GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

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

RE: License #: AS820013672
Investigation #: 2023A0116032
Hall Road Home

Dear Ms. Kennedy-Kinney:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

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 #:	2023A0116032
Complaint Receipt Date:	04/20/2023
Investigation Initiation Date:	04/20/2023
Report Due Date:	06/19/2023
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?
Complainant reported that the home only had one staff on shift on 4/17/2023, when she arrived. Complainant reported that Resident A is a two person assist. Complainant reported when she arrived at the home the one staff present on duty, was sitting in her car in the driveway. Staff Breanna Toomey was observed pushing and shoving Resident A down when she attempted to get out of her recliner.	No
Residents had a bad smell.	No

III. METHODOLOGY

04/20/2023	Special Investigation Intake 2023A0116032
04/20/2023	Special Investigation Initiated - Telephone Spoke with Recipient Rights Investigator, Tonia McMurray.
04/20/2023	Contact - Telephone call made Left a message for Relative A requesting a return call.
04/21/2023	Inspection Completed On-site Interviewed Service Coordinator, Deborah Hill, visually observed Resident A and B and reviewed visitor log and staff schedule for April 2023.
04/24/2023	Contact - Document Sent Email sent to Charmaine Parks, Adult Protective Services (APS) requesting a return call.
04/24/2023	Contact - Telephone call made Interviewed staff, Breanna Toomey.
04/24/2023	Contact - Telephone call made Interviewed staff, Mariana Salas.
04/24/2023	Contact - Telephone call made Left a message for Guardian A requesting a return call.
05/03/2023	Contact - Telephone call made

	Interviewed Jeri Sterrett, assigned rights investigator.
05/08/2023	Exit Conference With licensee designee, Stephanie Kennedy-Kinney.

ALLEGATION:

Complainant reported that the home only had one staff on shift on 4/17/2023, when she arrived. Complainant reported that Resident A is a two person assist. Complainant reported when she arrived at the home the one staff present on duty, was sitting in her car in the driveway. Staff Breanna Toomey was observed pushing and shoving Resident A down when she attempted to get out of her recliner.

INVESTIGATION:

On 04/20/23, I spoke with rights investigator, Tonia McMurry. Ms. McMurray reported that she referred the allegations to APS, and she provided contact information for Relative A.

On 04/21/23, I conducted an unscheduled onsite inspection and interviewed service coordinator, Deborah Hill, and visually observed Resident A. Resident A could not be interviewed as she is nonverbal. Resident A was observed sitting in her recliner in the family room watching television. Resident A was neatly dressed and groomed.

I interviewed Ms. Hill, and she reported that the allegations are retaliatory as the staff person named in the complaint, Breanna Toomey, disclosed to the management team that the home manager was doing some inappropriate things to a resident in the home and after an internal investigation, the home manager was terminated. I informed Ms. Hill that I was aware of the allegations and that the allegations were being investigated under SIR#2023A0116030.

Ms. Hill reported that she along with staff, Breanna Toomey and Mariana Salas were all working on 04/17/23 and reported that no one visited the home the entire day. Ms. Hill confirmed that by reviewing the visitor sign in log and reported during the time she was in the home from about 9:30 a.m. to around 3:00 p.m. there were no visitors. Ms. Hill also reported she spoke to Guardian A and shared the name of the alleged relative who reported observing staff, Breanna Toomey working alone in the home, sitting in the driveway when she arrived at the home, and pushing and shoving Resident A. Ms. Hill reported that Guardian A stated that they do not have any relatives or close family friends by that name. Ms. Hill reported that she has also spoken with the rights investigator who informed her that she would not be substantiating the case after confirming that the allegations were frivolous.

Ms. Hill reported that she has never observed or been made aware of Ms. Toomey mistreating Resident A or any of the other residents the short time she has been employed in the home.

I reviewed the staff schedule and observed that Breanna Toomey and Mariana Salas were the day shift staff on 04/17/23 and observed that there are two staff scheduled on each shift. I also reviewed the visitor sign in log and observed that no visitors had signed in on the log on 04/17/23.

On 04/24/23, I interviewed staff, Breanna Toomey, and she reported that the allegations are false. Ms. Toomey reported that the allegations are retaliatory due to the home managers recent termination. Ms. Toomey reported she worked from 7:00 a.m. to 3:00 p.m. on 04/17/23, along with Mariana Salas. Ms. Toomey reported that Ms. Hill was also working in the home on 04/17/23. Ms. Toomey reported that there were no visitors to the home during her shift and she denied that she pushed or shoved Resident A in her chair. Ms. Toomey also denied that she was sitting in her

car, leaving the residents alone in the home as alleged. Ms. Toomey added that anyone who knows Resident A would know that she does not attempt to get out of her recliner as she does not have the body strength to do so. Ms. Toomey reported Resident A would need the assistance of staff to get out of her recliner into her wheelchair.

On 04/24/23, I interviewed staff, Mariana Salas, and she reported that she worked the day shift (7:00 a.m.-3:00 p.m.) with Breanna Toomey on 04/17/23. Ms. Salas reported that service coordinator, Deborah Hill, was also in the home that day. Ms. Salas reported that there were no visitors to the home that day. Ms. Salas reported that there are two staff on each shift, denied that she has ever observed Ms. Toomey push, shove or mistreat Resident A, and denied that she has ever observed Ms. Toomey sitting in her car leaving Residents alone.

On 05/03/23, I interviewed rights investigator, Jeri Sterrett. Ms. Sterrett reported that she was the assigned investigator and reported that her case is closed. Ms. Sterrett reported that during the course of her investigation she was able to determine that the complaint allegations were frivolous and retaliatory in nature. Ms. Sterrett reported she spoke with Guardian A who confirmed that the family does not have any relatives or close family friends with the name of the person who alleged to have observed this during a visit to the home. Ms. Sterrett reported that Guardian A reported that it was bizarre that someone would make up these types of lies and then leave a name and phone number. Ms. Sterrett reported that she spoke with the alleged relative and reported she was African American. Ms. Sterrett reported that she contacted Guardian A who is Caucasian, and asked him if he had any family members or friends that were African American who would be visiting Resident A. Guardian A responded that he did not. Ms. Sterrett also reported that she confirmed that the home did not have any visitors on 04/17/23 and confirmed that there are two staff on each shift. Ms. Sterrett reported all allegations are unsubstantiated.

On 05/08/23, I conducted the exit conference with licensee designee, Stephanie Kennedy-Kinney and informed her of the findings of the investigation. Ms. Kinney agreed with the findings. Ms. Kinney reported that the allegations were retaliatory and reported that she has found Ms. Toomey to be an exceptional staff who has integrity.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Hill, Ms. Toomey, Ms. Salas and Ms. Sterrett, I am unable to corroborate the allegations. Ms. Hill, Ms. Toomey, and Ms. Salas all worked on 04/17/23, and all of them denied that there were any visitors to the home that day. Ms. Hill reported that she along with Ms. Toomey and Ms. Salas were all working in the home until around 3:00 p.m. Ms. Toomey denied that she has ever pushed or shoved Resident A and denied ever sitting in her vehicle leaving residents alone. Ms. Hill, Ms. Salas and Ms. Toomey reported that there are two staff per shift and denied that the residents were left unattended on 04/17/23 as alleged. Ms. Sterrett reported that her investigation is closed after she determined that the allegations were frivolous. Ms. Sterrett reported that the alleged relative does not appear to exist and could not have observed any of the things being alleged as there were no visitors in the home the day this all was alleged to have been witnessed by her. This violation is not established as the home has sufficient staff on duty for the supervision, personal care and protection of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Hill, Ms. Toomey, Ms. Salas and Ms. Sterrett I am unable to corroborate the allegations. Ms. Hill reported that the allegations are not true and were not observed by anyone as there were no visitors in the home on 04/17/23 while she Ms. Toomey and Ms. Salas were working. Ms. Toomey denied the allegation and reported that she has never pushed or shoved Resident A. Ms. Toomey added that Resident A does not have the body strength to attempt to get out of the recliner on her own and requires staff assistance. Ms. Toomey added if the alleged relative really knew Resident A they would have known that. Ms. Salas reported that this did not happen and denied that she has ever observed Ms. Toomey mistreat any of the residents. Ms. Sterrett reported this allegation was also unsubstantiated. This violation is not established as there is insufficient evidence that Ms. Toomey used any force with Resident A as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents had a bad smell.

INVESTIGATION:

On 04/21/23, I conducted an unscheduled onsite inspection and interviewed service coordinator, Deborah Hill, and visually observed Resident's A and B.

Both residents were neatly dressed and groomed and did not have an odor. Resident's C and D were not home at the time of the onsite.

Ms. Hill denied that the residents smell bad and reported that the allegation is false. Ms. Hill reported that the residents are showered every other day and more often if needed or requested.

On 04/24/23, I interviewed staff, Breanna Toomey, and she reported that the residents do not have a bad smell and reported that each of the ladies are showered

every other day. Ms. Toomey reported that on the days that they are not showered they are thoroughly washed up in the mornings.

On 04/24/23, I interviewed staff, Marianna Salas, and she reported that the residents do not smell and reported they are showered every other day. She added that in between showers, staff wash them up in the mornings.

On 05/03/23, I interviewed rights investigator, Jeri Sterrett, and she reported that this allegation was also unsubstantiated. Ms. Sterrett reported the person who alleged the resident's smell does not exist. Ms. Sterrett reported the rights investigations are closed.

On 05/08/23, I conducted the exit conference with licensee designee, Stephanie Kennedy-Kinney, and informed her of the findings of the investigation. Ms. Kinney agreed with the findings.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Hill, Ms. Toomey, Ms. Salas, Ms. Sterrett and consultant observation, I am unable to corroborate the allegations. Ms. Hill, Ms. Toomey and Ms. Salas all reported that the residents are showered every other day. They reported that staff also wash them up on no-shower days. They all denied that the residents small bad. Ms. Sterrett reported that there was no evidence to support this allegation and that the rights case is unsubstantiated. On 04/18/23 and 04/21/23 I made unscheduled onsite inspections and both times the residents appeared clean, were nicely groomed and did not smell. The 04/18/23 onsite was completed for SIR#2023A0116030. This violation is not established as the licensee has afforded the residents the opportunity for daily bathing and oral and personal hygiene.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

05/11/23
Date

Approved By:

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Ardra Hunter
Area Manager

Date: 05/11/2023