GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 4, 2025

Janice Hurst
Progressive Residential Services Inc
Suite # 265
6001 N. Adams Road
Bloomfield Hills, MI 48304

RE: License #: AS580415884
Investigation #: 2026A0116002
Vineyard Home

Dear Mrs. Hurst:

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS580415884 |
| | |
| **Investigation #:** | 2026A0116002 |
| | |
| **Complaint Receipt Date:** | 10/13/2025 |
| | |
| **Investigation Initiation Date:** | 10/13/2025 |
| | |
| **Report Due Date:** | 12/12/2025 |
| | |
| **Licensee Name:** | Progressive Residential Services Inc |
| | |
| **LicenseeAddress:** | Suite # 265<br>6001 N. Adams Road<br>Bloomfield Hills, MI 48304 |
| | |
| **Licensee Telephone#:** | (248) 641-7200 |
| | |
| **Administrator:** | Janice Hurst |
| | |
| **Licensee Designee:** | Janice Hurst |
| | |
| **Name of Facility:** | Vineyard Home |
| | |
| **Facility Address:** | 15127 South Dixie Hwy.<br>Monroe, MI 48161 |
| | |
| **Facility Telephone #:** | (734) 230-2110 |
| | |
| **Original Issuance Date:** | 08/02/2023 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/02/2024 |
| | |
| **Expiration Date:** | 02/01/2026 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff, Aireal Henderson, at the direction of the home manager, Renee Heath, administered Resident A's PRN 5 mg Lorazepam due to aggressive behaviors. The Lorazepam is prescribed for Resident A's anxiety at dental appointments and label instructions document that the medication is to be administered 30 minutes before dentist appointments. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/13/2025 | Special Investigation Intake<br>2026A0116002 |
| 10/13/2025 | Referral - Recipient Rights<br>Received. |
| 10/13/2025 | Special Investigation Initiated - On Site<br>Staff, Devin Vititow, district manager, Roger Heath, Resident A, reviewed Resident A's medication administration record (MAR). |
| 10/13/2025 | APS Referral<br>Made. |
| 10/27/2025 | Contact - Telephone call made<br>Staff, Aireal Henderson. Left a message requesting a return call. |
| 10/27/2025 | Contact - Telephone call made<br>Former home manager, Renee Heath. |
| 10/27/2025 | Inspection Completed-BCAL Sub. Compliance |
| 10/28/2025 | Contact - Telephone call received<br>Staff, Aireal Henderson. |
| 10/28/2025 | Exit Conference<br>Licensee designee, Janice Hurst. |

**ALLEGATION:**

**Staff, Aireal Henderson, at the direction of the home manager, Renee Heath, administered Resident A's PRN 5 mg Lorazepam due to aggressive behaviors. The Lorazepam is prescribed for Resident A's anxiety at dental appointments and label instructions document that the medication is to be administered 30 minutes before dentist appointments.**

**INVESTIGATION:**

On 10/13/25, I conducted an unscheduled onsite inspection and interviewed staff, Devin Vititow, district manager, Roger Heath, Resident A and reviewed Resident A's September MAR. Mr. Vititow reported that he is a new staff and has only been employed with the company for about a month. He reported that he was working the afternoon shift (4:00 p.m. -12:00 a.m.) on 09/20/25 with co-worker Aireal Henderson. Mr. Vititow reported that Resident A was having behaviors and was throwing things, charging at Ms. Henderson, and no matter how much he and Ms. Henderson tried to re-direct and calm him, the behaviors continued to escalate. Mr. Vititow reported that at around 11:00 p.m. Ms. Henderson called the home manager, Renee Heath, again as she had called her a few times throughout their shift because Resident A wanted to talk with her, and they were keeping her abreast of what was going on. Mr. Vititow reported that Ms. Henderson told Ms. Heath that Resident A was continuing to act out, was getting more aggressive and wanted to know what she thought about them calling 911. Mr. Vititow reported that Ms. Heath instructed Ms. Henderson to give Resident A his PRN 5mg Lorazepam to see if it would help calm him down. Mr. Vititow reported that Ms. Henderson asked Ms. Heath if she was sure she wanted her to do that, since it is only to be given to him prior to his dental appointments. Mr. Vititow reported that Ms. Heath told her yes to give him the medication and that if anything happened, she would take the blame for it. Mr. Vititow reported Ms. Henderson administered the medication, and Resident A eventually calmed down a little.

I interviewed district manager, Roger Heath, and he reported he was not present in the home at the time of the incident and could not provide specifics as to what occurred. Mr. Heath reported that home manager, Renee Heath, resigned.

I attempted to interview Resident A, however he would only repeat what I asked. Resident A wanted to show me some of the pictures he had taped on the wall in his bedroom. While in his bedroom, I attempted to ask basic questions, however he would not respond and was only focused on his pictures. Resident A was neatly dressed and groomed and appeared to be in a good mood, as he was smiling, walking around and engaging with his staff.

I observed Resident A's PRN lorazepam medication in a bubble pack. Resident A was prescribed seven tablets on March 5, 2025. The label instructions document for Resident A to take one tablet by mouth a half hour prior to dental procedures. I

observed that one tablet was popped out on 09/20/25 and initialed by Aireal Henderson. A second tablet was popped out on 09/23/25 and administered by home manager, Renee Heath. I confirmed that Resident A had a dental procedure on 09/23/25, and that the dose was administered properly. I reviewed Resident A's September 2025 MAR and confirmed that staff, Aireal Henderson initialed on 09/20/25 and home manager, Renee Heath, initialed on 09/23/25, that they administered the 5mg Lorazepam.

On 10/27/25, I interviewed former home manager, Renee Heath. Ms. Heath reported that on 09/20/25, that she did instruct staff, Aireal Henderson, to administer Resident A's 5mg Lorazepam medication, due to his escalating behavior. Ms. Heath reported that she knows that the medication was not prescribed for that and was aware that the label instructions document that the medication is only to be given 30 minutes before dental procedures. Ms. Heath reported that Resident A has been hitting staff, throwing things at staff, damaging property and was not able to be re-directed by staff. Ms. Heath reported that when Ms. Henderson called her again at 11:00 p.m. that night, she told her to give the lorazepam in hopes of getting Resident A to calm down and to help her staff. Ms. Heath admitted her wrongdoing and reported that she resigned because she is burned out and the stress of all the things she was dealing with was just too much. Ms. Heath also confirmed that on 09/23/25, she took Resident A to his dental appointment, and she administered the 5mg Lorazepam 30 minutes before the appointment as the label instructs.

On 10/28/25, I interviewed staff, Aireal Henderson, and she reported that she has been working the home since July 25, 2025. Ms. Henderson reported that she worked a double shift (8:00 a.m. to 12:00 a.m.) on 09/20/25 and reported that during the day shift while it was two female staff, Resident A was fine and was not exhibiting any behaviors. She reported when the male staff, Devin Vititow, came in at 4:00 p.m. Resident A became extremely aggressive and was throwing things at staff, damaging the items in his bedroom, flipped his bed and was not able to be re-directed. Ms. Henderson reported that it takes Resident A awhile to warm up and get comfortable with male staff, and on 09/20/25, it was one of the worst days she had witnessed Resident A have. Ms. Henderson reported that she had been in contact with home manager, Renee Heath, throughout the evening and night and during the 11:00 p.m. call, Ms. Henderson reported she asked Ms. Heath, should she call 911 or the crisis line. She reported that Ms. Heath said no and instructed her to give Resident A lorazepam to see if it would calm him down. Ms. Henderson reported that she asked Ms. Heath if she was sure, because they all know that the lorazepam is only to be given prior to dental procedures. Ms. Henderson reported that Ms. Heath told her to give it to him and said if anything comes back from this she would take the blame. I informed Ms. Henderson that although she followed the instruction given by her manager, she too bears responsibility, because she is medication trained and should know that she is to only administer medications for what they are prescribed. Ms. Henderson reported an understanding and reported in the future if a situation such as this arises, she will refuse to administer a medication that she knows she should not. Ms. Henderson added that since this incident, Resident A's

doctor has prescribed a PRN lorazepam to be administered to Resident A when he has an escalation of behaviors/anxiety.

On 10/28/25, I conducted the exit conference with licensee designee, Janice Hurst. I informed Ms. Hurst of the findings of the investigation and the specific rule cited. Ms. Hurst reported an understanding. Ms. Hurst reported before she was able to discuss this matter with Ms. Heath, she had resigned. Ms. Hurst reported she would submit an acceptable corrective action plan upon receipt of the report.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of staff, Devin Vititow, Renee Heath, Aireal Henderson, and my review of Resident A's lorazepam medication and September 2025 MAR, there is a preponderance of evidence to substantiate the allegation. Ms. Heath instructed Ms. Henderson to give Resident A his PRN 5mg Lorazepam to see if it would help calm him down. I reviewed Resident A's Lorazepam medication bubble pack and his September MAR and confirmed that Ms. Henderson administered the medication and initialed the MAR on 09/20/25.<br><br>This violation is established as Resident A's medication was not given pursuant to label instructions. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/31/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

11/04/25

Ardra Hunter
Area Manager

Date