GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 22, 2021

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

RE: License #: AS630271172
Investigation #: 2021A0988020
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) 975-5053.

Sincerely,

Kenyatta Lewis, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2078

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630271172
Investigation #:	2021A0988020
Complaint Receipt Date:	04/30/2021
Investigation Initiation Date:	05/03/2021
Report Due Date:	06/29/2021
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:	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:	08/27/2019
Expiration Date:	08/26/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The facility staff have continually neglected Resident J's wound care since 4/29/2021.	No
Resident J's wound leaked from 3/15/2021 - 4/8/2021 and facility staff did not take him to the doctor. On 4/20/2021 Resident J was finally taken to the hospital having to have another surgery to clean out the wound.	No
The facility staff do not provide the school with Resident J's medications.	Yes
The facility staff do not provide Resident J with clean clothes.	No

III. METHODOLOGY

04/30/2021	Special Investigation Intake 2021A0988020
04/30/2021	APS Referral Adult Protective Services (APS) referred the allegations to the department for investigation. Tina Edens is the assigned APS specialist.
05/03/2021	Special Investigation Initiated - Letter I initiated the special investigation by sending an email to Ms. Edens.
05/04/2021	Contact - Telephone call made I spoke to Tina Edens, APS. I also contacted the complainant and left a voice message.
05/04/2021	Contact - Document Received I received an email from MORC case manager Justin Gillespie that contained Resident D's medical appointment record dated 05/03/2021.
05/11/2021	Contact - Face to Face I participated in a Microsoft Teams meeting, where Ms. Honkanen, Ms. Edens, and I conducted joint interviews with the facility home manager, Lavernelle Williams.

05/11/2021	Contact - Document Received I received an email from Ms. Honkanen that contained Resident J's medication documents from the facility, including his health care chronological, his Appointment Information Records and his hospital visit documents.
05/17/2021	Contact - Document Received I received an email from Ms. Edens.
05/19/2021	Inspection Completed On-site I conducted an unannounced onsite investigation where I interviewed Resident J and the home manager, Ms. Williams.
06/23/2021	Exit Conference I conducted the exit conference by sending an email to the licensee designee, Gladys Sledge.

ALLEGATION:

The facility staff have continually neglected Resident J's wound care since 4/29/2021.

INVESTIGATION:

On 04/30/2021, Adult Protective Services (APS) referred the allegations to the department for investigation. Tina Edens is the assigned APS specialist.

On 05/03/2021, I initiated the special investigation by sending an email to Ms. Edens regarding the referral source.

On 05/04/2021, I spoke to Tina Edens, APS. Ms. Edens stated that Alana Honkanen, Office of Recipient Rights (ORR) is conducting an investigation regarding the allegations. The facility staff said that Resident J picks at the wound. Ms. Edens also stated that she spoke to Resident J's Macomb Oakland Regional Center (MORC) case manager, who stated that the facility staff have provided care to Resident J's wound as instructed by his physician.

On 05/11/2021, I participated in a Microsoft Teams meeting, where Ms. Honkanen, Ms. Edens, and I conducted joint interviews with the facility home manager, Lavernelle Williams. Ms. Williams denied the allegations and stated that Resident J received care as prescribed and he was transported to all of his medical appointments as scheduled.

On 05/11/2021, I received an email from Ms. Honkanen that contained Resident J's medication documents from the facility, including his health care chronological, his Appointment Information Records and his hospital visit documents. These documents

pertain to the recent wound infection and care. (Feb/March 2021 - May 2021). Ms. Honkanen also attached Resident J's documents from the original procedure (percutaneous cholecystostomy) which was completed back in June 2020.

On 05/17/2021, I received an email from Ms. Edens, APS. Ms. Edens documented that Resident J's s doctor office advised that they would fax APS a letter signed by the doctor that stated the home followed all the medical advice and they did not have any concerns for the client. Ms. Edens went to Resident J's school last week and she does not have any concerns. Ms. Edens will not substantiate the allegations.

On 05/19/2021, I conducted an unannounced onsite investigation where I interviewed Resident J and the home manager, Ms. Williams. Ms. Williams denied the allegations and reiterated the information she provided on 05/11/2021.

Resident J denied the allegations and stated that he doesn't pick at his wound. Resident J stated that he has been to the doctor many times and that the staff change his bandage and clean his wound all the time. I observed that Resident J was clean and well groomed. I also observed his bandage and noted no leakage.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information gathered through my interviews, review of pertinent investigation documents and onsite observation of Resident J, there is insufficient information to conclude that the facility staff have continually neglected Resident J's wound care since 4/29/2021.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident J's wound leaked from 3/15/2021 - 4/8/2021 and facility staff did not take him to the doctor. On 4/20/2021 Resident J was finally taken to the hospital having to have another surgery to clean out the wound.

INVESTIGATION:

On 05/04/2021, I spoke to Tina Edens, APS. Ms. Edens stated that the facility manager, Lavernelle Williams denied the allegations. Ms. Williams stated that Resident J received ongoing medical treatment as scheduled and as needed. On 05/04/2021, I also contacted the complainant and left a voice message.

On 05/11/2021, I participated in a Microsoft Teams meeting, where Ms. Honkanen, Ms. Edens, and I conducted joint interviews with the facility home manager, Lavernelle Williams. Ms. Williams denied the allegations and stated that she and her staff transported Resident J to his physician as scheduled.

On 05/11/2021, I received an email from Ms. Honkanen that contained Resident J's medication documents from the facility, including his health care chronological, his Appointment Information Records and his hospital visit documents. I reviewed each document and noted the following:

- 03/11/2021 Wound leakage, Dr. Michael Rebuk treated Resident J's wound with silver nitrate.
- 03/26/2021 Wound leakage, Dr. Michael Rebuk treated Resident J's wound with silver nitrate, staff instructed to clean, cover, and apply silver nitrate to wound daily.
- 04/07/2021 Resident J was picked up from school and taken to Beaumont Troy Emergency Room. Dr. Adam Vieter diagnosed Resident J with cellulitis and administered an injection of ketorolac 15 MG, and silver nitrate. Resident J returned to the facility.
- 04/12/2021, Resident J attended a scheduled follow up appointment with Dr. Nuilenell Johnson at Beaumont Troy. Excision scheduled for 04/20/2021.
- 04/20/2021, Resident J attended excision appointment at Beaumont. Returned to the facility. Staff instructed to remove gauze on 04/21/2021 and give pain medication as needed.
- 04/21/2021, Gauze removed from wound. No leakage felt warm. Resident J given pain pill.
- 04/26/2021, Resident J attended a follow up appointment with Dr. Rebuk, wound looked good. No concerns noted.
- 04/30/2021, School contacted facility to report that Resident J did not feel well, and his wound was leaking. School personnel contacted Resident J's physician and were advised to clean and redress the wound. After school, staff cleaned wound and noted no leakage.
- 05/01/2021, Wound cleaned, no leakage noted.
- 05/02/2021, Wound cleaned, noted a little leakage.
- 05/03/2021, Resident J attended post-operative follow up visit with Dr. Rebuk. Small opening and mild drainage noted. Sutures put in place. Bactrim prescribed 2 x's per day for 7 days.

On 05/17/2021, I received an email from Ms. Edens. Ms. Edens documented that Resident J's s doctor office advised that they would fax APS a letter signed by the doctor that stated the home followed all the medical advice and they did not have any

concerns for the client. Ms. Edens went to Resident J's school last week and she does not have any concerns. Ms. Edens will not substantiate the allegations.

On 05/19/2021, I conducted an unannounced onsite investigation where I interviewed Resident J and the home manager, Ms. Williams. Ms. Williams reiterated that Resident J received proper care and staff attended to his wound. Resident J stated that sometimes his wound leaked a little but never a lot. Resident J denied the allegations and stated that the staff take him to the doctor or hospital when he needs to go.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered through my interviews, review of pertinent investigation documents and onsite observation of Resident J, there is insufficient information to conclude that the facility staff did not take Resident J to the doctor or that his wound leaked continually. I observed Resident J's health care chronological, Appointment Information Records and hospital visit documents. The staff regularly documented Resident J's progress and obtained medical care as needed in a timely fashion.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility staff do not provide the school with Resident J's medications.

INVESTIGATION:

On 05/11/2021, I participated in a Microsoft Teams meeting, where Ms. Honkanen, Ms. Edens, and I conducted joint interviews with the facility home manager, Lavernelle Williams. Ms. Williams stated that Resident J was prescribed with pain medication as needed. The school contacted Ms. Williams to request Resident J's pain medication as it was not sent to school with Resident J. (Date unknown) Ms. Williams took the pain medication to the school for Resident J. Ms. Williams stated that on 04/20/2021, Dr. Rebuk performed an excision procedure and prescribed acetaminophen 500 mg. as needed, for Resident J. The acetaminophen was not sent to school with Resident J. Resident J stated that staff brought his pain pill to his school one day. Neither Ms. Williams nor Resident J could remember the date this occurred.

On 05/19/2021, I conducted an unannounced onsite investigation where I interviewed Resident J and the home manager, Ms. Williams. Ms. Williams stated that on 04/20/2021, Dr. Rebuk performed an excision procedure and prescribed acetaminophen 500 mg. as needed, for Resident J. The acetaminophen was not sent to school with Resident J. Resident J stated that staff brought his pain pill to his school one day. Neither Ms. Williams nor Resident J could remember the date this occurred.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on the information gathered through my interviews, review of pertinent investigation documents and onsite observation of Resident J, I concluded that on at least one unknown date, as needed pain medications were not sent to school with Resident J.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility staff do not provide Resident J with clean clothes.

INVESTIGATION:

On 05/04/2021, I spoke to Tina Edens, APS. Ms. Edens stated that the facility manager, Lavernelle Williams denied the allegations. Ms. Williams stated that Resident J received ongoing medical treatment as scheduled and as needed. On 05/04/2021, I also contacted the complainant and left a voice message.

On 05/11/2021, I participated in a Microsoft Teams meeting, where Ms. Honkanen, Ms. Edens, and I conducted joint interviews with the facility home manager, Lavernelle Williams. Ms. Williams denied the allegations and stated that Resident J always has clean clothes. Resident J's wound never leaked enough to stain his clothing. The wound leakage was always minor.

On 05/19/2021, I conducted an unannounced onsite investigation where I interviewed Resident J and the home manager, Ms. Williams. Ms. Williams denied the allegations and reiterated the information she provided on 05/11/2021.

Resident J denied the allegations and stated that he always has clean clothes. I observed that Resident J was clean and well groomed. I also observed his bandage and noted no leakage.

On 06/23/2021, I conducted the exit conference by sending an email to the licensee designee, Gladys Sledge. I shared my findings and requested a corrective action plan.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	Based on the information gathered through my interviews, review of pertinent investigation documents and onsite observation of Resident J, I cannot conclude that Resident J was not provided with clean clothes. The complainant did not return my phone call; therefore, I could not gather information to validate this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

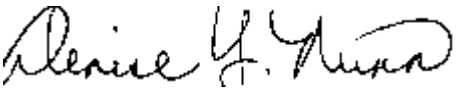
IV. RECOMMENDATION

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

07/01/2021

Kenyatta Lewis Date
Licensing Consultant

Approved By:



07/22/2021

Denise Y. Nunn Date
Area Manager