GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 24, 2022

Charles Leonard
Phoenix Residential Services Inc
PO Box 431034
Pontiac, MI 48341

RE: License #: AS630368424
Investigation #: 2022A0611015
Liza Home

Dear Mr. Leonard:

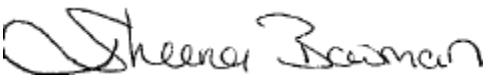
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630368424
Investigation #:	2022A0611015
Complaint Receipt Date:	02/17/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	04/18/2022
Licensee Name:	Phoenix Residential Services Inc
Licensee Address:	102 Franklin Blvd Pontiac, MI 48341
Licensee Telephone #:	(248) 338-3743
Administrator:	Charles Leonard
Licensee Designee:	Charles Leonard
Name of Facility:	Liza Home
Facility Address:	1253 Liza Blvd Pontiac, MI 48342
Facility Telephone #:	(248) 276-4719
Original Issuance Date:	04/13/2016
License Status:	REGULAR
Effective Date:	10/13/2020
Expiration Date:	10/12/2022
Capacity:	4
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 02/11/22, it was discovered that Resident S was not given his medication.	Yes

III. METHODOLOGY

02/17/2022	Special Investigation Intake 2022A0611015
02/22/2022	Special Investigation Initiated - Letter I emailed the licensee designee, Charles Leonard inquiring if anyone was sick or have symptoms of COVID-19 at the home.
02/23/2022	Inspection Completed On-site I completed an unannounced onsite. There was no answer at the door.
02/24/2022	Contact - Telephone call made I made a telephone call to the licensee designee, Charles Leonard. The allegations were discussed.
02/24/2022	Contact - Telephone call made I attempted to contact the home manager, Selfronette Green. However, there was no answer.
02/24/2022	Contact - Document Received I received a copy of the narcotic count sheet, the MAR for Resident S, and the write up for Ms. Sumpter.
02/25/2022	Contact - Telephone call made I made a telephone call to the home manager, Selfronette Green. The allegations were discussed.
02/25/2022	Exit Conference I completed an exit conference with the licensee designee, Charles Leonard via email.

ALLEGATION:

On 02/11/22, it was discovered that Resident S was not given his medication.

INVESTIGATION:

On 02/16/22, I received an incident report regarding the abovementioned allegations. As a result, an intake was created for a special investigation. According to the incident report, the date of incident is 02/11/22. When the home manager, Selfronette Green arrived to the AFC group home she completed a narcotic count and observed that Resident S was not administered his Lorazepam.

On 02/23/22, I completed an unannounced onsite. There was no answer at the door.

On 02/24/22, I made a telephone call to the licensee designee, Charles Leonard. Regarding the allegations, Mr. Leonard stated staff member Charity Sumpter, failed to administer Resident S his medication. Mr. Sumpter did administer the other residents medications. Ms. Sumpter was the only staff member in the home during this incident. Ms. Sumpter excuse for not administering Resident S medication was that she forgot and she is going through personal problems. Mr. Leonard stated Ms. Sumpter was written up, suspended for three days, and she was placed on six months' probation. Ms. Sumpter will also have to go through medication training again.

On 02/24/22, I received a copy of Resident S narcotic count sheet, Resident S MAR for February, and the write up for Ms. Sumpter. According to the narcotic count sheet, Resident S had 20 Lorazepam pills on 02/10/22 and 02/11/22. According to the MAR, Resident S is prescribed Lorazepam three times a day. On 02/11/22, there is missing staff initials at 4:00pm and 8:00 pm for Resident S Lorazepam.

According to the write up for Ms. Sumpter, a meeting was held on 02/21/22 regarding Ms. Sumpter's medication errors and work performance. The letter outlined Ms. Sumpter's 60-day probation and suspension.

On 02/25/22, I made a telephone call to the home manager, Selfronette Green. Regarding the allegations, Ms. Green stated the incident occurred on 02/11/22. Ms. Green stated she came to work on 02/12/22 during the day shift and completed the narcotic count. She noticed Resident S was not administered his Lorazepam on 02/11/22. Ms. Green stated Ms. Sumpter was responsible for administering Resident S his Lorazepam on 02/11/22 at 4:00 pm and 8:00 pm. Ms. Green stated based on the narcotic count, Ms. Sumpter administered Resident S Lorazepam at 4:00 pm but she did not initial the MAR. Ms. Sumpter stated during her disciplinary meeting, she didn't administer Resident S Lorazepam at 8:00 pm because she wasn't focused.

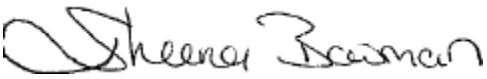
On 02/25/22, I completed an exit conference with the licensee designee, Charles Leonard via email. Mr. Leonard was informed that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to the February MAR for Resident S, he was not administered his Lorazepam on 02/11/22 at 4:00 pm or 8:00 pm. The home manager, Selfronette Green completed a narcotic count during the day shift on 02/12/22 and observed that Resident S did not receive his Lorazepam at 8:00 pm on 02/11/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Ms. Green, Resident S was given his Lorazepam at 4:00 pm on 02/11/22 however, Ms. Sumpter did not initial the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

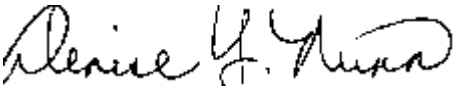
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



02/25/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



03/24/2022

Denise Y. Nunn — Date
Area Manager