GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

Priscilla Murrell
Radclift, Inc
23530 Radclift
Oak Park, MI 48237

RE: License #: AS630256456
Investigation #: 2025A0626012
Hazel House

Dear Ms. Murrell:

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,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630256456
Investigation #:	2025A0626012
Complaint Receipt Date:	03/06/2025
Investigation Initiation Date:	03/06/2025
Report Due Date:	05/05/2025
Licensee Name:	Radclift, Inc
Licensee Address:	23530 Radclift Oak Park, MI 48237
Licensee Telephone #:	(248) 569-9197
Administrator:	Priscilla Murrell
Licensee Designee:	Priscilla Murrell
Name of Facility:	Hazel House
Facility Address:	17115 Melrose Southfield, MI 48075
Facility Telephone #:	(248) 569-9197
Original Issuance Date:	11/22/2004
License **Status:**	REGULAR
Effective Date:	08/04/2024
Expiration Date:	08/03/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Hazel House staff refused to pick up Resident A after being discharged from the emergency department.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/06/2025	Special Investigation Intake 2025A0626012
03/06/2025	APS Referral A referral to APS was not made due to APS already being involved.
03/06/2025	Special Investigation Initiated - Telephone Special investigation initiated via telephone interview with APS investigator, Nathaniel Roberson.
03/06/2025	Contact - Document Sent The referral was sent to Office of Recipient Rights, via email.
03/06/2025	Contact - Telephone call made Attempted phone contact with Easter Seals social worker, Tallia Pruitt. A message was left requesting a return call.
03/10/2025	Contact - Face to Face Successful face to face contact with Resident A at New Horizons Rehabilitation Center in Madison Heights.A full interview was completed.
03/10/2025	Contact - Face to Face Completed an unannounced investigation at Hazel House. An interview was completed with licensee, Priscilla Murrell.
03/11/2025	Contact - Document Received The social work contact was received, via email, from Amber Oliver.

04/03/2025	Contact - Face to Face An unannounced visit took place at Hazel House. Interviews were conducted with direct staff members, Brittany Wilson and Montinique Watts. Private interviews took place with Resident B, Resident C, and Resident D.
04/04/2025	Contact - Telephone call made A telephone interview was completed with Dr. Ann Liesen, Resident A's therapist.
04/07/2025	Contact – Telephone call made A telephone interview was completed with Relative A1.
04/11/2025	Contact – Document received An email was received from Adult Protective Services investigator, Nathaniel Roberson containing a status update on his investigation.
04/23/2025	Exit conference An exit conference took place, via telephone, with licensee, Priscilla Murrell. The findings were discussed.

ALLEGATION:

Hazel House staff refused to pick up Resident A after being discharged from the emergency department.

INVESTIGATION:

On 03/06/2025, I received the complaint, via email, alleging Priscilla Murrell, owner and licensee at Hazel House, was refusing to pick up Resident A from the hospital when he was ready for discharge.

On 03/06/2025, I initiated the investigation with a conference with assigned Adult Protective Services (APS) investigator, Nathaniel Roberson. Mr. Roberson stated he is still trying to figure it all out, but Resident A is back at the home for now. He stated Resident A has behavioral issues and the home was aware of his behavioral issues prior to him being admitted. He stated that he had behaviors, and the police were called, and they took him to the hospital. Resident A did not meet admission criteria and the licensee, Priscilla Murrell, would not pick him up and stated the other residents do not feel safe with Resident A in the home and they want to move out due to it.

On 03/10/2025, I completed a private interview with Resident A at New Horizons Rehabilitation Services. Resident A stated he is currently living at 17115 Melrose, until his case worker can find a place where he can be happy and be closer to his mom and brothers. He stated he went to the hospital to try to get help because of his behavior, which he described as swearing and pushing people away. He stated the people pushed back and that he did not mean to push them. He stated he went to his bedroom to calm down and listen to music. He then informed me that a staff from another home came to get him at the hospital. He stated when the police came, they would not let him take his items with him and he was terrified because they put him in handcuffs, and they were too tight, he just wanted his mom and brother. Resident A stated he slept one night at the hospital.

On 03/10/2025, I completed an unannounced investigation at Hazel House. Priscilla Murrell was the only one at the home, the residents were all at their respective programs. She stated Resident A has been at Hazel House since October. She stated that Resident A was mad and started kicking the door and damaged his roommate's dresser. She stated she called 911 and they took him to the hospital. She stated he was there for one night, she spoke with the hospital social worker and asked if they could keep him longer, she was waiting to hear back and never did, so she sent staff there to pick him up. I requested Resident A's individual plan of service (IPOS) health care appraisal, and information record; all were provided.

On 03/11/2025, I received an email from Amber Oliver, specialist at the Office of Recipient Rights, indicating she spoke with social work at Henry Ford Hospital. She stated Resident A was in the emergency department on 03/04/2025, cleared for discharge on 03/05/2025 and he was picked up on 03/06/2025, shortly after 10am. The email also contained a social work progress note, written 03/05/2025 at 9:22 EST. The social work progress note indicates Resident A was left the hospital on 03/06/2025. The note reads:

> "SW spoke with Priscilla Murrell, group home staff, and they report the patient received a 30 day notice to move out of the group home. She reports the patient has known about his eviction. She reports the patient must have been triggered by something and began to destroy his room. She reports he broke his dresser and was punching holes in the wall. She reports that patient is not evicted from the house yet, but she does not want him back in the house. She reports, "I cannot keep the other residents safe when he is home". She states residents are afraid of him. She reports Easter Seals is currently looking for another placement for the patient."

On 04/03/2025, I conducted an unannounced onsite visit at Hazel House to interview residents. Resident A was present and was meeting with his therapist. He appeared well and said hello. He stated he was doing good right now.

On 04/03/2025, I completed a private, face to face interview with Resident B at Hazel House. Resident B stated she has been at Hazel House for approximately 16 years.

She likes it and feels safe. She stated she is well cared for, and the only bad part is the "new guy", Resident A. She stated he is a jerk and cusses and yells at everyone. She stated he isn't mean, he just acts out, even when no one is mean to him. Resident B stated, "I love Ms. Priscilla".

On 04/03/2025, I completed a private, face to face interview with direct care staff member, Brittany Wilson. Ms. Wilson has been employed at Hazel House for approximately one year. She stated the job has its ups and downs, especially when dealing with Resident A. She stated Resident A is angry, destructive, cusses, and threatens everyone. She stated Resident A does not like being told to change after soiling himself and he has triggers they don't even know about. She stated he has been physically violent once and hit another resident while the resident was sleeping; they are now keeping them separated. She stated Ms. Murrell tries to be nice to Resident A and he doesn't accept it. She denied being in the home when Resident A was taken to the hospital. They are still looking for another place for him to live and he has a meeting with a potential roommate next week, for an independent living situation.

On 04/03/2025, I completed a private, face-to-face interview with Resident C at Hazel House. She has lived there for eight years and likes it. She feels safe when Resident A isn't there. She stated Resident A has told them he is calling his brother to come beat them up and has said he will kill them. She stated everyone is nice to Resident A, but he still blows up for no reason. She stated Ms. Murrell is nice to everyone. She stated Resident A hit her and she told her social worker, so he stopped doing it, but told her he was going to have his sister-in-law beat her up. She stated Resident A does not like Ms. Murrell, but she does stuff for them that their parents won't even do, and she takes care of her.

On 04/03/2025, I completed an in-person interview with direct care staff member, Montinique Watts, at Hazel House. Ms. Watts has been at Hazel House for approximately one year and has been the one-to-one worker for Resident A for approximately one week. She stated she works with him every morning and every other Saturday. She stated he was having a lot of blow ups but has been better lately. She stated they are following his behavior plan, and he has an appointment with a potential roommate. She is working with Resident A on redirection, and it is her belief that Ms. Murrell reminds Resident A of someone who did something mean to him.

On 04/03/2025, I completed a private, face to face interview with Resident D. Resident D likes being where he is and stated that everyone takes care of him and has his back. He stated, "I do real good". He likes going on outings with Ms. Murrell, his favorite places to go are the park and the library. He stated Resident A scares him but hasn't done anything mean to him.

On 04/07/2025, I completed a phone interview with Relative A1. Relative A1 explained that he has no idea as to what is going on. He stated Resident A called

him and told him people were picking on him. He stated Resident A has mentioned wanting to leave Hazel House and that Resident A gets cranky when he doesn't get what he wants.

On 04/11/2025, I received an email from APS worker, Nathaniel Roberson, indicating he will be substantiating on the allegations regarding Resident A being left at the hospital after discharge.

On 04/23/2025, I completed an exit conference with Priscilla Murrell, via telephone. The findings were explained and discussed. Ms. Murrell did not agree with the findings, as she contends, she did pick up Resident A from the hospital. I explained to her what was provided by the hospital social worker, and she asked if she could have time to talk to the social worker to get something in writing stating she did not leave him as long as indicated. She indicated she is going on vacation until 05/05/2025. I agreed to wait for anything she could provide, in writing, until close of business on 05/06/2025. As of 05/08/2025, I have not received anything in writing. As to the allegations regarding the failure to follow Resident A's behavior plan, she indicated she understood why the violation was established, but did not feel the behavior plan was appropriate, nor helpful.

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:	Based upon a review of the information obtained during my investigation, there is sufficient evidence to conclude that Resident A was not provided with supervision or protection while at the hospital. Resident A was discharged, as he was not appropriate for admission, and was not picked up until the next day, per social work, leaving him being unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

ALLEGATION:

Licensee, Priscilla Murrell, is refusing to follow the established behavior plan created for Resident A.

INVESTIGATION:

On 03/06/2025, I completed a telephone interview with Easter Seals case manager, Tallia Pruitt. Ms. Pruitt stated Resident A moved into Hazel House on 10/24/2024 and the licensee, Priscilla Murrell, was there for Resident A's individual plan of service (IPOS) meeting. She stated things were going good at first, then Resident A called her and told her he was nervous and did not want to live there anymore. She stated they had a meeting with her, Ms. Murrell, and his other care coordinator assistant, Kasey Iapalucci. Ms. Pruitt stated that Ms. Murrell was making concerning comments regarding Resident A, such as asking him why he looked so pitiful and she kept on going with the comments, escalating Resident A and antagonizing him. Ms. Pruitt tried to stop it, but it kept on going. She stated she was able to calm Resident A, and they went over his behavior plan. I inquired about Resident A's behavior plan, and she explained he has been approved for 1:1 staff and did not have it by that point. She stated Resident A cannot be touched when he is upset, it sets him off, and Ms. Murrell touched his shoulder. Ms. Pruitt explained that Resident A has bowel incontinence and Ms. Murrell will tell him he needs to be a man and men don't wear diapers. According to Ms. Pruitt, Ms. Murrell told her she was not willing to follow the behavior plan. Ms. Pruitt informed me that Resident A has no guardian and attends a program at New Horizons in Madison Heights.
Ms. Pruitt also stated that Resident A was supposed to have a male to work with him 1:1 when he was admitted to the home, and he did not get one until January.
Ms. Pruitt stated that Ms. Murrell stopped taking Resident A out into the community and would make him stay home while the other residents went somewhere. Ms. Pruitt denied ever receiving any incident reports regarding Resident A.

On 04/03/2025, I completed an in-person interview with Priscilla Murrell at Hazel House. She stated Resident A has an appointment with a potential roommate next week. She stated they are going to place Resident A in an apartment with another man and she does not think it will work. She stated she was not sure where the apartment is or the details, when she asked about them to the caseworker, she asked her, "What's it to you?" She insisted that if they had just let her do what she felt was right to care for him, they wouldn't be having all of these issues with Resident A.

On 04/04/2025, I completed a phone interview with Dr. Ann Liesen, Resident A's behavioral therapist. She stated Resident A has had significant emotional trauma in his life. She stated Resident A has been moved several times and is looking for someone to rescue him. He has a "honeymoon period" with his caregivers, but it ends quickly. She stated Resident A is looking for a parent and Ms. Murrell thought she could be that parent, but she tries to use her authoritarian style with Resident A, which doesn't work with him. Dr. Liesen stated Ms. Murrell says derogatory things to Resident A and claims she is saying them to toughen him up. She stated Ms. Murrell tries to tell Resident A that she doesn't believe he has leaky bowels during a team meeting. She stated the team called her out and Ms. Murrell became belligerent, and she had screamed at Resident A after he called her a liar. Dr. Liesen stated that Ms.

Murrell cannot turn down a confrontation. Dr. Liesen tried to work with Ms. Murrell, at Hazel House, and teach her about how to handle Resident A, but Ms. Murrell doesn't want her there. She stated she was supposed to be there to work with Ms. Murrell on 04/03/2025 and she wouldn't come out of her office to even say hello. She stated the honeymoon period ended much quicker than it has before. Dr. Liesen stated Ms. Murrell has no respect for her opinion, she has informed Ms. Murrell that she needs to let Resident A calm down before talking to him and she won't. She stated she does caregiver training with Ms. Watts, Resident A's one-to-one worker, and she is doing well with Resident A. She stated Ms. Watts has a calm approach and because of this, Resident A has done better this past week. Dr. Liesen stated Resident A is not good at sharing his private space and must share a bedroom at Hazel House. She stated he needs to be alone when he is upset and he has been told he cannot go for a walk, he has limited outlets. She stated the only time Ms. Murrell gives Resident A space is when she is pouting and refusing to interact. Dr. Liesen is meeting with Resident A more often to try to keep him ok until he is moved.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.

ANALYSIS:	Based upon a review of the information obtained during my investigation, there is sufficient evidence to conclude that the behavior interventions established in Resident A's behavior plan were not being employed accordingly. Resident A's case manager and therapist have both reported Ms. Murrell told them she was not going to follow the plan. Both have also witnessed Ms. Murrell reacting to Resident A in a manner incongruent with the established behavior plan. Resident A was supposed to have a one-on-one direct care staff worker in October, and one was not hired until January. Furthermore, Ms. Murrell indicated to me that she did not agree with the behavior plan and was trying to do things how she felt was appropriate.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/08/2025

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Sara Shaughnessy Date
Licensing Consultant

Approved By:

For 06/05/2025

_____

Denise Y. Nunn Date
Area Manager