GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

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

RE: License #: AS820013672
Investigation #: 2025A0116016
Hall Road Home

Dear Mrs. 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 #:	AS820013672
Investigation #:	2025A0116016
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/07/2025
Report Due Date:	05/04/2025
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:	Hall Road Home
Facility Address:	22014 Chipmunk Trail Woodhaven, MI 48183
Facility Telephone #:	(734) 671-7695
Original Issuance Date:	02/28/1984
License Status:	REGULAR
Effective Date:	12/15/2024
Expiration Date:	12/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 2/28/2025, Resident A was taken to the hospital after falling out of her wheelchair while being transported by staff, Shalece Cottrell. It is alleged that Ms. Cottrell did not properly secure Resident A's wheelchair.	Yes

III. METHODOLOGY

03/05/2025	Special Investigation Intake 2025A0116016
03/05/2025	Referral - Recipient Rights Received.
03/07/2025	Special Investigation Initiated - On Site Interviewed Resident A and staff, Rolanda Allen.
03/11/2025	Contact - Telephone call made Left a message for assigned rights investigator, Tiffany Burgess, requesting a return call.
03/11/2025	Contact - Telephone call made Interviewed home manager, Miah Glover.
03/11/2025	Contact - Telephone call made Interviewed staff, Shalece Cottrell.
03/11/2025	Inspection Completed-BCAL Sub. Compliance
03/12/2025	APS Referral Made.
03/13/2025	Exit Conference With license designee, Stephanie Kennedy-Kinney.

ALLEGATION:

On 2/28/2025, Resident A was taken to the hospital after falling out of her wheelchair while being transported by staff, Shalece Cottrell. It is alleged that Ms. Cottrell did not properly secure Resident A's wheelchair.

INVESTIGATION:

On 03/07/25, I conducted an unannounced on-site inspection and interviewed Resident A and staff, Rolanda Allen. Resident A reported that on her way home from her workshop program, she tipped over in her wheelchair onto the floor of the van. Resident A reported that she had her wheelchair seat belt buckle secured around her waist and reported that she does not know how this happened. Resident A reported that staff always strap/secure her wheelchair to the floor of the van so that she does not move during transport. Resident A reported that she just remembers tipping over while still in the wheelchair on her right side. Resident A reported that staff, Shalece Cottrell, was driving and pulled over to get her back upright. Resident A reported that Ms. Cottrell took her to urgent care. Resident A reported that they did x-rays and a computed tomography scan (CT). Resident A reported that she did not sustain any injuries, and she feels fine. Resident A reported she has a follow up appointment with her doctor in two weeks.

I interviewed staff, Rolanda Allen, and she reported that she was not at work the day of the incident but heard what happened. I asked Ms. Allen if she could demonstrate how Resident A is supposed to be secured in the van during transport. Ms. Allen walked me through the process and showed how there are straps/ties that come up from the van floor and attach to both sides of Resident A’s wheelchair that secures the chair and prevents it from moving during transport.

On 03/11/25, I interviewed home manager, Miah Glover, and she reported that she was not present when the incident occurred, however, reported interviewing Resident A. Ms. Glover reported that Resident A reported that during transport she tipped over on her right side, while still in her wheelchair. Ms. Glover reported her belief that Resident A’s wheelchair was not properly secured, as that is the only way the wheelchair was able to move. Ms. Glover reported that since the incident she has re-in serviced all staff on the proper way to secure residents who utilize wheelchairs in the van.

On 03/11/25, I interviewed staff, Shalece Cottrell, and she reported that she picked Resident A up from her workshop program on 02/28/25, and reported that on the way home, she looked through her rearview mirror and didn’t see Resident A. Ms. Cottrell reported that she pulled the van over, got up and observed Resident A on the floor of the van, still in her wheelchair seat belt, and the wheelchair was still upright in place. I inquired as to how that was possible as the seat of the wheelchair attaches to the actual chair. Ms. Cottrell reported she was confused how that could occur but reported it did. Ms. Cottrell reported that she knows how to properly secure

Resident A's wheelchair in the van and reported that it was done properly on 02/28/25. Ms. Cottrell reported that Resident A had a red mark on her forehead, so as a precaution she took her to urgent care to be evaluated. Ms. Cottrell reported that at urgent care Resident A had an x-ray and CT scan and everything came back negative for injury.

On 03/13/25, I conducted the exit conference with licensee designee, Stephanie Kennedy-Kinney, and informed her of the findings of the investigation and the rule cited. Mrs. Kennedy-Kinney reported an understanding and stated that she is aware of the incident and that Resident A could not have been secured properly, which ultimately contributed to her tipping over in her wheelchair. Mrs. Kennedy-Kinney reported that she has been in contact with the rights investigator, Ms. Burgess, and reported that she substantiated the complaint as well. Mrs. Kennedy-Kinney reported that all staff have already been re-in serviced on properly securing wheelchairs in the van.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Resident A, home manager, Miah Glover, and staff, Shalece Cottrell, I am able to corroborate the allegation. Resident A reported that while being transported home from her workshop program, her wheelchair tipped over and she and the chair fell onto the van floor. Ms. Glover reported that although she was not present when the incident occurred, it is her belief that the only way Resident A and her wheelchair was able to tip over was due to the wheelchair not being properly secured. Ms. Cottrell reported that she properly secured Resident A and her wheelchair prior to transport. Ms. Cottrell reported that Resident A did fall out of the wheelchair onto the floor, with her wheelchair seat belt still attached, although she was unable to explain how that could happen. Ms. Cottrell maintains that the wheelchair remained upright. This violation is established, as staff, Shalece Cottrell did not attend to Resident A's personal needs, including protection and safety while transporting her home from her workshop program.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson
Licensing Consultant

03/17/25
Date

Approved By:

Ardra Hunter
Area Manager

03/19/25
Date