GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 7, 2023

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

RE: License #: AS630064520
Investigation #: 2023A0602007
Garretson CLF

Dear Mrs. 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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630064520
Investigation #:	2023A0602007
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/20/2023
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	1370 North Oakland Blvd, Suite 150 Waterford, MI 48327
Licensee Telephone #:	(248) 666-1365
Administrator:	Kathryn Simpson
Licensee Designee:	Kathryn Simpson
Name of Facility:	Garretson CLF
Facility Address:	5515 Garretson Oxford, MI 48371
Facility Telephone #:	(248) 820-9274
Original Issuance Date:	04/03/1995
License Status:	REGULAR
Effective Date:	07/30/2021
Expiration Date:	07/29/2023
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/19/2022, staff member Mark Bell left his shift early leaving four residents home alone. When staff Darlene Marley arrived, she found Resident A and Resident B locked in a room together as both are elopement risks.	Yes
Resident B had bruising on his eye and ear and his ear was swollen. Unknown how injuries occurred. Resident B was taken to urgent care and then McLaren Hospital.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A0602007
11/22/2022	Special Investigation Initiated - On Site Interviewed staff and observed residents.
11/22/2022	Contact – Document received Received requested documents from the home manager, Wesley Durmon.
12/06/2022	Contact – Telephone call made Message left for staff member, Mark Bell.
01/10/2023	Contact – Telephone call made Spoke with staff member, Denise Marley.
01/10/2023	Contact – Telephone call made Spoke with staff member, Shunteria Young
02/02/2023	Contact – Telephone call made Spoke with Resident A's Family Member 1
02/02/2023	Contact – Telephone call made Spoke with Resident B's Family Member 2
02/02/2023	Contact – Telephone call made Spoke with Resident C's Family Member 3
02/02/2023	Contact – Telephone call made Spoke with Resident D's Family Member 4

02/02/2023	Contact – Telephone call made Spoke with the home manager, Wes Durmon; requested additional documents.
02/02/2023	Contact – Document received Received requested documents.
02/02/2023	Exit Conference Message left for the licensee designee, Kathryn Simpson

ALLEGATION:

- **On 11/19/2022, staff member Mark Bell left his shift early leaving four residents home alone. When staff Darlene Marley arrived, she found Resident A and Resident B locked in a room together as both are elopement risks.**
- **Resident B had bruising on his eye and ear and his ear was swollen. Unknown how injuries occurred. Resident B was taken to urgent care and then McLaren Hospital.**

INVESTIGATION:

On 11/21/2022, a complaint was received and assigned for investigation alleging that on 11/19/2022, staff member Mark Bell left his shift early leaving four residents home alone. When staff member Darlene Marley arrived, she found Resident A and Resident B locked in a room together as both are elopement risks. Resident B had bruising on his eye and ear and his ear was swollen. Unknown how injuries occurred. Resident B was taken to urgent care and then McLaren Hospital.

On 11/22/2022, I conducted an unannounced on-site investigation at which time I interviewed staff member Kaitlyn Seirmarco and observed Resident A and Resident D. Ms. Seirmarco stated she was not working the day the incident occurred and had no firsthand knowledge of what occurred. The only information she had was what wash told to her by others. Ms. Seirmarco advised that I speak with staff member, Denise Marley, Mark Bell and Sunteria Young as they were involved in the incident and can provide firsthand information.

On 11/22/2022, I observed Resident A pacing back and forth throughout the home before sitting down at the kitchen table for a snack. I was unable to obtain any information from Resident A as he is non-verbal.

On 11/22/2022, I observed Resident D sitting in a chair in the living room of the home. Although Resident D is verbal, he was unable to provide any information regarding the incident.

On 11/22/2022, I requested and received a copy of Resident A's Individual Plan of Service – IPOS. According to the plan, Resident A suffers from PICA, has a history of smearing, is an elopement risk, and requires visual supervision every five minutes when staff are not in the same room with him. Staff must not leave until their replacement has arrived.

On 1/10/2023, I interviewed staff member Denise Marley by telephone. Ms. Marley stated she is a senior home manager for two other licensed Progressive Lifestyles Inc homes. She also works as a back-up on-call staff to pick up extra shifts when there are shifts that need to be covered. On 11/19/2022, Ms. Marley stated she was called in to work at the Garretson home because a dayshift staff had called in. Staff member Mark Bell called the on-call pager and stated he had an emergency and had to leave. Mr. Bell was told that Ms. Marley was on her way, and he agreed to stay until she arrived at 10 am. Ms. Marley arrived at the home at 10 am and found no staff on shift. Mr. Bell and the other staff member who was on shift with him, Shunteria Young were gone. The residents were home alone. As Ms. Marley was walking through the home checking on the residents, Resident A's parents arrived at the home. They asked her where the other staff members were, and she informed them she did not know because she had just arrived herself. Resident A's parents went to his room and found him pacing around the room while Resident B was lying in bed. There was a device on the doorknob on the inside of the bedroom door preventing it from being turned/opened. Resident C was awake but lying in his bed and Resident D was asleep in his room. Ms. Marley stated she observed that Resident B's left ear and eye were bruised, and his left ear was swollen. Ms. Marley contacted the on-call pager and informed the company administration of her findings. Staff member Matt Sekelsky arrived at the home around 10:30 am. Ms. Marley later found out that Mr. Sekelsky was scheduled to relieve Mr. Bell at 9 am but called the on-call pager and stated the battery in his car had died and he was waiting for his grandfather to pick him up and drop him off at the home. Mr. Bell was made aware of this. Resident B was taken to urgent care and then to McLaren Pontiac Hospital where he was treated for cauliflower ear (when skin separates from the outer ear and fluid buildup). His ear was drained, and he was returned to the home.

On 01/10/2023, I interviewed staff member, Shunteria Young by telephone. Ms. Young stated at the time the incident occurred she had only been working in the home for about three months. On 11/19/2023 she worked with Mr. Bell and left when her shift was over at 9 am. When she left, Mr. Bell was still at the home and there were no issues with any of the residents. She said she did not observe any marks or bruises on Resident B. About 30 minutes after she left the home, she received a call from Mr. Bell informing her that he had an emergency with his daughter and needed to get to the hospital. Mr. Bell stated the on-call administrator instructed him to tell her that she needed to remain at the home. Ms. Young stated she contacted the on-call administrator and was informed that Mr. Bell was not instructed to call her and tell her to remain in the home. Ms. Young said she was not aware that she had to wait until the oncoming staff arrived before she could leave her shift even if there was a staff member still on shift. Ms. Young was transferred to another home operated by Progressive Lifestyles.

On 02/02/2023, I interviewed Resident A's parents by telephone and was informed when they arrived at the home on 11/19/2022 to pick their son up for an outing, there was one staff member who had just arrived. The residents had been left home alone for an unknown amount of time. When Resident A's parents went into Resident A's room, they found him pacing around in the room and Resident B awake and lying in the bed. There was a child safety device taped on the doorknob on the inside of the door. It was apparent this was done to prevent Resident A and Resident B from exiting the room as they both are elopement risks. Resident A was clean and dressed and was not harmed. Resident A's parents stated they are very involved in their son's life and are at the home at least twice each week. Resident A has resided in the home for seven years now and the provider has always been forthcoming with them. They were informed that Mr. Bell no longer works for the company.

On 02/02/2023, I interviewed Resident B's mother by telephone and was informed that the provider made her aware of the incident. She said although Resident B has a history of hitting himself when he gets upset, she believes Resident A hit him while they were locked in the room together causing the bruise on his eye. Resident B's mother went on to state that her son has had issues with his ear in the past and does not believe the swelling of his ear was a result of him being left home alone. She now FaceTime her son daily as a comfort to herself and to him.

On 02/02/2023, I interviewed Resident C's father by telephone and was informed that he and his wife were contacted immediately after the incident occurred. The provider was very forthcoming with what had transpired at the home. Resident C's parents are very involved in his life and are at the home at least once each week. According to Resident C's father, there was no harm caused to his son.

On 02/02/2023, I interviewed Resident D's sister who is also his legal guardian. Resident D's sister stated the provider notified her of the incident the next day. She was informed that Resident D slept through the incident and there was no harm caused to him.

On 02/02/2023, I received and reviewed a copy of Resident B, Resident C, and Resident D's IPOS. According to Resident B's plan, he has a long history of elopement and must be within eyesight at all times during awake hours. Staff cannot leave until their replacement has arrived. Resident C's IPOS documents that staff must always know his whereabouts and remain within listening range due to his history of leaving the home in the past. Resident D's IPOS documents that staff must be aware of his whereabouts and be within hearing distance along with providing visual checks every 30 minutes.

I was unable to interview or observe Resident B and Resident C as they were not home at the time the unannounced on-site investigation was conducted. According to their IPOS's, Resident B and Resident C are both non-verbal.

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: (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	Based on the information obtained from Ms. Marley and Resident A's parents, there is sufficient information to determine that Resident A and Resident B were confined in Resident A's bedroom with the use of a child safety device attached to the doorknob on the inside of Resident A's bedroom door. According to Ms. Marley and Resident A's parents, on 11/19/2022 when they arrived at the home, they observed Resident A and Resident B confined to Resident A's bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A, Resident B, Resident C, and Resident D were not provided with protection and safety on 11/19/2022 as Mr. Bell and Ms. Young left their shift prior to the arrival of the oncoming staff, leaving the residents home alone. As documented in Resident A, Resident B, Resident C, and Resident D's IPOS, staff must be within eyesight or listening range of the residents at all times. Based on the information obtained from Ms. Young, Ms. Marley, and Resident B's mother, there is insufficient information to determine that the bruising on Resident B's left ear and left eye and swelling of the left ear was caused by Resident A.

	According to Ms. Young, she did not observe any marks or bruises on Resident B prior to her leaving her shift on 11/19/2022 at 9 am. According to Ms. Marley, on 11/19/2022 around 10 am, she observed some light bruising in the corner of Resident B's left eye and left ear as well as swelling of his left ear. Resident B's mother stated Resident B has had issues with his left ear in the past and she does not believe the swelling or bruising had anything to do with him being confined to Resident A's bedroom. She stated Resident B has a history of hitting himself when he becomes angry, but she believes Resident A may have hit him causing the bruise on his left eye.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/10/2023, I interviewed Ms. Marley by telephone. Ms. Marley stated on 11/19/2022 when she arrived at the home around 10 am, the home felt cold. She checked the thermostat and observed that the heat had been turned off and the thermostat had a reading of 60 degrees Fahrenheit.

On 02/02/2023, I interviewed Resident A's parents by telephone. Resident A's parents stated on 11/19/2022 when they arrived at the home, the heat was off, and the temperature was at 60 degrees Fahrenheit.

On 02/02/2023, I left a message for the licensing designee, Kathryn Simpson requesting a return call to conduct an exit conference.

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for

	variations from the temperatures and requirements specified in this rule.
ANALYSIS:	Based on the information obtained from Ms. Marley and Resident A's parents, there is sufficient information to determine that on 11/19/2022 the temperature in the home was below the required heating range of 68 and 72 degrees Fahrenheit. According to Ms. Marley and Resident A's parents when they arrived at the home on 11/19/2022, the heat had been turned off and the thermostat had a reading of 60 degrees Fahrenheit.
CONCLUSION:	**VIOLATION ESTABLISHED**

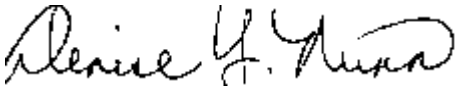
IV. RECOMMENDATION

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

02/06/2023

Cindy Berry Date
Licensing Consultant

Approved By:



02/07/2023

Denise Y. Nunn Date
Area Manager