GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2026

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

RE: License #: AS820014261
Investigation #: 2026A0992011
Lindsay Home

Dear Stephanie 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) 456-0439.

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 #:	AS820014261
Investigation #:	2026A0992011
Complaint Receipt Date:	12/12/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/10/2026
Licensee Name:	Saints Incorporated
Licensee Address:	2945 S. Wayne Road Wayne, MI 48184
Licensee Telephone #:	(734) 722-2221
Administrator:	Stephanie Kinney
Licensee Designee:	Stephanie Kinney
Name of Facility:	Lindsay Home
Facility Address:	33777 Beverly Road Romulus, MI 48174
Facility Telephone #:	(734) 728-1181
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	10/28/2025
Expiration Date:	10/27/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/3/25, Resident A was in his room with staff, and the staff went to use the restroom. Resident A unbuckled his seatbelt and attempted to transfer himself from his wheelchair to the chair in his room. In doing so, Resident A fell onto the ground. Resident A requires 1-to-1 staffing. There are concerns regarding adequate supervision.	Yes

III. METHODOLOGY

12/12/2025	Special Investigation Intake 2026A0992011
12/17/2025	Special Investigation Initiated - On Site Direct care staff Kbira El Ayyady, Foluke Sherrod, Rufus Barnes and Resident A.
12/23/2025	Contact - Telephone call made Licensee designee, Stephanie Kinney.
12/23/2025	Contact - Telephone call made Home manager, Joanne Gbadebo
12/23/2025	Contact - Telephone call made Resident A's guardian, Paul Torony.
01/16/2026	Referral - Recipient Rights
01/16/2026	Contact - Telephone call made Adult protective services (APS), Ashley Rasberry.

ALLEGATION: On 12/3/25, Resident A was in his room with staff, and the staff went to use the restroom. Resident A unbuckled his seatbelt and attempted to transfer himself from his wheelchair to the chair in his room. In doing so, Resident A fell onto the ground. Resident A requires 1-to-1 staffing. There are concerns regarding adequate supervision.

INVESTIGATION: On 12/17/2025, I completed an unannounced onsite inspection and interviewed direct care staff, Kbira El Ayyady; Foluke Sherrod; Rufus Barnes and Resident A regarding the allegation. Ms. El Ayyady confirmed she was on shift

the day the incident occurred. She stated she was in Resident A's bedroom with him and she had to use the restroom. She stated she notified Ms. Sherrod that she was going to the restroom. She stated while in the restroom direct care staff, Foluke Sherrod yelled out for her stating Resident A had fallen. Ms. El Ayyady stated she returned to his bedroom and assisted him back in his chair. She stated she asked Resident A what happened and he stated he unfastened his seatbelt and tried to move from his wheelchair to the recliner. I asked if Resident A requires 1-to-1 staffing, and she said yes. She stated staff are not assigned to a specific resident and typically it is a collective effort for the staff to check on all the residents during shift, which is why she notified Ms. Sherrod. She stated when she works the morning shift, she is assigned as Resident A's 1-to-1 but when working other shifts, the staff collectively care for all the residents. I explained that when a resident requires 1-to-1 that resident must be supervised according to the guidelines. She stated she notified Ms. Sherrod that she was going to the bathroom. I asked if Ms. Sherrod was in Resident A's bedroom when she left to go to the restroom, and she said no. Ms. El Ayyady denied Resident A sustained any injuries.

I interviewed Foluke Sherrod. Ms. Sherrod stated she was assigned to care for the ladies in the home and Ms. El Ayyady was assigned as Resident A's 1-to-1 staff; she stated that is the assignment every shift. She stated the home manager, Joanne Gbadebo makes them aware of their assignment every shift. Ms. Sherrod stated on the day the incident occurred, she was in the bedroom with Resident B and C assisting them. She stated Ms. El Ayyady stated she was going to the bathroom. Ms. Sherrod said once she was done with Resident B and C, she walked past Resident A's bedroom and noticed he was on the floor. She stated she immediately notified Ms. El Ayyady and they assisted him back in his wheelchair. Ms. Sherrod confirmed Resident A requires 1-to-1 staffing. Ms. Sherrod denied Resident A sustained any injuries.

I interviewed Rufus Barnes. Mr. Barnes stated he was on shift the day the incident occurred but was not aware Resident A fell. He stated he found out when he was contacted by adult protective services and interviewed regarding the allegation. Mr. Barnes said nothing like this has ever happened before and Ms. El Ayyady is very good about tending to Resident A's needs. Mr. Rufus stated at the start of their shift they are made aware of which resident they are responsible for during the shift. He stated Ms. El Ayyady is typically assigned as Resident A's 1-to-1 staff and with him all the time.

I attempted to interview Resident A. When I asked how he was doing, he smiled but did not engage. I asked him about unfastening his seatbelt, he smiled but did not engage. I observed Resident A fastened in his wheelchair. He appeared to be clean and adequately dressed. No unusual marks or bruises were observed on him.

I reviewed Resident A's individual plan of services (IPOS) regarding his 1-to-1 staffing guidelines. According to his IPOS, "1-to-1 staffing recommendation/ redirect

verbal aggression and oppositional defiance. Staff will provide encouragement, gentle teaching and promote coping skills."

On 12/23/2025, I contacted licensee designee, Stephanie Kinney regarding the allegation. Ms. Kinney stated she is aware of the allegation. She stated she immediately acted and addressed the issue. I made her aware of the interviews I conducted with the direct care staff and based on the information received, the allegation is substantiated. Due to the violations identified in the report, a written corrective action plan is required. Ms. Kinney agreed to submit a corrective action plan and denied having any questions.

On 12/23/2025, I contacted home manager, Joanne Gbadebo and interviewed her regarding the allegation. Ms. Gbadebo stated she was not on shift when the incident occurred but stated she is fully aware of the allegation. Ms. Gbadebo stated she asked Resident A about the incident the following day and she stated he unfastened his seatbelt because he wanted to sit in the recliner. Ms. Gbadebo stated Resident A tries to be more independent than he has the ability too. Ms. Gbadebo confirmed Resident A requires 1-to-1 staff and stated she addressed it with Ms. El Ayyady. She stated Ms. El Ayyady was reprimanded.

On 12/23/2025, I contacted Resident A's guardian, Paul Torony and interviewed him regarding the allegation. Mr. Torony stated he is aware of the allegation. He stated Resident A was trying to transfer himself to the recliner. He stated he did not sustain any injuries. Mr. Torony stated he has since visited with Resident A and tried to encourage him to wait for staff assistance. He stated Resident A tries to do more than he has the ability to do. He confirmed Resident A requires 1-to-1 staffing, but the staff had stepped away. I made Mr. Torony aware that when a resident requires 1-to-1 staff, it is the expectation that the staff follow the guidelines, which Mr. Torony agreed. He stated this appears to be an isolated incident. He stated the facility provides excellent care for the residents and this is one of his better facilities. He denied having any concerns.

On 1/16/2026, I contacted adult protective services (APS), Ashley Rasberry regarding the allegation. Ms. Rasberry confirmed she investigated the allegation and substantiated.

On 1/16/2026, I received email notification from office of recipient rights (ORR), Jerri Sterrett that the allegation was investigated and closed on 12/12/25.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum

	to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	During this investigation, I interviewed licensee designee, Stephanie Kinney; home manager, Joanne Gbadebo; direct care staff, Kbira El Ayyady, Foluke Sherrod, and Rufus Barnes; Resident A's guardian, Paul Torony with Faith Connections; APS, Ashley Rasberry; ORR, Jeri Sterrett regarding the allegation. All of which confirmed the allegation. Resident A did not engage during the interview. I reviewed Resident A's IPOS, which confirmed he requires 1-to-1 staffing. Based on the findings there is sufficient evidence to support the allegation that Resident A was not provided with supervision as outlined in his IPOS. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/16/2026

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Denasha Walker Date
Licensing Consultant

Approved By:

01/21/2026

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Ardra Hunter Date
Area Manager