GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 20, 2023

Timothy Bertram
Packard Specialized Residential, LLC
1173 S. Packard Ave.
Burton, MI 48509

RE: License #:	AM250406626
Investigation #:	2023A0872048
	Packard Specialized Residential

Dear Mr. Bertram:

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 #:	2023A0872048
Complaint Receipt Date:	06/07/2023
Investigation Initiation Date:	06/07/2023
Report Due Date:	08/06/2023
Licensee Name:	Packard Specialized Residential, LLC
Licensee Address:	1173 S. Packard Ave. Burton, MI 48509
Licensee Telephone #:	(248) 705-9802
Administrator:	Timothy Bertram
Licensee Designee:	Timothy Bertram
Name of Facility:	Packard Specialized Residential
Facility Address:	1173 S. Packard Ave. Burton, MI 48509
Facility Telephone #:	(833) 478-9464
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 06/03/23, Resident A gained access to staff's purse and ingested an unknown amount of medication. She is currently hospitalized.	Yes

III. METHODOLOGY

06/07/2023	Special Investigation Intake 2023A0872048
06/07/2023	APS Referral I made an APS complaint via email
06/07/2023	Special Investigation Initiated - Letter
06/08/2023	Inspection Completed On-site Unannounced
06/08/2023	Contact - Document Received I received a picture from Erica Moslander
06/08/2023	Contact - Document Received I exchanged emails with APS Worker, Daniel Spalthoff
06/15/2023	Inspection Completed On-site
06/16/2023	Contact - Document Sent I emailed Erica Moslander requesting information about this complaint
06/16/2023	Contact - Document Received I received AFC documentation related to this complaint
06/16/2023	Exit Conference I conducted an exit conference with the licensee designee, Timothy Bertram
06/16/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 06/03/23, Resident A gained access to staff's purse and ingested an unknown amount of medication. She is currently hospitalized.

INVESTIGATION: On 06/06/23, I reviewed an Incident/Accident Report (IR) dated 06/03/23 regarding Resident A. According to the IR, "While consumer was sitting in the common area staff noticed that consumer's speech was slurred and her gait was unsteady. Staff asked consumer did she go into staff's purse and take their medication. Staff noticed that their purse was wide open. Consumer stated she did go into staff's purse." Staff contacted 911 and Resident A was transported to Genesys hospital. The Genesys doctor performed a gastric suction and Resident A was released back to the facility. The corrective measures taken were, "Staff will monitor consumer closely, and follow up with PCP."

On 06/06/23, I reviewed another IR dated 06/04/23 regarding Resident A. According to the report, "Consumer was medically cleared from the hospital on 06/03/23. Consumer began to slur her words and was becoming unstable again. Staff called 911 and had consumer transported back to Genesys Hospital for further evaluation." The corrective measures taken were, "Staff will monitor consumer closely and keep the management updated."

On 06/08/23, I exchanged emails with Adult Protective Services Worker, Daniel Spalthoff. He said that on 06/07/23, he saw Resident A at the hospital. Resident A told him that she found the bottle of pills sitting on an end table in the living room. She told him that the prescription bottle was for a person named Michelle. He said that he has not yet been out to the facility.

On 06/08/23, I conducted an unannounced onsite inspection of Packard Specialized Residential Services Adult Foster Care facility. I interviewed Erica Moslander, CEO of Specialized Residential Services, and staff Katrina Bailey. Ms. Bailey and Ms. Moslander confirmed that on 06/03/23, Resident A gained access to staff Ajah Johnson's purse and ingested some of her medication. Ms. Moslander and Ms. Bailey said that Resident A was treated at the hospital and released the same day. However, her condition became unstable again, so she was transported to the hospital on 06/04/23 and was admitted. Resident A is still at the hospital, so I was not able to interview her.

Ms. Moslander and Ms. Bailey said that as soon as staff Ajah Johnson discovered that Resident A may have taken some of the medication out of her purse, she immediately notified management, called 911, took Resident A's vitals, and monitored her until EMS arrived.

According to Ms. Moslander and Ms. Bailey, Ms. Johnson will receive a 3-day suspension and a medication refresher course because of this incident. Ms. Moslander and Ms. Bailey said that Ms. Johnson is very remorseful about the incident and overall, she is a good and reliable staff.

I told Ms. Moslander and Ms. Bailey that Resident A told Mr. Spalthoff the prescription bottle belonged to someone named Michelle, but they said that they do not have a staff named Michelle who works at this facility. Ms. Moslander said that Ms. Johnson texted her a picture of the bottle of medication Resident A ingested. She agreed to text me the picture.

On 06/08/23, I received a photograph via text message from Ms. Moslander. The photograph was of a prescription bottle for 100mg of Lamotrigine in the name of Ajah Johnson.

On 06/15/23, I conducted another onsite inspection of Packard Specialized Residential Services. I interviewed staff, Ajah Johnson, Erica Moslander, Katrina Bailey, and Resident A.

Ms. Johnson said that she has worked at this facility since November 2022, and she has worked in the field of adult foster care since 2017. According to Ms. Johnson, on 06/03/23, she left her purse on a table in the dining room while she went to the bathroom. She said that she was gone for a very brief amount of time and when she came back, her purse was unzipped and one of the caps of her medication bottles was loose. Ms. Johnson said that when she left her purse on the table, her purse was zipped. She said that when she returned from the bathroom, she did not see any of the residents near her purse, so she was not sure if anything had happened.

According to Ms. Johnson, shortly after lunch, she noticed that Resident A was acting differently. Resident A had a difficult time getting up from her chair and once she got up, she staggered and almost fell. Ms. Johnson asked Resident A “Did you take something?” and Resident A responded “yes.” Ms. Johnson told me that she immediately suspected that Resident A may have taken some of the medications out of her purse. She said that she called management, and 911 and monitored Resident A until EMS arrived approximately 15-20 minutes later. Ms. Johnson said that she told EMS what medications Resident A may have ingested and Resident A was transported to the hospital.

Ms. Johnson said that typically, she either leaves her purse in her car or puts her purse in the locked office where most staff put their personal possessions, but she did not on 06/03/23. She said that she regrets this decision and said that she feels awful that Resident A ingested some of her medication. Ms. Johnson stated that she will never bring any of her medications to work again and she will always keep her personal belongings locked in the office.

I interviewed Resident A and mentioned that I tried to see her last week, but she was in the hospital. I asked her why she was in the hospital, and she said, “I swallowed some pills that didn’t belong to me.” I asked her how many pills she swallowed, and she said, “a lot.” I asked her where she got the pills and she said, “I went into another client’s purse.” I asked her the name of the client and she said she does not know. I asked her if the purse belonged to staff Ajah Johnson and she said she does not know. She said

the purse was on the table in the living room. Resident A hung her head during this interview and said that she feels bad for taking the medication. She said, “I’ll never do that again.” I asked Resident A if she ever had access to medications in the past while living at this facility and she said no.

Ms. Moslander and Ms. Bailey said that staff Ajah Johnson was given a 3-day suspension from work. She also received a refresher training regarding medication safety.

On 06/16/23, I received AFC documentation related to this complaint. According to Resident A’s Health Care Appraisal dated 03/01/23, she is diagnosed with intellectual developmental disorder; moderate and schizophrenia. According to her Assessment Plan, she requires staff supervision while in the community. She has a history of attention seeking behavior, and inappropriately calling 911. Under the section “exhibits self-injurious behaviors”, it states “(Resident A) has a history of taking several days’ worth of medication at a time with the intention of getting sick to avoid activities, without understanding the seriousness of overdose and possible death. To meet this concern, her CLS staff provide her with daily medications, and per licensing rules, all other medications are locked up. She has been hospitalized at least twice due to self-injurious behavior of taking too much medication. She also has a history of cutting herself superficially. There have been no self-harmful behaviors in the last 3 years (09/2021.)” She does not require 1:1 staffing or enhanced supervision.

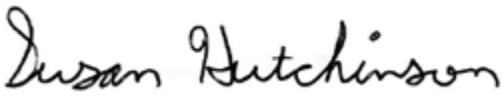
On 06/16/23, I conducted an exit conference with the licensee designee, Timothy Bertram. I discussed the results of my investigation and explained which rule violation I am substantiating. Mr. Bertram agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(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.**
	On 06/03/23, Resident A got into staff Ajah Johnson’s purse and took an unknown amount of her medication, Lamotrigine. Staff Ajah Johnson stated that she did leave her purse on a table in the living room while she went to the bathroom, and she did have personal medications in her purse. Resident A said that she “swallowed some pills that don’t belong to me” and was hospitalized for several days.

ANALYSIS:	According to Resident A's Assessment Plan, "she has a history of taking several days' worth of medication at a time with the intention of getting sick to avoid activities, without understanding the seriousness of overdose and possible death." I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

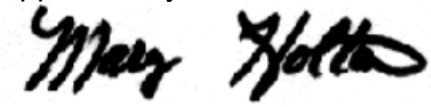
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



June 20, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



June 20, 2023

Mary E. Holton Area Manager	Date