GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2026

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

RE: License #: AS580015119
Investigation #: 2026A0116033
Borg

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 licensee designee 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) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
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 #:	AS580015119
Investigation #:	2026A0116033
Complaint Receipt Date:	06/12/2026
Investigation Initiation Date:	06/12/2026
Report Due Date:	08/11/2026
Licensee Name:	Progressive Residential Services Inc
Licensee Address:	Suite # 265 6001 N. Adams Road Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 641-7200
Administrator:	Janice Hurst
Licensee Designee:	Janice Hurst
Name of Facility:	Borg
Facility Address:	1279 Borg Temperance, MI 48182
Facility Telephone #:	(734) 224-0091
Original Issuance Date:	05/18/1993
License Status:	REGULAR
Effective Date:	05/08/2026
Expiration Date:	05/07/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Complainant reports that between the dates of 03/14/26 and 03/17/26 five different staff administered 5mg Lorazepam to Resident A. The medication was prescribed for another resident that does not reside in this group home.	Yes

III. METHODOLOGY

06/12/2026	Special Investigation Intake 2026A0116033
06/12/2026	Referral - Recipient Rights Received.
06/12/2026	Special Investigation Initiated - On Site Home manager, Alec Bauman, care coordinator, Amanda Verheul, staff Jasmine Lewis, visually observed Resident A and reviewed the medication bubble packs, electronic medication administration record (MAR) and prescription records for Resident A.
06/12/2026	Contact - Document Received Reviewed Recipient Rights investigative report.
06/12/2026	Inspection Completed-BCAL Sub. Compliance
06/23/2026	Contact - Telephone call made Staff, Dawn Wood.
06/23/2026	Contact - Telephone call made Guardian A1.
06/24/2026	APS Referral Made.
06/30/2026	Exit Conference Licensee designee, Janice Hurst.

ALLEGATION:

Complainant reports that between the dates of 03/14/26 and 03/17/26 five different staff administered 5mg Lorazepam to Resident A. The medication was prescribed for another resident that does not reside in this group home.

INVESTIGATION:

On 06/12/26, I conducted an unscheduled onsite inspection and interviewed home manager, Alec Bauman, care coordinator, Amanda Verheul, staff, Jasmine Lewis, visually observed Resident A and reviewed the medication bubble packs, electronic medication administration record (MAR) and prescription records for Resident A**.**

Mr. Bauman reported that he was not at work when the medication was delivered by the pharmacy staff. He reported that it was Saturday 03/14/26 when the medication was delivered. He reported that staff, Dawn Wood, called and told him that medication was delivered but never mentioned who it was prescribed to. Mr. Bauman reported that Ms. Wood knows the internal process and that all medications have to be approved by the administrators prior to administering, which is either him or care coordinator, Amanda Verheul. Mr. Bauman reported that he didn't ask any additional questions as he didn't feel he needed to as all of the staff know the internal processes. Mr. Bauman also reported that when Ms. Wood said that the medication was Lorazepam he assumed it was for Resident B as that is a medication that he is prescribed and has been taking. Mr. Bauman reported that he did not provide any additional guidance as he was not at work and did not have the medication or order available to review and ended the call. He denied instructing Ms. Wood to administer the medication.

I interviewed care coordinator, Amanda Verheul, and she reported that on 03/14/26 she was off work and did not return until 03/18/26. Ms. Verheul reported that on 03/14/26 she received a text message from staff, Dawn Wood, indicating that a new medication had been delivered to Resident A. She reported she informed Ms. Wood that Resident A had not had any recent medication changes and reminded her to contact Mr. Bauman for additional guidance as she was off until 03/18/26. Ms. Verheul reported as the care coordinator, she is responsible for scheduling medical appointments and is aware of medication changes. She further reported that Resident A hadn't had any recent medical appointments and so it was a "little weird" that all of a sudden, a new medication was delivered to the home for her. Ms. Verheul reported she never heard back from Ms. Wood for the duration of her time off. She reported that she returned to work on 03/18/26 and reviewed all of the Resident A's medications and observed the .5mg Lorazepam bubble packs with Resident A's name and instructions for use. She observed that the staff had been administering the medications 3 times per day, although the medication had not been reviewed and approved by an administrator (her or Mr. Bauman) in the electronic MAR system. Ms. Verheul clarified that the pharmacy updated the electronic MAR to include the passing of the Lorazepam, but she or Mr. Bauman still

have to approve the medication before staff can pass it and begin initialing it via the electronic MAR. Ms. Verheul reported that Ms. Wood documented the new medication onto a paper MAR and began administering it the evening of 03/14/26. She reported four additional staff continuing administering the Lorazepam 3 times daily with the last dose being given the evening of 03/17/26. Ms. Verheul reported that she reviewed the written prescription order that came with the medication and after careful review observed that the medication was prescribed to a female in another county and was prescribed by a doctor that was not one of Resident A's. Ms. Verheul reported that the confusing part was that the bubble pack label had Resident A's name and instructions for use and the electronic MAR sent from the pharmacy did as well. She reported that she knew then that the error began at the pharmacy. She reported that she contacted the pharmacy, and they confirmed it was their error and admitted their safeguards failed. The pharmacy confirmed that the medication was prescribed for a person in another county by her doctor. Ms. Verheul reported that she immediately discontinued the medication and updated the electronic MAR.

I interviewed staff, Jasmine Lewis, and she reported that she passed four doses of the Lorazepam medication to Resident A and reported that she did not review the prescription prior to passing the medication. She reported the medication was written on the MAR and the bubble pack had a pharmacy printed label with Resident A's name and instructions for use so she passed it. Ms. Lewis reported learning later that the pharmacy made the error and it was not caught by the staff until Ms. Verheul returned to work on 03/18/26.

I visually observed Resident A walking around the home. Resident A could not be interviewed due to the severity of her developmental disability. She was neatly dressed and groomed.

I reviewed Resident A's MAR, the bubble packs that contained the Lorazepam, and the written prescription order. The MAR and the bubble packs contained all of Resident A's identifying information and instructions for use. The MAR was initialed by five staff who administered the medication from 03/14/26 through 03/17/26. The staff were Dawn Wood, Angela Beebe, Candace Webster, Jasmine Lewis and Andrew Diltz. The prescription summary contained a label that was adhered to it with Resident A's identifying information, however, the printed prescription summary clearly documented the name, address and date of birth of another female who resides in a different county. This medication was prescribed to her by her doctor.

On 06/12/26, I reviewed the recipient rights investigative findings authored by Coy Hernandez. Mr. Hernandez, based on the facts of the investigation, substantiated neglect class III against the five staff who passed the medication to Resident A. Mr. Hernandez findings concluded that all five staff successfully completed the Monroe County Mental Health Authority's (MCMHA) medication administration training which requires staff to compare the written orders with the medication packages and MAR

before every medication pass. Mr. Hernandez documented that doing so would have prevented this medication error.

On 06/23/26, I interviewed staff, Dawn Wood, and she reported that she was on shift on 03/14/26, when a new medication was delivered for Resident A. Ms. Wood reported that when the medication was delivered, she felt like something was off, so she reached out to care coordinator, Ms. Verheul for guidance. She reported that Ms. Verheul reported that Resident A hadn't had any recent medical appointments or medication changes so she was not sure why a new medication would be delivered to the home. She reported that Ms. Verheul instructed her to contact home manager, Mr. Bauman for guidance as she off work for the next few days. Ms. Wood reported that she called and told Mr. Bauman that a new medication had been delivered, and he told her to complete a narcotic count sheet and begin passing the medication as prescribed and that's what she did. Ms. Wood reported that the label on the bubble pack and electronic MAR from the pharmacy had Resident A's name, date of birth and instructions for use and she assumed everything was good. Ms. Wood reported learning a few days later of the medication error began with the pharmacy and she and the other staff did not catch it. Ms. Wood admitted that she did not remember seeing a paper prescription and if it was with the medication she did not open it. I informed Ms. Wood that I reviewed the prescription order, and it listed the name and identifying information of another person for which the medication was prescribed and had she reviewed it the error would have been prevented. Ms. Wood reported an understanding and admitted that she made a mistake and was thankful that Resident A did not suffer any ill effects from the medication. Ms. Wood also admitted that in the medication training required by MCMHA it requires three pieces of matching identification prior to passing any medication. She reported those are the medication, MAR and prescription. Ms. Wood admitted that she passed the medication without the three matching documents.

On 06/23/26, I interviewed Guardian A1 and she reported that while she is thankful that Resident A is okay, she is upset that no one caught this error prior to Resident A being given days worth of medication that was not prescribed to her. Guardian A1 reported that she spoke to the Pharmacist, and they admitted to their error. Guardian A1 reported that the home is just as much at fault as the pharmacy and should have caught the error. Guardian A1 reported that she hopes the staff are retrained on their responsibilities when it comes to medication administration and actually apply it.

On 06/30/26, I conducted the exit conference with licensee designee, Janice Hurst, and informed her of the findings of the investigation and the rule cited. Ms. Hurst reported an understanding. Ms. Hurst reported that the staff involved have been reprimanded and additional procedures have been put in place to prevent reoccurrence. I also recommended to Ms. Hurst that a procedure be put in place when both Mr. Bauman and Ms. Verheul are both off work, so that if/when medications are delivered to the home, there is a knowledgeable person who can be

contacted by staff to assist them by reviewing and approving medications prior to them being passed.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the findings of the investigation, which included interviews with home manager, Alec Bauman, care coordinator, Amanda Verheul, staff, Jasmine Lewis, staff, Dawn Wood my review of Resident A's MAR, medication, prescription order and review of the recipient rights investigative findings, there is a preponderance of evidence to substantiate that staff, Dawn Wood, Angela Beebe, Candace Webster, Jasmine Lewis and Andrew Diltz administered .5mg Lorazepam for four days (10 doses) to Resident A for who this medication was not prescribed. Although the initial error began with the pharmacy, staff, Dawn Wood, did not follow the homes internal procedure, which requires the care coordinator or home manager to approve all medications prior to administration. Further, Ms. Wood, Ms. Beebe, Ms. Webster, Ms. Lewis and Mr. Diltz did not follow their medication training, required and provided by MCMHA, which requires them to check three pieces of identification that match (medication label/package, MAR and prescription) prior to the passing of every medication. Had they done so this error would have been prevented.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson
Licensing Consultant

07/08/26
Date

Approved By:

07/09/26

Ardra Hunter
Area Manager

Date