GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2023

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

RE: License #: AS630012777
Investigation #: 2023A0993025
Tamarack CLF

Dear Mrs. Simpson:

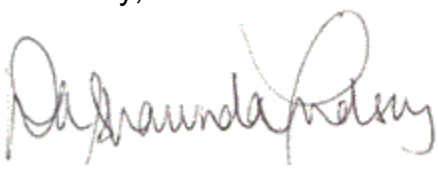
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012777
Investigation #:	2023A0993025
Complaint Receipt Date:	04/27/2023
Investigation Initiation Date:	05/01/2023
Report Due Date:	06/26/2023
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	Suite 150 - 1370 North Oakland Blvd Waterford, MI 48327
Licensee Telephone #:	(248) 807-2705
Administrator:	Kathryn Simpson
Licensee Designee:	Kathryn Simpson
Name of Facility:	Tamarack CLF
Facility Address:	6850 Tamarack Holly, MI 48442
Facility Telephone #:	(248) 634-0433
Original Issuance Date:	12/15/1992
License Status:	REGULAR
Effective Date:	04/02/2022
Expiration Date:	04/01/2024
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/27/2023, Oakland Community Health Network (OCHN) received two incident reports (IR). Home manager Dominique Ringo reported upon her arrival on 04/25/2023, Resident A stated she did not receive her 8:00am medications. Later that day, Ms. Ringo noticed Resident C was not acting normal. It was later determined that Resident C received Resident A's medications on 04/25/2023. Resident C received emergency medical treatment due to the medication error.	Yes

III. METHODOLOGY

04/27/2023	Special Investigation Intake 2023A0993025
04/27/2023	Referral - Recipient Rights Allegations received from recipient rights advocate Katie Garcia
05/01/2023	Special Investigation Initiated - Letter Emailed recipient rights advocate Katie Garcia
05/03/2023	Inspection Completed On-site Recipient rights advocate Katie Garcia and I conducted an unannounced onsite investigation
06/06/2023	Contact - Telephone call made Telephone call made to staff Edwin Perez
06/06/2023	Contact - Telephone call made Telephone call made to licensee designee Ashley Jennings
06/06/2023	Contact - Telephone call made Telephone call made to staff Chanae Reed. Left a message.
06/06/2023	Contact - Telephone call received Telephone call received from staff Chanae Reed
06/06/2023	Contact - Document Received Received verification of medication administration training
06/07/2023	APS Referral Forwarded allegations to adult protective services (APS)

06/07/2023	Exit Conference Attempted to hold with licensee designee Kathryn Simpson. Left a message.
06/07/2023	Exit Conference Exit conference held with licensee designee Ashley Jennings

ALLEGATION:

On 04/27/2023, Oakland Community Health Network (OCHN) received two incident reports (IR). Home manager Dominique Ringo reported upon her arrival on 04/25/2023, Resident A stated she did not receive her 8:00am medications. Later that day, Ms. Ringo noticed Resident C was not acting normal. It was later determined that Resident C received Resident A's medications on 04/25/2023. Resident C received emergency medical treatment due to the medication error.

INVESTIGATION:

On 04/27/2023, I received the allegations from recipient rights advocate Katie Garcia. I reviewed two incident reports (IRs). Home manager Dominique Ringo reported upon her arrival on 04/25/2023, Resident A stated she did not receive her 8:00am medications. Later that day, Ms. Ringo noticed Resident C was not acting normal. It was later determined that Resident C received Resident A's medications on 04/25/2023. Resident C received emergency medical treatment due to the medication error.

On 05/03/2023, recipient rights advocate Katie Garcia and I conducted an unannounced onsite investigation. We interviewed staff Mia Guerrero and home manager Dominque Ringo. We attempted to interview Resident A and Resident C with no success due to their limited cognitive abilities.

Ms. Guerrero stated when she arrived at the facility on 04/25/2023, Resident C did not come to her. Instead, she had to go find him in the facility. That is abnormal behavior for Resident C. When she went to his bedroom to speak to him, Ms. Guerrero stated Resident C looked different. He followed her back to the living room. However, he was very careful with his steps and was moving slowly. Ms. Guerrero asked Ms. Ringo to look at Resident C. Ms. Ringo felt Resident C was also acting abnormal. Ms. RIngo took Resident C to the emergency room for evaluation. In addition, Ms. Guerrero stated Resident A informed her that she did not receive her 8am medications. Ms. Guerrero asked Resident A if she was sure, and Resident A said yes. Ms. Guerrero informed Ms. Ringo. Per Ms. Guerrero, staff Edwin Perez (who goes by the name Louie or Lou Lou. She will be referred to as Louie for the rest of this report) administered morning medications to the residents on 04/25/2023. Ms. Guerrero stated she has completed medication administration training. All staff who administers medications have been trained to do so. Due to the medication error, all staff have been retrained to administer medications.

Ms. Ringo stated when she arrived at the facility on 04/25/2023, Resident A approached her and stated she did not receive her morning medications. In addition, Ms. Ringo noticed that Resident C weas not acting himself. Resident C could barely walk or talk. Ms. Ringo took Resident C to the emergency room (ER). While at the ER, a full body scan was conducted on Resident C. His urine was checked as well. Klonopin was found in Resident C's system. Per Ms. Ringo, Resident C is not prescribed Klonopin. Resident A is prescribed it. Resident C was kept in the hospital for 24 hours to be monitored. He was released afterwards. Ms. Ringo did not know if Resident C was just administered Resident A's Klonopin or if he was administered all Resident A's medications. Ms. Ringo stated all staff who administer medications have been trained to do so.

During the onsite investigation, I reviewed Resident A's and Resident C's medications and medication administration record (MAR). I did not observe any other medication administration errors.

On 06/06/2023, I conducted a telephone interview with staff known as Louie. Louie confirmed she mistakenly administered another resident's medications to Resident C. Louie could not recall the date of the mediation administration error. She verified Resident C was taken to the ER for evaluation. Louie confirmed she completed medication administration. She stated she is currently suspended pending the medication administration error investigation. Per Louie, all staff have been retrained to administer medications. Louie has not been retrained yet due to being suspended.

On 06/06/2023, I conducted a telephone interview with licensee designee Ashley Jennings. Ms. Jennings confirmed Louie administered Resident A's medications to Resident C. Louie is currently suspended pending the investigation. She confirmed all staff, except Louie, have been retrained to administer medications.

On 06/06/2023, I conducted a telephone interview with assistant manager Chanae Reed. Ms. Reed verified she was working in the facility when Louie administered Resident A's medications to Resident C. Ms. Reed stated she did not observe the medication administration error as she was in the back of the facility giving the female residents showers. Ms. Reed confirmed she has completed medication administration training. She confirmed all staff have been retrained to administer medications.

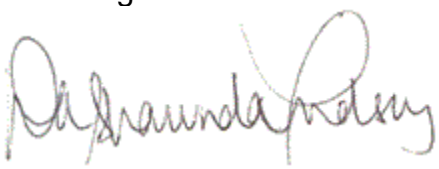
On 06/06/2023, I reviewed staff transcripts from Easter Seals/ Macomb Oakland Regional Center (MORC). I verified that Ms. Guerrero, Ms. Ringo, Louie, Ms. Reed, staff Hayley D'Autremont, and staff Kathryn Horton completed medication administration training.

On 06/07/2023, I conducted an exit conference with licensee designee Ashley Jennings. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 04/25/2023, staff Louie administered Resident A's medications to Resident C. Resident C was taken to the ER where he was monitored for 24 hours and released. I verified that Ms. Guerrero, Ms. Ringo, Louie, Ms. Reed, staff Hayley D'Autremont, and staff Kathryn Horton completed medication administration training.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

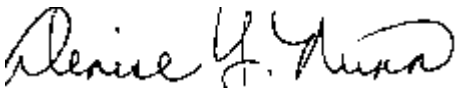
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



06/07/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



06/21/2023

Denise Y. Nunn — Date
Area Manager