GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

Gladys Sledge
Packard Group Inc
PO Box 2066
Southfield, MI 48037

RE: License #: AS630367512
Investigation #: 2022A0605011
Woodward Group Home

Dear Ms. Sledge:

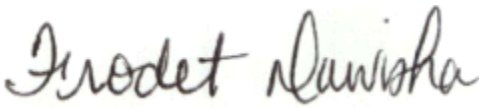
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
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(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630367512
Investigation #:	2022A0605011
Complaint Receipt Date:	11/05/2021
Investigation Initiation Date:	11/08/2021
Report Due Date:	01/04/2022
Licensee Name:	Packard Group Inc
Licensee Address:	Suite 303 731 Pallister Street Detroit, MI 48202
Licensee Telephone #:	(248) 626-3837
Administrator/Licensee Designee:	Gladys Sledge
Name of Facility:	Woodward Group Home
Facility Address:	2563 Lahser Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 335-0946
Original Issuance Date:	07/16/2015
License Status:	REGULAR
Effective Date:	01/16/2020
Expiration Date:	01/15/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 9/1/2021, Resident A was found in his bed unattended for 30 minutes with no briefs, feces on his body, no pants on, with his legs off the side of the bed. Direct care staff (DCS) David Sledge left shift without finishing changing Resident A. Resident A's plan calls for checks every 15 minutes.	Yes

III. METHODOLOGY

11/05/2021	Special Investigation Intake 2022A0605011
11/08/2021	Special Investigation Initiated - Telephone Office of Recipient Rights (ORR) Brittany Navetta will be investigating these allegations.
11/08/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed the home manager (HM) Daniella Young and assistant home manager (AHM) De-ja Caldwell and Macomb-Oakland Regional Center (MORC) case manager Amy Ciraulo. I observed Resident A and Resident B. I reviewed incident reports and Resident A's individual plan of service (IPOS).
11/09/2021	Contact - Telephone call made I interviewed direct care staff (DCS) Tracey Daniels, David Sledge and Resident A's mother/legal guardian regarding the allegations. I left a voice mail message for DCS Sallie Kenney.
11/17/2021	Contact - Telephone call made I left another message for DCS Sallie Kenney.
12/02/2021	Contact - Telephone call made ORR Brittany Navetta stated she is substantiating her case.
12/14/2021	Contact - Telephone call received APS worker Ra'Shawnda Robertson stated she substantiated her case.

12/22/2021	Exit Conference I conducted an exit conference with licensee designee Gladys Sledge regarding my findings.

ALLEGATION:

On 9/1/2021, Resident A was found in his bed unattended for 30 minutes with no briefs, feces on his body, no pants on, with his legs off the side of the bed. Direct care staff (DCS) David Sledge left shift without finishing changing Resident A. Resident A's plan calls for checks every 15 minutes.

INVESTIGATION:

On 11/05/2021, intake #183165 was referred by Oakland County Office of Recipient Rights (ORR) regarding Resident A was found in his bed with no briefs, feces on his body, and no pants with his legs off the side of the bed.

On 11/08/2021, I initiated the investigation by contacting ORR, Brittany Navetta. Ms. Navetta stated she is investigating these allegations.

On 11/08/2021, I conducted an unannounced on-site investigation. I interviewed the home manager (HM) Daniella Young, assistant home manager (AHM) De-ja Caldwell and Macomb-Oakland Regional Center (MORC) case manager Amy Ciraulo.

The HM was interviewed regarding the allegations. She has been working for Packard Group, Inc., since July 2021 as the HM. She works the day shift from 7AM-3PM and was working with direct care staff (DCS) David Sledge on 09/01/2021. The HM stated there was a shift change around 2:30PM between the morning and afternoon staff. DCS Sallie Kenney worked the afternoon shift on 09/01/2021. She began her shift at 3PM. Ms. Kenney did a walkthrough and reported to the HM that Ms. Kenney went into Resident A's bedroom and observed Resident A left unchanged with his legs hanging off the bed, no briefs on, no pants on, and with feces on his buttocks and back. The HM stated she went into Resident A's bedroom and observed what Ms. Kenney reported to the HM. The HM stated she also observed used wipes covered in feces on the bedroom floor near Resident A's bed. The HM stated that DCS David Sledge was assigned to Resident A on 09/01/2021; therefore, Mr. Sledge was responsible for providing personal care to Resident A. The HM stated she called Mr. Sledge on the phone because he had already left his shift. The HM stated when she told Mr. Sledge how she observed Resident A in his bedroom, Mr. Sledge told her, "I forgot to finish changing Resident A before I left." The HM stated that Mr. Sledge was suspended pending an investigation. The HM stated that she and Ms. Kenney were the only two individuals who observed Resident A in the condition he was in on 09/01/2021. The HM stated Resident A is completely paralyzed, nonverbal, and requires total care with personal hygiene.

The HM stated that Resident A is a two-hour check when he is in his bedroom, which is incorrect according to Resident A's individual plan of service (IPOS) completed by MORC on 09/30/2020. According to the IPOS, "Resident A needs full physical assistance in all areas of personal care and household tasks. He is in a wheelchair and has very limited movement. He is also non-verbal and makes vocal noises. Resident A needs to be visually checked every 15-minutes during waking hours. Staff should reposition Resident A throughout the day." The HM stated, "I didn't know that." The HM reported that she had not reviewed Resident A's IPOS and then stated, "I've never done a 15-minute check on Resident A whenever he's in his bedroom or not in my eyesight." I requested to review the incident report (IR) she completed regarding Resident A on 09/01/2021. The HM was unable to locate the IR; therefore, it was not available for my review.

I interviewed the AHM De-ja Caldwell regarding the allegations. The AHM has been worked for Packard Group, Inc., for one month. She was not present but heard that DCS David Sledge left Resident A hanging off his bed, without his briefs or his pants, and covered in feces and then left his shift. The AHM stated DCS Sallie Kenney was the staff who worked the afternoon shift and found Resident A in the condition he was in. Ms. Kenney changed Resident A and put him back into bed. The AHM stated she too did not know that Resident A was a 15-minute check as the AHM thought Resident A was a "30-minute check." The AHM stated that Resident A is usually within eyesight; however, Resident A likes to go into his bedroom after lunch, so whenever Resident A is in his bedroom, the AHM conducts a 30-minute check. The AHM stated the checks during waking hours are not conducted, only the bed checks during sleeping hours are. The AHM also stated she had not reviewed Resident A's IPOS dated 09/30/2020.

Note: I was unable to interview Resident A regarding these allegations as he is nonverbal. However, I observed Resident A in his wheelchair; he appeared to have good hygiene. I attempted to interview Resident B, but Resident B was unable to provide any details as to these allegations. He too appeared to have good hygiene.
I interviewed MORC's case manager Amy Ciraulo who arrived at Woodward Group Home during this visit. Ms. Ciraulo stated she was conducting a monthly check on all the residents as all the residents receive services through MORC. Ms. Ciraulo stated she has the updated IPOS dated 09/30/2021 and forwarded it to the HM to print and place in Resident A's file. Ms. Ciraulo stated due to Resident A being completely paralyzed, non-verbal, and dependent on full care, he is a 15-minute check during waking hours. Ms. Ciraulo stated she will review Resident A's IPOS with staff at Woodward Group Home since staff were not following Resident A's IPOS. Ms. Ciraulo had a copy of the IR on her laptop for my review.

Note: I reviewed the IR was dated 09/01/2021 at 3PM written by the HM Daniella Young and DCS Sallie Kenney. "Sallie did her walkthrough and witnessed Resident A laying in his bed. Resident A had no bottoms on or brief to cover him. He was covered in feces and his legs were hanging off his bed. Sallie and Daniella cleaned him up and put his clothes back on. Daniella contacted Dana Pikula (Regional Coordinator) and Gladys Sledge (licensee designee)."

The HM contacted the regional coordinator Dana Pikula via telephone regarding the missing IRs. Ms. Pikula stated the IRs should be in Resident A's file at Woodward Group Home as Ms. Pikula never removed them from the file after the audit the morning of 09/01/2021. Ms. Pikula stated she does not see the IR at their corporate office. She reported that DCS David Sledge was suspended and removed from the schedule, but then Mr. Sledge quit.

On 11/09/2021, I interviewed DCS Tracey Daniels regarding the allegations. Ms. Daniels has worked for Packard Group, Inc., for seven years. She works the midnight shifts with DCS David Sledge. Ms. Daniels stated she was not present when Resident A was found hanging off his bed without any briefs and pants and covered in feces, but she was told about what happened by the HM. Ms. Daniels stated she was "shocked," to here that Mr. Sledge left Resident A in "that condition," because "Mr. Sledge took good care of all the men." Ms. Daniels believes that Mr. Sledge was "probably distracted," because Mr. Sledge "was working too many hours." She stated Woodward Group Home was short staffed; therefore, Mr. Sledge would agree to work additional shifts, sometimes double shifts. Ms. Daniels stated when she worked with Mr. Sledge, he would meet all the needs of the residents. She stated Mr. Sledge never left any resident including Resident A unattended or in the condition that Resident A was found on 09/01/2021.

On 11/09/2021, I interviewed Resident A's mother/guardian regarding the allegations. The mother stated when she was told about the incident on 09/01/2021, she could not believe that DCS David Sledge left Resident A in the condition he was found. The mother stated that Mr. Sledge took good care of Resident A and Mr. Sledge was "nice and very attentive to Resident A." The mother stated she noticed Mr. Sledge was distracted within the last few months, but thought it was probably a "personal issue." The mother stated she visits Resident A regularly and picks Resident A up three times a week and brings him home. She stated Resident A is "well cared for," because "Resident A has no skin breakdowns or poor hygiene." The mother stated she has no concerns regarding any DCS at Woodward Group Home.

On 11/09/2021, I interviewed DCS David Sledge regarding the allegations. Mr. Sledge had been working for Packard Group, Inc., for the past seven years, but then he quit on 09/01/2021 after the incident. Mr. Sledge stated he worked the afternoon shift on 08/31/2021 at 2PM and his shift did not end until 09/01/2021 at 2:30PM. Mr. Sledge stated he was responsible for the care of Resident A on 09/01/2021. Resident A had a large bowel movement (BM) so he went into Resident A's bedroom to clean him up. He stated, "I cleaned him up and put him back into bed." Mr. Sledge stated he then went into the HM's office asking her about the staff schedule. Mr. Sledge was removed from the staff schedule, and he wanted to know why. The HM told him he needed to speak with his aunt, Gladys Sledge, so he left his shift and went home. Mr. Sledge stated about 30 minutes later, he got home and received a telephone call from the HM. The HM told him that DCS Sallie Kenney found Resident A hanging off his bed with no briefs or pants on covered in feces. Mr. Sledge stated, "I told the HM, I have never done that,

changed him." Mr. Sledge believes these allegations were "made up," because he was questing his paycheck. Mr. Sledge stated he has been having issues with his aunt, Gladys Sledge "not paying him for the hours he worked." He stated, "that's why I quiet. I was hurt I had to leave." Mr. Sledge denied leaving Resident A in the condition he was in and stated, "I take good care of all the residents."

On 12/08/2021, I contacted ORR worker Brittany Navetta regarding her investigation. Ms. Navetta stated she received a different version from DCS David Sledge regarding the allegations. Mr. Sledge told Ms. Navetta he received a telephone call from the HM 30-minutes after leaving his shift at Woodward Group Home. Mr. Sledge told Ms. Navetta that the HM told Mr. Sledge that "he left Resident A legs hanging off the bed, with no brief on and with feces all over him. Mr. Sledge then told Ms. Navetta "I was tired, and I assume it did happen and maybe I made a mistake."

On 12/14/2021, I contacted APS worker Ra'Shawnda Robertson who stated she is substantiating her investigation.

On 12/22/2021, I conducted the exit conference via telephone with licensee designee Gladys Sledge regarding my findings. Ms. Sledge stated she was informed about what DCS David Sledge during his shift on 09/01/2021 pertaining to Resident A. Mr. Sledge began cleaning Resident A who had feces on his back and legs. During Mr. Sledge wiping Resident A, Mr. Sledge left Resident A unattended and went home. Ms. Sledge stated DCS Sallie Kenney arrived at her shift and during a walkthrough, noticed Resident A hanging off his bed without any briefs and covered in feces. Ms. Sledge contacted DCS Mr. Sledge asking him what happened. Mr. Sledge told her, "I worked many hours. I'm human, I made a mistake and forgot to finish." Ms. Sledge stated she terminated Mr. Sledge's employment with Packard Group.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, Resident A was not provided with supervision, protection, and personal care as defined in his IPOS dated 09/30/2020. Resident A's IPOS specifically stated that due to Resident A being fully dependent on staff for his care, he requires a 15-minute check during waking hours. According to the HM Daniella Young and AHM De-ja Caldwell, staff had not been conducting 15-minute checks on Resident A during waking hours. The HM stated she was conducted two-hour checks and the AHM was conducting 30-minute checks of Resident A when he was not at eyesight.

CONCLUSION:	**VIOLATION ESTABLISHED**

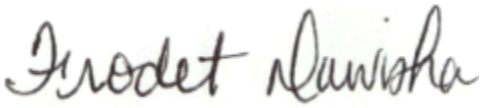
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, DCS David Sledge did not treat Resident A with dignity and Resident A's personal needs, including protection and safety were not attended to at all times. On 09/01/2021, Resident A had a BM and Mr. Sledge was helping change/clean Resident A. In the middle of attending to Resident A, Mr. Sledge left Resident A legs hanging off the bed without any briefs and pants and covered in feces. The HM Daniella Young and DCS Sallie Kenney observed Resident A in this condition. Mr. Sledge's employment with Packard Group, Inc., was terminated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During my on-site investigation on 11/08/2021, I requested to review the incident report (IR) dated 09/01/2021 written by both the HM and DCS Sallie Kenney. The HM was unable to locate the IR; therefore, it was not available for the departments review.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my investigation and information gathered, Resident A is dependent on staff to meet all his needs, including personal hygiene; therefore, on 09/01/2021, DCS David Sledge did not ensure Resident A's hygiene was completed before leaving his shift. Resident A had a large BM. Mr. Sledge left Resident A's legs and back covered in feces after Mr. Sledge left Resident A in the middle of being changed/cleaned and went home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

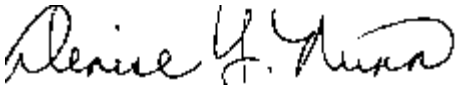
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



12/22/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



12/22/2021

Denise Y. Nunn Date
Area Manager