GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 24, 2021

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

RE: License #: AS820014261
Investigation #: 2021A0116021
Lindsay Home

Dear Ms. Kennedy-Kinney:

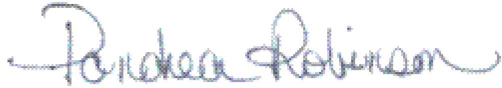
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:** | AS820014261 |
| | |
| **Investigation #:** | 2021A0116021 |
| | |
| **Complaint Receipt Date:** | 06/01/2021 |
| | |
| **Investigation Initiation Date:** | 06/01/2021 |
| | |
| **Report Due Date:** | 07/01/2021 |
| | |
| **Licensee Name:** | Saints, Incorporated |
| | |
| **Licensee Address:** | 2945 S. Wayne Road<br>Wayne, MI 48184 |
| | |
| **Licensee Telephone #:** | (734) 722-2221 |
| | |
| **Administrator:** | Stephanie Kennedy-Kinney |
| | |
| **Licensee Designee:** | Stephanie Kennedy-Kinney |
| | |
| **Name of Facility:** | Lindsay Home |
| | |
| **Facility Address:** | 33777 Beverly Road<br>Romulus, MI 48174 |
| | |
| **Facility Telephone #:** | (734) 728-1181 |
| | |
| **Original Issuance Date:** | N/A |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/28/2019 |
| | |
| **Expiration Date:** | 10/27/2021 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| On 5/28/2021, staff woke Resident A up at 5:00 a.m. to administer medications and noted a small abrasion on his forehead. Manager arrived at the home at 11:00 a.m. and advised staff to take resident to urgent care for evaluation and treatment. Resident A was later transferred to the hospital and diagnosed with a brain bleed. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/01/2021 | Special Investigation Intake<br>2021A0116021 |
| 06/01/2021 | Special Investigation Initiated - Letter<br>Email sent to complainant requesting a telephone call. |
| 06/01/2021 | Contact - Telephone call made<br>To complainant, phone just rang, and no message could be left. |
| 06/01/2021 | APS Referral<br>Referral rejected by APS for investigation. |
| 06/02/2021 | Inspection Completed On-site<br>Interviewed Home manager Joann Gbadedo and Resident B. |
| 06/08/2021 | Contact - Telephone call made<br>Interviewed staff Chidozi Uche. |
| 06/08/2021 | Contact - Telephone call made<br>Spoke with Ms. Gbadedo. |
| 06/08/2021 | Contact - Telephone call made<br>Interviewed staff Foluke Sherrod. |

| | |
|---|---|
| 06/08/2021 | Contact - Telephone call made<br>Left a message for staff Rufus Barnes requesting a return call. |
| 06/08/2021 | Contact - Telephone call made<br>Interviewed staff Linda Gwess. |
| 06/09/2021 | Contact - Telephone call received<br>Interviewed Mr. Barnes. |
| 06/11/2021 | Contact - Telephone call made<br>Left a message for Amy Torony, Public Guardian through Faith Connections. |
| 06/11/2021 | Contact - Telephone call received<br>Interviewed Ms. Torony. |
| 06/11/2021 | Inspection Completed-BCAL Sub. Compliance |
| 06/11/2021 | Exit Conference<br>With licensee designee Stephanie Kennedy-Kinney. |

**ALLEGATION:**

**On 5/28/2021 staff woke Resident A up at 5:00 a.m. to administer medications and noted a small abrasion on his forehead. Manager arrived at the home at 11:00 a.m. and advised staff to take resident to urgent care for evaluation and treatment. Resident A was later transferred to the hospital and diagnosed with a brain bleed.**

**INVESTIGATION:**

I conducted an unscheduled onsite inspection at the home on 06/02/21 and interviewed home manager Joann Gbadedo (home manager) and Resident B. Ms. Gbadedo reported that on 05/28/21 she arrived at the home at around 11:00 a. m. and reported as she was entering the home Resident A walked directly to her and that is when she observed the abrasion to his forehead and nose area. Ms.

Gbadedo reported she contacted the midnight staff Mr. Uche and Ms. Sherrod to ascertain what happened to Resident A and neither of them were able to provide an explanation. Ms. Gbadedo reported that they both reported checking on him a couple of times throughout the night, didn't hear anything, and reported the abrasions were not observed until they woke him up at 5:00 a.m. Ms. Gbadedo reported that they think Resident A may have had an unwitnessed fall during the night. Ms. Gbadedo reported that she advised both staff that they should have sought medical treatment immediately after observing the abrasion to Resident A's head, especially because they were not sure of how or what caused it.

Ms. Gbadedo reported that Resident A is nonverbal and unable to share any information about the injury. She reported that she instructed the day shift staff, Mr. Olewaluwo and Ms. Gwess to take Resident A to urgent care for evaluation. Ms. Gbadedo reported that she spoke with both day shift staff about their decision not to seek medical treatment upon observing Resident A's injury at the start of their shift.

Ms. Gbadedo reported that when Resident A arrived at Urgent Care, they advised staff to take him to the hospital because they did not have the facilities to scan/x-ray his head and neck area. Resident A was transported to Beaumont Annapolis and later transferred to Beamont Dearborn and diagnosed with a brain bleed. Ms. Gbadedo reported that Resident A remains hospitalized but is doing okay.

Ms. Gbadedo allowed me to view the picture of Resident A's face that she had on her cell phone. The abrasion on Resident A's head was about the size of a quarter and resembled a carpet burn. The top layer of skin was gone. There were also abrasions on Resident A's nose and under his nose.

Ms. Gbadedo added that she spoke to Resident B, who is the twin brother to Resident A and also shares a room with him, to see if he knew what happened to Resident A. Ms. Gbadedo reported that Resident B reported that he did not hear or see anything.

I interviewed Resident B and he reported that his brother is in the hospital. Resident B reported that he did not hear anything during the night of 05/27/21 and did not see anything. He reported that he did not know what happened to Resident A.

I interviewed Mr. Uche on 06/08/21 and he reported that he worked the midnight shift (11:00 p.m. to 7:00 a.m.) on 05/27/21. He reported that Resident A was in bed when he arrived on shift. Mr. Uche reported that he conducted bed checks throughout the night and reported that because Resident A sleeps with his covers over his body and face, he did not see his face until he actually went to wake him up at 5:00 a.m. for his medication. Mr. Uche reported that he did not hear any noise coming from Resident A's room during the night.

Mr. Uche reported that once he administered Resident A's medication he showered him and applied an antibiotic ointment to the abrasions on Resident A's face. Mr.

Uche reported that Resident A ate breakfast and appeared to be his normal self. Mr. Uche reported that he did not exhibit any behaviors that would lead him to believe that he required medical care. Mr. Uche reported that his co-worker Ms. Sherrod texted the home manager notifying her of what they observed regarding Resident A but did not receive a response.

I interviewed Ms. Sherrod on 06/08/21 and she reported that she worked the midnight shift on 05/27/21 with Mr. Uche. She reported that it was a normal night and that she also conducted bed checks. Ms. Sherrod reported that Resident A sleeps with the covers over his face and that when she goes in his room to check on him and Resident B, she turns the lights on, touches their arm or legs, see that they make some sort of movement and leave out. Ms. Sherrod reported that she did not hear anything that night that was of concern and reported that she observed the abrasion on Resident A's face after Mr. Uche called her in to observe it. Ms. Sherrod reported they applied ointment to the abrasion and Resident A appeared fine. Ms. Sherrod reported that Resident A did not exhibit any signs that would have led her to believe that he required medical treatment. She re-iterated that Resident A was his normal self.

I spoke with Ms. Gbadedo on 06/08/21 and she reported that Resident A is doing better but may be discharged to a step-down hospital before returning to the home.

I interviewed Ms. Gwess on 06/08/21 and she reported that she worked the afternoon shift (3:00 p.m. -11:00 p.m.) on 05/27/21 and the day shift (7:00 a.m. to 3:00 p.m.) on 05/28/21. Ms. Gwess reported that on 05/27/21 Resident A was fine and his normal self. She reported that Resident A is a 1 on 1 from 7:00 a.m. to 9:00 p.m. Ms. Gwess reported that on 05/28/21 when she arrived at work and saw Resident A's head and asked the midnight staff what happened. Ms. Gwess reported that they both stated that they did not know but thought Resident A may have fallen during the night.  Ms. Gwess reported that Ms. Sherrod reported that she had notified Ms. Gbadedo and that they had applied antibiotic ointment to the abrasions. Ms. Gwess reported that she monitored Resident A and reported at no time did he appear in distress or in any pain.  Ms. Gwess reported that Ms. Gbadedo came to the home at 11:00 a. m. and after observing the abrasions to Resident A's face she instructed her and Mr. Olawaluwo to take Resident A to Urgent Care immediately. Ms. Gwess reported while at Urgent Care they informed them they do not complete x-rays of the neck and up and advised that they take him to the hospital. Ms. Gwess reported that they transported Resident A to Beaumont Annapolis where he was diagnosed with a brain bleed. Ms. Gwess reported Resident A was then transferred via ambulance to Beaumont Dearborn and they were informed that hospital staff would communicate with Resident A's guardian from that point on.

I interviewed Mr. Barnes on 06/09/21 and he reported that he was Resident A's 1 on 1 on 05/27/21 from 4:00 p. m. to 9:00 p.m. and reported that he was fine and was his normal self. Mr. Barnes reported he was surprised to hear that Resident A was

hospitalized the following day with a brain bleed. Mr. Barnes reported that Resident A did not have any marks, bruises, or abrasions on his face when he left work at 9:00 p.m. on 05/27/21.

I interviewed Ms. Torony on 06/11/21 and she reported that prior to this incident she had not had any concerns regarding the care being provided in the home. Ms. Torony reported that Resident A has done very well in the home and is thriving. Ms. Torony reported her current concern is why medical treatment was not sought immediately by the midnight staff and then day shift staff upon observing the abrasions to Resident A's head/nose and upper lip area, as they were significant. Ms. Torony reported the fact that Resident A had an unwitnessed fall of some sort and no one could be certain of what happened or knew what he hit his head on in and of itself was reason enough to err on the side of caution and seek medical treatment. Ms. Torony reported that if Ms. Gbadedo would not have gone to the home and instructed staff to seek medical treatment for Resident A, this outcome could have been tragic.

Ms. Torony reported that she spoke with the nurse case manager at the hospital who reported that the neurologist found during testing of Resident A that he had a breakthrough seizure (defined as the first seizure after a minimum of 12 months seizure free) that likely precipitated the fall that caused the brain bleed. Ms. Torony reported that Resident A is doing ok and has returned to the home. She reported that she has concern that Resident A may have suffered a stroke while in the hospital so Ms. Gbadedo is keeping a close eye on him, as he may require physical therapy and other supportive services.

I conducted the exit conference on 06/11/21 with Stephanie Kennedy-Kinney. I informed her of the findings of the investigation, and she reported an understanding. Mrs. Kinney reported that all four staff received written reprimands for not seeking immediate medical treatment for Resident A, especially since no one witnessed the fall.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |

| ANALYSIS: | Based on the findings of the investigation, which included interviews with Ms. Gbadedo, Mr. Uche, Ms. Sherrod, Ms. Gwess, Ms. Torony and Mrs. Kinney I am able to corroborate the allegation.<br><br>Resident A sustained an injury (brain bleed) likely from an unwitnessed fall after having a breakthrough seizure sometime during the night. The following morning staff observed the abrasions on Resident A head, nose and upper lip area and failed to seek immediate medical attention. |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

06/18/21

Pandrea Robinson — Date
Licensing Consultant

Approved By:

06/24/21

Ardra Hunter — Date
Area Manager