GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2023

Callen Fillio
Progressive Lifestyles Inc
1370 North Oakland Blvd
Suite 150
Waterford, MI 48327

RE: License #: AS630084341
Investigation #: 2023A0991022
Eston CLF

Dear Ms. Fillio:

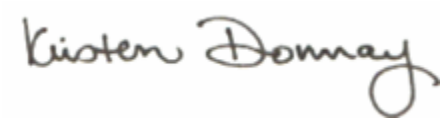
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630084341
Investigation #:	2023A0991022
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/15/2023
Report Due Date:	07/14/2023
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	1370 North Oakland Blvd Suite 150 Waterford, MI 48327
Licensee Telephone #:	(248) 875-4033
Licensee Designee:	Callen Fillio
Name of Facility:	Eston CLF
Facility Address:	8665 Eston Clarkston, MI 48348
Facility Telephone #:	(248) 394-1222
Original Issuance Date:	06/25/1999
License Status:	REGULAR
Effective Date:	07/17/2021
Expiration Date:	07/16/2023
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per incident report dated 05/12/23, staff Perry Fortin noticed that Resident A's 8:00pm medications from 05/11/23 were still in the blister packs. Mr. Fortin forgot to pass the medications the night before.	Yes

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A0991022
05/15/2023	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR)- Sarah Rupkus
05/15/2023	Referral - Recipient Rights Referred to ORR worker, Sarah Rupkus
05/15/2023	APS Referral Referred to Adult Protective Services (APS) Centralized Intake
05/17/2023	Contact - Telephone call made To home manager, Perry Fortin
05/22/2023	Inspection Completed On-site Unannounced onsite inspection
05/23/2023	Contact - Telephone call made Left message for director, Callen Fillio
05/23/2023	Contact - Document Received Copy of medication records, disciplinary action, training verification
05/25/2023	Exit Conference Via telephone with licensee designee, Callen Fillio

ALLEGATION:

Per incident report dated 05/12/23, staff Perry Fortin noticed that Resident A's 8:00pm medications from 05/11/23 were still in the blister packs. Mr. Fortin forgot to pass the medications the night before.

INVESTIGATION:

On 05/15/23, I received a complaint that Resident A did not receive his 8:00pm medications on 05/11/23. I reviewed a copy of the incident report from Eston CLF, which was completed by the home manager, Perry Fortin. It notes that Mr. Fortin was looking at Resident A's medications and noticed that the 8:00pm medications were still in the blister packs from the night before. Mr. Fortin was the staff responsible for passing the medications, but he missed them. I initiated my investigation on 05/15/23 by contacting the assigned Office of Recipient Rights (ORR) worker, Sarah Rupkus, and by making a referral to Adult Protective Services (APS) Centralized Intake.

On 05/17/23, I interviewed the home manager, Perry Fortin, via telephone. Mr. Fortin stated that he has been working in this field for 30 years and he has never made a medication error until now. He stated that they were having a hectic day on 05/11/23, as they were preparing for a health and safety audit the following day, and they were going to take the residents to the park that evening. He stated that he overlooked giving Resident A his 8:00pm medications, which are Colace and Seroquel. The other two residents in the home received their medications. Mr. Fortin stated that he noticed the medication error the following day when he was going through the medications. He wrote an incident report and reported the error to his manager. Mr. Fortin stated that he did not contact Resident A's physician, as the standing missed medical order states to give the next dose as prescribed. Mr. Fortin stated that Resident A did not have any negative effects from missing his medications. He was with Resident A all evening and the following day, and he did not notice anything out of the ordinary. Mr. Fortin stated that they use an electronic medication administration record (MAR). He initialed the MAR on 05/11/23 at 8:00pm indicating that the medications were passed, but he did not administer them. Mr. Fortin stated that there was another staff working at the time, Hannah Clock, but she was assisting the residents and getting them ready for their outing. She was not responsible for passing medications.

On 05/22/23, I conducted an unannounced onsite inspection at Eston CLF. I interviewed the home manager, Perry Fortin. The information he provided was consistent with the information that he gave during his phone interview. I observed Resident A in the home. Resident A is non-verbal and could not participate in an interview. He was active during my onsite visit and appeared to be well cared for and happy.

During the onsite inspection, I reviewed a copy of Resident A's May 2023 MAR. I noted that the MAR was initialed for the 8:00pm dose of Docusate 100mg (Colace) and Quetiapine 300mg (Seroquel). I observed that both medications remained in the bubble

packs for 05/11/23. I reviewed Resident A's 8:00am, 4:00pm, 8:00pm, and 11:00pm medications as well as the medications for Resident B and Resident C. I did not note any other discrepancies.

I reviewed a copy of the standing missed medication orders for Resident A's Docusate 100mg Cap and Quetiapine 300mg Tab. Both medications state, "give up to 2 hours late, after that time lapse call for directions."

I reviewed a copy of the Progressive Lifestyles Inc. disciplinary memo for Perry Fortin. It notes an infraction of failing to document and/or administer medications. The details of the infraction indicate that Mr. Fortin noticed on 05/12/23 that Resident A's medications from the night before at 8:00pm were not passed and were still in the bubble packs. The two medications were Docusate 200mg and Quetiapine 300mg. Mr. Fortin completed an incident report and documented it in the health care chronological. The memo notes that this was Mr. Fortin's first incident and he met with administration for the medication error. The eight rights of medication passing were reviewed. Mr. Fortin's medication training is current. I reviewed a copy of his medication training verification form from Easter Seals/MORC which shows he completed a six-hour medication course on 03/22/22, which is valid through 03/01/25.

On 05/25/23, I conducted an exit conference via telephone with the licensee designee, Callen Fillio. Ms. Fillio stated that she would submit a corrective action plan to address the violations in the report. The home manager, Perry Fortin, was already in-serviced regarding the medication error. Ms. Fillio stated that typically the standing missed medical orders, which are signed by the doctor, state to omit the next dose if more than two hours have passed. She stated that she would conduct an in-service with regards to reviewing and following the standing medical orders.

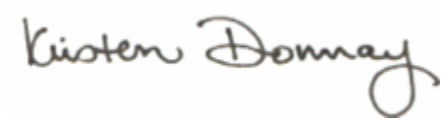
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A did not receive his 8:00pm dose of Docusate 100mg (Colace) and Quetiapine 300mg (Seroquel) on 05/11/23. The home manager, Perry Fortin, noticed the medications were still in the bubble packs the following day. He stated that he forgot to pass Resident A's medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home manager, Perry Fortin, initialed Resident A's medication administration record on 05/11/23 at 8:00pm indicating that the medications were passed; however, Mr. Fortin did not administer Resident A's 8:00pm dose of Docusate 100mg (Colace) and Quetiapine 300mg (Seroquel) on 05/11/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the appropriate health care professional was not contacted following the medication error that was made on 05/11/23. Mr. Fortin stated that he followed the instructions on the standing missed medical orders; however, the orders state "give up to 2 hours late, after that time lapse call for directions." Mr. Fortin did not contact a physician for directions on 05/12/23 when he discovered Resident A did not receive his 8:00pm medications from the previous night.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

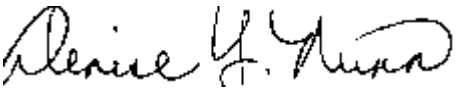
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



05/25/2023

Kristen Donnay Date
Licensing Consultant

Approved By:



06/01/2023

Denise Y. Nunn Date
Area Manager