GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2022

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

RE: License #: AS630368424
Investigation #: 2023A0611004
Liza Home

Dear Mr. Leonard:

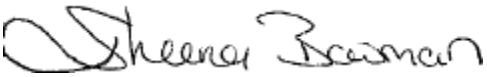
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0611004
Complaint Receipt Date:	10/25/2022
Investigation Initiation Date:	10/26/2022
Report Due Date:	12/24/2022
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:	10/13/2022
Expiration Date:	10/12/2024
Capacity:	4
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident S did not receive his Quetiapine 25 mg as he was on a leave of absence longer than expected.	Yes

III. METHODOLOGY

10/25/2022	Special Investigation Intake 2023A0611004
10/26/2022	Special Investigation Initiated - Telephone I made a telephone call to the home manager Selfronette Green to obtain details concerning the incident report. Ms. Green provided additional information.
10/31/2022	Inspection Completed On-site I completed an unannounced onsite. I spoke with the home manager, Selfronette Green.
10/31/2022	Contact - Face to Face I completed an unannounced onsite at Prosperity House (AS630084857). I interviewed Resident S and; staff member Joe Buckler provided me contact information for Resident S sister.
11/01/2022	Contact - Telephone call made I made a telephone call to Resident S sister. The allegations were discussed.
11/01/2022	Contact - Document Received I reviewed Resident S MAR for the month of October 2022.
11/01/2022	Contact - Telephone call made I made a telephone call to the home manager Selfronette Green. Resident S MAR was discussed.
11/01/2022	Exit Conference I completed an exit conference with the licensee designee, Charles Leonard via telephone.

ALLEGATION:

Resident S did not receive his Quetiapine 25 mg as he was on a leave of absence longer than expected.

INVESTIGATION:

On 10/19/22, I received an incident report regarding the abovementioned allegations. As a result, an intake was created. The incident report is dated 10/18/22 at 5:10pm. According to the incident report, the AFC group home received a phone call at 5:05pm from Resident S relative stating she is running late from returning Resident S back to the AFC group home. Resident S relative stated she found one of Resident S's pills on the floor at her mother's house and gave it to him for his 4:00pm medication. Resident S was not administered his 4:00pm dose of Quetiapine (Seroquel) as Resident S relative was supposed to return Resident S from his leave of absence prior to 4:00pm.

On 10/26/22, I made a telephone call to the home manager Selfronette Green to obtain details concerning the incident report. Ms. Green stated on 10/18/22, Resident S was on a leave of absence (LOA) with his relative. Resident S leave of absence was scheduled for 11:00am to 2:30pm. Ms. Green stated she received a phone call from Resident S relative at 5:10pm stating she was running late with returning Resident S back to the AFC group home. Ms. Green informed Resident S relative that he missed his 4:00pm dose of Seroquel. Resident S relative told Ms. Green not to worry as she found one of Resident S pills on the floor and gave it to him. Resident S relative stated the pill she gave Resident S was his 4:00pm medication. Resident S returned to the AFC group home at 5:35pm. Ms. Green stated she did not administer Resident S 4:00pm dose of Seroquel because she did not know what his relative had already given him. Ms. Green stated Resident S has never returned late to the AFC group home before from a LOA.

Ms. Green stated while Resident S was with his relative, she thinks the relative took Resident S to the hospital to visit his mother and; then they stopped by his mother's home and that is where she gave him the medication she found. Ms. Green stated Resident S relative, and mother wanted Resident S medications to be decreased. Resident S relative asked Resident S doctor to decrease his medications about five months ago because she felt like he was overmedicated. The doctor informed Resident S relative that he will have to gradually decrease Resident S medications. Ms. Green stated that Resident S was initially prescribed two pills of Seroquel however; last month (September) his Seroquel was decreased to one pill. Ms. Green thinks when Resident S was on LOA's prior to September his relative was not administering Resident S both pills of his Seroquel; which would explain why she found an extra pill to give him on 10/18/22.

On 10/31/22, I completed an unannounced onsite. I was informed by the home manager Selfronette Green that Resident S was discharged from the AFC group home on 10/21/22. Resident S was moved to another AFC group home named Prosperity House due to his level of care increasing. Ms. Green stated Resident S became a fall risk as he could no longer go up and down the stairs and he has arthritis in both of his knees.

On 10/31/22, I completed an unannounced onsite at Prosperity House (AS630084857). Staff member Joe Buckler provided me contact information for Resident S sister. I interviewed Resident S. Regarding the allegations, Resident S stated he takes medications every day in the morning and at night. Resident S stated the home manager administers his medications. Resident S stated he has not seen his sister recently however; when he is on a visit with his sister, she gives him his medications.

On 11/01/22, I made a telephone call to Resident S sister. Regarding the allegations, Resident S sister could not give a straight answer to any of the questions. Resident S sister stated she has taken Resident S on a leave of absence in the month of October 2022, but she is unsure of the exact date without looking at her calendar. Resident S sister stated she may have brought Resident S back to the AFC group home later than expected but, whenever that happens, she always calls the AFC group home. Resident S sister stated Resident S might have missed his 4:00pm dose of Seroquel while he was with her on a leave of absence. Resident S sister stated there are loose pills at her mother's house, but she does not know if the loose pills belong to her mother or Resident S. Resident S sister stated whenever she finds a loose pill, she throws it away. Resident S sister denied ever given Resident S a pill from the floor.

On 10/27/22, I received a copy of Resident S MAR for the month of October 2022, and I reviewed it on 11/01/22. According to the MAR, Resident S was administered his Seroquel on 10/18/22 at 4:00pm. The MAR also indicated that Resident S was not administered his Seroquel at 4:00pm on 10/19/22 as the initial "NG" was listed which means not given. Resident S MAR does not coincide with the incident report which indicates Resident S did not receive his 4:00pm dose of Seroquel on 10/18/22.

On 11/01/22, I made a telephone call to the home manager Selfronette Green. Ms. Green confirmed that Resident S did not receive his 4:00pm dose of Seroquel on 10/18/22. Ms. Green confirmed the number three that was documented on the MAR for Resident S 4:00pm dose of Seroquel on 10/18/22 was initialed by her. The number three implies that Resident S did receive his 4:00pm dose of Seroquel on 10/18/22. Ms. Green could not explain why "NG" was initialed on 10/19/22 for Resident S 4:00pm dose of Seroquel.

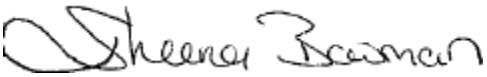
On 11/01/22, I completed an exit conference with the licensee designee, Charles Leonard. Mr. Leonard was informed that the allegations will be substantiated based on the discrepancy on Resident S MAR. Mr. Leonard was advised that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my findings and information gathered, there is not sufficient information to confirm the allegations. On 10/18/22, Resident S was on a leave of absence, and he was expected to return to the AFC group home by 2:30pm. However, Resident S did not return to the AFC group home until 5:35pm. Therefore, it was out of the AFC group home control that Resident S missed his 4:00pm dose of Seroquel because he did not return to the AFC group home at the expected time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
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 Resident S MAR for the month of October 2022, Resident S was administered his Seroquel on 10/18/22 at 4:00pm. The MAR also indicated that Resident S was not administered his Seroquel at 4:00pm on 10/19/22 as the initial "NG" was listed which means not given. Resident S MAR does not coincide with the incident report which indicates Resident S did not receive his 4:00pm dose of Seroquel on 10/18/22. The discrepancy on Resident S MAR, indicates that the staff are not following the 5 rights when they are administering and/or completing the resident's MAR's.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

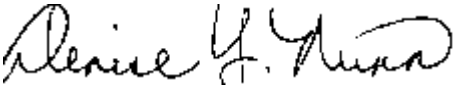


11/01/22

Sheena Bowman
Licensing Consultant

Date

Approved By:



11/02/2022

Denise Y. Nunn
Area Manager

Date