GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 4, 2021

Gladys Sledge
Packard Group Inc
PO Box 2066
Southfield, MI 48037

RE: License #: AS630367512
Investigation #: 2021A0611019
Woodward Group Home

Dear Ms. Sledge:

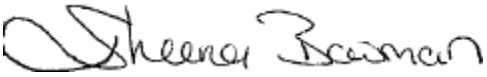
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630367512
Investigation #:	2021A0611019
Complaint Receipt Date:	05/14/2021
Investigation Initiation Date:	05/19/2021
Report Due Date:	07/13/2021
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:	Woodward Group Home
Facility Address:	2563 Lahser Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 335-0946
Original Issuance Date:	07/16/2015
License Status:	REGULAR
Effective Date:	01/16/2020
Expiration Date:	01/15/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident L was physically abused on 05/11/21 by a staff member.	Yes

III. METHODOLOGY

05/14/2021	Special Investigation Intake 2021A0611019
05/14/2021	APS Referral An Adult Protective Services (APS) referral was denied.
05/19/2021	Special Investigation Initiated - Letter I sent an email to the recipient rights specialist, Brittany Navetta requesting a copy of the incident report.
05/19/2021	Contact - Document Received I received a copy of the incident report from recipient rights specialist, Brittany Navetta.
05/25/2021	Contact - Telephone call made I made a telephone call to staff member, Lisia Williams. There was no answer and the mailbox was not set up.
05/25/2021	Contact - Telephone call made I made a telephone call to staff member, Laquitta Jones. The allegations were discussed.
05/25/2021	Contact - Telephone call received I received a telephone call from staff member, Lisia Williams. The allegations were discussed.
05/25/2021	Contact - Document Sent I sent an email to the recipient rights worker, Brittany Navetta regarding the outcome of her investigation.
05/25/2021	Inspection Completed On-site I completed an unannounced onsite. The home manager was present. Resident L was not present as she was at workshop.
05/25/2021	Contact - Document Received I received an email from recipient rights specialist, Brittany Navetta. Ms. Navetta stated she will start her interviews next week.

05/26/2021	Exit Conference I completed an exit conference with the licensee designee, Gladys Sledge via telephone.

ALLEGATION:

Resident L was physically abused on 05/11/21 by a staff member.

INVESTIGATION:

On 05/14/21, I received an intake regarding the abovementioned allegations.

On 05/19/21, I received a copy of the incident report from recipient rights specialist, Brittany Navetta. The incident took place on 05/11/21. According to the incident report, staff member, Lisia Williams witnessed staff member, Laquitta Jones ask Resident L to go to the bathroom before dinner. Resident L did not move. Ms. Jones then pulled Resident L's chair from under her causing her to fall. Ms. Jones walked away. Ms. Williams helped Resident L off the floor, asked her if she was ok and took her to the bathroom. Ms. Jones did not apologize to Resident L.

On 05/21/21, I made a telephone call to the AFC group home. I spoke to the house manager, Nicole Womble. Ms. Womble stated Resident L is non-verbal. Ms. Womble was made aware of the allegations by Resident L's support coordinator. Ms. Womble was informed that Ms. Jones wanted Resident L to use the bathroom and she wouldn't. Ms. Jones then pulled Resident L's chair causing her to fall to the ground. Resident L was not injured. Ms. Jones has been taken off the schedule until pending investigation. Ms. Womble stated Ms. Jones has not been accused of anything like this before.

On 05/25/21, I made a telephone call to staff member, Laquitta Jones. Regarding the allegations, Ms. Jones stated she asked Resident L to go to the bathroom because everyone has to go to the bathroom before dinner time. Resident L shook her head no. Ms. Jones stated she slowly pulled Resident L's chair up so she can slide out of the chair. However, Resident L fell out of the chair and hit the floor. Ms. Jones stated Resident L did not hurt herself and she did not have any marks or bruises. Ms. Jones admitted that her actions were not appropriate. Ms. Jones stated after Resident L fell, she helped her up and took her to the bathroom. Ms. Jones stated another staff member was present but she does not know her name.

On 05/25/21, I received a return phone call from staff member, Lisia Williams. Regarding the allegations, Ms. Williams stated she was washing dishes and preparing lunch, when Ms. Jones asked Resident L to go to the bathroom. Resident L did not move. Ms. Jones walked over to Resident L and snatched the chair from under Resident L causing her to fall to the ground. Ms. Jones then walked away. Resident L was on the floor crying. Ms. Williams helped Resident L up and took her to the bathroom and helped her change into her pajamas.

Ms. Williams stated she then called the home manager and told her what happened. Ms. Williams was instructed to complete an incident report. Ms. Williams stated later that day, she saw Ms. Jones walk over to Resident L while she was sitting on the couch and smacked her on the arm. Ms. Williams sent a text message to the home manager informing her what Ms. Jones did. Ms. Williams stated Ms. Jones employment was terminated.

On 05/25/21, I completed an unannounced onsite. Ms. Womble was present. Resident L was not present as she was at workshop. Resident L is non-verbal.

On 05/26/21, I completed an exit conference with the licensee designee, Gladys Sledge. Ms. Sledge was informed that the allegations will be substantiated and a corrective action plan will be required.

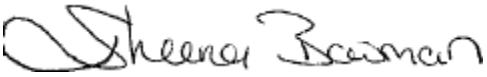
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Ms. Jones did not treat Resident L with dignity nor did she protect her when she deliberately pulled Resident L's chair from under her causing her to fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	Ms. Jones intentionally used physical force by pulling Resident L's chair from under her causing her to fall to the ground. According to Ms. Williams, Ms. Jones did not help Resident L up from the floor. Ms. Williams also observed Ms. Jones smacking Resident L on the arm while she was sitting on the couch.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

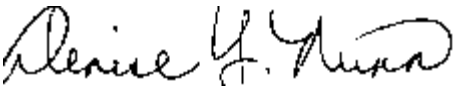


05/26/21

Sheena Bowman
Licensing Consultant

Date

Approved By:



06/04/2021

Denise Y. Nunn
Area Manager

Date