care chronological
12/12/2022	Exit Conference Held via telephone with licensee designee, Kathryn Simpson

ALLEGATION:

Per incident report, on 11/28/22, the home manager, Nakia Stanley, passed another resident's medications to Resident A.

INVESTIGATION:

On 11/30/22, I received a complaint alleging that on 11/28/22, the home manager, Nakia Stanley, passed another resident's medications to Resident A. I reviewed a copy of the incident report dated 11/28/22, which indicates that staff prepared the medication and gave it to the wrong resident. Staff called the on-call number and notified poison control. Staff gave poison control the information they needed and followed the directions that were given. The incident report notes that staff will continue to monitor Resident A and will do three checks and five rights when passing medications. I initiated my investigation on 11/30/22 by contacting the assigned Office of Recipient Rights (ORR) worker, Rishon Kimble.

On 12/02/22, I interviewed the home manager, Nakia Stanley, via telephone. On 12/08/22, I conducted an onsite inspection with the assigned ORR worker, Rishon Kimble. The following information was gathered through my phone and in-person interviews with the home manager, Nakia Stanley. Ms. Stanley stated that she has worked at the home for three months, but she has worked for Progressive Lifestyles for 18 years. On 11/28/22, Ms. Stanley was passing morning medications. She sat the residents down for breakfast and was preparing their medications. She heard a bang in the back of the house, so she went to make sure everyone was okay. The other staff who was working, Lily Prince, was in the back of the house changing one of the residents and had dropped a case of wipes. Ms. Stanley returned to continue passing medications. She grabbed the medications that she had already prepared out of the cabinet, walked to Resident A, and administered the medications. Immediately after giving Resident A the medications, Ms. Stanley realized that she had passed the medications to the wrong resident. The medications that she administered to Resident A belonged to Resident B. The medications that were administered were: Loratadine tab 10mg, Lisinopril tab 10mg, Senna/Docusate tab 8.6-50mg, Sertraline tab 50mg, Omeprazole cap 20mg, and Vitamin D 50,000U cap. Ms. Stanley immediately contacted the Progressive Lifestyles on-call phone number and called poison control. Per their website, the Michigan Poison & Drug Information Center (MiPC) is part of the Emergency Medicine Department at Wayne State University School of Medicine. All calls to the MiPC are answered by physicians, nurses, pharmacists, and other health care professionals with specific training in toxicology.

Ms. Stanley stated that Mario (last name unknown) from Wayne State School of Medicine answered her phone call to poison control. She provided him with a list of the medications that Resident A incorrectly received, as well as a list of the medications that he is prescribed. Mario advised Ms. Stanley that it was safe to pass all of Resident A's prescribed 8:00am medications, other than Senna Tab 8.6mg and Oyster Shell CA 500+Vitamin D3, as Resident A received these medications with Resident B's

medications. Mario also advised Ms. Stanley to keep Resident A flushed with fluids, to monitor him for symptoms, and to seek medical attention if Resident A seemed lethargic or was not acting like himself. Ms. Stanley stated Resident A did not exhibit any negative symptoms throughout the day. Staff monitored him throughout the day, and he participated in his regular activities, including going to Meals on Wheels.

Ms. Stanley stated that they passed Resident B's 8:00am medications as prescribed on 11/28/22. They took pills from the end of the blister pack and contacted the pharmacy to get an extra dose of his medications, so that he did not miss any doses. Ms. Stanley stated that she completed her checks and followed the five rights of medication passing when she initially prepared the medications. She did not recheck the medications after she got distracted by the noise in the back of the house. She made a mistake and walked to the wrong resident. Ms. Stanley acknowledged that she should have conducted another check of the medications prior to administering them.

During the onsite inspection, I observed Resident A sitting at the kitchen table and interacting with staff. Resident A appeared to be happy and healthy. He was unable to answer questions due to limited verbal/cognitive abilities.

On 12/08/22, I interviewed Callen Fillio, one of the directors of Progressive Lifestyles. Ms. Fillio stated that the on-call supervisor contacted her and informed her of the medication error on 11/28/22. Ms. Fillio checked in with Ms. Stanley and verified that she contacted poison control. She advised Ms. Stanley and staff to keep a close eye on Resident A for the rest of the day. Ms. Fillio provided documentation which shows that Ms. Stanley completed a medication refresher training earlier this year on 02/07/22. Ms. Fillio also provided documentation showing that Ms. Stanley was in-serviced regarding the proper medication passing protocol and received a written warning on 11/29/22 due to the medication error.

During the onsite inspection, I observed Ms. Stanley as she conducted a simulated medication pass. She completed the proper checks and verified the five rights of medication passing. I reviewed Resident A's November 2022 medication administration record (MAR). The MAR indicates that Resident A did not receive Oyster Shell CA 500+Vit D3 or Senna Tab 8.6mg on 11/28/22 at 8:00am, as poison control advised staff not to pass these medications after Resident A received Resident B's medications. I reviewed Resident B's November 2022 MAR, which shows he received all medications as prescribed. I reviewed a note in Resident A's health care chronological (HCC) dated 11/28/22 which conveys the same information that Ms. Stanley provided during her interviews. I reviewed the medications for the residents in the home, no other discrepancies were noted.

On 12/12/2022, I conducted an exit conference via telephone with the licensee designee, Kathryn Simpson. Ms. Simpson stated that she was aware of the medication error and would submit a corrective action plan to address the violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B's medication was used by a person other than the resident for whom the medication was prescribed. The home manager, Nakia Stanley, got distracted by a noise in the home while passing morning medications on 11/28/22. When she returned to passing medications, she did not complete another check or go through the five rights of medication passing. She walked to wrong resident and administered Resident B's 8:00am medications to Resident A. Resident A received Resident B's Loratadine tab 10mg, Lisinopril tab 10mg, Senna/Docusate tab 8.6-50mg, Sertraline tab 50mg, Omeprazole cap 20mg, and Vitamin D 50,000U cap. Ms. Stanley contacted poison control and followed the instructions that were given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

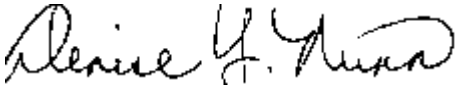
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

12/12/2022

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



12/12/2022

_____

Denise Y. Nunn Date
Area Manager