GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2024

Victoria Kennedy
Saints Incorporated
2945 S. Wayne Road
Wayne, MI 48184

RE: License #: AS820013647
Investigation #: 2024A0121034
Harrison House

Dear Mrs. Kennedy:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On June 25, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820013647
Investigation #:	2024A0121034
Complaint Receipt Date:	05/24/2024
Investigation Initiation Date:	05/28/2024
Report Due Date:	07/23/2024
Licensee Name:	Saints Incorporated
Licensee Address:	2945 S. Wayne Road Wayne, MI 48184
Licensee Telephone #:	(734) 722-2221
Administrator:	Paul Kennedy, Stephanie Kinney
Licensee Designee:	Victoria Kennedy, Stephanie 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:	03/19/2024
Expiration Date:	03/18/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 5/19/24, direct care staff Deloris Reeves did not administer Resident A's atorvastatin medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/24/2024	Special Investigation Intake 2024A0121034
05/24/2024	APS Referral Received
05/24/2024	Referral - Recipient Rights
05/28/2024	Special Investigation Initiated - Telephone Home Manager, Nellie Dixon
05/30/2024	Contact - Telephone call made. Follow up call to the facility; spoke with direct care staff Beatrice (last name unknown).
06/11/2024	Inspection Completed-BCAL Sub. Compliance Interviewed Home Manager, Nellie Dixon and Resident A-B
06/13/2024	Exit Conference Licensee designee, Stephanie Kennedy-Kinney
06/25/2024	Corrective Action Plan Received/Approved
07/24/2024	Contact - Telephone call made. Phone interview with direct care staff, Deloris Reeves.
07/24/2024	Contact - Telephone call made. Dwight Snodgrass with Recipient Rights.

ALLEGATION: On 5/19/24, direct care staff Deloris Reeves did not administer Resident A's atorvastatin medication as prescribed.

INVESTIGATION: I initiated the complaint with a phone call to home manager, Nellie Dixon. Ms. Dixon reported direct care staff, Sanequa Dallas called her on the morning of 5/20/24 to report that Resident A's 7:00 P.M. dose of atorvastatin 40mg was still in the pharmacy supplied container. Ms. Dixon stated she reviewed the staff schedule and determined direct care staff, Deloris Reeves was responsible for the medication error. According to Ms. Dixon, Ms. Reeves admitted to making the mistake when questioned about why Resident A's atorvastatin pill was not given.

On 6/11/24, I conducted an unannounced on-site inspection at the facility. I reviewed Resident A's medication records. I observed Resident A's atorvastatin tab 40mg was signed out by Ms. Reeves on 5/19/24 at 7:00 P.M. as if it had been administered. However, Ms. Dixon confirmed the tablet was not given as prescribed because it was still available the following day. I observed Resident A sitting quietly on the day of inspection. Resident A is non-verbal, so I interviewed Resident B who reported Staff administer resident medication daily. Resident B indicated she has no problems or concerns regarding medication. I attempted to interview Resident C, but she declined to participate in an interview.

On 6/13/24, I completed an exit conference with licensee designee, Stephanie Kinney. Mrs. Kinney reported Resident A and Ms. Reeves are new to the facility. Mrs. Kinney acknowledged Ms. Reeves caused a medication error involving Resident A. Mrs. Kinney did not dispute the findings and recommendation of the investigation.

On 7/24/24, I interviewed Ms. Reeves by phone. Ms. Reeves stated she's been working at the facility for 1 year. Ms. Reeves stated she is fully trained. However, Ms. Reeves acknowledged she made a medication error by not giving Resident A her 7:00 P.M. dose of atorvastatin. Ms. Reeves plainly stated, "I just missed it … I thought I gave it to her." Ms. Reeves reported she has since completed a medication refresher course, and pursuant to this investigation, Ms. Dixon monitored her handling of medication for 5 days.

On 7/24/24, I interviewed Recipient Rights Investigator, Dwight Snodgrass. Mr. Snodgrass reported Recipient Rights substantiated the medication error did occur.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	On 7/19/24 at 7:00 P.M., Resident A did not receive her atorvastatin medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: I asked Ms. Dixon if Resident A received medical treatment or evaluation following the medication error that occurred on 7/19/24, and she replied, "No … we monitored {Resident A} and didn't notice any physical changes with her." However, Mrs. Kinney reported the protocol is for residents to be evaluated by a medical professional whenever a medication error occurs. In fact, Mrs. Kinney explained the protocol was recently reviewed with all staff. Mrs. Kinney could not offer an explanation why the protocol wasn't followed on 7/19/24.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Staff Deloris Reeves did not give Resident A her evening medication as prescribed on 7/19/24. The medication error was discovered by Ms. Dallas the following morning. However, staff did not follow proper protocol by not consulting with an appropriate health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

07/24/24

Kara Robinson — Date
Licensing Consultant

Approved By:

07/25/24

Ardra Hunter — Date
Area Manager