GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2025

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820080515
Investigation #: 2025A0119004
Price Hannan

Dear Mr. Jordan:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820080515
Investigation #:	2025A0119004
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/13/2024
Report Due Date:	01/11/2025
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	22610 Rosewood Oak Park, MI 48237
Licensee Telephone #:	(248) 399-8115
Administrator:	Kenneth Jordan
Licensee Designee:	Kenneth Jordan
Name of Facility:	Price Hannan
Facility Address:	39445 Price Rd Romulus, MI 48174
Facility Telephone #:	(734) 942-1010
Original Issuance Date:	07/15/1998
License **Status:**	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 11/06/2024, Resident A was observed to have the appearance of rope burns on each of his arms.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A0119004
11/13/2024	APS Referral Received
11/13/2024	Special Investigation Initiated - On Site Home Manager- William Jones, Staff- Alesha Leali, Brandy Drayton, Fatou Touray, Demarko Hunter, Observed Residents A
11/13/2024	Contact - Telephone call made Licensee Designee/ Administrator- Kenneth Jordan
11/13/2024	Contact- Document Received All staff being in-serviced and re-trained on proper care of residents
11/14/2024	Contact- Telephone call made Resident A's guardian and Resident A's supports coordinate Diamond Snipes, left message
11/14/2024	Referral - Recipient Rights Made
11/18/2024	Contact - Telephone call made Area Manager- Stacy Washington
11/19/2024	Contact- Document Received Resident A's medication logs for October and November
11/20/2024	Contact - Telephone call made Previous Home Manager- Danyelle Parkhurst, Staff- Chfone McGillberry

01/07/2024	Contact- Telephone call made Resident A's guardian left message and Resident A's supports coordinator- Diamond Snipes
01/07/2024	Contact- Telephone call made Staff- Kevin Person (left message), Staff- Marcellous Lawler
01/08/2024	Contact- Document Received Several staff medication training documents
01/09/2024	Exit Conference Licensee Designee- Kenneth Jordan

ALLEGATION:

On 11/06/2024, Resident A was observed to have the appearance of rope burns on each of his arms.

INVESTIGATION:

On 11/13/2024, I completed an unannounced onsite inspection and interviewed Home Manager- William Jones, Staff- Alesha Leali, Staff- Brandy Drayton, Staff- Fatou Touray, and Staff- Demarko Hunter regarding the above allegations. I observed Resident A and he could not be interviewed due to being nonverbal. Mr. Jones stated he is the new manager and has only been working in the home for two days. Mr. Jones stated previous home manager- Danyelle Parkhurst has been suspended due to this incident. He provided Resident A's urgent care medical documentation, incident reports, photographs of both Resident A's arms, the staff schedule and Resident A's individual plan of service during the onsite inspection. Mr. Jones provided Resident A's incident report, dated 11/08/2024 with the time of 9:00 p.m. completed by Staff- Faton Touray and Staff- Stella Swift.

I received Resident A's medical documentation dated 11/08/2024 from Harmony Cares Medical Group. The medical documentation indicates Resident A was treated for abrasions of bilateral biceps consistent with possible restraint with open skin and some blistering noted.

I reviewed incident reports dated 11/08/2024 with time of 9:00 p.m. completed by Staff Faton Touray and Staff- Stella Swift which indicated they were providing evening hygiene care to Resident A. The incident report indicated that Ms. Touray and Ms. Swift observed dark colored marks wrapped about one inch in diameter around Resident A's left arm with blister and bruises and his right arm has a dark reddish color mark wrapped around with blister and bruising.

A review of photographs submitted were of a male persons right and left arms with broken and torn skin to the front of the arms. The photographs show both arms to have some healing and scabbed areas. The photographs show the bruising to be in a complete line wrapping around his arms.

A review of Resident A's individual plan of service, dated 03/17/2024 from Community Living Services indicates Resident A requires the use of a wheelchair, needs assistance with getting onto the commode, transferring to and from his bed and with all ADLs and hygiene. The plan further indicates Resident A requires staff monitoring overnight from 10:00 p.m. until 6:00 a.m. with 30 minutes checks and Resident A should be monitored during meals, and showering times by staff.

A review of the staff schedule shows the following:

Staff	Monday 11/04/2024	Tuesday 11/05/2024	Wednesday 11/06/204
Chfone McGillberry	12:00am- 8:00am	12:00am-8:00am	12:00am- 8:00am
Brandy Drayton			12:00am- 8:00am
Marcellous Lawler	12:00am- 8:00am 4:00pm- 12:00am		
Kevin Person	4:00pm- 12:00am	4:00pm- 12:00am	
Kierra Powell		12:00am- 8:00am	
Damika Ballard	2:30pm- 9:30pm	2:30pm- 9:30pm	
Rita Checks		11:00am- 7:00pm	
Stella Swift			4:00pm- 12:00am
Fatou Touray	11:00am- 7:00pm		

Ms. Leali stated there are three to four staff working on most shifts. Ms. Leali stated she is a new staff to the home. Ms. Leali stated she has no direct knowledge of how Resident A sustained his injuries.

Ms. Drayton stated she started working in the home in September. She stated she was informed by Staff- Kevin Person, previous working staff that Resident A continued to have behaviors during the previous shift on 11/05/2024. She stated Resident A remained in his chair all night due to his behaviors which including yelling and screaming. She stated the manager- Ms. Parkhurst was contacted for assistance in how to handle Resident A's behaviors during her shift. Ms. Drayton stated Mr. McGillberry provided Resident A's hygiene care and got him ready for bed. Ms. Drayton stated she has no direct knowledge of how Resident A sustained his injuries. She stated Mr. McGillberry got Resident A ready for the next day and was finally able to calm him down as well as put Resident A in his bed.

Ms. Touray stated she and Staff- Stella were completing Resident A's evening hygiene care and observed the dark colored bruising to both of his arms. She stated she observed lines with bruises, burns, and blisters around both of his arms. She

stated she has no direct knowledge of how Resident A sustained these injuries to both of his arms.

Mr. Hunter stated he has no direct knowledge of how Resident A sustained injuries to both of his arms. Mr. Hunter stated he works the morning shift and does not provide Resident A with hygiene care.

On 11/13/2024, I telephoned and interviewed Licensee Designee/ Administrator- Kenneth Jordan regarding the above allegations. Mr. Jordan stated he has no direct knowledge of how Resident A sustained injuries to both his arms. Mr. Jordan stated all staff have been in-service about the proper care of residents.

On 11/18/2024, I telephoned and interviewed Area Manager - Stacy Washington regarding the above allegations. Ms. Washington stated no staff noted any seepage through his clothing or that he was in any type of pain because of his injuries. Ms. Washington stated she has no direct knowledge of how Resident A sustained injuries to both his arms. Ms. Washington stated she filed a police report on 11/06/2024 with the Van Buren Township Department of Public Safety and the case number is 24-13033.

On 11/20/2024, I telephoned and interviewed Previous Home Manager- Danyelle Parkhurst and Staff- Chfone McGillberry regarding the above allegations. Ms. Parkhurst stated she has no direct knowledge of how Resident A's sustained injuries to both of his arms. Ms. Parkhurst stated prior to 11/06/2024, Resident A wore short sleeved shirts. She stated Resident A always worn short sleeves shirts and shorts daily. Ms. Parkhurst stated on 11/06/2024, upon her arrival for work, Resident A was wearing a long-sleeved shirt.

Mr. McGillberry stated he has no direct knowledge of how Resident A sustained his injuries. He stated he worked the midnight shift on 11/06/2024. Mr. McGillberry stated he was informed by Staff- Kevin Person that Resident A was having behaviors the entire shift. Mr. McGillberry stated Mr. Person told him that Resident A was provided with food, music, and a movie but Resident A's behaviors continued throughout the shift. Mr. McGillberry stated he changed Resident A's clothing at 7:00 a.m. and was able to calm him down. Mr. McGillberry stated he was told by Ms. Parkhurst to give Resident A snacks. He stated he was unsure of what else to do to calm Resident A.

On 01/07/2024, I telephoned and interviewed Support's Coordinator Supervisor- Diamond Snipes and Staff- Marcellus Lawler regarding the above allegations. Ms. Snipes stated she has no concerns prior to this incident regarding the care of Resident A. Ms. Snipes stated she has noticed a great deal of staff changes since July 2024. Ms. Snipes stated there has been three home managers and inconsistent staff changes which is troubling for her.

Mr. Lawler stated he has no direct knowledge of how Resident's A sustained his injuries to both of his arms. Mr. Lawler stated he worked the prior Monday and Sunday and did not observe any marks, bruise, or injuries to Resident A's arms or anywhere on his body.

On 01/09/2024, I completed an exit conference with Licensee Kenneth Jordan regarding the above allegations. Mr. Jordan stated he is trying to get better staff but the staffing pool is not good. He stated he has in-serviced staff and they are not doing their job as instructed. He stated he self-report this incident and does not want a provisional license. He feels that he has maintained his business for 30 years without a provisional license.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Licensee Designee/ Administrator- Kenneth Jordan, Area Manager - Stacy Washington, Home Manager- William Jones, Staff- Alesha Leali, Staff- Brandy Drayton, Staff- Fatou Touray, Staff- Demarko Hunter, Previous Home Manager- Danyelle Parkhurst, Staff- Chfone McGillberry, and Staff- Marcellus Lawler stated they have no direct knowledge of how Resident A sustained injuries to both his arms. Resident A's individual plan of service, dated 03/17/2024 from Community Living Services indicates Resident A requires the use of a wheelchair, needs assistance with getting onto the commode, transferring to and from his bed and with all ADLs and hygiene. The plan further indicates Resident A requires staff monitoring overnight from 10:00 p.m. until 6:00 a.m. with 30 minutes checks. Therefore, Resident A suffered and sustained injuries to both his arms and no one knows how these injuries occurred despite needing assistance from staff for all ADLs and hygiene care and was not provided with supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION 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: (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:	Resident A's medical documentation dated 11/08/2024 from Harmony Cares Medical Group indicates Resident A was treated for abrasions of bilateral biceps consistent with possible restraint with open skin and some blistering noted. Incident report dated 11/08/2024 with the time of 9:00 p.m. completed by Staff- Faton Touray and Stella Swift which indicated they were providing evening hygiene care to Resident A and observed dark colored marks wrapped about one inch in diameter around Resident A's left arm with blister and bruises and his right arm has a dark reddish color mark wrapped around with blister and bruising. A review of photographs submitted were of a male person right and left arms with broken and torn skin to the front arms. The photographs show both arms to have some healing and scabbed areas. The photographs show the bruising to be in a complete line wrapping around his arms. Therefore, there is a preponderance of the evidence that Resident A was restrained from movement by binding or tying for the purpose of immobilizing a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITONAL FINDINGS:

INVESTIGATION:

On 11/13/2024, I completed an unannounced onsite inspection and interviewed Staff- Brandy Drayton, Staff- Fatou Touray, and Staff- Demarco Hunter regarding the above allegations. Ms. Drayton stated previously Resident A was exhibiting behaviors on the previous shift and remained in his chair with continued yelling and

screaming all night long. She stated Resident A does not take any type of medication to assist with calming him when he is experiencing increased anxiety.

Ms. Touray stated she has no direct knowledge of that Resident A has medication to assist him when he is experiencing increased anxiety. Ms. Touray stated there is nothing that can be done when Resident A is yelling and screaming other than re-direct him.

Mr. Hunter stated he provides Resident A with redirection and administers his medications during the morning shift. He stated Resident A is calm throughout his shift. Mr. Hunter stated Resident A does not scream and yell at all while he is working.

On 11/18/2024, I telephoned and interviewed Area Manager - Stacy Washington regarding the above allegations. Ms. Washington stated Resident A does have medications to assist him when he is experiencing an escalating behavior. Ms. Washington provided Resident A's medication administration record sheet for November 2024. The medication administration record shows that Resident A was prescribed Hydroxycine HCL 25mg to be administered one tablet 2 times a day as needed for increased anxiety. The medication administration record shows that Resident A was given this medication only at the 8:00 a.m. dosage on 11/03/2024, 11/04/2024, 11/05/2024, and 11/06/2024 by staff Demarco Hunter, however, it was not administered again in the evening or midnight.

On 11/20/2024, I telephoned and interviewed Previous Home Manager- Danyelle Parkhurst and Staff- Chfone McGillberry regarding the above allegations. Ms. Parkhurst stated she was not aware that Resident A has medications to calm him when he is experiencing increased anxiety. Ms. Parkhurst stated usually a snack will calm Resident A.

Mr. McGillberry stated Resident A does not have any medications to address his rocking and yelling behaviors. Mr. McGillberry stated previously, Resident A was exhibiting behaviors the previous shift and throughout the night. He stated he was unsure of what else to do to calm Resident A.

On 01/07/2024, I telephoned and interviewed Staff- Marcellus Lawler regarding the above allegations. Mr. Lawler stated Resident A is not known to have behaviors and can easily be redirected with giving him a snack, watch a movie with him. Mr. Lawler stated Resident A like to have attention and that usually calms him down.

On 01/09/2024, I received Staff- Brandy Drayton, Chfone McGillberry, Damika Ballard, Kevin Person, and Kierra Powell's medication training documentation from Area Manager- Stacy Washington which verifies they have been medication trained. As indicated in the staff schedule chart above, these staff were scheduled to work in the afternoon and midnight shifts on 11/04/2024, 11/05/2024, and 11/06/2024.

On 01/09/2024, I completed an exit conference with Licensee Kenneth Jordan regarding the above allegations. Mr. Jordan stated he is trying to get better staff but the staffing pool is not good. He stated he has in-serviced staff and they are not doing their job as instructed. He stated he self-reported this incident and does not want a provisional license. He feels that he has maintained his business for 30 years without a provisional license.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Previous Home Manager- Danyelle Parkhurst, Staff- Brandy Drayton, Staff- Fatou Touray, and Staff- Chfone McGillberry stated they were not aware that Resident A had medication to be used when he was experiencing increased anxiety. Resident A has been prescribed Hydroxycine HCL 25mg to be administered one tablet 2 times a day as needed for increased anxiety. Despite having trained working staff in medication administration, on 11/04/2024, 11/05/2024, and 11/06/2024, Resident A was not given the above listed medication due to his increased anxiety. Staff- Brandy Drayton, Chfone McGillberry, Damika Ballard, Kevin Person, and Kierra Powell are trained in medication administration. Therefore, Resident A was not given medication by staff based on the instruction label.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I am recommending a six-month provisional license with increase monitoring with monthly visitation by the department.

01/09/2025

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Shatonla Daniel Date
Licensing Consultant

Approved By:

01/09/2025

_____

Ardra Hunter Date
Area Manager