



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2023

Tina Dorman
RDP Rehabilitation, Inc.
51145 Nicolette Dr.
New Baltimore, MI 48047

RE: License #: AS500411265
Investigation #: 2023A0617021
Progressions 42192 Toddmark

Dear Ms. Dorman:

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.

A previous recommendation for provisional license was made in Renewal Inspection Report dated 02/16/23, which remains in effect.

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', written in a cursive style.

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500411265
Investigation #:	2023A0617021
Complaint Receipt Date:	02/24/2023
Investigation Initiation Date:	02/27/2023
Report Due Date:	04/25/2023
Licensee Name:	RDP Rehabilitation, Inc.
Licensee Address:	Suite 102 36975 Utica Road Clinton Township, MI 48036
Licensee Telephone #:	(586) 651-8818
Administrator:	Tina Dorman
Licensee Designee:	Tina Dorman
Name of Facility:	Progressions 42192 Toddmark
Facility Address:	42192 Toddmark Lane Clinton Township, MI 48038
Facility Telephone #:	(586) 267-5284
Original Issuance Date:	06/29/2022
License Status:	TEMPORARY
Effective Date:	06/29/2022
Expiration Date:	12/28/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
Staff are sleeping during the midnight shift and no one can account for the residents.	Yes

III. METHODOLOGY

02/24/2023	Special Investigation Intake 2023A0617021
02/27/2023	Special Investigation Initiated - Letter Email sent to LD Ms. Waynick
03/02/2023	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Wilbert Garner, Mercedes Parker, Program manager Melissa DiFronzo, Resident A and Resident B.
03/29/2023	Contact - Telephone call made I conducted an interview with Mr. Huckabee
03/29/2023	Contact - Telephone call made I conducted an interview with an anonymous resident of the facility
03/29/2023	Exit Conference I held an exit conference with licensee designee Tina Dorman to inform her the findings of the investigation.
04/13/2023	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed Program Manager Melissa DiFronzo, licensee designee Ms. Tina Dorman and Resident F.

ALLEGATION:

Staff are sleeping during the midnight shift, and no one can account for the residents.

INVESTIGATION:

On 02/24/23, I received a complaint regarding the Progression 42192 Toddmark facility. The complaint indicated that staff are sleeping during the midnight shift and no one can account for the residents.

On 03/02/23, I conducted an unannounced onsite investigation at the facility. I interviewed staff Hannah Archer, Wilbert Garner, Mercedes Parker, Program manager Melissa DiFronzo, Resident A and Resident B.

According to Mr. Garner, Resident C has made complaints regarding staff Tarmaine Huckabee sleeping and playing video games during the midnight shift. Mr. Garner stated that Resident C has been very upset with Mr. Huckabee lately due to his poor work performance. Mr. Garner stated that he is unaware of any other staff sleeping. Mr. Garner showed me the staff work phone which included text messages from Resident C. One of the messages from Resident C to staff indicated that staff are unhelpful, sleep and play video games during their shift instead of assisting the residents.

During the onsite investigation on 03/02/23, staff Wilbert Garner could not account for all of the residents in the facility. Mr. Garner stated that residents are supposed to come to the staff office to sign in and out of the facility. Mr. Garner provided me with a sign in and out folder. The folder did not indicate that Residents C, D, and E were not in the facility. Mr. Garner took me to Resident D's apartment, and we waited several minutes while he knocked for Resident D to let us in. After approximately 5 minutes, Mr. Garner went back into the staff office and retrieved the spare keys to Resident D's apartment. We entered Resident D's apartment and discovered that Resident D was not home. Mr. Garner stated that Resident D has a car and sometimes will leave the facility and not tell staff. Mr. Garner was unaware of Resident D's whereabouts and stated that he will try and reach out to her to see where she was. Ms. DiFronzo called Resident D's cell phone and Resident D stated that she was at work.

Mr. Garner then took me to Resident C's apartment. Mr. Garner stated that he didn't believe Resident C was home because she should be at work, but he wasn't 100% sure. We inspected Resident C's apartment and discovered a male sleeping in the home. The male identified himself as Resident C's son and he was there visiting, although Resident C was not home. Mr. Garner stated that he was unaware that the male was in the facility. He did not know how long he had been there. Mr. Garner stated that Resident C's son often comes to visit but he had no log to show when Resident C's son enters and exits the facility.

According to Ms. Archer, she has not been made aware of any staff sleeping. Ms. Archer stated that none of the residents from any of the three facilities has made complaints to her.

According to Ms. Parker, Resident C has made complaints regarding staff Tarmaine Huckabee sleeping and playing video games during the midnight shift. Ms. Parker stated that there have been times where residents have sent requests for assistance to Mr. Huckabee during his shift, but he doesn't always respond.

According to Resident A, he is unaware of any staff sleeping during the night shift or any other shift. Resident A stated that he had no concerns to report regarding the food or menu that has been provided.

According to Resident B, Mr. Huckabee doesn't do any work when he's there. He often sleeps and it is hard to wake him up. Resident B stated that she called him one night for a PRN medication for pain and he was unavailable due to being sleep. She stated that she had to call repeatedly to get him awake to answer.

According to Program manager Ms. DiFronzo, she was unaware of any complaints of staff sleeping on shift. Ms. DiFronzo stated that she will look into the complaints, but she has not had any issues or concerns regarding Mr. Huckabee's performance.

On 03/29/23, I conducted an interview with Mr. Huckabee. Mr. Huckabee stated that when he first got hired at the facility, he was told he was allowed to bring his video game to work. Mr. Huckabee stated that he stopped bringing his game to work about a month ago. Mr. Huckabee denies ever sleeping on the job but did admit to dosing off before. Mr. Huckabee stated that he is unaware of any resident issues regarding staff sleeping or being unhelpful.

On 03/29/23, I conducted an interview with an anonymous resident of the facility. The anonymous resident stated that she had concerns about the facility but feared that she would be retaliated against for speaking on the issues. The resident stated that staff often sleeps on the midnight shift and offers very little assistance or support to the residents. The resident stated that several times, staff has cooked for themselves during the night shift and set off smoke alarms. Staff failed to respond to the alarms or alert residents on what was happening. The resident stated that staff do not follow the menus or provide nutritious meals for the residents. According to the resident, she called staff one evening for dinner because she did not feel like cooking and all her food in her apartment was frozen. Staff never responded to her request for dinner for several hours. When staff did respond they offered her the same food from lunch. The resident stated that there is food in the staff office, but certain staff refuse to cook it but will cook for themselves. The resident also stated that staff do not assist with cleaning resident apartments. The resident stated that she is scared for her safety as staff are not often aware of who is in the facility. Staff often staff in the staff apartment and are unaware of what is going on throughout the building.

On 03/29/23, I held an exit conference with licensee designee Tina Dorman to inform her the findings of the investigation. Mrs. Dorman understood the findings of the investigations and stated that she would provide a corrective action plan once the report was received.

On 04/13/23, I conducted an unannounced onsite investigation at the facility. I interviewed Program Manager Melissa DiFronzo, licensee designee Ms. Tina Dorman and Resident F.

When I arrived at the facility, I buzzed for the staff office apartment to let me in but no one responded. I then buzzed all of the apartments and Resident F let me in. I went to the staff office which was unlocked but I was unable to locate staff.

During the onsite investigation, I interviewed Resident F. According to Resident F, she is unaware of where staff was. She was not aware that staff was not in the building. Resident F stated that she usually has a personal one on one aid but not the day of the onsite inspection. According to Resident F, she has no issues or concerns with regards to staff sleeping on shift. Resident F stated that she has no concerns about the food being provided to her. As of a few weeks ago, staff now prepares three meals a day for the residents. Resident F stated that staff are following the menu.

Since I was unable to locate staff, I knocked on all of the apartments to see if any other resident was home and there was not. I went next door to the affiliated AFC Progressions 42196 Toddmark and interviewed Program Manager Ms. DiFronzo. According to Ms. DiFronzo, she was covering both buildings because staff from Progressions 42192 Toddmark had to take one of the residents to the doctor. Ms. DiFronzo stated that there were two additional staff working but they went grocery shopping.

During the onsite investigation I interviewed licensee designee Ms. Dorman via telephone. According to Ms. Dorman, there should've been enough staff to cover all three buildings. She is unsure why two staff went grocery shopping because she orders the groceries and have them delivered to the facilities. Ms. Dorman stated she understood that facilities should be properly staffed at all times when residents are home.

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 gathered through my interviews and documentation reviews, there is sufficient information to conclude that the residents are not being provided supervision and protection at all times. Several residents report that staff sleep during the night shift and are unavailable to assist the residents. Staff Mr. Huckabee stated that he has dosed off a few

	<p>times while on shift. Mr. Huckabee also admitted to bringing his video game console to work and playing while on shift.</p> <p>During the onsite investigation on 03/02/23, staff Wilbert Garner could not account for all of the residents in the facility. Mr. Garner stated that residents are supposed to come to the staff office to sign in and out of the facility. Mr. Garner provided me with a sign in and out folder. The folder did not indicate that Residents C, D, and E were not in the facility. Mr. Garner stated that Resident D has a car and sometimes will leave the facility and not tell staff. Mr. Garner was unaware of Resident D's whereabouts at the time of the onsite investigation.</p> <p>During the onsite investigation on 04/13/23, there were no staff at the facility leaving residents alone and unsupervised. According to Ms. DiFronzo, she was covering both buildings because staff from Progressions 42192 Toddmark had to take one of the residents to the doctor. Ms. DiFronzo stated that there were two additional staff working but they went grocery shopping.</p>
CONCLUSION:	VIOLATION ESTABLISHED

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 the information gathered through my interviews and documentation reviews, the facility did not have a sufficient number of staff scheduled, to care for the needs of the residents. During the onsite investigation on 04/13/23, there were no staff at the facility leaving residents alone and unsupervised. According to Ms. DiFronzo, she was covering both buildings because staff from Progressions 42192 Toddmark had to take one of the residents to the doctor. Ms. DiFronzo stated that there were two additional staff working but they went grocery shopping.
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.

A previous recommendation for a provisional license was made in Renewal Inspection Report dated 02/16/23, which remains in effect.



04/13/23

Eric Johnson
Licensing Consultant

Date

Approved By:



05/17/2023

Denise Y. Nunn
Area Manager

Date