GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2023

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

RE: License #: AS820013601
Investigation #: 2023A0992022
Beverly House

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820013601
Investigation #:	2023A0992022
Complaint Receipt Date:	04/04/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	06/03/2023
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:	Beverly House
Facility Address:	6380 Merriman Romulus, MI 48174
Facility Telephone #:	(734) 721-4712
Original Issuance Date:	07/31/1990
License Status:	REGULAR
Effective Date:	06/03/2022
Expiration Date:	06/02/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On Feb 24, 2023, Resident A was choking on her lunch, taken to Beaumont Wayne Hospital and placed on life support. There are concerns that the staff failed to comply with Resident A's individual plan of service. She required partial physical assistance with eating; staff is supposed to assist her with feeding herself, cutting her food into small pieces, ensure she was chewing her food slowly to avoid choking and sit and watch her to make sure she wasn't putting too much food into her mouth.	No
Additional Findings	Yes

III. METHODOLOGY

04/04/2023	Special Investigation Intake 2023A0992022
04/04/2023	Special Investigation Initiated - On Site Cammie Pace, home manager and Whitney Carter, direct care staff.
04/04/2023	APS Referral Denied at intake
04/04/2023	Referral - Recipient Rights
04/05/2023	Contact - Document Received Incident report received and death certificate.
04/07/2023	Contact - Telephone call made Stephanie Kinney, licensee designee
04/11/2023	Contact - Telephone call made Charles Carter, Office of Recipient Rights
04/12/2023	Contact - Telephone call made Sherry Underwood, Office of Recipient Rights (ORR)
04/12/2023	Contact - Telephone call made Tamara Walton, Resident A's supports coordinator with Adult Wellbeing Services. She was not available. Message left.

04/12/2023	Contact - Telephone call made Dawanda Pleasant, direct care staff (DCS)
04/19/2023	Contact - Document Sent Medical Records request sent to Beaumont Hospital (MRO)
04/20/2023	Contact - Telephone call made Ms. Walton
04/20/2023	Contact - Telephone call made Paul Torony, Resident A's guardian
05/17/2023	Contact - Document Sent Medical Records request sent to Beaumont Hospital (MRO). Second attempt.
05/31/2023	Contact - Face to Face Beaumont (Corewell) Hospital Medical Records. Medical records obtained.
05/31/2023	Exit Conference Ms. Kinney

ALLEGATION: On Feb 24, 2023, Resident A was choking on her lunch, taken to Beaumont Wayne Hospital and placed on life support. There are concerns that the staff failed to comply with Resident A's individual plan of service. She required partial physical assistance with eating; staff is supposed to assist her with feeding herself, cutting her food into small pieces, ensure she was chewing her food slowly to avoid choking and sit and watch her to make sure she wasn't putting too much food into her mouth.

INVESTIGATION: On 04/04/2023, I completed an unannounced onsite inspection and interviewed Cammie Pace, home manager, and Whitney Carter, direct care staff, regarding the allegations. Ms. Pace said on the day in questions, she was out running errands and direct care staff Dawana Pleasant was on shift. She said she received a call from Ms. Pleasant stating Resident A had just finished her lunch and fell on her way to the bathroom, but she was not injured. Ms. Pace said when she returned Resident A laid on the couch and she noticed her lips were swelling. She said Resident A stood up and gasped for air; Ms. Pace said she called 911 because Resident A had shortness of breath. She said when the emergency medical services (EMS) arrived, Resident A put her shoes on and got on the stretcher by herself. Ms. Pace said EMS transported Resident A to the hospital and she followed behind EMS. Ms. Pace said once she arrived and spoke with the hospital personnel, they said Resident A had some form of allergic reaction. Ms. Pace said she remained at

the hospital for hours and Resident A was admitted. Ms. Pace said Resident A also had Parkinson's Disease. She said Resident A did not have any known allergies to her knowledge. I asked what Resident A had for lunch on the day in question, and she said peanut butter and jelly, pudding, and water. I asked to review the menu and Ms. Pace said they don't have menus and the meals are determined daily. I asked if Resident A had a peanut allergy and she said no. Ms. Pace said Resident A often ate peanut butter and jelly sandwiches. I asked if Resident A had any specific eating requirements and she said Resident A's food had to be cut into small pieces to prevent her from choking. Ms. Pace said Resident A did not require assistance when eating, she was able to feed herself, but staff would sit near her.

Ms. Carter said she was not on shift when the incident occurred and was made aware of the incident by staff.

While onsite I reviewed Resident A's resident file including her individual plan of services (IPOS) and past medication administration records (MARs). According to the IPOS, food and nutrition section "due to her high cholesterol her doctor has recommended a low cholesterol diet. I have no known allergies. Group provides nutritious food and watches carb intake and portion size to prevent weight gain. Food is cut up small by staff due to stuffing food in her mouth." Based on review of the MARs, I observed medications that were not initialed on the MARs and no explanation was provided.

On 04/05/2023, I received copies of the incident reports completed by Ms. Pace and Pleasant and Resident A's death certificate. The death certificate rules Resident A's death as natural due to acute hypoxic failure, hypoxic brain encephalopathy, cardiac arrest, and Parkinson's Disease.

On 04/07/2023, I contacted Stephanie Kinney, licensee designee, and interviewed her regarding the allegations. Ms. Kinney stated that she spoke with the hospital personnel and was told Resident A appeared to have an allergic reaction to something. Ms. Kinney said if there is anything I need her to assist with the investigation to contact her. I made her aware upon completion of the investigation, that I will contact her to have an exit conference.

On 04/11/2023, I contacted Charles Carter, Office of Recipient Rights (ORR) regarding the reported allegations. Ms. Carter made me aware that he was a part of the ORR strike team when the intake was received but the investigation was assigned to Sherry Underwood, ORR; he provided me with her contact information.

On 04/12/2023, I contacted Ms. Underwood, regarding the reported allegation. Ms. Underwood stated that she contacted the Wayne County Medical Examiner regarding the postmortem report and was made aware that they did not conduct an autopsy but was notified of the death; Resident A was cremated. Ms. Underwood said the investigation is pending and she agreed to follow-up with upon completion.

On 04/12/2023, contacted Dawanda Pleasant, direct care staff (DCS) and interviewed her regarding the allegations. Ms. Pleasant confirmed she was on shift with Ms. Pace, but Ms. Pace was running errands at the time. Ms. Pleasant said Resident A had very limited verbal skills and she would use gestures to communicate. Ms. Pleasant said after working with her for a while, you tend to learn her language. She said Resident A pointed at her mouth, which meant she was hungry, so she made her a peanut butter and jelly sandwich, which she cut-up into small pieces and gave her some pudding. She said Resident A sat on the couch. Ms. Pleasant said moments later Resident A pointed to her bottom, which meant she had to use the bathroom. She said on her way to the bathroom, she fell. Ms. Pleasant said she helped her up, checked for injuries and she had a small carpet burn on her face. Ms. Pleasant said Resident A looked in the mirror and went and sat on the couch in the living room; she said she did not use the bathroom. Ms. Pleasant said by this time, Ms. Pace had returned. She said Resident A started to make some strange noises. Ms. Pleasant said Ms. Pace looked at Resident A and immediately called 911. Ms. Pleasant said Resident A put her shoes on and once EMS arrived, she sat on the stretcher and was transported to the hospital.

On 04/20/2023, I contacted Tamara Walton, Resident A's supports coordinator with Adult Wellbeing Services regarding the reported allegation. Ms. Walton denied having any concerns regarding the staff not complying with Resident A’s IPOS. Ms. Walton said following the incident she spoke with the staff regarding the incident. She denied having any concerns.

On 04/20/2023, I contacted Paul Torony, Resident A's guardian regarding the reported allegations. Mr. Torony denied having any concerns regarding the staff not complying with Resident A’s IPOS. He said he often visited with Resident A during mealtime and observed the staff. He said the staff followed the guidelines. He said he is aware that the initial medical concern was an allergic reaction but Resident A expired due to cardiac arrest. Mr. Torony denied having any concerns.

On 05/31/2023, I obtained a copy of Resident A’s medical record from Beaumont (Corewell) Hospital Medical Records. According to the chief complaint, the resident was transported due to shortness of breath and possible allergic reaction; resident coded while in route to the hospital. As of 3/5/2023, resident was discharged to hospice. The significant diagnostic studies, procedures and treatments included cardiac arrest, acute hypoxic respiratory failure Parkinson disease, hypoxic encephalopathy, autism, and mental retardation.

On 05/31/2023, I completed an exit conference with Ms. Kinney. I made her aware that based on the investigative findings, there is insufficient evidence to support the allegation. Ms. Kinney denied having any questions.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	During this investigation, I interviewed Stephanie Kennedy-Kinney, licensee designee; Cammie Pace, home manager; Dawanda Pleasant, direct care staff; Tamara Walton, Resident A's Supports Coordinator with Adult Wellbeing Services; Paul Torony, Resident A's guardian with Faith Connections; all of which denied the allegation. Based on the investigative findings, there is no evidence to support the allegation that the licensee designee failed to provide the services specified in Resident A's assessment plan. The allegation is substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/04/2023, I completed an unannounced onsite inspection and interviewed Cammie Pace, home manager. I asked to review the menu and Ms. Pace said they don't have menus and the meals are determined daily. She said during the last staff meeting it was decided that the menus would be made daily. Ms. Pace was unable to provide any menus for 2023.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	At the time of inspection, menus were not posted or available for review. Ms. Pace stated menus are decided daily.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 04/04/2023, I completed an unannounced onsite inspection and reviewed Resident A's MARs, I observed medications that were not initialed on the MARs and no explanation was provided. Based on review of the MARs, the person who administered the medication failed to initial at the time the medication was given.

The MARs dated 01/01/2023 through 01/31/2023 was as follows:

- Senna 8.6 Mg Tablet; take 1 capsule by mouth every day at bedtime was not initialed on 01/27/2023 at 8:00 p.m.
- Docusate Sodium 100Mg Softgel; take 1 tablet by mouth twice daily was not initialed on 01/27/2023 at 8:00 p.m.
- CARBIDOPA-LEVODOPA 25-100 MG TAB; take 1 tablet by mouth four times daily was not initialed on 01/27/2023 at 4:00 p.m. or 8:00 p.m.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on review of Resident A's medication administration records, the person who administered the medication, failed to initial at the time the medication was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

06/01/2023

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Denasha Walker Date
Licensing Consultant

Approved By:

06/01/2023

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Ardra Hunter Date
Area Manager