GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2026

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

RE: License #: AS630384567
Investigation #: 2026A0602020
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) 972-9136.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Blvd
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630384567
Investigation #:	2026A0602020
Complaint Receipt Date:	08/04/2026
Investigation Initiation Date:	08/05/2026
Report Due Date:	10/03/2026
Licensee Name:	Packard Group Inc
Licensee Address:	731 Pallister Street, Suite 303 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:	06/20/2025
Expiration Date:	06/19/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident B was hospitalized for mental health changes and weight loss, when an unexplained facial fracture of unknown origin was discovered.	Yes

III. METHODOLOGY

08/04/2026	Special Investigation Intake 2026A0602020
08/04/2026	APS Referral Adult Protective Services (APS) referral received.
08/05/2026	Special Investigation Initiated - Telephone Call made to APS
08/12/2026	Inspection Completed on-site Met with Resident B and staff at the Lahser Pre-Vocational Center in Clarkston.
09/24/2026	Inspection Completed on-site Interviewed the assistant home manager, Georgetta Womble.
09/24/2026	Contact – Telephone call made Message left for staff member Brittnay Scarborough.
09/24/2026	Contact – Telephone call made Spoke with Resident A's mother.
09/24/2026	Contact – Telephone call made Spoke with staff member Jessica Woods.
09/24/2026	Contact – Telephone call made Spoke with staff member Angie Allen.
09/24/2026	Contact – Telephone call made Call made to staff member Jazmine Robinson, no answer.
10/01/2026	Contact – Telephone call made Spoke with Resident B's case coordinator, Aliesa Tolen.

10/06/2026	Contact – Document received Received document from Resident B's mother.
10/06/2026	Exit Conference Held with the licensee designee, Gladys Sledge by telephone.

ALLEGATION:

Resident B was hospitalized for mental health changes and weight loss, when an unexplained facial fracture of unknown origin was discovered.

INVESTIGATION:

On 8/04/202,6 a complaint was received and assigned for investigation alleging that Resident B was hospitalized for mental health changes and weight loss, when an unexplained facial fracture of unknown origin was discovered.

On 8/12/2026, I conducted an unannounced on-site investigation at the Lahser Vocational Center in Clarkston. I interviewed Resident B's instructor, Lanita Moore, the case coordinator, DeKisha Harris, and observed Resident B. Resident B is non-verbal and was unable to provide any information regarding the allegations. I observed him to be neat and clean and utilizing his electric wheelchair. Ms. Moore stated last month while at the center, Resident B was not acting like himself. He seemed to be a bit lethargic and put his head down on the table and his nose started to bleed. Ms. Moore notified the case coordinator and emergency medical services (EMS) were contacted.

On 8/12/2026, Ms. Harris stated that on 7/10/2026, Resident B was acting very lethargic and did not want to participate. He laid his head on the table and had a nosebleed. Resident B's mother was contacted and agreed to have him transported to the hospital. Ms. Harris said he remained in the hospital for a couple of days and returned to the center the following week with clearance from his physician. She was not aware of any injuries to Resident B's face and was not given any information as to why he was hospitalized as it is not required. Resident B's mother informed her that this was not the first time something like this had occurred with him. This is all the information Ms. Harris had regarding the incident.

On 9/24/2026, I conducted an unannounced on-site investigation at which time I interviewed the acting assistant manager, Georgetta Womble. Ms. Womble stated she worked for the company a few years ago, left and recently returned about a month ago. She had no knowledge of the incident that occurred with Resident B at Lahser Pre-Vocational Center back in July 2026.

On 9/24/2026 I reviewed Resident B's weight record dated 7/1/2025 – 9/6/2026. According to the record, on 7/1/2026 Resident B weighed 199 pounds and on 9/1/2026 he weighed 141.1 pounds. There is a note written on the record dated 6/25/2026,

documenting that the scale needed to be calibrated as it was off by 40 pounds. On 6/25/2026 Resident B's weight was documented as 182.6 pounds and on the next weight entry, his weight was documented as 140 pounds.

On 9/24/2026, I interviewed staff member Brittnay Scarborough by telephone. Ms. Scarborough stated she works Fridays, Saturdays, and Sundays and had no firsthand knowledge of Resident B having a fracture on his face. She said she was aware that he was transported from the Lahser Pre-Vocational Center to the hospital, but she had no details surrounding the incident.

On 9/24/2026, I spoke with Resident B's mother by telephone. Resident B's mother stated on 7/10/2026 she received a call from Ms. Harris from Lahser Pre-Vocational Center informing her that Resident B had a nosebleed and was acting very lethargic. She instructed Ms. Harris to have him transported to the hospital. He was initially transported by EMS to McClaren Hospital but transferred to Corewell Health where he was admitted. Resident B had a CT scan completed where it determined that the bone in his nasal cavity was broken as well as a broken left ocular bone. She said she spoke with the staff at the Lahser Pre-Vocational Center, and they informed her that he did not obtain any injuries while at the center and staff at the home did not report him having any injuries when he was picked up that morning. Resident B's mother went on to state that when she contacted the home regarding his diagnosis, staff could not provide any explanation as to how he sustained the injury to his face. She said her son moved into the facility a little over a year ago and the staff turnover rate has been extremely high. Resident B's mother stated she also has concerns about him losing a lot of unexplained weight since moving into the facility. She is currently looking for another placement as he was issued a 30-day discharge notice because she and the licensee designee, Gladys Sledge, had a disagreement. She arrived at the facility (exact date unknown) to pick Resident B up for a doctor's appointment. Staff did not have the necessary paperwork ready with she arrived. So, she went into the office with the staff member to obtain documents. The staff member called Ms. Sledge and told her she was in the office. Ms. Sledge began yelling at her that she could not be in the office as the other resident's personal information was there and she should not have access to it.

On 9/24/2026, I interviewed staff member Jessica Woods by telephone. Ms. Woods stated she began working for the company a few months ago and works the midnight shift between the hours of 11 pm and 7 am, filling in when needed. She said she had no knowledge regarding how Resident B obtained the fracture on his face or any issues surrounding his weight.

On 9/24/2026, I interviewed staff member Angie Allen by telephone. Ms. Allen stated she began working for the company in 2020 and started working at the facility in 2024. She said the staff turnover rate is extremely high, and it is best described as a revolving door. Ms. Allen stated she had no idea how Resident B obtained the injury to his face as he was taken to the hospital from the Lahser Pre-Vocational Center back in July. She said she did not observe any bruises on his face prior to going to the hospital. Resident B's mother handles all his medical appointments and should be able to provide

documentation regarding the injury. Ms. Allen stated although Resident B utilizes an electric wheelchair, he can stand and transfer himself in and out of the wheelchair and has done it without staff present. Ms. Allen said she was unaware of any significant weight loss Resident B had.

On 10/01/2026, I spoke with Resident B's case coordinator, Aliesa Tolen by telephone. Ms. Tolen stated she is aware that there is a high staff turnover rate at the home but has never had any concerns regarding the care or lack of Resident B receives. She said when she was made aware of the injury to Resident B's face, she looked at all the incident reports she received since he was placed at facility. She could not locate any that would support such an injury during the timeframe the injury could have occurred. There were a couple of incident reports received documenting that he fell while trying to transfer himself from his wheelchair without staff assistance. However, these incidents occurred after he was diagnosed with the face fracture. Ms. Tolen went on to state that Resident B was issued a 30-day discharge notice because Resident B's mother was verbally aggressive with staff and Ms. Sledge.

On 10/06/2026, I received and reviewed a copy of Resident B's CT scan results dated 07/10/2026. According to the report, Resident B has minimally displaced fractures of the anterior and posterolateral walls of the left maxillary sinus, minimally depressed fracture of the left orbital floor, minimally displaced fracture of the left lateral orbital wall and a mild rightward nasal septal deviation. The clinical indication is listed as facial trauma.

On 10/06/2026, I conducted an exit conference with the licensee designee, Gladys Sledge by telephone. I informed Ms. Sledge of the investigative findings and recommendation documented in this report. Ms. Sledge stated when she was made aware of the injury to Resident B's face, she conducted an unannounced visit to the home to talk with the staff members. She asked if anything unusual had occurred with Resident B that would cause such an injury and no one could provide a clear explanation of how the injury occurred. Ms. Sledge said the staff members who were working during that time were terminated. She reported that there has been a high turnover rate with staffing due to poor work performance. Ms. Womble recently started working in the home and things are starting to turn around. A new home manager has been hired and is scheduled to start this week. Ms. Sledge stated Resident B has not lost a large amount of weight as there was an issue with the scale. The scale was recalibrated and Resident B's weight is accurate. Ms. Sledge agreed to provide me with proof that the scale was calibrated. She also agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate that Resident B sustained a facial trauma causing a minimal fracture to his upper left jaw/cheek and bottom left eye socket.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

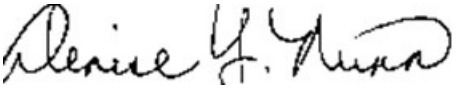
Upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



10/06/2026

Cindy Berry Date
Licensing Consultant

Approved By:



10/06/2026

Denise Y. Nunn Date
Area Manager