GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 23, 2026

Andre Lee
Lee Health Systems LLC
9611 Hazelton
Redford, MI 48239

RE: License #: AS820418207
Investigation #: 2026A0993030
Hazelton House

Dear Mr. Lee:

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 (313) 456-0380.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820418207
Investigation #:	2026A0993030
Complaint Receipt Date:	08/20/2026
Investigation Initiation Date:	08/21/2026
Report Due Date:	10/19/2026
Licensee Name:	Lee Health Systems LLC
Licensee Address:	16519 Five Points Redford, MI 48239
Licensee Telephone #:	(586) 868-3718
Administrator:	Andre Lee
Licensee Designee:	Andre Lee
Name of Facility:	Hazelton House
Facility Address:	9611 Hazelton Redford, MI 48239
Facility Telephone #:	(313) 633-4558
Original Issuance Date:	01/06/2025
License Status:	REGULAR
Effective Date:	07/06/2025
Expiration Date:	07/05/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A continued receiving discontinued medications after hospital discharge despite repeated notifications. Medication administration errors were discovered on 08/04/2026, and corrected orders were provided to the facility.	Yes

III. METHODOLOGY

08/20/2026	Special Investigation Intake 2026A0993030
08/20/2026	Referral - Recipient Rights Allegations received from Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
08/21/2026	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation. I interviewed staff, Windell Pace and Resident A. I also interviewed licensee designee, Andre Lee via telephone.
08/22/2026	APS Referral Forwarded allegations to adult protective services (APS)
08/24/2026	Contact - Telephone call made Telephone call made to PsyGenics case manager, Alex Barich
08/25/2026	Contact - Document Sent Requested staff medication administration training as well as Resident A's 07/10/2026 discharge paperwork
08/25/2026	Contact - Telephone call made Telephone call made to PsyGenics case manager, Stephanie Schave. Left a message.
08/26/2026	Contact - Telephone call received Telephone call received from PsyGenics case manager, Stephanie Schave
08/26/2026	Contact - Document Received Received a copy of Resident A's medication administration record (MAR) and communication sent to Mr. Lee from Mr. Barich and Ms. Schave

08/26/2026	Contact - Document Received Received verification that staff completed medication administration training as well as a copy of Resident A's 07/10/2026 discharge paperwork
09/16/2026	Exit Conference Held with licensee designee, Andre Lee

ALLEGATION:

Resident A continued receiving discontinued medications after hospital discharge despite repeated notifications. Medication administration errors were discovered on 08/04/2026, and corrected orders were provided to the facility.

INVESTIGATION:

On 08/20/2026, I received allegations from Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 08/21/2026, I conducted an unannounced onsite investigation. I interviewed staff, Windell Pace and Resident A. I also interviewed licensee designee, Andre Lee via telephone.

Mr. Pace stated he completed medication administration training. To his knowledge, all medications are administered as prescribed.

Resident A stated staff administered his medications to him as prescribed.

Mr. Lee acknowledged there was confusion with Resident A's medications. Staff administered the medications provided by Metropolitan Behavior Health Hospital to Resident A. Mr. Lee did not go into detail about the confusion surrounding Resident A's medications. Per Mr. Lee, there are two staff in the facility. Both staff completed medication administration training. Staff administered medications as prescribed.

While at the facility, I observed Resident A's July 2026 and August 2026 medication administration record (MAR) as well as Resident A's current medications. I observed the following:

Month of July 2026:

- Per the July 2026 MAR, Resident A was prescribed Brivaracetam 50mg twice daily for 14 days, Cobenfy 50mg twice daily, Dexmethylphenidate (no dose listed) daily, Lurasidone HCL 40mg (also referred to as Latuda in this report) daily, Paliperidone ER 5mg daily, Hydroxyzine 50mg three times daily as needed, Lithium Carbonate 300mg twice daily and Amlodipine Besylate 2.5mg daily.

- Staff did not initial MAR to show administration of Brivaracetam 50mg at 8pm on 07/31/2026.
- Staff did not initial MAR to show administration of Lithium Carbonate 300mg at 8pm on 07/21/2026 and 07/31/2026.
- Staff did not initial MAR to show administration of Amlodipine Besylate 2.5mg at 8am from 07/11/2026 to 07/17/2026.
- Staff administered Cobenfy 50mg, Lurasidone HCL 40mg, and Dexmethylphenidate (no dose listed) to Resident A despite it being discontinued on 07/10/2026.

Month of August 2026:

- Per the August 2026 MAR, Resident A was prescribed Paliperidone ER 6mg daily, Hydroxyzine 25mg three times daily as needed, Lithium Carbonate ER 300mg twice daily, Amlodipine Besylate 2.5mg daily, Dexmethylphenidate ER 10mg daily, Brivaracetam 100mg twice daily, and Acetaminophen 325mg every two hours as needed.
- Resident A was prescribed Polyethylene Glycol 3350 17 17grams daily. This medication was not listed on the August 2026 MAR.
- Staff did not initial MAR to show administration of Paliperidone ER 6mg at 8am on 08/08/2026 as well as from 08/14/2026 to 08/21/2026.
- Staff did not initial MAR to show administration of Lithium Carbonate ER 300mg at 8am on 08/08/2026 as well as from 08/14/2026 to 08/21/2026.
- Staff did not initial MAR to show administration of Lithium Carbonate ER 300mg at 8pm on 08/07/2026 as well as from 08/10/2026 to 08/20/2026.
- Staff did not initial MAR to show administration of Amlodipine Besylate 2.5mg at 8am from 08/08/2026 to 08/21/2026.
- Staff did not initial MAR to show administration of Brivaracetam 100mg at 8am on 08/08/2026, 08/09/2026 as well as from 08/13/2026 to 08/21/2026.
- Staff did not initial MAR to show administration of Brivaracetam 100mg at 8pm from 08/07/2026 to 08/20/2026.
- Staff administered Cobenfy 50mg, Lurasidone HCL 40mg, and Dexmethylphenidate (no dose listed) to Resident A despite it being discontinued on 07/10/2026.

On 08/22/2026, I forwarded allegations to adult protective services (APS).

On 08/24/2026, I conducted a telephone interview with PsyGenics case manager, Alex Barich. He stated he saw Resident A on or around 07/24/2026. He is currently on leave from work and suggested I contact the agency to talk to the case manager who is covering his case load.

On 08/26/2026, I conducted a telephone interview with PsyGenics case manager, Stephanie Schave. She stated she went to the facility to check on Resident A as well as review his medications and MAR due to past concerns with staff over medicating him. She stated after reviewing Resident A’s medication and MAR as well as discussing

what she observed with her supervisor and the PsyGenics doctor, she learned that staff were administering too much medication to Resident A.

On 08/26/2026, I received a copy of Resident A's medication administration record (MAR) and communication sent to licensee designee, Andree Lee, from Mr. Barich and Ms. Schave. On 07/22/2026, Mr. Barich advised Mr. Lee to administer only the medications recommended by Metropolitan Behavioral Health to Resident A. He stated that the other medications are not advised until Resident A meets with Dr. Fouche-Brazzle on 07/28/2026. On 08/04/2026, Ms. Schave notified Mr. Lee that the only psychiatric medications approved to be administered to Resident A are Hydroxyzine Pamoate 50mg, Lithium Carbonate 300mg, and Paliperidone 6mg. In addition, staff could also administer his seizure and blood pressure medication. Ms. Schave notified Mr. Lee that the following medications were discontinued Cobenfy 50mg, Focalin XR 10mg, Latuda 40mg, Miralax 17gm/dose, and Melatonin 3mg.

On 08/26/2026, I received verification that Mr. Pace and staff, Michelle Radford completed medication administration training. I reviewed Resident A’s discharge paperwork from Metropolitan Behavior Health Hospital. Per the paperwork, Resident A was discharged from the hospital on 07/10/2026. Resident A’s medication changes were as follows:

- Start taking Chlorpromazine and Paliperidone
- Change how you take Hydroxyzine and Lithium Carbonate
- Stop taking Cobenfy, Dexmethylphenidate, Latuda and Melatonin

On 09/16/2026, I conducted an exit conference with licensee designee Andre Lee. I informed him of the findings.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Staff administered Cobenfy 50mg, Lurasidone HCL 40mg, and Dexmethylphenidate (no dose listed) to Resident A in July and August despite it being discontinued on 07/10/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Staff did not initial MAR to show administration of Brivaracetam 50mg at 8pm on 07/31/2026. Staff did not initial MAR to show administration of Lithium Carbonate 300mg at 8pm on 07/21/2026 and 07/31/2026. Staff did not initial MAR to show administration of Amlodipine Besylate 2.5mg at 8am from 07/11/2026 to 07/17/2026. Resident A was prescribed Polyethylene Glycol 3350 17 17grams daily. This medication was not listed on the August 2026 MAR. Staff did not initial MAR to show administration of Paliperidone ER 6mg at 8am on 08/08/2026 as well as from 08/14/2026 to 08/21/2026. Staff did not initial MAR to show administration of Lithium Carbonate ER 300mg at 8am on 08/08/2026 as well as from 08/14/2026 to 08/21/2026. Staff did not initial MAR to show administration of Lithium Carbonate ER 300mg at 8pm on 08/07/2026 as well as from 08/10/2026 to 08/20/2026. Staff did not initial MAR to show administration of Amlodipine Besylate 2.5mg at 8am from 08/08/2026 to 08/21/2026. Staff did not initial MAR to show administration of Brivaracetam 100mg at 8am on 08/08/2026, 08/09/2026 as well as from 08/13/2026 to 08/21/2026.

	Staff did not initial MAR to show administration of Brivaracetam 100mg at 8pm from 08/07/2026 to 08/20/2026. Evidence supports that staff did not initial the MAR at the time the medication was administered to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Staff administered Cobenfy 50mg, Lurasidone HCL 40mg, and Dexmethylphenidate (no dose listed) to Resident A in July and August despite it being discontinued on 07/10/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



09/19/2026

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



09/23/2026

Ardra Hunter — Date
Area Manager