



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

July 19, 2024

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

RE: License #: AS820014638  
**Wabash Ais Home**  
**39400 Wabash**  
**Romulus, MI 48174**

Dear Ms. Kennedy:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license and special certification are renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, you may contact the local office at (313) 456-0380.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 919-1934

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

<b>Licensee #:</b>	AS820014638
<b>Licensee Name:</b>	Saints Incorporated
<b>Licensee Address:</b>	2945 S. Wayne Road Wayne, MI 48184
<b>Licensee Telephone #:</b>	(734) 722-2221
<b>Licensee/Licensee Designee:</b>	Victoria Kennedy
<b>Administrator:</b>	Stephanie Kennedy-Kinney
<b>Name of Facility:</b>	Wabash Ais Home
<b>Facility Address:</b>	39400 Wabash Romulus, MI 48174
<b>Facility Telephone #:</b>	(734) 941-8608
<b>Original Issuance Date:</b>	06/18/1991
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED
<b>Certified Programs:</b>	DEVELOPMENTALLY DISABLED

## II. METHODS OF INSPECTION

Date of On-site Inspection(s): 07/18/2024

Date of Bureau of Fire Services Inspection if applicable:

Date of Environmental/Health Inspection if applicable:

No. of staff interviewed and/or observed

1

No. of residents interviewed and/or observed

3

No. of others interviewed

2

Role: Home manager & Area manager

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐ If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☐ No ☒ If no, explain.  
N/A
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s:  
N/A ☒
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

## III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

The facility is in compliance with all applicable rules and statutes.

#### **IV. RECOMMENDATION**

I recommend issuance of a 2-year regular adult foster care license.



Edith Richardson  
Licensing Consultant

07/19/2024  
Date