GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 16, 2026

Janet Patterson
Advocates for Self Determination, LLC
Suite 102
28237 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AS630309605
Investigation #: 2026A0465012
Philip AFC

Dear Ms. Patterson:

Attached is the Special Investigation Report for the above-referenced facility. No substantial violations were found.

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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630309605
Investigation #:	2026A0465012
Complaint Receipt Date:	01/22/2026
Investigation Initiation Date:	01/25/2026
Report Due Date:	03/23/2026
Licensee Name:	Advocates for Self Determination, LLC
Licensee Address:	Suite 102 28237 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Administrator:	Janet Patterson
Licensee Designee:	Janet Patterson
Name of Facility:	Philip AFC
Facility Address:	23823 Philip Dr. Southfield, MI 48075
Facility Telephone #:	(248) 353-9702
Original Issuance Date:	11/03/2011
License Status:	REGULAR
Effective Date:	12/25/2024
Expiration Date:	12/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
In January 2026, Resident A was improperly discharged from the facility.	No

III. METHODOLOGY

01/22/2026	Special Investigation Intake 2026A0465012
01/22/2026	APS Referral Adult Protective Services Referral assigned to APS Worker, Anne Hauger, for investigation
01/25/2026	Special Investigation Initiated - Letter Email exchange with Adult Protective Services Worker, Anne Hauger
01/26/2026	Contact - Document Received Email exchange with APS Worker, Anne Hauger
02/02/2026	Contact - Document Received Email exchange with APS Worker, Anne Hauger
02/04/2026	Inspection Completed On-site I conducted an onsite investigation at the facility. I completed a walk-through of the home, reviewed resident files, observed residents, and interviewed direct care staff, Shanessa Box
02/05/2026	Contact - Document Received Facility documents received via email
02/18/2026	Contact - Telephone call made Attempted to speak to Guardian A1; Phone not in working order
03/04/2026	Contact - Telephone call made I spoke to Human Resources Staff, Tamekka Swift, via telephone to confirm receipt of facility documents
03/04/2026	Contact - Telephone call made I spoke to licensee designee/administrator, Janet Patterson, via telephone
03/04/2026	Contact - Document Received

	Facility documents received via email
03/04/2026	Contact – Document Received Email exchange with Ms. Box
03/04/2026	Contact - Telephone call made I attempted to call Guardian A1. Called two additional phone numbers provided by facility; One number is not in service; The second number had a voice mail box that was full and unable to leave a message
03/05/2026	Contact - Telephone call made I spoke to CNS Case Manager, Tanyi Baiyee, via telephone
03/05/2026	Contact - Telephone call made Attempted to call Guardian A1; One number is out of service; 2nd number has full voice mail box; third number not in service.
03/05/2026	Exit Conference I conducted an Exit Conference with licensee designee/administrator, Janet Patterson, via telephone

ALLEGATION:

In January 2026, Resident A was improperly discharged from the facility.

INVESTIGATION:

On 1/22/2026, a complaint was received, alleging that in January 2026, Resident A was improperly discharged from the facility. The complaint stated that, on 1/13/2026, Resident A was transported to the hospital after a physical altercation with another resident. The complaint stated that Resident A was evaluated by hospital staff on 1/14/2026 and 1/15/2026, and it was determined that he did not meet the criteria for inpatient hospitalization. The complaint stated that there were multiple phone calls made to the facility to coordinate discharge. The complaint stated that Resident A's legal guardian, Guardian A1, wanted Resident A to remain in the hospital for further evaluation prior to returning to the facility.

On 1/25/2026, 1/26/2026 and 2/2/2026, I spoke to Adult Protective Services Worker, Anne Hauger, via email. Ms. Hauger stated that she completed an investigation of this complaint. Ms. Hauger stated that Resident A is still currently residing at the facility and was not discharged from the home. Ms. Hauger stated that she did substantiate and is in the process of closing her investigation.

On 2/4/2026, I conducted an onsite investigation at the facility. At the time of my onsite investigation, Resident A was residing at the facility. I was unable to locate any information to confirm that the facility has discharged Resident A in the last six months. I completed a walk-through of the home, reviewed resident files, observed residents, and interviewed direct care staff, Shanessa Box.

I reviewed Resident A's record. The *Face Sheet* stated that Resident A was admitted to the facility on 5/18/2024 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia and Anxiety. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of aggressive behavior, independently completes self-care tasks with staff prompting and does not require use of assistive devices for mobility. The *Incident/Accident Report,* dated 1/13/2026, stated the following:

1/13/2026 at 5:00pm; Completed by Shanessa Box: Resident A had a disagreement with Resident B. Resident B was attacked and assaulted by Resident A. Staff called emergency services. Staff separated residents and waited for police. Resident A was taken by police. Guardian notified.

On 2/4/2026 and 3/4/2026, I spoke to direct care staff, Shanessa Box, who stated that she has worked at the facility for nine years. Ms. Box stated, "This is not true. Resident A is still living here. He was never discharged. On 1/13/2026, Resident A was involved in an altercation with another resident, and he was not acting himself. The police were called and they took him. We thought he was taken to jail but were informed he was taken to the hospital for treatment. I spoke to Guardian A1 and was asked to submit a petition for inpatient hospitalization. There was contact between us and the hospital reading the petition and we provided a completed petition to the hospital on 1/15/2026. The hospital did call the next day and said Resident A was ready for discharge and they did not feel he needed to be inpatient, were not willing to honor or approve the petition, or have a full psychiatric evaluation. However, we and Guardian A1 felt that Resident A needed to be evaluated. The hospital finally agreed to the psychiatric evaluation and once it was completed, we picked Resident A up and brought him back to the facility. We never discharged him from the home and there was never an intent to refuse to allow him to return to the facility. We picked Resident A up from the hospital on 1/21/2026." Ms. Box denied this complaint is true.

On 3/5/2026, I spoke to CNS Case Manager, Tanyi Baiyee, via telephone. Mr. Baiyee stated that he has been the case manage for Resident A for one year. Mr. Baiyee stated, "I am aware of the incident that occurred on 1/13/2026 regarding Resident A. I was involved in those conversations while he was in the hospital. The facility never planned to discharge him from the home. The main issue was that the facility wanted Resident A to have a psychiatric evaluation before he returned to the home, to ensure he was mentally stable. He was in a manic state and was not safe to be at the facility. They only wanted to make sure he was stable before he

returned. Resident A is back at the facility now and has been doing better now that he has had some medication changes to assist in mood stabilization.

On 3/5/2026, I spoke to and conducted an Exit Conference with licensee designee/administrator, Janet Patterson, via telephone. Ms. Box is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(6) A licensee shall take all of the following steps before discharging a resident under subrule (5) of this rule: **(c) A resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	According to Ms. Box and Mr. Baiyee, Resident A was admitted to the hospital from 1/13/2026 – 1/21/2026 for a psychiatric and medication evaluation. Resident A returned to the facility on 1/21/2026. On 2/4/2026, I conducted an onsite investigation and observed Resident A was living at the facility. Based on the information above, there is not sufficient information to confirm that the facility improperly discharged Resident A from the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez 3/5/2026

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Jay Calewarts For 3/16/2026

Denise Y. Nunn Date

Area Manager