GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 25, 2024

Janette Thiel
Macomb Family Services Inc
124 West Gates
Romeo, MI 48065

RE: License #: AS500238356
Investigation #: 2024A0617009
Sherwood

Dear Ms. Thiel:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500238356
Investigation #:	2024A0617009
Complaint Receipt Date:	12/18/2023
Investigation Initiation Date:	12/19/2023
Report Due Date:	02/16/2024
Licensee Name:	Macomb Family Services Inc
Licensee Address:	124 West Gates Romeo, MI 48065
Licensee Telephone #:	(586) 246-1378
Administrator:	Janette Thiel
Licensee Designee:	Janette Thiel
Name of Facility:	Sherwood
Facility Address:	20419 Sherwood Macomb, MI 48044
Facility Telephone #:	(586) 246-1378
Original Issuance Date:	09/06/2001
License Status:	REGULAR
Effective Date:	03/05/2022
Expiration Date:	03/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was reportedly transferred to the hospital due to an emergency eviction. The guardian was notified and received notice of eviction. Group home refuses to pick up Resident A.	Yes

III. METHODOLOGY

12/18/2023	Special Investigation Intake 2024A0617009
12/19/2023	Special Investigation Initiated - Letter Email sent to the LD Ms. Theil
01/11/2024	APS Referral Adult Protective Services (APS) referral received - worker Emily Poley
01/11/2024	Contact - Document Received I interviewed Adult Protective Services (APS) worker Emily Poley.
01/19/2024	Contact - Telephone call made I conducted and interview with Licensee Designee Ms. Janette Thiel
01/19/2024	Contact - Document Received I received and reviewed an incident report dated 12/11/23, a petition for mental health treatment dated 12/11/23, and a 30-day discharge dated 8/4/23.
01/22/2024	Contact - Telephone call made I interviewed Ms. Tiffany Terenzi who is Resident A's support coordinator
01/22/2024	Inspection Completed On-site I conducted an unannounced investigation of the Sherwood Home. I interviewed home manager Rodney Thompson.
01/23/2024	Contact - Telephone call made I interviewed Ms. Renea Hall, social worker at Henry Ford Hospital Macomb

01/23/2024	Exit Conference I conducted an exit conference with Licensee Janette Theil to discuss the findings of this report
01/25/2024	Contact - Telephone call made I interviewed Resident A's guardian
01/25/2024	Contact - Telephone call made I interviewed Mr. Rodney Thompson

ALLEGATION:

Resident A was reportedly transferred to the hospital due to an emergency eviction. The guardian was notified and received notice of eviction. Group home refuses to pick up Resident A.

INVESTIGATION:

On 12/18/23, I received a complaint on the Sherwood facility. The complaint indicated that Resident A was reportedly transferred to the hospital due to an emergency eviction. The guardian was notified or received notice of eviction. Group home refuses to pick Resident A up.

On 01/11/24, I interviewed Adult Protective Services (APS) worker Emily Poley. According to Ms. Poley, Resident A has a developmental disability and autism. He is also nonverbal but can communicate with sign language. Resident A had been admitted to the hospital four times in October. Resident A was brought to the hospital for aggression and hitting his head. According to Ms. Poley, the group home provided two different stories. Staff Tia indicated that Resident A got upset because the carbon monoxide alarm was going off. He became upset and ran full force at the walls and dooring hitting his head. The group home manger Rodney provided a different story. He said Resident A had physical aggression towards others in the past. He was also doing things to cause harm to himself (no specifics). Rodney also indicated that if Resident A was sent home from the hospital, the staff would not open the door to the home.

On 01/19/24, I conducted an interview with Licensee Designee Ms. Janette Thiel. According to Ms. Thiel, Resident A was given a 30-day discharge notice on 08/04/23 due to the Sherwood facility no longer being able to meet his needs. Resident A's behavioral challenges have increased over the last several months and the facility thought it would be in his best interest to find a more suitable placement. Ms. Thiel stated that Resident A was hospitalized several times in recent months due to self-inflicting injuries, aggressive behavior towards staff and the other residents, as well as property damage. Resident A was most recently hospitalized on 12/11/23 for aggressive behavior towards himself and others in the home. According to Ms. Thiel, the home manager Mr. Thompson filed a petition for Mental Health treatment for Resident A. Ms. Theil stated that Henry Ford Hospital agreed to keep Resident A until a more suitable

placement could be found. Ms. Theil stated that it was her understanding that Henry Ford Hospital was seeking placement for Resident A. Resident A is still at Henry Ford currently and will be moving to his new placement on 01/23/24. Ms. Theil could not provide any documentation indicating that Henry Ford would keep Resident A until a placement could be located.

On 1/19/24, I received and reviewed an incident report dated 12/11/23, a petition for mental health treatment dated 12/11/23, and a 30-day discharge notice dated 8/4/23. According to the incident report, Resident A became upset and started running into the walls of the home and attacking staff and the other residents around 6:30 AM on 12/11/23. Staff contacted EMS and the police for assistance. EMS transported Resident A to Henry Ford Macomb. The petition for mental health treatment is not signed by the hospital, therefore it is unknown if the petition was filed with the hospital or just filled out. I was able to verify that the 30-day discharge notice was provided to myself, and Resident A's support coordinator on 8/4/23. The 30-day discharge notice indicated that Resident A was no longer suitable for the Sherwood facility. Resident A's behavior challenges and self-injuring behaviors were putting himself and others at risk of injury.

On 01/22/23, I interviewed Ms. Tiffany Terenzi who is Resident A's support coordinator. According to Ms. Terenzi, Resident A was provided with a 30-day discharge notice on 8/4/23 due to his behaviors in the home. Ms. Terenzi began looking for placement, but it was extremely difficult due to his behavior challenges. According to Ms. Terenzi, Resident A was hospitalized on 12/11/23 due to self-inflicted injuries. Resident A was ready for discharge soon after arriving at the hospital but no one from the facility picked him up. Resident A was still currently at Henry Ford Hospital Macomb as on 1/22/23. A new placement was obtained for Resident A on 1/4/23 and he moved on 1/23/24.

On 01/22/24, I conducted an unannounced investigation of the Sherwood Home. I interviewed home manager Rodney Thompson.

According to Mr. Thompson, Resident A was given a 30-day discharge notice on 08/04/23 due to the Sherwood facility no longer being able to meet his needs. Resident A's behavioral challenges have increased over the last several months and the facility thought it would be in his best interest to find a more suitable placement. Resident A was most recently hospitalized on 12/11/23 for aggressive behavior towards himself and others in the home. Mr. Thompson stated that Resident A became upset and started running into the walls of the home and attacking staff and the other residents around 6:30 AM on 12/11/23. Staff contacted EMS and the police for assistance. EMS transported Resident A to Henry Ford Macomb. According to Mr. Thompson, he filed a mental health petition to have Resident A committed for mental health treatment. Mr. Thompson stated that Henry Ford Hospital agreed to keep Resident A until a more suitable placement could be found. Mr. Thompson stated that it was his understanding that Henry Ford Hospital was seeking placement for Resident A. Mr. Thompson stated that he was never made aware that Resident A was ready for discharge. Mr. Thompson stated that he did not communicate and follow up with the hospital to find out if and when Resident A would be discharged. Mr. Thompson stated that since Resident A

received a discharge notice from the facility, and the hospital said they would help seek an appropriate placement for Resident A, he did not have to do anything further. Mr. Thompson could not provide any documentation or contact information for anyone at the hospital that could verify his statements.

On 01/23/24, I interviewed Ms. Renea Hall, social worker at Henry Ford Hospital Macomb. According to Ms. Hall, Resident A was brought to the hospital on 12/11/23 at 7:24 am. Resident A was seen by the psychiatrist that afternoon and was ready for discharge on the same day of 12/11/23. Ms. Hall stated that the facility refused to pick up Resident A. Resident A is still in the hospital as of 1/23/24 but will be moving to his new placement later in the day. Ms. Hall stated that the social work department worked closely with Resident A's support coordinator to obtain new placement. According to Ms. Hall, Resident A is nonverbal therefore he was unable to participate in an interview. Ms. Hall stated that Resident A is doing well currently.

On 01/23/24, I conducted an exit conference with Licensee Janette Theil to discuss the findings of this report. Ms. Thiel did not answer, and a voicemail was left.

On 01/25/24, I conducted an interview with Resident A's guardian. According to Resident A's guardian, she was not made aware that Resident A was hospitalized until she was contacted by the hospital about two weeks after Resident A was admitted. Resident A's guardian stated that she called the facility to inquire about her son's whereabouts, but no one answered, and she had to leave a multitude of messages. Resident A's guardian had to make numerous calls to the home over the course of several days before she was able to speak with Mr. Thompson. When Resident A's guardian spoke with Mr. Thompson, he told her that Resident A is in the hospital, and he was not allowed to return the home. Resident A's guardian stated that she never received a copy of the 30-day discharge notice from the Sherwood facility. Resident A's guardian had to contact Resident A's support coordinator to get the details of the discharge notice. Resident A's guardian stated that Resident A moved into a new facility on 01/24/23 but the facility never released Resident A's belongings. Resident A's guardian stated that she had to go out and purchase all new clothing for Resident A.

On 01/25/24, I conducted an interview with Mr. Rodney Thompson. According to Mr. Thompson, he contacted Resident A's guardian on 12/11/23 to inform her that her son was in the hospital. Mr. Thompson stated that he called and left her a voicemail on 12/11/23 around noon and she called him back around 3PM that same day. Mr. Thompson denies telling Resident A's guardian that Resident A could not return to the home. Mr. Thompson stated that the facility does still have Resident A's clothing and belongings. Mr. Thompson stated that he has received a voicemail from Resident A's guardian, but he hasn't had time to call her back. Mr. Thompson stated that he would contact her by the end of the day.

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.**
	(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: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information.** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternative to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(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.**
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility has violated this rule. Resident A was sent to Henry Ford Hospital on 12/11/23 at 7:24 am. Resident A was seen by the psychiatrist that afternoon and was ready for discharge on the same day on 12/11/23. According to Ms. Hall, the facility refused to pick up Resident A. Resident A is still in the hospital as of 1/22/24.

	Resident A's guardian stated that she never received a copy of the 30-day discharge notice from the Sherwood facility. Resident A's guardian had to contact Resident A's support coordinator to get the details of the discharge notice. According to Resident A's guardian, she was not made aware that Resident A was hospitalized on 12/11/23, until two weeks later when the social worker from the hospital contacted her. According to Mr. Thompson, it was his understanding that Henry Ford Hospital was seeking placement for Resident A. Mr. Thompson stated that he was never made aware that Resident A was ready for discharge. Mr. Thompson stated that he did not communicate and follow up with the hospital to find out if and when Resident A would be discharged. Mr. Thompson stated that since Resident A received a discharge notice and the hospital said they would help seek an appropriate placement for Resident A, he did not have to do anything further. However, Mr. Thompson could not provide any documentation or contact information for anyone at the hospital that could verify his statements.
CONCLUSION:	**VIOLATION ESTABLISHED**

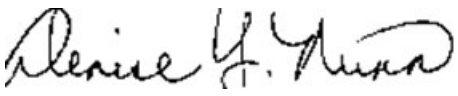
IV. RECOMMENDATION

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

01/25/24

Eric Johnson Date
Licensing Consultant

Approved By:



01/25/2024

Denise Y. Nunn Date
Area Manager