GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 23, 2025

Gladys Sledge
Packard Group Inc
P.O. Box 2066
Southfield, MI 48037

RE: License #: AS630271172
Investigation #: 2025A0612027
Foxmoor Lane

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) 972-9136.

Sincerely,

Johnna Cade, Licensing Consultant
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630271172
Investigation #:	2025A0612027
Complaint Receipt Date:	08/13/2025
Investigation Initiation Date:	08/13/2025
Report Due Date:	10/12/2025
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:	Foxmoor Lane
Facility Address:	28510 Lorraine Farmington Hills, MI 48336
Facility Telephone #:	(248) 476-8139
Original Issuance Date:	02/23/2005
License Status:	REGULAR
Effective Date:	03/13/2024
Expiration Date:	03/12/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized with a distended stomach. There is an overall concern of poor care and lack of communication.	No
Additional Findings	Yes

II. METHODOLOGY

08/13/2025	Special Investigation Intake 2025A0612027
08/13/2025	Special Investigation Initiated - Letter I made a referral to Oakland Community Health Network - Office of Recipient Rights via email.
08/13/2025	Contact - Telephone call made Telephone call to reporting source. There was no answer. I left a voicemail requesting a return call.
08/13/2025	APS Referral I made a referral to Adult Protective Services (APS) via centralized intake.
08/13/2025	Contact - Telephone call made Telephone interview completed with home manager Kierra Stubbs, Resident A's Guardian, and MORC Easter Seals RN, Janet Butler.
08/13/2025	Contact - Document Received Facility documentation received via text message from home manager Kierra Stubbs. Photo of Resident A's stomach received via text message from Resident A's Guardian.
08/14/2025	Contact - Document Received I received a copy of Resident A’s Individual Plan of Service and Crisis Plan sent via email from Recipient Rights Specialist Rachel Moore.
08/18/2025	Contact - Telephone call made Telephone call to reporting source. There was no answer. I left a voicemail requesting a return call.

08/18/2025	Contact - Telephone call made Telephone interview completed with direct care staff Clinton Mitchel.
08/21/2025	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed home manager Kierra Stubbs, Resident B, and Resident C.
08/25/2025	Contact - Document Received I received a copy of Resident A's hospital discharge paperwork sent via text message from Resident A's Guardian.
08/27/2025	Exit Conference I placed a telephone call to licensee designee Gladys Sledge to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.
08/27/2025	Contact – Telephone received Exit conference conducted with licensee designee Gladys Sledge via telephone.

ALLEGATION:

Resident A was hospitalized with a distended stomach there is an overall concern of poor care and lack of communication.

INVESTIGATION:

On 08/13/25, I received a referral that in summary indicates, Resident A's mom arrived at the group home and found that his stomach was descended. She took him to the hospital, and he was admitted. Resident A is diabetic, hypertensive, and he has cognitive impairments. There is an overall concern with the home and staff. They did not call the reporting source or Resident A's mom to let them know what was wrong. On 08/13/25, I initiated my investigation by making a referral to Oakland Community Health Network – Office of Recipient Rights via email. The investigation was assigned to Recipient Rights Specialist Rachel Moore. On 08/13/25, I also made a referral to Adult Protective Services (APS) via centralized intake. The investigation was assigned to APS worker Ra'Shawnda Robertson. During this investigation, I made several attempts to interview the reporting source, however, there was no answer at the telephone number provided. I left voicemails requesting a return call. As of the date of this report, a return call was not received.

On 08/13/25, I completed a telephone interview with home manager, Kierra Stubbs. Ms. Stubbs stated Resident A went to his mother‘s house on Saturday, 08/09/25. On

Sunday, 08/10/25, Resident A's Mother contacted staff and informed them that she was taking Resident A to the hospital because he did not feel well, she asked for his insurance card. The staff took a photo of the insurance card and sent it to Resident A's Mother. Ms. Stubbs stated Resident A is at Providence Hospital, he is impacted and constipated. Ms. Stubbs stated Resident A's Mother said that he has dealt with similar issues growing up. Ms. Stubbs stated direct care staff, Clinton Mitchell who was working on Saturday, said that he gave a Resident A milk of magnesia on Saturday morning because Resident A told him that he had not had a bowel movement. Resident A left the house at noon. He had not had a bowel movement prior to leaving the home. Ms. Stubbs stated Resident A's bowel movements are tracked. Resident A does not have a bowel movement every day. Ms. Stubs stated Resident A works Monday through Friday 7:00 am to 2:30 pm he does not require assistance with toileting, staff must rely on him to verbally report he had a bowel movement, including if he went while he was at work. Ms. Stubbs stated an incident report regarding Resident A's hospitalization was not completed because he was taken to the hospital by his mother while he was in her care. However, documentation regarding the hospitalization was completed in Resident A's Health Care Chronological.

On 08/13/25, I completed a telephone interview with Resident A's Mother/ Guardian. Resident A's Guardian stated Resident A has always had issues with constipation. When she picked him up from the group home on Saturday, 08/09/25, he was distressed. Resident A's Guardian stated she picks Resident A up every other week he typically has his bags by the door ready to go. When she arrived at the home, Resident A was in bed laying down. When he got into the car he could hardly sit down. Resident A did not want dinner that evening which is uncommon. Resident A's Guardian stated on Sunday, 08/10/25, she observed that Resident A's stomach was distended she remarked that he appeared seven months pregnant. Resident A's Guardian took Resident A to Providence Hospital. The doctor determined that he likely had not had a bowel movement for two to three weeks. Resident A's bowels are pressing against his kidneys and bladder; his intestines are inflamed. At this time, it is not expected that he will require surgery. Since being admitted on Sunday Resident A has only had one bowel movement. They are continuing with treatments. Resident A's Guardian stated Resident A is currently using a Foley Catheter and he will be discharged with it. Resident A's Guardian does not feel comfortable returning Resident A to the group home while he is using the catheter. As such, she will be taking Resident A to her home upon discharge. It is expected that he will require the catheter for one to two weeks. Resident A's Guardian stated on 07/08/25, she met with the MORC Easter Seals RN, Javan Hester and home manager, Kierra Stubbs regarding increasing Resident A's fiber in his diet. Resident A is not on a special diet, but he should have high fiber meals. Resident A's Guardian stated Resident A does not currently receive assistance with toileting. However, he is not able to accurately communicate discomfort and/or if he had

a bowel movement. Resident A's Guardian stated she and Resident A's Father are co guardians. Resident A's Guardian stated Resident A's Father told her that he filed this complaint. Resident A's Guardian stated she goes to the home every other week and staff communicates with her regarding Resident A's care. Resident A's Guardian stated Resident A's Father is not active in his routine treatment, he visited Resident A in the hospital however he had not seen him prior to that for some time and that is likely the reason why the home did not communicate with him.

On 08/13/25, I completed a telephone interview with MORC Easter Seals RN, Javan Hester. Ms. Hester stated she held a meeting with Resident A's Guardian and home manager Ms. Stubbs on 07/08/25. Resident A's primary care physician prescribed an 1800 – 2000 calorie diabetic diet. Ms. Hester stated Resident A has been experiencing constipation. Home manager Ms. Stubbs has been in contact with Resident A's primary care physician and the pharmacy to obtain medications for this ongoing issue. Ms. Hester stated Resident A had an appointment with his primary care physician on 07/31/25, due to nausea and vomiting. It was recommended that he complete a gastric empty study to address his ongoing constipation. Resident A has uncontrolled diabetes, and they are working to get him into an endocrinologist. Resident A's primary care physician indicated until his caloric intake is steadier his diabetes will be hard to control. Ms. Hester stated at the appointment changes were made to Resident A's medication to address the constipation. Resident A was taking Rybelsus (semaglutide) which has a side effect of constipation. This medication was discontinued to see if symptoms of constipation would resolve. If there were no improvement, the physician planned to prescribe Lactulose. Ms. Hester stated per Resident A he has a bowel movement every three to four days. Resident A works in the community. Staff do not assist Resident A with toileting. Ms. Hester stated Resident A is responsible for communicating to staff when he has a bowel movement even when it is during work hours. Ms. Hester stated Resident A is very agreeable and if asked if he had a bowel movement he would likely answer yes especially if there were no follow-up questions asked. Ms. Hester stated Resident A's next follow up with his primary care was scheduled for 08/14/25.

On 08/18/25, I interviewed direct care staff Clinton Mitchel via telephone. Mr. Mitchel has been employed with this company for three years. He works on the midnight shift from 11:30 pm – 7:00 am. Mr. Mitchel stated on Saturday, 08/09/25, Resident A woke up and he prepared him waffles and sausage for breakfast. Resident A ate his breakfast and took his medication. Mr. Mitchel noticed that Resident A was limping. Mr. Mitchel asked Resident A why he was limping, and Resident A said that he needed to have a bowel movement, but he did not want to. Mr. Mitchel explained to Resident A why it is important for him to go to the bathroom and asked if he would like milk of magnesia to help. Resident A agreed and he was given the medication. Mr. Mitchel stated Resident A continued to walk around the house as if he needed to go to the bathroom. Mr.

Mitchel encouraged Resident A to go into the bathroom and sit on the toilet, but he declined. Resident A's Guardian arrived at the home to pick him up. Mr. Mitchel informed her that Resident A had not had a bowel movement and told her that he had taken milk of magnesia. Mr. Mitchel stated he did not see that Resident A's stomach was distended because Resident A was wearing a big shirt. Resident A dresses himself. Mr. Mitchel remarked, he is very independent. Mr. Mitchel stated to his knowledge, Resident A is not on a special diet or a specific calorie count. Mr. Mitchel stated Resident A should eat things such as bread, fruit, smoothies, oatmeal, and milk. Mr. Mitchel stated Resident A is responsible for telling staff when he has a bowel movement staff do not assist him in the bathroom. Mr. Mitchel stated in the mornings when he is assisting the other residents with getting up Resident A is usually in the bathroom. Mr. Mitchel stated it is common for Resident A to be constipated and not have a bowel movement every day. Mr. Mitchel stated Resident A's Guardian/ Mother regularly comes to the home. Staff regularly communicate with Resident A's Mother regarding his care. Mr. Mitchel stated he has never had contact with Resident A's father.

On 08/21/25, I completed an unscheduled onsite investigation. I interviewed home manager Kierra Stubbs, Resident B, and Resident C. At the time of the onsite investigation Ms. Stubbs reported Resident A had been discharged from the hospital at was currently staying with his mother.

On 08/21/25, I interviewed Resident B. Resident B was observed sitting in the living room. He was appropriately dressed and well groomed. Resident B stated all the staff in the home are good, he receives his medication daily, and he is happy with the food that he is served. Resident B had no issues or concerns.

On 08/21/25, I interviewed Resident C. Resident C was observed playing video games in the living room. He was appropriately dressed and well groomed. Resident C moved into the home on 08/11/25, he stated things have been going very well since he moved in. Resident C stated he receives his medications as prescribed, and he is getting along with his housemates and staff. Resident C had no issues or concerns.

On 08/21/25, I completed a second interview with home manager Kierra Stubbs. Ms. Stubbs stated upon discharge from the hospital Resident A's Guardian took Resident A to her home. Resident A's Guardian stated Resident A would return to Fooxmoor Lane on Sunday, 08/24/25. Ms. Stubbs stated the home did not receive any hospital discharge paperwork as it was given to Resident A's Guardian. Ms. Stubbs stated Resident A's Guardian informed her that she changed Resident A's primary care physician. Ms. Stubbs further stated the home has regularly communicated with Resident A's Mother/ Guardian she did not have contact information for Resident A Father and he has not come to the home. Ms. Stubbs stated Resident A has his own

cellphone and she believes that he speaks to his dad sometimes. Since Resident A's hospitalization Resident A's Father has reached out and provided his contact information. Resident A's files have been updated and Resident A's Father will be contacted regarding his care moving forward. Regarding Resident A's diet, Ms. Stubbs stated Resident A has diabetes, however, he is not on a special diet. The home was not given a diet plan to follow for Resident A.

I reviewed Resident A's July 2025 & August 2025 bowel movement records. The following is relevant information:

Resident A had a bowel movement on: 08/01/25 and 08/04/25.

Notes:
On 08/09/25, Resident A was on Leave of Absence (LOA)
On 08/10/25, Resident A was hospitalized.
Resident A was given milk of magnesia on: 08/05/25, 08/08/25, and 08/09/25.

Resident A had a bowel movement on: 07/01/25, 07/02/25, 07/07/25, 07/10/25, 07/11/25, and 07/12/25.

Notes:
Resident A was given milk of magnesia on:07/07/25, 07/08/25, and 07/09/25, 07/10/25.
Resident A was on Leave of Absence (LOA) from 07/04/25 – 07/06/25.

I reviewed Resident A's August 2025 Health Care Chronological (HCC). The following is relevant information:

On 08/01/25, Resident A stopped Rybelsus (semaglutide) and his primary care physician prescribed MiraLAX.
On 08/05/25, Resident A was given milk of magnesia. He stated that he had not had a bowel movement, and his stool was hard to push.
On 08/08/25, Resident A said he had not had a bowel movement in a couple of days. He was given milk of magnesia.
On 08/09/25, Resident A was given milk of magnesia to help have a bowel movement.
On 08/10/25, Resident A's Guardian notified staff that Resident A was being taken to the hospital.
On 08/11/25, Resident A's Guardian notified staff that Resident A was admitted to the hospital.
On 08/11/25, Resident A's MORC Easter Seals RN was notified of Resident A's hospitalization.

I reviewed Resident A's August 2025 Medication Administration Record (MAR). Milk of Magnesia (instructions for use: 400 ml/ 5 ml, use as directed per standing medication order) was administered to Resident A on 08/05/25, 08/08/25, and 08/09/25.

I reviewed a photo of Resident A's stomach received via text message from Resident A's Guardian. The photo was taken on Sunday, August 10, 2025, while Resident A is in the hospital. Resident A's abdomen appears distended.

I reviewed Resident A's Individual Plan of Services (IPOS) and Crisis Plan. In summary, the IPOS and Crisis Plan indicate the home will monitor Resident A's health and communicate changes to the care team and record all changes in the health care chronological. Caregivers will follow the diet as ordered by primary care physician -1800 calorie, low carbohydrate diet. The home will monitor bowel regularity for signs/symptoms of distress. Resident A is independent with toileting. Resident A's IPOS and/or Crisis Plan do not provide his father's name or any contact information.

I reviewed Resident A's Providence Hospital discharge paperwork. Resident A was diagnosed with Colitis, Hydroureter, and Constipation.

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 the information gathered during this investigation there is insufficient information to conclude that Resident A was not provided with supervision, protection, and personal care as defined in his individual plan of service (IPOS). Resident A's IPOS indicates Resident A is independent with toileting. The home will monitor bowel regularity for signs/symptoms of distress. The facility provided Resident A's bowel movement tracker for July 2025 and August 2025. Direct care staff must rely on Resident A to communicate when he has had a bowel movement as he does not require assistance with toileting. This includes while Resident A is out of the home at work Monday – Friday 7:00 am to 2:30 pm. Per facility documentation Resident A was given milk of magnesia as prescribed by his physician during times he was not having regular bowel movements or when he reported hard stool. Additionally, MORC Easter Seals RN, Javan Hester stated Resident A was taking Rybelsus (semaglutide) which has a side

	effect of constipation. On 07/31/25, this medication was discontinued to see if symptoms of constipation would resolve. The facilities documentation is thorough, consistent, and meets the requirements of Resident A's IPOS.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**
ANALYSIS:	Based on the information gathered during this investigation there is insufficient information to conclude that Resident A's representative was not made aware of his medical condition/ hospitalization. On Saturday, 08/09/25, Resident A went to his Guardian / Mother's house. On Sunday, 08/10/25, Resident A's Mother contacted staff and informed them that she was taking Resident A to the hospital. As such, Foxmoor Lane staff were not responsible for notifying the reporting source to make him aware of the hospitalization as Resident A was not in their care at the time of his hospitalization. Additionally, because the incident (hospitalization) did not occur while Resident A was in the care of Foxmoor Lane staff, an Incident Report is not required. However, details regarding the hospitalization were documented in Resident A's Health Care Chronological. Moreover, Resident A's IPOS, Crisis Plan, nor staff at the facility had the reporting sources' name and/or contact information. Resident A's Guardian / Mother indicated that the reporting source has not been involved in Resident A's ongoing treatment however, she confirms that she maintains contact with group home staff regarding Resident A's care. Several attempts were made to contact the reporting source regarding the allegations made. A return call was not received.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION:

I reviewed Resident A's Individual Plan of Services (IPOS) and Crisis Plan. In summary, the IPOS and Crisis Plan indicate caregivers will follow the diet as ordered by primary care physician -1800 calorie, low carbohydrate diet.

On 08/21/25, I completed an unscheduled onsite investigation. I observed that the facility had a menu posted on the refrigerator, but there was no menu posted which included a meal plan for Resident A's special diet/specific calorie count.

On 08/13/25, I completed a telephone interview with MORC Easter Seals RN, Javan Hester. Ms. Hester stated Resident A's primary care physician prescribed an 1800 – 2000 calorie diabetic diet.

On 08/21/25, I completed a second interview with home manager Kierra Stubbs. Ms. Stubbs stated Resident A has diabetes, however, he is not on a special diet. The home was not given a diet plan to follow for Resident A.

On 08/18/25, I interviewed direct care staff Clinton Mitchel via telephone. Mr. Mitchel stated to his knowledge, Resident A is not on a special diet or a specific calorie count.

On 08/27/25, I placed a telephone call to licensee designee Gladys Sledge to conduct an exit conference. There was no answer. I left a detailed message detailing my findings. Ms. Sledge was advised that a corrective action plan is required.

On 08/27/25, I received a return call from Ms. Sledge. She stated home manager Ms. Stubbs has been in contact with the MORC dietitian to obtain a menu for Resident A's diet. She has also contacted the physician to obtain a prescription for the special diet. Ms. Sledge stated the team has coordinated with Resident A's guardian regarding Resident A's recommended diet and spoke to staff regarding eliminating snacks in the home. Ms. Sledge stated Resident A does not want staff assistance with toileting, however they are continuing to work on creative ways that staff can monitor his bowel movement. Moving forward, all attempts will be documented.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude per Resident A's

	Individual Plan of Service and MORC Easter Seals RN, Javan Hester Resident A's primary care physician prescribed an 1800 calorie, low carbohydrate diet. Per the staff interviewed, the home has not been providing Resident A with this prescribed diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

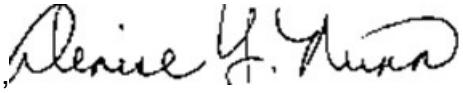
III. RECOMMENDATION

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

08/27/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



09/23/2025

Denise Y. Nunn — Date
Area Manager