GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2025

Charles Leonard
Phoenix Residential Services Inc
P.O. Box 431034
Pontiac, MI 48341

RE: License #: AS630012331
Investigation #: 2025A0612014
Leonard 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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012331
Investigation #:	2025A0612014
Complaint Receipt Date:	03/19/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	04/18/2025
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:	Leonard Home
Facility Address:	127 Franklin Boulevard Pontiac, MI 48341
Facility Telephone #:	(248) 335-7198
Original Issuance Date:	09/18/1977
License Status:	REGULAR
Effective Date:	08/23/2023
Expiration Date:	08/22/2025
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Since 10/14/24, Resident B's Individual Plan of Service authorizes clubhouse twice a week, but he has not attended.	Yes
Staff have been putting their hands on Resident A and putting him in a headlock to try and restrain him when he gets combative.	No
The facility has a long-standing bed bug problem.	No
Additional Findings	Yes

III. METHODOLOGY

03/19/2025	Special Investigation Intake 2025A0612014
03/19/2025	APS Referral Referral received from Adult Protective Services (APS). Referral denied by APS.
03/19/2025	Special Investigation Initiated - Letter Referral made to Oakland Community Health Network - Office of Recipient Rights via email.
03/20/2025	Contact - Document Received Email received from Recipient Rights Specialist Amanda Clasman which contained Resident A and Resident B's Individual Plans of Service.
03/20/2025	Contact - Telephone call made Telephone interview completed with CNS case manager Cady Tobias, licensee designee Charles Leonard, home manager Keyanna Price, and direct care staff Lamuriel Calvin.
03/20/2025	Contact - Document Received Orkin Service reports received via email from licensee designee Charles Leonard.
03/21/2025	Inspection Completed On-site I completed an unscheduled onsite inspection. I interviewed Resident A, Resident B, Resident D, and Resident E.

03/24/2025	Contact - Document Received Orkin Service report received via email from licensee designee Charles Leonard.
03/26/2025	Exit Conference I placed a telephone call to licensee designee Charles Leonard to conduct an exit conference.

ALLEGATION:

Since 10/14/24, Resident B's Individual Plan of Service authorizes clubhouse twice a week, but he has not attended.

INVESTIGATION:

On 03/19/25, I received a referral from Adult Protective Services (APS). APS denied the referral for investigation. The referral indicated Resident A does not need assistance with ambulation but needs assistance with activities of daily living. He has a learning disability and does not talk much. He can advocate for himself. Lately, Resident A has been getting combative. The home staff have been putting their hands on him in return. For example, if Resident A puts someone in a headlock they will put him in a headlock. There is no visible injury on Resident A. It is unknown if he is fearful of anyone. The home has a long-standing bed bug problem.

On 03/19/25, I initiated my investigation by making a referral to Oakland Community Health Network - Office of Recipient Rights via email. On 03/20/25, I received an email from assigned Recipient Rights Specialist Amanda Clasman. Ms. Clasman indicated that she went to the home on 03/19/25, and there is a bad bed bug problem. Ms. Clasman further indicated that home manager Keyanna Price admitted that she will pry Resident A by grabbing his fingers, hands, or arms and pull him off the other residents, but denied putting him in a headlock. Ms. Clasman also reported that Resident B has had it in his plan of service since 10/14/24, to go to the clubhouse twice a week, but he has yet to go because the home manager has failed to arrange/schedule an orientation with Visions Clubhouse. Ms. Clasman provided a copy of Resident A and Resident B's CNS Individual Plan of Service (IPOS).

On 03/20/25 I interviewed CNS case manager Cady Tobias via telephone. Ms. Tobias stated Resident B's IPOS indicates that he should attend clubhouse twice a week. There is a CNS Health Care clubhouse in Southfield and Pontiac, both near Resident B's home. During monthly case management contacts Resident B expresses interest in attending clubhouse by saying that he is bored at home, and he is excited to go to clubhouse. Ms. Tobias stated home staff have failed to arrange the clubhouse orientation.

On 03/20/25, I interviewed home manager Keyanna Price. Ms. Price stated Resident B attended clubhouse for the first time on 03/20/25. Ms. Price explained that Resident B did not attend clubhouse prior to this date because the home only has one staff on each shift. None of the other residents attend clubhouse. The residents cannot be left home alone so they must ride with staff to transport Resident B to clubhouse. Most of the residents are willing to do so however, Resident C is not. Resident C will refuse to get up and out of bed and he cannot stay home alone. Therefore, staff cannot leave to drive Resident B to and from clubhouse. Ms. Price stated on 03/20/25, an additional staff was scheduled on shift so that one staff could transport Resident B while the other staff remained at the home with the other residents.

On 03/20/25, I interviewed direct care staff Lamuriel Calvin via telephone. Ms. Calvin stated Resident B attended clubhouse for the first time on 03/20/25. Ms. Calvin stated Resident B was offered the opportunity to attend clubhouse prior to then, but he refused.

On 03/20/25, I interviewed licensee designee Charles Leonard via telephone. Mr. Leonard stated Resident B attended clubhouse for the first time on 03/20/25. Mr. Leonard stated Resident B was offered the opportunity to attend clubhouse prior then, but he refused. Mr. Leonard stated unfortunately his refusals were not documented. Going forward Mr. Leonard has advised staff that if Resident B refuses to attend clubhouse it must be documented.

On 03/21/25, I completed an unscheduled onsite inspection. I interviewed Resident A, Resident B, Resident D, and Resident E. Resident C was home at the time of my onsite inspection however, he was in bed and declined to be interviewed.

On 03/21/25, I interviewed Resident A. Resident A is minimally verbally. Resident A was well groomed and appropriately dressed. He did not provide eye contact, and he did not respond to interview questions asked.

On 03/21/25, I interviewed Resident B. Resident B stated he attended clubhouse for an orientation on 03/20/25, he enjoyed it. Resident B stated he plans to attend regularly starting next week. Resident B stated he has been wanting to attend clubhouse for a while however instead he and his housemates were taken to the library.

On 03/21/25, I interviewed Resident D. Resident D did not answer interview questions asked. Resident D spoke about historical incidents and asked for toothpaste.

On 03/21/25, I interviewed Resident E. Resident E stated he does not attend clubhouse. He and his housemates go to the library on outings.

On 03/20/25, I reviewed Resident B’s CNS Individual Plan of Service (IPOS) amended 10/14/24. Resident B’s IPOS indicates that he will attend clubhouse twice a week.

Resident B will attend groups and do the assigned jobs at clubhouse. Home staff/ clubhouse staff will transport Resident B to clubhouse twice a week.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(5) A licensee shall provide both of the following when specified in the resident's written assessment plan: **(b) An opportunity for involvement in educational, employment, and day programs.**
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident B has not been given the opportunity to attend a day program. Resident B's CNS Individual Plan of Service (IPOS) amended 10/14/24, authorizes clubhouse twice a week. Resident B did not attend clubhouse until 03/20/25. Home manager Keyanna Price stated Resident B did not attend clubhouse due to issues related to staffing. Resident B stated he wanted to attend clubhouse prior to 03/20/25, however instead he and his housemates were taken to the library. Licensee designee Charles Leonard stated Resident B was offered the opportunity to attend clubhouse prior to 03/20/25, but he refused. The refusals were not documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff have been putting their hands on Resident A and putting him in a headlock to try and restrain him when he gets combative.

INVESTIGATION:

On 03/20/25, I interviewed CNS case manager Cady Tobias via telephone. Ms. Tobias stated she has been working with Resident A since October 2024, recently she was informed by home staff that he is becoming violent. Staff report this happens out of nowhere, Resident A will put other residents into a headlock and home staff must use their hands to pry Resident A off them. Ms. Tobias stated she has not received any Incident Reports regarding Resident A's violence. Ms. Tobias stated currently this behavior is not addressed in Resident A's IPOS but now that she has been made aware of this concern, she will be working to update Resident A's crisis plan to provide proactive and reactive interventions for staff to us to address this behavior.

On 03/20/25, I interviewed direct care staff Lamuriel Calvin via telephone. Ms. Calvin stated she has worked at this home for three years she has only seen Resident A

become aggressive once. It occurred last year or the year before. Ms. Calvin remarked Resident A reached out to connect with another resident, but he did not make contact. Ms. Calvin stated Resident A is chill guy, she has never witnessed him put anyone in a headlock. Ms. Calvin denies witnessing any staff restrain Resident A and/or put him in a headlock.

On 03/20/25, I interviewed licensee designee Charles Leonard via telephone. Mr. Leonard stated he has no information regarding Resident A being aggressive or placing anyone in a headlock. Mr. Leonard stated Resident A has been in his care since 1980. In the 80's and 90's Resident A would elope. However, now Resident A very seldomly speaks. He is not active, he stays to himself, and he is shy. Mr. Leonard stated he has never heard of Resident A being aggressive.

On 03/20/25, I interviewed home manager Keyanna Price. Ms. Price stated she has worked with Resident A for 13 years. Previously, he was not physically aggressive. However, recently, every now and then he will want to fight. Resident A will ball up his fist or if a staff is walking past him holding the laundry basket, he will grab the basket and not let go. Ms. Price stated Resident A has grabbed Resident B and put him into a headlock. Ms. Price stated she gave verbal prompts for him to stop and let go, but Resident A did not respond to the prompts. Ms. Price used her hands to physically remove Resident A's hands from around Resident B's neck. Ms. Price denied putting Resident A into a headlock. Ms. Price stated Resident A's crisis plan does not provide any interventions on how to manage his physical aggression and therefore she chose the safest approach to maintain Resident A and Resident B's safety.

On 03/21/25, I completed an unscheduled onsite inspection. I interviewed Resident A, Resident B, Resident D, and Resident E. Resident C was home at the time of my onsite inspection however, he was in bed and declined to be interviewed.

On 03/21/25, I interviewed Resident A. Resident A is minimally verbally. Resident A was well groomed and appropriately dressed. He did not provide eye contact, and he did not respond to interview questions asked.

On 03/21/25, I interviewed Resident B. Resident B stated Resident A has attacked him 4-5 times, using his fist to try and hit him. Resident B said that he does not fight back. Staff have to pull Resident A off him. Resident B denies that staff have put Resident A into a headlock.

On 03/21/25, I interviewed Resident D. Resident D did not answer interview questions asked. Resident D spoke about historical incidents and asked for toothpaste.

On 03/21/25, I interviewed Resident E. Resident E stated he has never witnessed Resident A become combative and he has never seen staff restrain Resident A and/or put him in a headlock.

On 03/20/25, I reviewed Resident A's CNS Individual Plan of Service (IPOS) amended 01/08/25. Resident A's IPOS does not provide approval for use the use of physical intervention to address behavioral issues. Further, Resident A's IPOS does not indicate that he is aggressive towards others. Resident A's IPOS indicates Resident A has a history of thoughts of self-harm and auditory hallucinations directing him to harm himself. Resident A will cooperate with staff support and direction each day for the coming year. Resident A will receive daily support services in the home and in the community. Staff provides 24 hours of supervision, 7 days a week. Staff will provide supervision to reduce risk of elopement, to provide medication management, assistance with coordinating and linking consumer to psychiatric services and appointments for medical care with Primary Care Physician. Staff will supervise and coach Resident A to perform activities of daily living including but not limited to meal preparation/planning, self-care, and home chores. Home staff will assist to support community integration to increase meaningful activities and interaction/socialization with others.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this investigation there is insufficient information to conclude that any staff have been putting Resident A into a headlock to try and restrain him when he gets combative. Resident B stated Resident A has attacked him 4-5 times, using his fist to try and hit him. Staff have to pull Resident A off him. Resident B denies that staff have put Resident A into a headlock. Home manager Keyanna Price stated Resident A has put Resident B into a headlock. She verbally prompted him to stop and let go, but Resident A did not respond to the prompts. Ms. Price used her hands to physically remove Resident A's hands from around Resident B's neck. Ms. Price denied putting Resident A into a headlock. An attempt was made to interview Resident A however, he did not respond to interview questions asked. There were no other reports of Ms. Price or any staff putting Resident A into a headlock. Resident A's Individual Plan of Service does not provide proactive or reactive interventions for staff to follow in the event

	of a behavioral crisis. Without a standard of care to guide her behavior, Ms. Price used the least restrictive approach to maintain Resident A and Resident B's safety.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility has a long-standing bed bug problem.

INVESTIGATION:

On 03/20/25 I interviewed CNS case manager Cady Tobias via telephone. Ms. Tobias stated she conducts case management visits at this home once a month and there have been instances when they have canceled their appointments due to the home being treated for bed bugs. Ms. Tobias stated on one occasion, she was at the home while it was being treated, and the pest control worker stated that the bed bugs had spread to other rooms and the issue was less contained. Ms. Tobias stated Resident B told her that he has bugs in his bed.

On 03/20/25, I interviewed direct care staff Lamuriel Calvin via telephone. Ms. Calvin stated the home had bed bugs. The facility was being treated every other week, at the last treatment she was informed that there was no live activity. Ms. Calvin stated she has not seen any bed bugs recently.

On 03/20/25, I interviewed licensee designee Charles Leonard via telephone. Mr. Leonard stated in November 2024 a new resident moved into the home, and they got bed bugs. They have been working with Orkin to address the issue. Orkin comes out weekly to biweekly to treat the home. In February 2025, the home was treated three times. Mr. Leonard stated he was advised by Orkin to spray bedding and surface areas with 99% alcohol in between visits which he has been doing. All the resident's clothes have been washed then dried three times as advised by Orkin. Mr. Leonard stated during the last Orkin treatment on 02/21/25, there was live and dead bed bug activity found. Mr. Leonard further stated over the last two weeks he has not seen any bed bugs. The next Orkin treatment is scheduled for 03/24/25.

On 03/20/25, I interviewed home manager Keyanna Price. Ms. Price stated the home had bed bugs. Orkin was coming out weekly to biweekly to treat the home. In between visits they sprayed bedding and surface areas with 99% alcohol. Ms. Price stated she has not observed any live bed bug activity recently.

On 03/21/25, I completed an unscheduled onsite inspection. I interviewed Resident A, Resident B, Resident D, and Resident E. Resident C was home at the time of my onsite inspection however, he was in bed and declined to be interviewed. During my onsite

inspection I observed licensee designee Charles Leonard onsite treating the home for bed bugs which included spraying alcohol.

On 03/21/25, I interviewed Resident A. Resident A is minimally verbally. Resident A was well groomed and appropriately dressed. He did not provide eye contact, and he did not respond to interview questions asked.

On 03/21/25, I interviewed Resident B. Resident B stated the home has bed bugs, he has seen them in his bedroom. Resident B stated the home is sprayed to treat the bed bugs.

On 03/21/25, I interviewed Resident D. Resident D did not answer interview questions asked. Resident D spoke about historical incidents and asked for toothpaste.

On 03/21/25, I interviewed Resident E. Resident E stated he was never bothered with bed bugs, he has not seen any in the home.

On 03/20/25 and 03/24/25, I reviewed Orkin Service reports received via email from licensee designee Charles Leonard. The following was noted:

- Date of service: 12/16/24 – evaluation for bed bugs: live activity noted.
  Comments: will have a technician out on the 19th.
- Date of service: 12/19/24 – house treated; live activity noted.
  Comments: returning in January to retreat.
- Date of service: 01/02/25 – house treated; activity dead.
  Comments: Going to return in a week to retreat.
- Date of service: 01/09/25 – house treated; live activity noted.
  Comment: Going to return in a week to retreat.
- Date of service: 01/16/25 – house treated; live activity noted.
  Comments: activity noticed in all bedrooms.
- Date of service: 02/21/25 – Performed full reapplication to entire building.
  Comments: we put in another follow up 2 weeks from today to check activity and retreat as needed.
- Date of service: 03/24/25 – house treated; activity dead. Status: resolved. Recommendation: Treatment Rendered.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.

ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that the facility has had bed bugs since December 2024. Proof of Orkin Service reports indicate that the facility has been continuously working with a pest control program to treat the issue. In addition, licensee designee Charles Leonard and home manager Keyanna Price consistently stated that in between Orkin treatments they sprayed bedding and surface areas with 99% alcohol and all the resident's clothes were washed and then dried three times per instructions by Orkin. As of 03/24/25, there was no live bed bug activity found. The issue has been resolved, and treatment was rendered.
CONCLUSION:	VIOLATION ESTABLISHED (BUT CORRECTED)

ADDITIONAL FINDINGS:

INVESTIGATION:

During this investigation, it was reported that Resident A showed reoccurring aggressive behavior towards others. There were no incident reports written, regarding the reported incidents of him placing Resident B into headlocks and his case manager was not notified. As such, Resident A's Individual Plan of Services (IPOS) was not updated to include interventions for staff to use to manage aggressive behavior.

On 03/26/25, I placed a telephone call to licensee designee Charles Leonard to conduct an exit conference and review my findings. My Leonard acknowledged that a corrective action plan is required. Mr. Leonard stated that he plans to continue with routine bed bug treatments to decrease the risk of reoccurrence. His next appointment is scheduled with Orkin. Mr. Leonard stated that Resident B refused to attend Clubhouse on Monday, 03/24/25, his refusal was documented. Resident B returned to Clubhouse on Tuesday, 03/25/25. Mr. Leonard stated the home has adequate staffing to ensure Resident B is transported to and from Clubhouse and he will work with the home manager to address this. Mr. Leonard stated since the initiation of this investigation they have coordinated with Resident A's case manager to amend his IPOS to include interventions to address aggressive behavior. Additionally, he has contacted Michigan Assisted Living to obtain training resources to train staff in managing aggressive behaviors.

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 on the information gathered during this investigation there is sufficient information to conclude that Resident A's Individual Plan of Services (IPOS) does not include interventions to address aggressive behavior. Home manager Keyanna Price reported incidents of Resident A balling up his fist, aggressively grabbing the laundry basket and refusing to let go and putting Resident B into a headlock. Ms. Price stated when these incidents occur Resident A does not respond to verbal prompts, and he must be physically removed to avoid harm to himself or others. Resident B stated that Resident A has put him into a headlock 4-5 times. CNS case manager Cady Tobias has been working with Resident A since October 2024. It was not until recently that she was informed that he is becoming violent and putting other residents into headlocks where home staff must use their hands to pry Resident A off them. Ms. Tobias stated she has not received any Incident Reports regarding Resident A's violence and therefore, this behavior is not currently addressed in Resident A's IPOS. Now that Ms. Tobias has been made aware she will be working to update Resident A's crisis plan to provide proactive and reactive interventions for staff to use in the event of a behavioral crisis.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.**

ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A displayed a pattern of aggressive behavior towards others. No incident reports were written, and his case manager was not notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

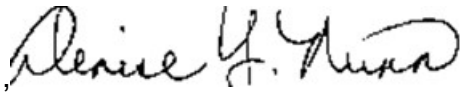
IV. RECOMMENDATION

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

03/26/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



04/09/2025

Denise Y. Nunn — Date
Area Manager