GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 8, 2026

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

RE: License #: AS630237099
Investigation #: 2026A0605024
Phoenix II

Dear Charles Leonard:

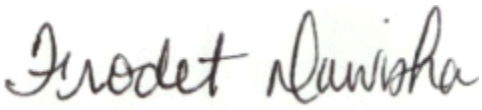
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 972-9136.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
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(248) 303-6348

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630237099
Investigation #:	2026A0605024
Complaint Receipt Date:	05/29/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/28/2026
Licensee Name:	Phoenix Residential Services Inc
Licensee Address:	102 Franklin Blvd Pontiac, MI 48341
Licensee Telephone #:	(248) 338-3743
Administrator:	Beatrice 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:	03/23/2025
Expiration Date:	03/22/2027
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff spend time outside of the home and are often on their phones.	No
Staff say they don't have to cook daily. Some days staff only cook once and residents must fend for themselves. Staff are not wearing gloves when preparing meals.	Yes
Staff are administering medications with their bare hands and not wearing gloves.	No
The home manager, Barbara Robinson, called Resident A "bitch" sometime within the last month.	Yes

III. METHODOLOGY

05/29/2026	Special Investigation Intake 2026A0605024
06/01/2026	APS Referral Adult Protective Services (APS) made referral but will not be investigating these allegations
06/01/2026	Special Investigation Initiated - Letter Email to Oakland County Office of Recipient Rights (ORR) worker Amanda Clasman
06/01/2026	Inspection Completed On-site Conducted unannounced on-site investigation
06/08/2026	Contact - Document Received Email from ORR worker Sarah Rupkus
06/15/2026	Contact - Telephone call made Discussed allegations with licensee designee Charles Leonard
06/15/2026	Contact - Document Sent Email to licensee designee Charles Leonard
06/16/2026	Contact - Document Sent Email to clinical social worker, Tia Morgan with Walter P. Reuther Psychiatric Hospital

06/17/2026	Contact - Face to Face Interviewed Resident A and clinical social worker Tia Morgan at Walter P. Reuther Psychiatric Hospital regarding the allegations.
06/19/2026	Contact - Document Received Email from Charles Leonard
06/25/2026	Contact - Telephone call made Discussed allegations with DCS and left messages for DCS to return my call
06/25/2026	Contact - Telephone call received Discussed allegations with DCS
06/30/2026	Contact - Document Received Email from Charles Leonard
07/07/2026	Contact – Document sent Email to and from Charles Leonard
07/07/2026	Contact – Telephone call received DCS left message
07/08/2026	Contact – Telephone call made Interviewed DCS regarding allegations
07/08/2026	Exit Conference Left detailed message for licensee designee Charles Leonard with my findings

ALLEGATION:

Staff spend time outside of the home and are often on their phones.

INVESTIGATION:

On 05/29/2026, intake #210843 was referred to by Adult Protective Services (APS) who will not be investigating these allegations.

On 06/01/2026, I referred this complaint to the Oakland County Office of Recipient Rights (ORR). ORR worker Sarah Rupkus was assigned to this investigation.

On 06/01/2026, I conducted an unannounced on-site investigation regarding these allegations. Present was the home manager (HM), Barbara Lawrence, and Residents B,

C, and D. Resident A was at Havenwyck, but HM believes Resident A was discharged to another hospital.

I interviewed Resident B regarding the allegations. Resident B stated that there are times when Resident B was looking for staff and staff were not in the home. The staff working morning shift are “usually,” outside doing “yardwork.” Staff are watering the grass or cutting flowers. They are outside for 30-40 minutes. Sometimes Resident B observes staff on their phones in the garage and inside the home. When staff are outside, the residents are inside the house by themselves. There is one direct care staff (DCS) per shift. Resident B was unable to provide staff names. There have not been any incidents that have occurred when staff are outside on their phones or playing games.

Note: During this interview, Resident B reported that the bathtub upstairs was dirty. I observed the bathtub and there was a bathmat inside the tub and the tub was not clean. However, after contacting the licensee designee, Charles Leonard, he immediately addressed the concerns. He submitted pictures of the cleaned and recalked bathtub without the bathmat and with non-skid strips applied. Therefore, there will not be any rule violations pertaining to the bathtub, as technical assistance was provided and the concerns were addressed immediately.

I interviewed Resident C regarding the allegations. Resident C stated sometimes staff (names unknown) are outside on their phones and sometimes they are inside on their phones. When staff are outside on their phones, residents are inside by themselves. She is unsure how long they are outside. She was unable to provide any further information. There have not been any incidents that have occurred when staff are outside on their phones or playing games.

I interviewed Resident D regarding the allegations in the garage where she was sitting and talking on the phone. Resident D got off the phone. Resident D stated that there are times when staff are outside in the garage smoking cigarettes and talking on the phone. Sometimes staff are inside on their phones playing games when residents are either in the living room watching TV or upstairs in their bedrooms. She too was unable to provide staff names. There have not been any incidents that have occurred when staff are outside on their phones or playing games.

I interviewed HM Barbara Lawrence regarding the allegations. HM works morning shift from 8AM-4PM. There is one DCS per shift. Staff get 15 minutes of break time. HM is a “smoker,” so she smokes in the garage. She stated that when she has a cigarette, she is on her cellphone. HM stated, “I have games on my cell phone, so when I’m smoking a cigarette, I play games.” She believes other staff have games on their cell phones and play games, but no resident has complained about staff being on their cell phones too much or about staff being outside too long. When she is outside smoking a cigarette and on her cell phone, residents are inside by themselves.

On 06/15/2026, I interviewed the licensee designee, Charles Leonard, regarding the allegations. He stated staff should only use their cell phones for work and/or emergency purposes. There is a cell phone policy, but due to these allegations Mr. Leonard will update the policy and forward it to me via email. He will speak with all staff and address these allegations immediately.

On 06/17/2026, I interviewed clinical social worker, Tia Morgan, with Walter P. Reuther Psychiatric Hospital regarding Resident A. Resident A was admitted into this hospital on 05/20/2026 after being discharged from Havenwyck Hospital. Resident A has not disclosed any concerns regarding this group home. Resident A is fixated on not wanting guardianship. Resident A's legal guardian is Kathryn Byrd. Ms. Byrd reported to Ms. Morgan that Resident A was "sneaking her boyfriend into the basement of this group home." It is unclear where staff were when this happened. There is no discharge date for Resident, A as she was admitted into this hospital because she was in violation of a not-guilty by reason of insanity (NGRI) order.

On 06/17/2026, I interviewed Resident A at Walter P. Reuther Psychiatric Hospital regarding the allegations. Resident A stated that most of the time when DCS Diera (last name unknown) works, she is on her phone outside. Other times, there are staff outside smoking cigarettes in the garage with no staff inside with the residents. Resident A stated the only good DCS at this group home are Donna and Jennifer. She does not know their last names.

On 06/25/2026, I interviewed DCS Ajan'ee Metcalf regarding the allegations. She works midnight shifts from 12AM-8AM. Ajan'ee denied being on her phone outside and denied playing games on her phone. She stated, "I have too much to do around here during my shift for me to be on my phone." She has not received any complaints from residents nor staff about other staff being on their phones or playing games on their phones during their shifts.

On 06/25/2026, I interviewed DCS Terriah Viverette regarding the allegations. Terriah works afternoon shifts from 4PM-12AM on Tuesdays and Thursdays and sometimes on the weekends. Terriah has six children at home, so if one of her children call her, she answers; however, she only answers when she is not providing care for the residents. She does not answer when the residents are present. She never plays games on her phone during her shift. Terriah has not received any complaints from residents or staff about other DCS being on their phones outside of the home or playing games.

On 06/25/2026, I interviewed DCS Donna Leonard regarding the allegations. Donna works all shifts. She works alone as there is one DCS per shift. During her shift, she does not go outside to use the phone. She stated she only uses her cell phone to talk when all the residents are in their bedrooms or asleep. When the residents are sleeping, she will play games on her cell phone but never during waking hours. She has not received complaints from any residents regarding other staff being outside on their cell phones or inside on their cell phones playing games.

On 06/25/2026, I attempted to call DCS Diera Burrows, but the recording stated, “calling restrictions, can’t complete call.”

On 06/25/2026, I left messages for DCS Jennifer Prince-Washington but received no return calls.

On 06/30/2026, I received an email from the licensee designee, Charles Leonard, with the updated cell phone policy for Phoenix Residential Services, Inc. pertaining to personal use of electronic devices and their usage during work hours. It states staff are prohibited from using their electronic devices unless there is an emergency and there is no shopping, gaming, or browsing the internet for personal use allowed.

On 07/07/2026, I emailed licensee designee Charles Leonard advising him that I have made attempts to reach DCS Diera and Jennifer but have been unsuccessful. Mr. Leonard emailed back stating that DCS Diera Burrows has put in her resignation letter as of 07/15/2026, but that he will have both DCS call me by the end of business day today.

On 07/08/2026, I interviewed Jennifer Prince-Washington regarding the allegations. Jennifer stated that she never goes outside and leaves residents alone in the home. She does not talk on her phone outside and the only time she has ever played games on her cell phone was when she worked midnight shifts when all the residents were sleeping. She does not know about any other staff as she works alone during her shifts.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered, DCS can meet the physical, emotional, intellectual, and social needs of each resident. Some staff make phone calls outside or play games on their cell phones; however, this did not negatively impact the care of the residents. The licensee designee, Charles Leonard, immediately implemented a cell phone policy regarding prohibited cell phone usage during working hours.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff say they don't have to cook daily. Some days staff only cook once and residents must fend for themselves. Staff are not wearing gloves when preparing meals.

INVESTIGATION:

On 06/01/2026, I interviewed Resident B regarding the allegations. Resident B stated that staff, specifically the weekend staff, were only cooking breakfast and dinner, but not lunch saying, "I don't feel like cooking today." That changed when Resident B reported these concerns to her support coordinator, Racquel Roney, with CNS Healthcare. After reporting these concerns, Ms. Roney spoke with the licensee designee, Charles Leonard, who told all the staff that they must prepare three meals daily, which now staff have been doing. Resident B stated that staff are "taking pictures," of the meals they cook and sending them to Mr. Leonard showing they are doing what they are supposed to be doing. When staff prepare meals, she does not see them wearing gloves even when the gloves are in the kitchen. Resident B gets enough to eat and has seconds if she wants.

On 06/01/2026, I interviewed Resident C regarding the allegations. Resident C stated that during the weekdays, she was getting three meals, but not on the weekends. The weekend staff only prepare breakfast and dinner and "that's about it." The staff say, "I don't feel like making lunch. I don't want to do it." Resident C stated, "It's the new girl. I don't know her name." Currently, weekend staff are now providing three meals a day and taking pictures of the meals. She does not know why staff are taking pictures. She gets enough to eat when meals are prepared. She does not know if staff wear gloves when preparing meals or not.

On 06/01/2026, I interviewed Resident D regarding the allegations. Resident D stated DCS Diera Burrows does not make breakfast or lunch when she works but only makes dinner. There are times when meals are made, but Resident A and Resident B are sleeping, so they miss breakfast. When Resident A and Resident B come downstairs after waking up, breakfast is already put away so they do not eat. Currently, all the staff are preparing three meals after Resident B complained to CNS Healthcare who told Mr. Leonard. Resident D stated, "I don't eat. All I do is drink coffee and smoke my cigarettes." She believes staff wear gloves when preparing meals, but she is usually in the garage smoking cigarettes.

On 06/01/2026, I interviewed HM Barbara Lawrence regarding the allegations. Midnight staff are responsible for preparing breakfast; however, HM stated, "If I come in and breakfast hasn't been made yet, I will make it." HM always makes meals when she is working and there are options when residents do not want to eat what is on the menu. HM stated, "We have a menu but sometimes we stray off the menu. The substitutions are written in the computer." HM was unable to confirm that other DCS are preparing

meals during their shifts. Most of the time, HM wears gloves when preparing meals but does not wear gloves when the food is packaged.

Note: On 06/01/2026, I observed plenty of food in the refrigerator and freezer and pantry. I also observed the menu on the refrigerator and HM was following the menu while making what was stated for lunch; deli sandwich, fruit, plus a snack with beverage of choice.

On 06/15/2026, I interviewed the licensee designee, Charles Leonard, regarding the allegations. Mr. Leonard spoke with the supervisor at CNS Healthcare about residents complaining that staff have not prepared three meals daily. He has implemented a policy that all staff received stating that staff must provide three meals daily, plus snacks. Staff read, reviewed, and signed the policy. He has requested staff take pictures of the meals they prepared to ensure they are following policies and procedures. Staff are also advised to follow the menus and document substitutions when substitutions are made.

On 06/17/2026, I interviewed Resident A regarding the allegations. Resident A does not eat breakfast because that is her preference, but then she stated, “This is a group home, and they must make us three meals a day. Jennifer doesn’t cook for us and leaves us to fend for ourselves.” Resident A stated that HM Barbara does not wear gloves when she prepares the meals. Resident A observed HM cleaning the kitchen counter with her bare hands and then preparing meals. She stated, “That’s cross contamination and I didn’t see proper procedures being followed.”

On 06/19/2026, I received an email from the licensee designee, Charles Leonard, with the staff memo regarding meal preparation, documentation, and picture policy. The policy implemented on 05/14/2026 stated, “Effective immediately, all staff are required to ensure that breakfast, lunch, and dinner are prepared and documented for all individuals each day. Even if a client refuses a meal or does not want the food, staff must still prepare the meal and document that it was made.”

On 06/25/2026, I interviewed DCS Ajan’ee Metcalf regarding the allegations. She stated that whenever she works, which is every other weekend during the midnight shift, she is responsible for preparing breakfast. She prepares breakfast before she leaves her shift at 8AM. Sometimes the residents are awake and other times they are not. However, breakfast is made for them to eat when they want it. She has never told any resident that “I don’t feel like cooking,” because she stated, “Cooking is part of my job description.” She does not know about what other staff do because she works alone and she does what she is supposed to do during her shifts. There is a memo staff received stating staff must prepare three meals daily. Residents have not complained about other staff not cooking. She always wears gloves when preparing meals.

On 06/25/2026, I interviewed DCS Terriah Viverette regarding the allegations. Terriah stated, “At first, it was not mandatory to cook because residents were self-sufficient, but then Resident B complained to her support coordinator and now all staff are required to

make breakfast, lunch, and dinner plus snacks. We also must take pictures of the food we prepare and send them to Mr. Leonard to confirm we are doing what we are supposed to be doing." She follows the menu and when she does not, she writes the substitutions down. The residents always get plenty of food to eat. Terriah always wears gloves when she prepares meals, as the gloves are sitting on the kitchen counter.

On 06/25/2026, I interviewed DCS Donna Leonard regarding the allegations. Donna stated that during her shift, she always makes breakfast, lunch, and dinner. There are times when the residents are not awake yet or do not want to come downstairs to eat, but they eventually do. She stated, "Food is always offered to all of them and if they do not want what is on the menu, there are other options I offer." Donna stated that a memo was sent out by Mr. Leonard stating all DCS must prepare three meals daily. She has not heard any complaints from residents about other staff not preparing meals. She always wears gloves whenever she prepares meals.

On 07/08/2026, I interviewed DCS Jennifer Prince-Washington regarding the allegations. Jennifer has been with this corporation for about six years. She works mostly afternoon shifts but sometimes picks up midnight shifts too. When she first started working at this group home, residents that used to reside there sometimes bought their own food and prepared it themselves. At other times, staff would prepare only breakfast and dinner. Currently, it has been made mandatory that staff prepare three meals a day for the residents. There was always food in the home and residents got enough to eat. When Jennifer prepares meals, she wears gloves whenever she is handling food or making residents' plates. The only time she does not wear gloves is when she is cooking food on the stove for safety reasons; does not want gloves to catch on fire.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on my investigation and information gathered, DCS were not preparing three meals for residents daily. Some staff were only preparing breakfast and dinner. Resident B reported these concerns to her support coordinator with CNS Healthcare, who then reported them to the licensee designee, Charles Leonard. Mr. Leonard implemented a policy on 05/14/2026, informing DCS that they are required to provide three meals daily with snacks even if/when residents refuse to eat. DCS are now preparing three meals daily plus snacks.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are administering medications with their bare hands and not wearing gloves.

INVESTIGATION:

On 06/01/2026, I interviewed Resident B regarding the allegations. Resident B stated that DCS pops the pills out of the blister pack and gives Resident B her medications in Resident B's hands. Resident B stated, "I do not trust my medications going into a cup. I have to see what medication they are giving me." Resident B stated, "They never wear gloves when they pass medications."

On 06/01/2026, I interviewed Resident C regarding the allegations. Resident C receives her medications in a cup. She does not see staff wearing gloves, but she also does not see staff handling her medications with their bare hands.

On 06/01/2026, I interviewed Resident D regarding the allegations. Resident D receives her medications in a cup. She too does not see staff wearing gloves but stated that she gets called down from her bedroom to receive her medications and does not know if the medication was handled by their hands.

On 06/01/2026, I interviewed HM Barbara Lawrence regarding the allegations. HM denied passing medications with her bare hands. There is a box of latex gloves next to the medication cabinet. HM simulated a medication pass and stated she always wears gloves and medications are always popped one at a time. They are never allowed to put everyone's medications in a cup at once. Everyone receives their medications one at a time. I did not observe any cups full of medications in the medication cabinet.

On 06/17/2026, I interviewed Resident A regarding the allegations. Resident A stated that DCS do not wear gloves when administering her medications. She stated, "They never follow protocol." Her medications are put in a cup, but when the cup is handed to her, she does not see gloves on staff's hands. She assumes they handled her medications without gloves on.

On 06/25/2026, I interviewed DCS Ajan'ee Metcalf regarding the allegations. She completed medication administration training. Ajan'ee stated there are gloves next to the medication cabinet that she always puts on when handling medications. She pops everyone's medications out in the cup and hands it to them. She has never popped all the medications at once and placed them in cups.

On 06/25/2026, I interviewed DCS Terriah Viverette regarding the allegations. Terriah completed medication administration training. She stated that she calls Resident C first to come down to get her medications. She wears one glove, on the hand she handles the medications with, puts the medication in the cup and watches Resident C take it. She then calls down Resident A and Resident D and goes through the same process. Terriah stated that sometimes Resident B does not want to come downstairs, so Terriah

puts the medications in the cup and takes it to Resident B and watches her take the medications. She stated that she never places everyone's medications in cups beforehand and always passes each person's medications one at a time.

On 06/25/2026, I interviewed DCS Donna Leonard regarding the allegations. Donna completed medication administration training. She stated she always wears gloves when she passes medication and never pops all the medications at once. She passes each person's medications one at a time.

On 07/08/2026, I interviewed DCS Jennifer Prince-Washington regarding the allegations. Jennifer completed medication administration training. She stated she always wears gloves when she passes medications to the residents. Jennifer stated she has never popped everyone's medications and put them in cups prior to when they are supposed to be administered. She pops one person's medications at a time.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on my investigation and information gathered, all DCS completed their medication administration training and denied handling medications without wearing gloves. All DCS stated they follow all medication administration procedures when they are passing medications to the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The home manager, Barbara Robinson, called Resident A "bitch" sometime within the last month.

INVESTIGATION:

On 06/01/2026, I interviewed Resident B regarding the allegations. Resident B does not know anything about HM calling Resident A, "bitch." She has never heard HM say that word, but stated that HM "fusses, back and forth," with Resident A or "tries to talk to Resident A in a sarcastic way."

On 06/01/2026, I interviewed Resident C regarding the allegations. Resident C has heard HM Barbara Lawrence “argue a couple of times,” with Resident A. Although she has not heard HM curse at Resident A, she stated, “HM argues back and forth,” with not only Resident A but all the residents. She was unable to provide details as to the arguments between HM and the residents.

On 06/01/2026, I interviewed Resident D regarding the allegations. Resident D stated she was sitting in the garage about two to three weeks ago when she heard HM and Resident A arguing. Resident A was cursing at HM and called HM a “bitch.” Resident D heard HM say, “you’re a bitch too.” Resident D stated that Resident A argues not only with staff, but also with the residents. HM has never argued with Resident D, because Resident D stated, “she knows better not to mess with me.”

On 06/01/2026, I interviewed HM Barbara Lawrence regarding the allegations. HM denied the allegations. For the most part, HM gets along “OK,” with Resident A. HM stated, “nothing I did was right,” according to Resident A. Resident A was accusing HM of “stealing stuff from her.” Resident A said that the HM stole her makeup bag or her key to her bedroom. HM denied stealing anything from Resident A or any other resident. Resident A cussed HM out and HM stated, “I walked away. I didn’t cuss her back.” HM denied arguing back and forth with Resident A or any other resident.

On 06/08/2026, I received a call from Oakland County Office of Recipient Rights (ORR) Sarah Rupkus regarding the allegations. Ms. Rupkus is investigating these allegations.

On 06/15/2026, I interviewed the licensee designee, Charles Leonard, regarding the allegations. Mr. Leonard was made aware of the allegations and immediately discussed these allegations with HM Barbara Lawrence. HM denied calling Resident A “bitch,” however, Mr. Leonard wrote HM up and gave her a verbal warning. He emailed me a copy of the letter which summarized his meeting with HM on 06/01/2026 with HM’s signature. Mr. Leonard stated to HM that it is inappropriate to speak with Resident A or any other resident in this manner and that this allegation is serious and could result in an ORR or licensing violation.

On 06/17/2026, I interviewed clinical social worker Tia Morgan regarding the allegations. Ms. Morgan stated that she has observed two sides to Resident A, a verbally aggressive side and a compassionate side. About a week ago, Resident A was verbally aggressive to hospital staff. Ms. Morgan was firm with Resident A regarding her actions, and she told Resident A that if she wanted her to spend additional time with her, Resident A must treat all hospital staff with professionalism. Ms. Morgan stated that seemed to work with Resident A, and Resident A’s attitude changed. Since then, there have not been any incidents of aggression by Resident A. Ms. Morgan stated that Resident A does not respond well to individuals going “back and forth,” with her and seems to have a positive reaction to being firm with her.

On 06/17/2026, I interviewed Resident A regarding the allegations. Resident A stated that HM disrespects Resident A. She stated, “She called me a bitch. (HM) kept saying

‘bitch, bitch, bitch’ and doesn’t have a caring spirit. She has a dislike for me and for the other clients. She keeps going back and forth.” Resident A could not recall why HM called her that word and did not recall what led to HM calling her that word. She was unable to provide any further details. However, she wants to return to this group home because she “likes it there,” because she stated, “I have my own room,” and “access to the community.”

On 06/25/2026, I interviewed DCS Ajan’ee Metcalf regarding the allegations. Ajan’ee does not know anything about the incident between HM and Resident A. She works alone and has never worked with HM Barbara. Resident A nor any other resident mentioned anything to her about HM calling Resident A that word.

On 06/25/2026, I interviewed DCS Terriah Viverette regarding the allegations. Terriah has no information regarding the incident between HM and Resident A. She only speaks to the HM in passing during shift change and no one has said anything to Terriah regarding HM being disrespectful towards Resident A or any other resident.

On 06/25/2026, I interviewed DCS Donna Leonard regarding the allegations. Resident A told Donna that HM Barbara “goes back and forth,” with Resident A. Resident A called HM a “bitch,” and HM told Resident A, “you’re one also.” Donna never worked with HM and only spoke to her in passing during shift change. Donna stated that Resident A is “abusive, towards other residents,” but that when “Resident A calms down, she always apologizes,” and says, “I wasn’t having a good day.”

On 07/08/2026, I interviewed DCS Jennifer Prince-Washington regarding the allegations. Jennifer never witnessed any incident between HM and Resident A as she works alone. However, she did hear that there was an argument between HM and Resident A where Resident A called HM a “bitch,” and HM possibly said, “You’re one too.”

On 07/08/2026, I left a detailed message for licensee designee, Charles Leonard with my findings. I also emailed Mr. Leonard with my findings and advised him to call me with any questions.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Based on my investigation and information gathered, Resident A was not treated with dignity and respect by HM Barbara Lawrence. There was an argument between HM and Resident A about two to three weeks before Resident A was hospitalized. Resident A called HM a “bitch,” and it was reported that HM either called Resident A “bitch,” or stated, “You’re one too.” The argument was heard by Resident D and Resident A confirmed this was said to her by HM. HM denied these allegations; however, licensee designee Charles Leonard gave HM a written warning. I reviewed the written warning signed by HM Barbara Lawrence on 06/01/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Frodet Dawisha 07/08/2026

Frodet Dawisha Date
Licensing Consultant

Approved By:

Kristen Domnay

WOC Area Manager for 07/08/2026

Denise Y. Nunn Date
Area Manager