GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 3, 2025

Naomi Kennedy
Kennedy's Care Enterprise Inc.
27509 Cherry Hill Rd.
Inkster, MI 48141

RE: License #: AS820247826
Investigation #: 2025A0119008
Romulus Home

Dear Ms. Kennedy:

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820247826
Investigation #:	2025A0119008
Complaint Receipt Date:	12/05/2024
Investigation Initiation Date:	12/05/2024
Report Due Date:	02/03/2025
Licensee Name:	Kennedy's Care Enterprise Inc.
Licensee Address:	27509 Cherry Hill Rd. Inkster, MI 48141
Licensee Telephone #:	(313) 274-0044
Administrator:	Naomi Kennedy
Licensee Designee:	Naomi Kennedy
Name of Facility:	Romulus Home
Facility Address:	9650 Tobine Romulus, MI 48174
Facility Telephone #:	(734) 942-9919
Original Issuance Date:	07/19/2002
License Status:	REGULAR
Effective Date:	11/18/2024
Expiration Date:	11/17/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/23/24, Staff- Jawan Wimberly administered the wrong evening medication to Resident A.	Yes

III. METHODOLOGY

12/05/2024	Special Investigation Intake 2025A0119008
12/05/2024	Referral - Recipient Rights Received
12/05/2024	Special Investigation Initiated - Telephone Adult Protective Service Investigator- Tiffany Burgess
12/05/2024	APS Referral Received
12/11/2024	Inspection Completed On-site Resident B and Staff- Beverly Adam and Staff- Laura Tolbert
12/11/2024	Contact - Face to Face Home Manager- Oluwaseun Olawunmi
12/11/2024	Contact – Telephone call made Staff- Jawan Wimberly, left message
12/12/2024	Contact - Document Received Incident Report
01/28/2025	Contact - Telephone call made Resident A's guardian- Paul Torney with Faith Connections Staff- Jawan Wimberly
01/28/2025	Exit Conference Licensee Designee- Naomi Kennedy

ALLEGATION:

On 11/23/24, Staff- Jawan Wimberly administered the wrong evening medication to Resident A.

INVESTIGATION:

On 12/05/2024, I telephoned and interviewed Adult Protective Service Investigator- Tiffany Burgess regarding the above allegations. Ms. Burgess stated the allegations are true and Resident A did receive Resident B's medication instead of his own due to an error made by Staff- Jawan Wimberly.

On 12/11/2024, I completed an unannounced on-site inspection and interviewed Resident B and Staff- Beverly Adam and Staff- Laura Tolbert regarding the above allegations. Ms. Adams and Ms. Tolbert stated they have no direct knowledge of the incident. Ms. Adams and Ms. Tolbert stated there is always two staff working every shift.

Resident B stated he received his correct medication from staff daily. Resident B stated he has no knowledge of any residents receiving the wrong medications.

On 12/11/2024, I completed a face-to-face interview with Home Manager- Oluwaseun Olawunmi regarding the above allegations. Mr. Olawunmi stated the incident did occur and he was notified by Mr. Wimberly on the day of the incident. He stated Resident A was given several of the wrong medications.

On 12/12/2024, I received Resident A's medication administration records and Incident Reports completed by Staff- Jawan Wimberly and Staff- Denise Wise. Ms. Wise's incident report indicated Mr. Wimberly was the administering medications and notified her that Resident A was given the wrong medication and the action taken was Resident A was monitored by staff and transported to the nearest hospital for emergency medical treatment. Mr. Wimberly's incident report states he gave Resident A the wrong medication and took immediate action to get Resident A emergency medical treatment. Mr. Wimberly's incident report also indicated Resident A returned home without incident.

According to Resident B's medication administration sheet, he is prescribed the following evening medications: Amantadine HCL 100mg, Metoprolol Tartrate 50mg, Quetiapine Fumarate 50mg.

On 01/28/2024, I telephoned and interviewed Resident A's guardian- Paul Torney with Faith Connections and Staff- Jawan Wimberly regarding the above allegations. Mr. Torney stated he was informed of the incident. Mr. Torney stated he has had no other problems with the care Resident A receives at the facility

Mr. Wimberly stated he was moving too fast and he made a horrible mistake. He stated this is his first time working with vulnerable adults and he has learned he needs to slow down. Mr. Wimberly stated he was trained on dispensing medications prior to this incident happening. He stated he noticed the error right away and told the other staff working. Mr. Wimberly stated he ensured Resident A received emergency medical care immediately. Mr. Wimberly stated he could not remember which of Resident B's medication he gave to Resident A.

On 01/28/2024, I telephoned and completed an exit conference with Licensee Designee- Naomi Kennedy regarding the above allegations. Mrs. Kennedy stated she has ensured Mr. Wimberly has been retrained in medication administration along with other staff development to ensure this does not happen again. Mrs. Kennedy stated Resident A has been at the facility for over 10 years and she wants to ensure he receives the best care from staff.

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:	Licensee Designee- Naomi Kennedy, Home Manager- Oluwaseun Olawunmi and Staff- Jawan Wimberly stated Resident A was given the wrong medication and he was notified by Mr. Wimberly on the day of the incident. He stated Resident A was given several of the wrong medications. Staff- Denise Wise and Staff- Jawan Wimberly's incident reports both indicated Mr. Wimberly was the administering medications and notified Ms. Wise that Resident A was given the wrong medication and the action taken was Resident A was monitored by staff and transported to the nearest hospital for emergency medical treatment. According to Resident b's medication administration sheet, he is prescribed the following evening medications: Amantadine HCL 100mg, Metoprolol Tartrate 50mg, Quetiapine Fumarate 50mg. Mr. Wimberly stated he did not administer Resident B's medication to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/31/2025

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Shatonla Daniel Date
Licensing Consultant

Approved By:

02/03/2025

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Ardra Hunter Date
Area Manager