GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

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

RE: License #: AS630237099
Investigation #: 2023A0993017
Phoenix II

Dear Mr. Leonard:

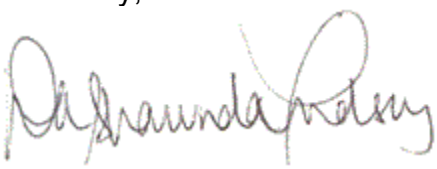
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630237099
Investigation #:	2023A0993017
Complaint Receipt Date:	02/07/2023
Investigation Initiation Date:	02/08/2023
Report Due Date:	04/08/2023
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:	Phoenix II
Facility Address:	631 Fox River Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 253-7349
Original Issuance Date:	01/04/2002
License Status:	REGULAR
Effective Date:	03/22/2021
Expiration Date:	03/21/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 02/03/2023, recipient rights advocate received an incident report indicating Resident B had not returned home on 02/02/2023. On 02/06/2023, home manager Nina McClendon indicated Resident B told staff she was leaving the facility. She then left and did not return.	No
Additional Findings	Yes

III. METHODOLOGY

02/07/2023	Special Investigation Intake 2023A0993017
02/07/2023	Referral - Recipient Rights Received allegations from recipient rights advocate Aaron Winston
02/08/2023	Special Investigation Initiated - Telephone Telephone call made to recipient rights advocate Aaron Winston. Left a message.
02/08/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
02/08/2023	APS Referral Received allegations from adult protective services (APS). APS denied the intake.
02/09/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Aaron Winston
02/16/2023	Contact - Telephone call made Telephone call made to staff Myea Jerrings. Mailbox was full. Sent a text message.
02/16/2023	Contact - Telephone call made Telephone call made to Resident B's guardian (and brother)
02/16/2023	Contact - Telephone call made Telephone call made to staff Christine Huantes. Left a message.

02/23/2023	Contact - Telephone call made Telephone call made to staff Myea Jerrings. Mailbox was full. Sent a text message.
02/23/2023	Contact - Telephone call made Telephone call made to staff Christine Huantes. Left a message.
02/28/2023	Contact - Telephone call made Telephone call made to staff Myea Jerrings
02/28/2023	Contact - Telephone call made Telephone call made to staff Christine Huantes. Left a message.
03/01/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
03/02/2023	Contact - Telephone call made Telephone call made to staff Christine Huantes
03/09/2023	Exit Conference Attempted to hold with licensee designee Charles Leonard. Left a message.

ALLEGATION:

On 02/03/2023, recipient rights advocate received an incident report indicating Resident B had not returned home on 02/02/2023. On 02/06/2023, home manager Nina McClendon indicated Resident B told staff she was leaving the facility. She then left and did not return.

INVESTIGATION:

On 02/07/2023, I received the allegations from recipient rights advocate Aaron Winston.

On 02/08/2023, I conducted an unannounced onsite investigation. I interviewed home manager Nina McClendon. Ms. McClendon stated Resident B left the facility in the early morning (around 12:45am) of 02/01/2023. When Ms. McClendon arrived at the facility at 8am on 02/01/2023, Resident B had not returned. Per Ms. McClendon she was informed by staff Myea Jerrings, who was on shift at the time, Resident B stated she had a ride waiting on her and she was leaving. Ms. Jerrings informed Resident B she

needed to call her guardian and get permission. Resident B told Ms. Jerrings that she could call him, but she was still leaving. Per Ms. McClendon, Resident B's guardian was notified, and he knew where Resident B was at. Ms. McClendon stated Resident B's guardian asked her to pick up Resident B and transport her to medication review appointment she had scheduled on 02/02/2023. Ms. McClendon stated she picked up Resident B on 02/02/2023 and brought her back to the facility to shower and change her clothes. She then transported her to her medication review appointment. Resident B was petitioned and transported to a hospital. Ms. McClendon stated Resident B was still hospitalized, but she did not know where she was at.

During the onsite visit, I reviewed Resident B's assessment plan. Per the plan, Resident B cannot move independently in the community.

On 02/09/2023, I conducted a telephone interview with recipient rights advocate Aaron Winston. He stated Resident B's treatment plan does not specify if she has community access.

On 02/16/2023, I conducted a telephone interview with Resident B's guardian (and brother). Resident B's guardian stated Resident B is supposed to get permission before she is allowed to move independently in the community. Lately, Resident B has been chasing drugs and leaving the facility without permission. He stated Resident B is "head strong" about doing what she wants to do. He stated he is afraid Resident B may leave without permission and something may happen to her. Resident B's guardian verified Resident B was hospitalized. She received a medication adjustment. She is back in the facility and there has not been any concerns.

On 02/28/2023, I conducted a telephone interview with staff Myea Jerrings. She could not recall the date of the incident, but she confirmed Resident B left out of the facility without permission. Per Ms. Jerrings, Resident B came downstairs with her coat on. She told Ms. Jerrings she was leaving out with a friend. Ms. Jerrings called Resident B's guardian. Resident B's guardian and Resident B had a few words. Resident B's guardian told her she was not leaving, but Resident B still left. Resident B did not return to the facility during Ms. Jerring's shift. Ms. Jerring stated she did not contact the police as Resident B's guardian was aware that Resident left. In addition, Resident B's guardian told her he knew where Resident B was at. Ms. Jerring stated Resident B told her she was not going to be back by morning. Mr. Jerring gave Resident B her morning medication. Ms. Jerring confirmed Resident B was located and taken to the hospital. She has since returned to the facility.

On 03/01/2023, I conducted an unannounced onsite investigation. I interviewed Resident B. Resident B confirmed she left out the facility. She stated she could do so if she signs in and signs out. I did not receive any other information from Resident B as she fell asleep during the interview.

I also spoke with Ms. McClendon during the onsite. Ms. McClendon stated Resident B thinks she can leave whenever she wants as long as signs in and out. She thinks so because the police spoke with her and told her to let staff know when she leaves. Per Ms. McClendon, Resident B's guardian must give Resident B permission to move independently in the community. Resident B's guardian wants to be informed where Resident B is going and who she is going with. Ms. McClendon verified staff gave Resident B's her medications in the past when she left. However, she stated this is no longer the case due concerns that Resident B is using recreational drugs.

On 03/01/2023, I conducted a telephone interview with staff Christine Huantes. Ms. Huantes verified Resident B has left out the facility without permission during her shift. Ms. Huantes could not recall the date of the incident. She stated Resident B ran down the stairs, ran out the door and got into a car. Resident B did not say where she was going. Resident B did not sign out. Ms. Huantes stated she thought Resident B was just going outside to smoke. When Resident B took off, Ms. Huantes stated she documented it and notified her guardian. She did not contact the police as Resident B left in a car. Per Ms. Huantes, ever since Resident B's guardian gave Resident B permission to stay overnight at someone's house (around the beginning of February 2023), Resident B thinks she can just take off.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Per Resident B's assessment plan, Resident B cannot move independently in the community. Resident B left the facility without permission Staff contacted her guardian. Her guardian knew of her location. Resident B was petitioned and hospitalized on 02/02/2023. She has since returned to the facility. There have not been any concerns.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident B left the facility without permission Staff contacted her guardian. Her guardian knew of her location. Resident B was petitioned and hospitalized on 02/02/2023. She has since returned to the facility. There have not been any concerns.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/28/2023, I interviewed staff Myea Jerrings. She confirmed Resident B left the facility without her guardian's permission. Ms. Jerring stated because Resident B told her she was not going to be back by morning, Mr. Jerring gave Resident B her morning medication.

On 03/01/2023, I spoke with Ms. McClendon. She verified staff gave Resident B's her medications in the past when she left. However, she stated this is no longer the case due concerns that Resident B is using recreational drugs.

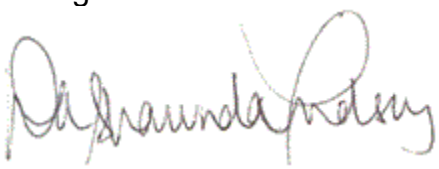
On 03/09/2023, I attempted to conduct an exit conference with licensee designee Charles Leonard with no success. I left a message.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	Ms. Jerring stated Resident B told her she was not going to be back by morning. Mr. Jerring gave Resident B her morning medication. Ms. McClendon verified staff gave Resident B's her medications in the past when she left.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

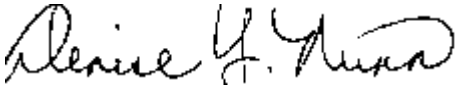
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



03/09/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



03/10/2023

Denise Y. Nunn — Date
Area Manager