GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2023

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

RE: License #: AS820013672
Investigation #: 2023A0116030
Hall Road 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 #:	AS820013672
Investigation #:	2023A0116030
Complaint Receipt Date:	04/14/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/13/2023
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:	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:	12/15/2022
Expiration Date:	12/14/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 04/14/23, incident report received documented that on 04/04/23, staff Breanna Toomy, observed Resident A restrained and tied to a kitchen chair. Ms. Toomey reported the home manager reported Resident A was restrained so that she could "monitor her."	Yes

III. METHODOLOGY

04/14/2023	Special Investigation Intake 2023A0116030
04/14/2023	Referral - Recipient Rights Made by staff Breanna Toomy.
04/18/2023	Special Investigation Initiated - On Site Interviewed staff, Breanna Toomey, staff, Ranequa Kelley-Boyd, visually observed Resident A, and interviewed Resident B and C.
04/19/2023	APS Referral Made.
04/24/2023	Contact - Telephone call made Interviewed staff, Babatunde Shonibare.
04/24/2023	Contact - Telephone call made Interviewed staff, Jacqueline White.
04/24/2023	Inspection Completed-BCAL Sub. Compliance
04/28/2023	Exit Conference With licensee designee Stephanie Kennedy-Kinney.

ALLEGATION:

On 04/14/23, incident report received documented that on 04/04/23, staff Breanna Toomy, observed Resident A restrained and tied to a kitchen chair. Ms. Toomey reported the home manager reported Resident A was restrained so that she could "monitor her."

INVESTIGATION:

On 04/18/23, I conducted an unscheduled onsite inspection and interviewed staff Breanna Toomey, staff, Ranequa Kelley-Boyd, visually observed Resident A and interviewed Residents B and C. Ms. Toomey reported that on 04/04/23, she observed Resident A strapped to the kitchen chair with a gait belt. Ms. Toomey reported that home manager, Literia McGrew, said that she straps Resident A in the chair so she can “monitor” her. Ms. Toomey reported that she knew that what Ms. McGrew was doing was not right and she struggled with what to do, because Ms. McGrew was the manager and had been working for the company for years. Ms. Toomey reported that she eventually notified licensee designee, Stephanie Kennedy-Kinney of what was going on in the home and Ms. McGrew was terminated after an internal investigation was conducted. Ms. Toomey reported she has worked in the home for about five weeks.

I interviewed staff Ranequa Kelly-Boyd and she reported that she has worked in the home since February 2023 and has observed home manager, Literia McGrew restrain Resident A to the kitchen chair on numerous occasions. Ms. Boyd reported that she knew it was wrong and that she should have reported it, however, because Ms. McGrew was the home manger, she was afraid that she would lose her job for reporting. Ms. Boyd reported that Resident A is very “busy” and walks all over the house and loves going in and out of the bathroom turning the water on. Ms. Boyd reported her belief that Ms. McGrew restrained Resident A because it was just easier for her to do, instead of simply re-directing her or following her to make sure she was not doing anything to cause herself harm.

Ms. Boyd reported that she re-directs Resident A and she will either go to her bedroom or she will go sit on the couch and watch television. Ms. Boyd reported that when she is on duty, she keeps a close eye on Resident A and just lets her walk and pace as long as she is not doing anything that compromises her safety. Ms. Boyd further reported that the sad part of this is that Resident A had gotten so use to being restrained to the kitchen chair, that once she sits down in the kitchen chair, she automatically raises her arms waiting for the gait belt to be strapped around her.

I visually observed Resident A up walking around the house and up and down the hallway. Resident A could not be interviewed as she is non-verbal.

I interviewed Resident B and she reported that some of the staff tie Resident A to the chair. Resident B reported that staff Jacqueline White and Babatunde Shonibare

tie Resident A to the chair at night sometimes. Resident B reported that she did not want to talk anymore, and I concluded the interview.

I interviewed Resident C and she reported observing staff tie Resident A to the kitchen chair with a strap. Resident B refused to share the name(s) of the staff.

On 04/24/23, I interviewed staff, Babatunde Shonibare, and he denied that he has ever tied or strapped Resident A to the kitchen chair. Mr. Shoibare was very upset at the allegations and reported that he would never use any type of restraint to prevent a resident from moving freely. Mr. Shoibare reported that he works Thursday and Friday midnight shift from 11:00 p.m. to 7:00 a.m. and reported that the residents are in bed when he arrives. Mr. Shoibare reported that this allegation has overwhelmed him, and he may resign due to all of the changes and issues going on in the home.

On 04/24/23, I interviewed staff, Jacqueline White. Ms. White denied the allegations. Ms. White reported that she works the midnight shift from 11:00 p.m. to 7:00 a.m. on Tuesday, Wednesday and Saturday. Ms. White reported that some nights Resident A will get out of bed and go in the bathroom and turn the water on, or she will walk the hallway and living room area. Ms. White reported that Resident A is easily redirected, and most times will go back to bed or go to the living room and watch television on the couch. Ms. White reported that the only person she has ever observed restraining Resident A was, home manager, Literia McGrew. Ms. White reported that seeing Resident A strapped to the kitchen chair bothered her. Ms. White reported that she asked Ms. McGrew why she was strapping Resident A to the kitchen chair, and reported Ms. McGrew responded by telling her she does it to better monitor and keep an eye on Resident A Ms. White reported she did not question her any further as she was the home manager and there was nothing she felt she could do.

On 04/28/23, I conducted the exit conference with licensee designee, Stephanie Kennedy-Kinney. Ms. Kinney reported that she is aware of the allegations, and after an internal investigation, confirmed that Ms. McGrew was strapping Resident A to the kitchen chair as a means to restrict her movement. Ms. Kinney reported that Ms. McGrew admitted that she routinely used a restraint belt on Resident A. Ms. Kinney reported that Ms. McGrew was terminated, and the home currently is in a great transition period. Ms. Kinney reported that she is glad that Ms. Toomey reported this, as it shed light on some other things that were going on that should not have been. Ms. Kinney reported all staff were re-trained and in-serviced on reporting requirements as the staff who were aware that this was happening, failed to report this to ORR, APS and to the company.

I informed Ms. Kinney of the findings of the investigation and the specific rule cited. Ms. Kinney reported an understanding.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Toomey, Ms. Boyd, Ms. White, Resident C, and Ms. Kinney I am able to corroborate the allegations. Ms. Toomey and Ms. Boyd both reported observing home manager, Literia McGrew, use a gait belt to restrain Resident A to the kitchen chair. They both reported that Ms. McGrew reported to them that she did that to better monitor Resident A. Ms. White reported she had observed Ms. McGrew restrain Resident A to the kitchen chair with a gait belt. Ms. White reported that she asked Ms. McGrew why she was using the gait belt as a restraint and Ms. McGrew reported to monitor and keep a close eye on Resident A. Resident C reported that she observed staff strap Resident A to the kitchen chair but refused to name the staff. Ms. Kinney reported that an internal investigation was conducted and during the investigation, Ms. McGrew admitted that she routinely used a restraint belt on Resident A. This violation is established, as Ms. McGrew restrained Resident A’s movement by strapping her to a kitchen chair for the purpose of immobilizing her.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/01/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:

05/09/23

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Ardra Hunter
Area Manager

Date