GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Mitchell Naegele
Packard Specialized Residential, LLC
1173 S. Packard Ave.
Burton, MI 48509

RE: License #:	AM250406626
Investigation #:	2023A0872004
	Packard Specialized Residential

Dear Mr. Naegele:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250406626
Investigation #:	2023A0872004
Complaint Receipt Date:	10/25/2022
Investigation Initiation Date:	10/26/2022
Report Due Date:	12/24/2022
Licensee Name:	Packard Specialized Residential, LLC
Licensee Address:	1173 S. Packard Ave. Burton, MI 48509
Licensee Telephone #:	(810) 288-2226
Administrator:	Timothy Bertram
Licensee Designee:	Mitchell Naegele
Name of Facility:	Packard Specialized Residential
Facility Address:	1173 S. Packard Ave. Burton, MI 48509
Facility Telephone #:	(810) 288-2226
Original Issuance Date:	03/05/2021
License Status:	REGULAR
Effective Date:	09/05/2021
Expiration Date:	09/04/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 08/25/22, Resident A was found wandering down the road from his AFC home. He was taken to Memorial Hospital in Owosso. AFC staff refused to pick him up when he was ready for discharge.	No
Additional Findings	Yes

III. METHODOLOGY

10/25/2022	Special Investigation Intake 2023A0872004
10/25/2022	APS Referral This complaint was referred by APS. Janeen Rouse is the worker
10/26/2022	Special Investigation Initiated - Letter I emailed the Adult Protective Services Worker, Janeen Rouse
10/27/2022	Inspection Completed On-site Unannounced
10/27/2022	Contact - Telephone call made I interviewed APS Worker, Ms. Rouse about this complaint
11/29/2022	Contact - Document Sent I emailed the licensee designee, Mitch Naegele, requesting information related to this complaint
11/29/2022	Contact - Telephone call made I interviewed Resident A's guardian, Patti Bush
11/29/2022	Contact - Document Received I received AFC documentation from Mr. Naegele
11/30/2022	Contact - Telephone call made I spoke to the licensee designee, Mitch Naegele
11/30/2022	Exit Conference I conducted an exit conference with Mr. Naegele
11/30/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 08/25/22, Resident A was found wandering down the road from his AFC home. He was taken to Memorial Hospital in Owosso. AFC staff refused to pick him up when he was ready for discharge.

INVESTIGATION: On 10/27/22, I conducted an unannounced onsite inspection of Packard Specialized Residential Services Adult Foster Care facility. I interviewed staff Whitney Kononchuk and Resident A.

Ms. Kononchuk said that Resident A was in the hospital for a couple of weeks in September 2022 but when he was discharged, he returned to this AFC home. Ms. Kononchuk said to her knowledge, at no time did anyone refuse to allow Resident A to return to the facility. Ms. Kononchuk said that she did not hear anything about Resident A wandering from the AFC facility. She said that Resident A is allowed to move independently in the community as long as he signs in and out on the facility log.

Resident A confirmed that he resides at Packard Specialized Residential Services AFC and has lived here for approximately three months. He said that a couple of months ago, he was hospitalized and then transferred to a hospital in Owosso. Resident A told me that to his knowledge, staff at Packard AFC never refused to allow him to come home.

I asked Resident A about the incident that resulted in his hospitalization. He said that a couple of months ago, one morning he was going to his friend's house who owns a junkyard. He signed out on the facility sign out log, told staff he was leaving, and where he was going. Resident A told me, "I ran out of gas (got tired), so I stopped to rest at that doctor's office." He said that he did not feel like walking anymore, so he went inside the doctor's office and asked to use their phone. He said that since the police know him, he called them and asked them if they would come and pick him up and give him a ride to his friend's house. Resident A stated that when the police showed up, they told him they would not take him to his friend's house, so he started walking again. He said that the police followed him and told him to get in the car, so he did. Resident A said that since he had not been taking his medication, the police took him to the hospital. He said that after being at the hospital, "they transferred me to the mental hospital in Lansing." Resident A was lucid and pleasant during this interview. He appeared to be clean, dressed appropriately, and well taken care of.

On 10/27/22, I interviewed Adult Protective Services Worker, Janeen Rouse via telephone. Ms. Rouse said that since making this referral to LARA, she has since learned that Resident A was never refused admittance back to Packard Specialized Residential Services. She said that it sounds like there was miscommunication between the personnel in the psychiatric unit of the hospital and the AFC facility. Ms. Rouse said that she is not substantiating any allegations.

On 11/29/22, I interviewed Resident A's public guardian, Patti Bush, via telephone. Ms. Bush said that she has been Resident A's payee for approximately seven years and has been his guardian for approximately one year. I reviewed the allegations with Ms. Bush,

and she said that she is aware a complaint was made. According to Ms. Bush, Resident A was admitted to Packard Specialized Residential Services AFC in June 2022. He was compliant and cooperative so after 30 days, he was allowed limited unsupervised community access. Ms. Bush said that Resident A was allowed to sign out of the facility and go for a walk, by himself which he did almost every day. In August 2022, Resident A left the facility after signing out, saying he was going for a walk. Later, that morning, she, and Packard Residential staff received a call that Resident A was holding up traffic and the police were taking him to the hospital. Ms. Bush said for a couple of days leading up to this incident, Resident A was being noncompliant with some of his medications which she and staff were addressing with his psychiatrist. However, Ms. Bush said that there were no indications that Resident A was going to have a "psychotic break" which is why his community access was not limited.

Ms. Bush told me that at no time did she or Packard Residential Services staff refuse to allow Resident A to return to the AFC facility. She said that as soon as Resident A was medically cleared, he returned to Packard AFC, and he has been doing well since that time. She said that he is now on a psychotropic injectable, Invega, and he is stable. Ms. Bush stated that the staff at Packard Residential are "excellent" and she has no complaints about the care Resident A receives. Ms. Bush said that she has worked closely with Packard Residential staff and the licensee designee, Mitchell Naegele, and they all want what is best for Resident A. Now that he is once again stable, he is allowed to have limited unsupervised community access.

On 11/29/22, I received AFC documentation from the licensee designee, Mitchell Naegele. Resident A was admitted to Packard Specialized Residential Services on 06/08/22. According to his Health Care Appraisal, he is diagnosed with bipolar disorder, hyperlipidemia, and Parkinson's disease. According to his Assessment Plan dated 06/08/22, he is allowed to move independently in the community, but he requires "monitoring and supervision." It states that Resident A "enjoys going on walks. Staff will monitor and encourage him to remain physically active as he tolerates."

According to his Shiawassee Health & Wellness Individualized Plans of Service (IPOS) dated 6/17/22 and 10/06/22, he does not require 1-on-1 or enhanced supervision. It states, "(Staff) will provide opportunities for (him) to go into the community in a safe manner on a regular basis and will provide transportation to all appointments."

On 11/30/22, I spoke to Mr. Naegele via telephone. He confirmed that Resident A has resided at his facility since June 2022. Mr. Naegele also confirmed that up until the incident in August 2022, Resident A was allowed to have unsupervised contact in the community if he signed in and out and notified staff where he was going.

According to Mr. Naegele, when Resident A left the facility on 8/27/22, he signed out and told staff he was going on a walk. He said that Resident A was not behaving erratically and when staff received the phone call from the police, it was unexpected. Mr. Naegele told me that staff accompanied Resident A to the hospital and stayed with him until he was admitted. Mr. Naegele said that he stayed in close contact with hospital

staff and at no time did anyone refuse to allow Resident A to return to Packard Specialized Residential. Once Resident A was stabilized, he returned to the facility, and he has been doing well since then. He is now on an injectable psychotropic medication and his mood and behavior have remained stable.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
ANALYSIS:	**(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
	According to the APS Worker, Janeen Rouse, after making this complaint to LARA, she learned that Resident A was never refused admittance back to Packard Specialized Residential Services.

	Staff Whitney Kononchuk, Resident A, Resident A's guardian, Patti Bush, and the licensee designee, Mitchell Naegele said that Packard Specialized Residential staff never refused to accept Resident A back to the facility. I conclude there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	According to staff Whitney Kononchuk, Resident A, Resident A's guardian, Patti Bush, and the licensee designee, Mitchell Naegele, at the time of the incident on 8/27/22, Resident A was allowed limited unsupervised community access. According to Resident A's Assessment Plan dated 06/08/22, he is allowed to move independently in the community, but he requires "monitoring and supervision." According to his Shiawassee Health & Wellness Individualized Plans of Service (IPOS) dated 6/17/22 and 10/06/22, he does not require 1-on-1 or enhanced supervision. It states, "(Staff) will provide opportunities for (him) to go into the community in a safe manner on a regular basis and will provide transportation to all appointments." I conclude there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A was hospitalized on 08/27/22. On 11/30/22, I spoke to the licensee designee, Mitchell Naegele about the hospitalization. He told me that he is not able to find documentation that an Incident/Accident Report was completed a filed regarding this hospitalization.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Resident A was hospitalized on 08/27/22. On 11/30/22, I spoke to the licensee designee, Mitchell Naegele about the hospitalization. He told me that he is not able to find documentation that an Incident/Accident Report was completed a filed regarding this hospitalization which is a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/30/22, I conducted an exit conference with the licensee designee, Mitchell Naegele. I discussed the findings of my investigation and explained which rule violation I am substantiating. Mr. Naegele agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

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

Susan Hutchinson December 1, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton December 1, 2022

Mary E. Holton Area Manager	Date