GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 04, 2021

Stephanie Kennedy-Kinney
Saints, Incorporated
2945 S. Wayne Road
Wayne, MI 48184

RE: License #: AS820014363
Investigation #: 2022A0116002
Sylvania Home

Dear Ms. Kennedy-Kinney:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014363
Investigation #:	2022A0116002
Complaint Receipt Date:	10/07/2021
Investigation Initiation Date:	10/08/2021
Report Due Date:	12/06/2021
Licensee Name:	Saints, Incorporated
Licensee Address:	2945 S. Wayne Road Wayne, MI 48184
Licensee Telephone #:	(734) 722-2221
Administrator:	Stephanie Kennedy-Kinney
Licensee Designee:	Stephanie Kennedy-Kinney
Name of Facility:	Sylvania Home
Facility Address:	37555 Pennsylvania New Boston, MI 48164
Facility Telephone #:	(734) 753-3521
Original Issuance Date:	04/01/1991
License Status:	REGULAR
Effective Date:	11/08/2019
Expiration Date:	11/07/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff, Korzu Kangar, gave Resident A her medication through her mouth, and she is a tube feeder with a nothing by mouth (NPO) order. Resident A was taken to the emergency room where x-rays were taken. There was no injury or complications found.	Yes

III. METHODOLOGY

10/07/2021	Special Investigation Intake 2022A0116002
10/07/2021	APS Referral Received
10/07/2021	Referral - Recipient Rights Rights is currently investigating the allegations and referred the allegations to APS.
10/08/2021	Special Investigation Initiated - Telephone Interviewed licensee designee, Stephanie Kennedy-Kinney.
10/08/2021	Contact - Telephone call made Interviewed home manager, Juanita Taylor.
10/13/2021	Contact - Telephone call made Interviewed staff, Korzu Kangar.
10/14/2021	Inspection Completed-BCAL Sub. Compliance Reviewed Resident A's medication administration record (MAR), employee records for Ms. Kangar, and visually observed Resident A.
11/04/2021	Exit Conference With licensee designee, Stephanie Kennedy-Kinney.

ALLEGATION:

Staff, Korzu Kangar, gave Resident A her medication through her mouth, and she is a tube feeder with a nothing by mouth (NPO) order. Resident A was taken to the emergency room where x-rays were taken. There was no injury or complications found.

INVESTIGATION:

On 10/08/21, I interviewed licensee designee, Stephanie Kennedy-Kinney. Ms. Kennedy-Kinney reported that she had not been informed of the medication error and reported that staff should know better, and they have to be more careful.

On 10/08/21, I interviewed home manager, Juanita Taylor. Ms. Taylor reported that she was not on duty when the incident occurred. Ms. Taylor reported that she was surprised when she was told about the medication error. Ms. Taylor reported that Ms. Kangar is a really good staff, who has worked in the home almost a year with no issues. Ms. Taylor reported that she in-serviced Ms. Kangar again on medication processes and administration and reported that she is fully trained.

Ms. Taylor reported that Resident A was taken to the hospital as a precaution on 09/26/21, and the exam was within normal limits with no concerns. Ms. Taylor reported that on 10/01/21, they took Resident A to her primary care physician for a follow up. Ms. Taylor reported that Resident A's doctor stated that Resident A was fine and suffered no ill effects from ingesting her medications by mouth.

On 10/13/21, I interviewed staff, Korzu Kangar. Ms. Kangar reported that she was having a stressful day at work and made a big mistake. Ms. Kangar reported that she knows all of the residents and their specific needs but admitted that she let her own personal issues get in the way. Ms. Kangar reported that she crushed all of Resident A's 8:00 p.m. medications as usual, but instead of putting them in water to push through her percutaneous endoscopic gastrostomy (PEG) tube, she administered them with a spoonful of yogurt. Ms. Kangar reported as soon as she took the spoon out of Resident A's mouth, she realized her error. Ms. Kangar reported that Resident A's guardian was notified, and calls were made to her primary care doctor, but they did not return their calls. Ms. Kangar reported she was advised to take Resident A to the emergency room as a precaution. Ms. Kangar reported that Resident A was examined, an x-ray was taken, and the results were normal.

Ms. Kangar reported that she was given a verbal reprimand for the medication error as this was her first medication error. Ms. Kangar reported she was also in-serviced on proper medication administration.

On 10/14/21, I conducted a scheduled onsite inspection and spoke with Ms. Taylor. Ms. Taylor reported that Resident A is doing fine and has not had any issues since the incident.

I visually observed Resident A sitting at the table working on a puzzle. Resident A could not be interviewed as she is nonverbal. Resident A was neatly dressed and groomed.

I reviewed Resident A's MAR and medication labels. The MAR and labels all document that each medication is to be given via PEG tube. I also reviewed Ms.

Kangar's employee record and confirmed that she was fully trained in medication administration.

On 11/04/21, I conducted the exit conference with licensee designee, Ms. Kennedy-Kinney, and informed her of the findings of the investigation. Ms. Kennedy-Kinney reported an understanding of the rule violation and reported she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A is a tube feeder with a NPO order in place. On 09/26/21, Ms. Kangar crushed and administered Resident A's 8:00 p. m. medications by mouth instead of through her PEG tube. Resident A's MAR and medication labels document that each medication is to be given via the PEG tube. This violation is established, as Resident A's medication was not given pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

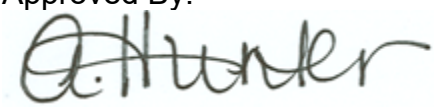
Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/04/21

Pandrea Robinson
Licensing Consultant

Date

Approved By:



11/04/21

Ardra Hunter
Area Manager

Date