



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2026

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

RE: License #: AS630012392
Investigation #: 2026A0605014
Potter Road House

Dear Callen 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) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Frodet Dawisha".

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd., Ste 9-100
Cadillac Place
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012392
Investigation #:	2026A0605014
Complaint Receipt Date:	03/18/2026
Investigation Initiation Date:	03/18/2026
Report Due Date:	05/17/2026
Licensee Name:	Progressive Lifestyles Inc
Licensee Address:	Suite 150 1370 North Oakland Blvd Waterford, MI 48327
Licensee Telephone #:	(248) 842-2332
Administrator:	Jennifer Bohne
Licensee Designee:	Callen Fillio
Name of Facility:	Potter Road House
Facility Address:	2669 Potter Road Wixom, MI 48393
Facility Telephone #:	(248) 666-4136
Original Issuance Date:	05/21/1984
License Status:	REGULAR
Effective Date:	08/05/2025
Expiration Date:	08/04/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found injured after a fall without immediate hospital transport, and he was later hospitalized with a fractured neck after staff observed worsening injuries.	Yes

III. METHODOLOGY

03/18/2026	Special Investigation Intake 2026A0605014
03/18/2026	Special Investigation Initiated - Letter Emailed Oakland County Office of Recipient Rights (ORR) Rachel Moore
03/18/2026	APS Referral Adult Protective Services (APS) is investigating these allegations
03/18/2026	Contact - Document Sent Email to APS worker Brad Edwards
03/18/2026	Inspection Completed On-site Conducted unannounced on-site visit with APS Brad Edwards
03/18/2026	Contact - Telephone call made With licensee designees Kathryn Simpson and Callen Fillio
03/18/2026	Contact - Telephone call received Discussed allegations with ORR Rachel Moore
03/19/2026	Contact - Telephone call made Discussed allegations with DCS and with Resident A's sister
03/25/2026	Contact - Telephone call made Followed up with HM
03/25/2026	Exit Conference Conducted exit conference with licensee designee Callen Fillio with my findings

ALLEGATION:

Resident A was found injured after a fall without immediate hospital transport, and he was later hospitalized with a fractured neck after staff observed worsening injuries.

INVESTIGATION:

On 03/18/2026, intake #209896 was referred by both Oakland County Office of Recipient Rights (ORR) and Adult Protective Services (APS) regarding Resident A. ORR worker Rachel Moore and APS worker Brad Edwards are investigating these allegations.

On 03/18/2026, I emailed ORR worker Rachel Moore and APS worker Brad Edwards advising them that I was investigating these allegations.

On 03/18/2026, I, along with APS worker Brad Edwards conducted an unannounced on-site investigation. Present were the home manager (HM) Jessica Coombs, direct care staff (DCS) Lyonna Fischer who was in training and DCS Brittany Adkins. Also present were Residents A, B, C, D, and E. Resident F was at school during this visit.

I interviewed Resident A in his bedroom. Resident A was sitting in a chair on his simulator. He had a neck brace on. Resident A stated, "I fell off the bed twice. It was on Valentine's Day. I called for help and Amanda, who didn't know what to do, called Zaine. Zaine came and picked me up like a baby. I went to Henry Ford Hospital." Resident A said he fell twice on this day but was unable to provide specifics. He stated he sleeps with a soft brace and now has bedrails, which I observed on his hospital bed on both sides of the bed. Resident A also had an alert button necklace around his neck and a walker next to him. He was unable to provide any further information.

I did not interview Residents B, C, D, and E as they were non-verbal. I did observe them sitting in the living room watching TV. They all appeared well with no concerns noted.

I interviewed HM Jessica Coombs regarding the allegations. HM was not working on 02/14/2026 as she was out with her daughter. She received a text message from DCS Amanda Brown around 8PM-8:30PM stating that "Resident A fell," and that Amanda "called Resident A's sister who said not to take him to the hospital." HM did not call Amanda back because, "since the sister did not want him to go to the hospital, she did not feel it was necessary to call her back." On 02/15/2026, DCS Makayla Marley called HM saying she was running late to work. HM worked from 11AM-1:30PM when Makayla arrived. During this time, HM did not go into Resident A's bedroom to check up on him. HM stated that Resident A was on his stimulator the entire time. HM reviewed the incident report (IR) completed by Amanda on 02/14/2026 but again did not feel it was necessary to check on him because he did not go to the hospital. HM then worked on 02/16/2026, and when she arrived around 8:30-9AM, she went to check on Resident A

in his bedroom and observed a large size bruise above his right eyebrow, the size of a battery and a scratch on his left hand. She immediately transported him to Henry Ford West Bloomfield Hospital (HFWBH). HM stated, "If I would have went to see him in his bedroom the day I came in, then I would have immediately taken him to the hospital." Hospital staff took X-rays and a Cat Scan that showed an old neck fracture and a new neck fracture. HM stated the protocol for Progressive Lifestyles, Inc., regarding falls is that if there is an unwitnessed fall, 911 must be contacted and/or if a resident falls and hits his head, then 911 must be contacted. HM is unsure why Amanda did not follow protocol since Resident A's fall was both unwitnessed and he hit head, instead of calling Resident A's sister. Resident A was in the hospital for about three weeks and discharged with bedrails and an alert system he wears around his neck. Resident A pushes the alert button whenever he wants to either get out of bed or out of his chair as he is a one-on-one for ambulation. HM emailed me Resident A's HFWBH discharge paperwork and pictures of Resident A's injuries.

I interviewed DCS Iyonna Fisher regarding the allegations. Iyonna has only been working at Potter Road House since 03/03/2026 and is currently still in training. She was not working at the time Resident A fell but stated that Resident A presses his alert around his neck to alert staff to go into his bedroom and assist him with ambulation. She is unsure what happened to him but was told that he fell. She had no other information to offer.

I interviewed DCS Brittany Adkins regarding the allegations. Brittany was on vacation from 02/12/2026-02/18/2026. When she returned to work, Resident A was in the hospital. After Resident A returned home, he told Brittany, "I fell on Valentine's Day and Amanda didn't know what to do." Amanda told Brittany that, "Resident A fell and then she called Resident A's sister who said, no hospital." Brittany stated that protocol for falls is that if it is unwitnessed or a resident hits their head, then 911 must be called. Brittany is unsure why Amanda did not follow protocol.

On 03/18/2026, I contacted licensee designee Kathryn Simpson to advise her of the allegations. She was aware of what happened and stated that I can contact licensee designee Callen Fillio who oversees Potter Road House.

On 03/18/2026, I contacted licensee designee Callen Fillio who agreed to advise DCS that I and APS worker Brad Edwards will be contacting staff tomorrow via telephone conference to interview them regarding the allegations. Ms. Fillio agreed to send me the staff schedule from 02/14/2026-02/16/2026. I received the staff schedule.

On 03/18/2026, I received a return call from ORR Rachel Moore. Ms. Moore was informed by Resident A that "he fell twice." HM Jessica Coombs was not "upfront," with Ms. Moore regarding some information until DCS Amanda Brown advised Ms. Moore that HM worked on 02/15/2026. Ms. Moore was advised that according to HM, she worked on 02/15/2026 from 11AM-1:30PM but never went into Resident A's bedroom to check on him. HM stated she did not check on Resident A even after reviewing the IR because, "he did not go to the hospital per instructions from his sister." Ms. Moore

advised that Resident A's individual plan of service (IPOS) and crisis plan amended on 12/12/2025, specifically state that if there is an unwitnessed fall or a fall that results in Resident A hitting his head, then 911 must be contacted. Amanda did not follow protocol. After Resident A was discharged from HFWBH, he is currently a one-on-one for ambulation, hygiene, and toileting during waking hours only. He has bedrails on both sides of his hospital bed and wears an alert system around his neck. Ms. Moore will be substantiating her case for neglect.

Note: I received and reviewed Resident A's IPOS/crisis plan completed by Easterseals amended on 12/25/2025 that stated, "if there is an unwitnessed fall or a fall that results in Resident A hitting his head, then 911 must be contacted."

On 03/19/2026, I reviewed HFWBH discharge paperwork. "On 03/05/2026 Signed by Donald Seyfried, MD. Resident A treatment of a neck fracture, as well as chronic kidney disease and high blood pressure additional diagnoses included falls, Type 2 diabetes mellitus without complications, mood problems, mixed hyperlipidemia, and chronic anemia. Resident A experiences organ dysfunction, Parkinson's disease, and difficulty swallowing. Treatment included monitoring spine, initial encounter for sepsis without an acute organ dysfunction, and management of blood pressure due to risk for deep venous thrombosis and closed neck fracture. Discharge instructions stated the following- always wearing Aspen collar, except when removed for hygiene. Resident A will continue with home health and follow-up with specialists in nephrology, dermatology, and the ICU as needed. Follow up with Neurosurgeon is scheduled for 03/15/2026."

On 03/19/2026, I interviewed DCS Zaine Swartz via telephone regarding the allegations in collaboration with APS worker Brad Edwards. Zaine worked from 1PM-9AM on 02/14/2026 and from 9AM-10PM on 02/15/2026. On 02/14/2026 he worked with assistant HM Amanda Brown. Around dinner time, he was preparing the evening meal when he heard Resident A "call for Amanda." Amanda went to check on Resident A and returned saying, "Resident A fell. I need help." Zaine and Amanda returned to the bedroom, and both lifted Resident A up and placed him on the bed. Zaine stated, "it looked like he was on the chair and flipped out of the chair onto the floor." Zaine observed a bump on his head with a scrape on his arm. Zaine asked Amanda we need to take Resident A to the hospital, but Amanda said, "I have to call his sister because of insurance issues." Amanda called Resident A's sister regarding the fall, so Zaine left the bedroom. He does not know what was said. Zaine stated there was a scab on Resident A's forehead that occurred during a fall a couple of months prior to this incident, hitting his head and resulted in a cut. When Resident A fell this time, it irritated the scab. Even though Zaine stated that protocol for unwitnessed falls or falls resulting in the residents hitting their heads, 911 is called immediately he stated that Amanda was the assistant HM, so he took her lead as she was in charge. Zaine and Amanda monitored Resident A the rest of the night by conducting wellbeing checks every half hour. Resident A's answers were consistent; he ate dinner and was acting normal throughout the night. Resident A's right arm was bandaged because it looked like a scrape burn, but it was not bleeding. On 02/15/2026, he worked with Amanda until 12PM and then the HM

Jessica Coombs arrived to relieve Amanda because DCS Makayla Marley was not answering her phone. Amanda told the HM that Resident A fell and showed the HM the injuries. Zaine stated to him, the injuries did not look serious. He does not know what the HM said but stated that the HM did not take Resident A to the hospital until the next day on 02/16/2026.

On 03/19/2026, I interviewed DCS Makayla Marley regarding the allegations in collaboration with APS worker Brad Edwards. Makayla worked on 02/14/2026 from 9AM-1PM and on 02/15/2026 from 12PM-9AM. She and Zaine worked together during these shifts. Resident A did not fall during her shift on 02/14/2026. She was running late to work on 02/15/2026, so the HM Jessica Coombs covered for her from 11AM-12PM. When she arrived at her shift, the HM informed her that "Resident A had a pretty bad fall and had fallen twice the same day, but that his sister did not want him to go to the hospital." HM told her Resident A fell once trying to take his brief off and then again trying to take his pants off. Two separate falls on 02/14/2026. HM left and Makayla went into the laundry room to put a load in the washer. Within 30 minutes of being at the home, she went to check in on Resident A. She stated, "when I looked at him, he looked pretty bad. There was a baseball size knot over his right eye with visible bruising." Later in the day, she went into his bedroom and helped Resident A out of his clothes. She also noticed scratches on his right knee and left hand. There was dressing on his left hand which appeared soiled in blood, so she changed it. She monitored him throughout the night. On 02/16/2026, when the HM arrived, Makayla advised the HM that Resident A needs to be seen at the hospital because his hand was bleeding a lot and the bruising above his right eye was worse. HM advised Makayla she did not have to document anything nor write up an IR as that was already completed. Makayla stated that protocol for Progressive Lifestyles and for Resident A is that any unwitnessed fall or if a resident hits their head, then 911 must be called. She is unsure why Amanda did not call 911.

On 03/19/2026, I interviewed shift lead Danielle Carter regarding the allegations in collaboration with APS worker Brad Edwards. Danielle worked on 02/15/2026 from 10PM-9AM with Makayla Marley. When Danielle arrived, she was never informed by Makayla or Zaine, who were working the shift that Resident A fell or that an incident occurred. Resident A was already in bed, so Danielle opened his bedroom door, said hi, and left as he was in bed. Nothing occurred during the night. The next morning, 02/16/2026, when Danielle was doing rounds and getting medication ready, she went into Resident A's bedroom to take his blood sugar before passing his medications. He was sitting in his bed and that is when she observed the big knot on his head. Danielle asked Resident A, "What happened?" He told her, "I fell on Saturday. I fell out of my bed and didn't go to the hospital." Danielle was concerned as she was about to call the HM Jessica, HM walked in the door. The HM saw Resident A's injuries and took Resident A to the hospital. Danielle asked Amanda, "What happened?" Amanda said, "I was working with Zaine when I heard Resident A yell, help I fell." I called his sister who told me not to take him to the hospital." Amanda also told Danielle that Resident A fell twice again in the middle of the night out of bed. The protocol for Progressive Lifestyles and in Resident A's IPOS/crisis plan is that if there is an unwitnessed fall or a resident hit their head, 911 must be called immediately. Danielle also reported that a couple of months

ago prior to this fall, Resident A fell, hit his head and required stitches. She is not sure why Amanda did not follow protocol.

On 03/19/2026, assistant HM Amanda Brown was interviewed via telephone in collaboration with APS worker Brad Edwards. Amanda worked on 02/14/2026 when Resident A fell. She was preparing dinner when she heard Resident A yell, "help I fell." She ran into his bedroom and found him on the floor and the chair was tipped over. She helped him sit up on the floor and it appeared he hit his head above his eyebrow and his hand was scraped. She yelled for Zaine to help. Zaine came to the bedroom, and both lifted Resident A up and onto the bed. Resident A said he was ok. Amanda believed that Resident A was sitting on the chair, trying to take his pants off because his pants were at his ankles and then he fell forward onto the floor. She applied first aide to his hand because it was bleeding and then called Resident A's sister. She told the sister that he fell and there is a "knot on his forehead and his hand was bleeding." Amanda stated that she told the sister that the protocol for Progressive Lifestyles, Inc. is to take Resident A to the hospital. The sister said that the last time Resident A fell and went to the hospital, she received a \$4000 bill and there was nothing wrong with him. Amanda said, "I thought the sister had all the power to make the decision but now I know that's not the case." The sister spoke with Resident A on the phone and Resident A wanted dinner, so he ate dinner and appeared ok. Amanda sent the HM Jessica Coombs a text message of what happened and that Resident A's sister said, no hospital. The HM texted Amanda back about the sister emailing the HM about a dermatologist appointment and an MRI. The HM never advised Amanda to call 911 or to take Resident A to the hospital. Amanda monitored Resident A closely throughout the night. On 02/15/2026, Resident A got up, ate breakfast and then called his sister. Amanda completed the IR and because DCS Makalya Marley did not arrive for her shift, Amanda stayed until HM arrived around 11AM. Amanda informed the HM what happened and afterwards HM went and asked Resident A how he was doing and observed his injuries. Resident A was in the dining room when HM looked him over. HM also reviewed the IR and then told Amanda to go as HM was staying until Makayla arrived. The "knot," above Resident A's head had gone down but now a bruise was forming above his right eyebrow. His left hand was skinned, like raw skin. Amanda left and found out that Resident A was taken to the hospital by HM on 02/16/2026 and had a fractured neck. Amanda stated that she knew what the protocol was regarding unwitnessed falls or falls resulting in residents hitting their heads and that is to call 911. Resident A fell about one-to-three months ago and hit his head and required stitches. Resident A's sister was called; she came to the home, picked him up and took him to the hospital. The sister was upset about receiving a \$4000 medical bill so after that, HM said to call the sister if Resident A falls, which Amanda stated she did. Amanda stated that she thought she was following protocol based on what HM told her and that is, to call Resident A's sister after a fall and the sister will determine if Resident A should go to the hospital or not. Amanda stated, "I don't want anyone to think I'm negligent."

On 03/19/2026, I interviewed Resident A's sister via telephone regarding the allegations in collaboration with APS worker Brad Edwards. Amanda called Resident A's sister on 02/14/2026 around 6:30PM saying that Resident A fell, but that "he's ok." Resident A

was sitting on a chair trying to change his brief when he fell over and hit his head. Amanda told the sister that there were scratches on his hand, and that his hand is “fine,” but never said his hand was bleeding. Amanda said, there’s a “goosebump,” on his head but again, “he’s fine.” The sister told Amanda, “if he’s fine, then that’s good, he doesn’t need to go to the hospital.” After the call, the sister sent the HM Jessica Coombs an email saying that Resident A will need an MRI scheduled along with a dermatologist appointment for the cancer that was removed from his forehead. On 02/15/2026, Resident A called his sister and told her he had “some falls.” He then told his sister, “I fell out of bed later on.” Amanda got on the phone and confirmed what Resident A said. Amanda told the sister, “he fell out of bed but didn’t hit anything, he’s fine.” Amanda also informed the sister that the “goosebump,” went “way down,” and there was “just bruising.” The sister reiterated that Amanda told her he “fell twice,” that night. On 02/16/2026, the HM arrived and saw Resident A’s hand bleeding, so she immediately took him to Henry Ford West Bloomfield Hospital where the sister met them. After waiting for eight hours, and an X-ray plus an MRI, it was determined that Resident A’s neck was fractured. There was an old and a new fracture. The sister stated that in October or November 2025, the sister was called and informed that Resident A fell and hit his head. She transported him to the hospital for a cut on his head. At that time, no fracture was found. He received stitches and a large bill for the visit. The sister stated she never had a conversation with the HM nor with any staff at Potter Road House advising them to call her first for permission to seek medical treatment. She denied refusing to have Resident A taken to the hospital and was very upset that Amanda “downplayed,” Resident A’s injuries. The sister stated she did not know why Amanda called her to seek permission to take Resident A to the hospital as “this has never happened before.” The sister thought that the group home would only inform her that Resident A was taken to the hospital and not to call her for permission. She does not understand why Amanda did not follow protocol regarding falls. The sister wanted to inform us that she never refused medical care for Resident A and that she was his advocate and would never want him to not seek immediate care if he was injured.

Note: APS worker Brad Edwards stated he will substantiate these allegations for neglect.

On 03/19/2026, I received a call from licensee designee Callen Fillio stating that Resident A’s sister called her upset and does not want anyone to think she refused care for Resident A’s injuries. Ms. Fillio acknowledged that Amanda should have contacted 911 immediately instead of calling Resident A’s sister for permission. She will be in-servicing Amanda and staff on Progressive Lifestyle’s Inc., protocols and on Resident A’s IPOS/crisis plan.

On 03/25/2026, I followed up with the HM Jessica Coombs. HM never observed Resident A on 02/15/2026 as reported by both DCS Amanda Brown and Zaine Swartz. HM stated, “if I would have observed his injuries this day, I would have taken him to the hospital immediately, but I was focused on the laundry.” HM stated that there was laundry backed up that took her two hours to do until DCS Makayla arrived at the group home. HM also denied informing Amanda to get permission from Resident A’s sister to

take Resident A to the hospital after any fall unwitnessed or not. HM was not on-call on 02/14/2026, so Amanda should have texted/contacted the on-call pager but did not after Resident A fell. Amanda did not follow protocol after Resident A fell.

On 03/25/2026, I conducted the exit conference with licensee designee Callen Fillio with my findings. Ms. Fillio stated she met with DCS Amanda regarding her not following protocol regarding policy on unwitnessed falls and did not call the on-call pager for instructions. Amanda advised her that she was “going off what the sister said, I don’t want him to go to the hospital.” Ms. Fillio advised Amanda that it was not Resident A’s sisters’ call to make and that Amanda should have followed protocol. If Amanda had contacted the on-call pager, she would have been instructed to call 911 immediately.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, DCS Amanda Brown did not provide protection as specified in Resident A’s IPOS/crisis plan. I reviewed Resident A’s IPOS/crisis plan completed by Easterseals amended on 12/25/2025 that stated, “if there is an unwitnessed fall or a fall that results in Resident A hitting his head, then 911 must be contacted.” Amand never contacted 911 on 02/14/2026 when Resident A had an unwitnessed fall and hit his head. Resident A was taken to the hospital on 02/16/2026 by the HM. It was determined that the fall resulted in Resident A fracturing his neck.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on my investigation and information gathered, DCS Amanda Brown did not seek immediate health care for Resident A on 02/14/2026. Resident A had an unwitnessed fall, hit his head and scraped his hand. Amanda did not follow Progressive Lifestyle's Inc., protocol of seeking immediate medical treatment. Amanda called Resident A's sister, advised the sister that Resident A fell, but that he was "fine." Resident A's sister advised Amanda that if Resident A was "fine," then Resident A did not need to go to the hospital. Resident A was taken to the hospital on 02/16/2026, as his hand would not stop bleeding and it was discovered he had a neck fracture.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Frodet Dawisha

03/25/2026

Frodet Dawisha
Licensing Consultant

Date

Approved By:

Jay Calwerts

For

03/25/2026

Denise Y. Nunn
Area Manager

Date