STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 11, 2024

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

RE: License #: AS820013647
Investigation #: 2024A0116011
Harrison House

Dear Ms. Kennedy-Kinney:

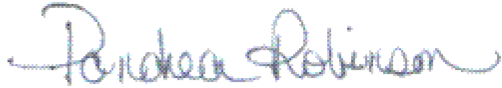
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS820013647
Investigation #:	2024A0116011
Complaint Receipt Date:	12/18/2023
Investigation Initiation Date:	12/19/2023
Report Due Date:	02/16/2024
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:	Harrison House
Facility Address:	717 Harrison Inkster, MI 48141
Facility Telephone #:	(313) 563-5396
Original Issuance Date:	12/19/1980
License Status:	REGULAR
Effective Date:	03/19/2022
Expiration Date:	03/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her 20 mg tablet of Olanzapine 12/09/23.	Yes

III. METHODOLOGY

12/18/2023	Special Investigation Intake 2024A0116011
12/18/2023	APS Referral Received.
12/18/2023	Referral - Recipient Rights Received (ORR was the initial referral source).
12/19/2023	Special Investigation Initiated - On Site Interviewed Staff, Lucy Johnson, home manager, Nellie Dixon and Resident A. I reviewed Resident A's December medication administration record (MAR).
12/19/2023	Inspection Completed-BCAL Sub. Compliance
01/08/2024	Exit Conference With licensee designee, Stephanie Kennedy-Kinney.

ALLEGATION:

Resident A did not receive her 20 mg tablet of Olanzapine 12/09/23.

INVESTIGATION:

On 12/19/23, I conducted an unscheduled onsite inspection and interviewed staff, Lucy Johnson, home manager, Nellie Dixon and Resident A. Ms. Johnson reported that she is the staff that made the medication error. Ms. Johnson reported that she is new to the home and had been working for about three weeks. Ms. Johnson reported that on 12/09/23, it was her first time working the afternoon shift alone and there was a lot going on. She reported that she began passing medication and believed that she had passed each resident all of their prescribed medication. Ms. Johnson reported that the following day the error was caught by the a.m. staff,

Deloris Reeves, who in turn reported it to Ms. Dixon. Ms. Johnson reported that she failed to pass Resident A's 20mg tablet of Olanzapine. Ms. Johnson reported that she was written up, in-serviced on the five rights of medication and was given a one-day suspension. Ms. Johnson reported that since the medication error she has been taking her time and double and triple checking to ensure everyone is receiving all of their prescribed medications.

I interviewed home manager, Nellie Dixon, and she confirmed the information provided by Ms. Johnson. Ms. Dixon added that she took immediate action once she was made aware of the incident. Ms. Dixon reported that there have not been any medication errors by Ms. Johnson since the initial occurrence.

I interviewed Resident A and she reported she loves living in the home and reported that the staff take really good care of her and the other ladies. Resident A reported that she takes medication every day, and the staff administer it. Resident A was observed to be neatly dressed and groomed.

I reviewed Resident A's December 2023 MAR and did not observe any concerns
.
Ms. Dixon provided a copy of Ms. Johnson's written discipline, notice of one day suspension and five rights of medication in-service training.

On 01/08/24, I conducted the exit conference with licensee designee, Stephanie Kennedy-Kinney and informed her of the findings of the investigation. Ms. Kennedy-Kinney reported an understanding of the rule violation and reported she would submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	This violation is established as staff, Lucy Johnson, failed to administer Resident A’s 20mg Olanzapine tablet on 12/09/23 as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

01/10/24

Pandrea Robinson
Licensing Consultant
Date

Approved By:

01/11/24

Ardra Hunter
Area Manager
Date