GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2022

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

RE: License #: AS630384567
Investigation #: 2022A0611021
Hollow Lake Home

Dear Ms. Sledge:

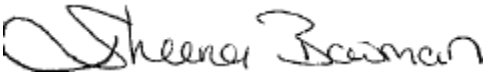
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630384567
Investigation #:	2022A0611021
Complaint Receipt Date:	03/22/2022
Investigation Initiation Date:	03/24/2022
Report Due Date:	05/21/2022
Licensee Name:	Packard Group Inc
Licensee Address:	Suite 303 - 731 Pallister Street Detroit, MI 48202
Licensee Telephone #:	(248) 626-3837
Administrator:	Gladys Sledge
Licensee Designee:	Gladys Sledge
Name of Facility:	Hollow Lake Home
Facility Address:	10658 Big Lake Road Davisburg, MI 48350
Facility Telephone #:	(313) 872-7826
Original Issuance Date:	12/20/2016
License Status:	REGULAR
Effective Date:	06/20/2021
Expiration Date:	06/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
On 3/19/22, Resident A had an altercation with staff member Cyanah Pruitt causing resident to be visibly upset and crying.	No
Additional Findings	Yes

III. METHODOLOGY

03/22/2022	Special Investigation Intake 2022A0611021
03/24/2022	APS Referral I made an Adult Protective Services (APS) referral.
03/24/2022	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed staff member, Cyanah Pruitt, staff member, Alyssa Gross, and I attempted to interview Resident A. I received a copy of Resident A's personal care/community living supports log.
03/25/2022	Contact - Document Received I received an email from adult licensing complaint intakes, stating the APS referral was denied.
03/29/2022	Contact - Telephone call made I made a telephone call to the home manager, Dana Pikula. The allegations were discussed.
03/30/2022	Contact - Telephone call made I made a telephone call to staff member, Lisia Williams. The allegations were discussed.
03/30/2022	Contact - Telephone call made I made a telephone call to recipient rights specialist, Kathleen Garcia. The allegations were discussed.
03/30/2022	Exit Conference I completed an exit conference with the licensee designee, Gladys Sledge via telephone.

04/04/2022	Contact-Document Received I received a copy of Resident A's health care chronological and a prescription for his hospital bed rails and shower chair.
04/19/2022	Contact-Document Received I received a copy of Resident A's Individual Plan of Service.

ALLEGATION:

On 3/19/22, Resident A had an altercation with staff member Cyanah Pruitt causing resident to be visibly upset and crying.

INVESTIGATION:

On 03/22/22, I received the abovementioned allegations. The allegations were received from recipient rights specialist, Kathleen Garcia.

On 03/24/22, I completed an unannounced onsite. I interviewed staff member, Cyanah Pruitt, staff member, Alyssa Gross, and I attempted to interview Resident A. I received a copy of Resident A's personal care/community living supports log. I also received a copy of the employee schedule.

On 03/24/22, I interviewed staff member Cyanah Pruitt. Ms. Pruitt stated she thinks staff member, Lisia Williams quit working at the AFC group home on 03/21/22 as she did not call or show up for her shift. Regarding the allegations, Ms. Pruitt stated Resident A wanted her to change the adjustment settings on his wheelchair as it was on a high level and he wanted it to go down to a low level. Ms. Pruitt stated prior to Resident A asking her to change the settings on his wheelchair, she had just assisted him with using the urinal in the bathroom. After Resident A used the urinal, some urine got on his brief and Ms. Pruitt needed to take him to his room and place him on his bed to change his brief. Ms. Pruitt explained to Resident A that she needed to change her gloves first before changing his settings so she could then change his brief. Ms. Pruitt stated Resident A did not like that she was not moving fast enough as he started to come at her in his wheelchair. Ms. Pruitt stated this was the second time Resident A has charged at her in his wheelchair.

Ms. Pruitt asked Resident A if he needed to go to his bedroom and calm down. Resident A responded by saying no and “F*** you”. This occurred in the bathroom. Ms. Pruitt told Resident A she needed to change his brief. At this time, they were in Resident A’s bedroom and Resident A started to thrust himself out of his wheelchair. Ms. Pruitt told Resident A to calm down. Ms. Pruitt suggested to call Resident A’s sister or another staff member to calm him down. Resident A responded by saying he didn’t care and “F*** you”. Ms. Pruitt asked Resident A if she should call the police and his response was the same.

Ms. Pruitt stated she used a Hoyer lift to transport Resident A onto his bed. Once Resident A was on his bed, he tried to throw himself off the bed. In order to prevent Resident A from falling off the bed, Ms. Pruitt turned his bed around because the bed rail that was on the side Resident A was thrusting himself off the bed does not work. Once Ms. Pruitt turned Resident A's bed around, she was able to put up the other bed rail to keep Resident A from throwing himself off the bed. Ms. Pruitt stated staff member, Alyssa Gross was in and out of the bedroom because she did not know what to do. Ms. Pruitt stated after she turned Resident A's bed around, she told Ms. Gross to call the home manager, Dana Pikula. Resident A talked to Ms. Pikula over the phone by himself and he calmed down. Ms. Pruitt stated Resident A refused to eat, drink, and he stayed in his bedroom for the rest of the night.

Ms. Pruitt stated when staff member, Lisia Williams arrived for her midnight shift, she went into Resident A's bedroom and Resident A started crying and said what was reported in the allegations. Ms. Pruitt stated she did not inform Ms. Williams about the incident that took place but, she did document the incident in Resident A's log book. Ms. Pruitt did not complete an incident report because she was busy and forgot. This incident occurred at the end of day shift. Ms. Pruitt stated at the beginning of every shift, staff members are expected to read the staff log book but not the residents log book. Ms. Pruitt stated this was unusual for Resident A to behave this way. Ms. Pikula told Ms. Pruitt that she thinks Resident A is acting out because his sister has not visited him in a while. Ms. Pruitt stated that she has a close relationship with Resident A and there have been no issues since this incident. While I was speaking to Ms. Pruitt she started to cry. Resident A appeared concerned and asked Ms. Pruitt if she was ok.

On 03/24/22, I attempted to interview Resident A however, it is very hard to understand him. Resident A stated he likes living at the AFC group home. Resident A denied having any problems with any of the staff members. Resident A denied any staff members hurting him, hitting him, or doing anything they weren't supposed to. I observed Resident A's bed rails and saw the bed rail on the right side does not work and the left side bed rail near the wall does work but it takes a lot of effort to pull it up.

On 03/24/22, I interviewed staff member Alyssa Gross. Regarding the allegations, Ms. Gross stated Ms. Pruitt took Resident A to the bathroom. Ms. Gross stated she heard Ms. Pruitt say "I'm going to do it just let me take my gloves off, don't get mad". Ms. Gross went into Resident A's bedroom and Ms. Pruitt had Resident A in the hoyer lift. Resident A was throwing himself around and Ms. Pruitt had to hold his legs. Ms. Gross assisted Ms. Pruitt by holding one of Resident A's legs. Resident A started swearing and kicked Ms. Pruitt. Ms. Gross left the bedroom to call Resident A's sister. Ms. Pruitt got Resident A into his bed. Resident A was trying to throw himself off the bed on the side that had the broken bed rail. Ms. Pruitt turned Resident A's bed around in order to put up the bed rail that works. When Resident A's bed was turned around, his head was at the foot of the bed. Ms. Gross stated Ms. Pikula was contacted and Resident A started to talk to her. Ms. Gross stated Resident A does not usually display this type of behavior. However, she witnessed another incident where Resident A charged at Ms. Pruitt in his wheelchair. Resident A was upset because Ms. Pruitt told him he had to

wait for his cereal to get soft before he could eat it. This incident occurred 2 ½ months ago. Ms. Gross stated she does not know if an incident report was completed regarding that incident.

Ms. Gross stated she does not know if Ms. Pikula is aware of Resident A's broken bed rail. Ms. Gross stated Resident L's bed rails are also broken.

Ms. Gross stated Ms. Williams was not properly taking care of Resident A as she did not brush his teeth. Ms. Gross showed me pictures of a spec of feces on the outside cover of wipes and on Resident A's nightstand from 03/20/22. Ms. Gross stated Ms. Williams would ignore Resident A during sleeping hours when he needed to be changed. Ms. Gross stated Resident A would not want to take any fluids before bedtime because he knew Ms. Williams would not change him. Ms. Gross informed Ms. Pikula about this and she advised that Resident A must be hydrated. I observed Resident A's bedroom and it appeared clean and in good condition. Resident A was also observed to be clean and properly groomed.

On 03/24/22, I received a copy of Resident A's personal care/community living supports log dated 03/19/22. The personal care/community living supports log described the incident that occurred during the dayshift between Resident A and Ms. Pruitt signed by Ms. Gross. During the afternoon shift, it was documented by Brittany Scarbrough that Resident A refused to eat dinner, he had a bad attitude, he stayed in bed, and he was checked and changed every two hours. On 03/24/22, I received a copy of the employee schedule. According to the employee schedule, Ms. Williams was taken off the schedule on 03/22/22.

On 03/29/22, I made a telephone call to the home manager, Dana Pikula. Regarding the allegations, Ms. Pikula stated Ms. Pruitt contacted her and informed her that while she was assisting Resident A in the bathroom, he asked for the speed on his wheelchair to be decreased from high to low. Ms. Pruitt jokingly told Resident A no because he is a speed racer. Resident A became upset and charged at Ms. Pruitt in his wheelchair. Ms. Pruitt explained to Resident A that he needed to be changed because he had some urine on his brief. While Ms. Pruitt had Resident A in the hoyer lift, he started throwing his body weight around. When Ms. Pruitt got Resident A in his bed, he tried to roll himself out of the bed. Ms. Pruitt tried to lift Resident A's bed rail but it was broken. Ms. Pruitt then turned Resident A's bed around so that she could lift the other bed rail. Resident A was swearing at Ms. Pruitt as he was telling her to "F*** off".

Ms. Pruitt offered to call Resident A's sister and/or Ms. Pikula but Resident A's response was he didn't care. Ms. Pikula stated Ms. Pruitt did call her and gave the phone to Resident A. Ms. Pikula spoke to Resident A and Ms. Pruitt left the bedroom. Ms. Pikula asked Resident A what was going on. Resident A denied anyone hitting or hurting him. Resident A admitted to trying to get out of the hoyer lift and trying to roll out of his bed because he was mad. Ms. Pruitt told Resident A it is ok for him to get angry but she doesn't want him to hurt himself. Resident A stated he was going to take a nap.

Ms. Pikula stated she was informed by the afternoon staff member, Brittany Scarbrough that Resident A stayed in his bedroom during the entire shift as he refused to do anything.

On 03/21/22, Ms. Pikula explained to Ms. Pruitt and Ms. Gross that an incident report should have been completed despite the fact that they notified her about the incident. Ms. Pikula did not advise them to complete an incident report because it was after the fact. Ms. Pikula stated she was not aware of Resident A's broken bed rail. Ms. Pikula stated Resident A doesn't usually use his bed rails. Ms. Pikula stated she is waiting for Resident A's occupational therapist to either repair or replace Resident A's bed rail. Ms. Pikula is hoping this will occur by the end of the month. Ms. Pikula was not aware of Resident L's bed rail not working. Ms. Pikula stated she will follow up on Resident A's bed rail.

Ms. Pikula stated Ms. Williams was taken off the schedule for not showing up to work or calling on 03/21/22. This was Ms. Williams fifth no call/no show. Ms. Williams has not been terminated as she will be offered to transfer to another group home.

On 03/30/22, I made a telephone call to Lisia Williams. Ms. Williams stated she was taken off the schedule at the AFC group home for a no call/no show. Ms. Williams denied the no call/no show as she sent a text message to Ms. Pikula notifying her, she would not be able to make it to work. Regarding the allegations, Ms. Williams stated she arrived to the AFC group home for her shift at 11:00 pm. Resident A heard Ms. Williams when she arrived and he called out her name. Ms. Williams went into Resident A's bedroom and saw that his head was facing the foot of the bed and his legs were at the headboard. Ms. Williams asked Resident A why he was upside down in bed. Resident A stated he had been in a fight. Ms. Williams thought Resident A meant an argument as he only has about 30% mobility with his arms and he cannot kick or lift his legs. Resident A informed Ms. Williams that he was in a fight with Ms. Pruitt. Resident A also stated he wasn't fed and he was put in his bedroom. Ms. Williams stated Resident A was crying and upset. Ms. Williams sent Ms. Pikula a text message informing her about the situation.

Resident A told Ms. Williams that Ms. Pikula is not going to do anything about it. Ms. Williams stated that Resident A did not want Ms. Williams to tell anybody about what happened because he did not want her to get into trouble. Ms. Pikula' s response to Ms. Williams text message was that she spoke to Resident A and he admitted to trying to run Ms. Pruitt over with his wheelchair and tried to roll out of the Hoyer lift. Ms. Pikula stated she plans to talk to Resident A again on 03/21/22. Ms. Pikula also stated that Brittany Scarbrough tried to feed him during the afternoon shift and he refused to eat.

Ms. Williams stated Resident A told her about a month ago that Ms. Pruitt had yelled at him and he wanted to move. Ms. Williams informed the assistant manager, Becky about this and Becky stated she will speak to Resident A about it. Ms. Williams does not know Becky's last name. Ms. Williams denied ever observing Ms. Pruitt being abusive or neglectful towards Resident A. Ms. Williams stated she has heard Ms. Pruitt raise her

voice to Resident L while responding to him. Ms. Williams stated the staff in the home have had verbal arguments in front of the residents.

On 03/30/22, I made a telephone call to recipient rights specialist, Kathleen Garcia. Ms. Garcia stated Resident A told her that Ms. Pruitt yelled at him and told him to go to bed. Resident A did not say anything about a fight. Ms. Garcia interviewed Resident E and Resident J and they did not report any concerns. Ms. Garcia stated she will not substantiate her investigation.

On 03/30/22, I completed an exit conference with the licensee designee, licensee designee, Gladys Sledge. Ms. Sledge was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 03/24/22, Resident A denied having any problems with any of the staff members. Resident A denied any staff members hurting him, hitting him, or doing anything they weren't supposed to. The recipient rights specialist, Kathleen Garcia interviewed Resident A and he stated Ms. Pruitt yelled at him and told him to go to bed. Resident A did not say anything about a fight. Ms. Pruitt and Ms. Gross explained the incident that took place with Resident A and neither one of them reported any form of physical force towards Resident A. Ms. Williams denied ever observing Ms. Pruitt being abusive or neglectful towards Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

On 03/24/22, I observed Resident A's bed rails and saw the bed rail on the right side does not work and the left side bed rail near the wall does work but it takes a lot of effort to put it up.

On 04/04/2022, I received a copy of Resident A's prescription for his hospital bed rails. The prescription is dated for 01/09/21.

On 04/19/2022, I received a copy of Resident A's individual plan of service dated 07/12/21. According to the individual plan of service, Resident A is prescribed a hospital bed with rails.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.
ANALYSIS:	On 03/24/22, I observed Resident A's bed rails and saw the bed rail on the right side does not work and the left side bed rail near the wall does work but it takes a lot of effort to pull it up. Resident A's bed rails cannot ensure his well-being as they do not work properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Sheena Bowman 04/19/22
Licensing Consultant Date

Approved By:

Denise Y. Nunn 04/19/2022
Area Manager Date