GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 29, 2022

Queen Ogunedo
Grace Mercy Faith, LLC
2726 Clark Street
Jackson, MI 49202

RE: License #: AS380391105
Investigation #: 2022A0007020
Plymouth Street Home

Dear Mrs. Ogunedo:

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,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380391105
Investigation #:	2022A0007020
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	07/02/2022
Licensee Name:	Grace Mercy Faith, LLC
Licensee Address:	2726 Clark Street Jackson, MI 49202
Licensee Telephone #:	(517) 414-6615
Administrator:	Queen Ogunedo
Licensee Designee:	Queen Ogunedo
Name of Facility:	Plymouth Street Home
Facility Address:	1506 Plymouth Street Jackson, MI 49202
Facility Telephone #:	(517) 795-1296
Original Issuance Date:	07/11/2018
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Queen, Home Manager, yells at residents and is physically aggressive with residents.	No
Resident A and Resident B are fed expired food.	No
Additional Findings	Yes

III. METHODOLOGY

05/03/2022	Special Investigation Intake - 2022A0007020
05/03/2022	APS Referral - Received.
05/04/2022	Special Investigation Initiated – Telephone to APS Worker #1. Discussion.
05/26/2022	Inspection Completed On-site - Unannounced - on- site inspection. Face to face contact with Mr. Ogunedo, his child, Resident A, Resident B and Resident C.
06/27/2022	Contact - Face to Face contact with APS Worker #1. Documents Received.
06/27/2022	Inspection Completed On-site - Unannounced - Face to face contact with Mr. Ogunedo, Mrs. Ogunedo, Resident A and Resident C.
06/27/2022	Contact - Telephone call made to Guardian C. Message left.
06/27/2022	Contact - Telephone call received from Guardian C. Discussion.
06/28/2022	Exit Conference conducted with Mrs. Ogunedo, Licensee Designee.

ALLEGATIONS:

Queen, Home Manager, yells at residents and is physically aggressive with residents.

INVESTIGATION:

As a part of this investigation, I spoke with APS Worker #1. She informed me that she went to the home and interviewed Resident A and Resident B. Resident A reports to be bored in the home; however, the licensee's husband, Mr. Ogunedo reports that they go out in the community. Resident A did not confirm that he was pushed and hit by Queen Ogunedo, Licensee. APS Worker #1 also interviewed Resident B. It was alleged that Resident B had bruising from Mrs. Ogunedo. Resident B confirmed that she had bruising in the past. She pointed to the area above her knee, pointing to where the bruising had been. When asked how it happened, Resident B informed that she had fallen. This occurred last year. Resident B would not maintain eye contact with APS Worker #1. According to APS Worker #1, all the residents want to move but they all report to like it in the home.

On May 26, 2022, I conducted an unannounced on-site investigation. Upon arrival, I noticed that the home was equipped with a ramp. The home is not licensed as wheelchair accessible. There was rainwater pooling on the landing of the ramp. I spoke with the husband to the licensee, Mr. Ogunedo, regarding this matter. He informed me that the ramp was installed by Responsible Agency A for one of the residents (Resident C). He also stated that none of the residents utilize a wheelchair, and the ramp is utilized for a rollator.

Mr. Ogunedo informed me that they have had many staffing challenges, and Queen Ogunedo, Licensee, had been doing most of the shift coverage. Mr. Ogunedo stated that the complaint might be related to a disgruntled employee (Employee #1). He stated that Mrs. Ogunedo had asked Employee #1 to go home one morning and calm down because she was "in overdrive." Employee #1 kept getting louder and louder, so she was asked to go home. Then Employee #1 never returned to work, and she recently filed for unemployment.

As a part of this investigation, I reviewed the file for Employee #1. It contained all the required training information, qualifications, and background check clearances.

During the on-site inspection, I observed Mr. Ogunedo interact with the residents. He was kind, attentive and caring. He treated the residents with respect. I inquired about the home activities, and Mr. Ogunedo reported things had changed since covid; however, they still go out in the community, and they have games, cards, puzzles, and television as entertainment in the home.

I then went and interviewed Resident A. It was also noted that Resident A's bedroom door had been colored on with markers and needed to be repaired or repainted. Resident A reported to be admitted into the home for a few years and things were good. He reported that Mrs. Ogunedo has not gotten upset and pushed him. Resident A reported that the staff treated him "good," and he did not have any concerns to report.

I attempted to interview Resident B. Prior to speaking with Resident B, I had reviewed her file and weight records. It was noted that Resident B was diagnosed with dementia. Resident B reported that things were pretty good. Resident B did not provide any information to confirm or refute the allegations regarding how she was treated by Mrs. Ogunedo. Resident B did not report that she had any concerns.

I observed Resident C talking to Mr. Ogunedo. Resident C appeared to be somewhat confused when talking to Mr. Ogunedo.

It was also noted that there was a baby-gate installed, blocking the second means of egress. Mr. Ogunedo was informed that the gate needed to be removed. I also observed the trim in the living room, which was no longer attached to the wall and required repair.

On June 27, 2022, I conducted another unannounced on-site inspection and made face to face contact with Mr. Ogunedo, Mrs. Ogunedo, Resident A and Resident C. I interviewed Mrs. Ogunedo in the kitchen area of the home. Mrs. Ogunedo explained that she would come into work and relieve Employee #1. When she arrived, Employee #1 was yelling and complaining about Resident A. Mrs. Ogunedo did not like that Employee #1 was yelling. She asked her to just step out and calm down. Mrs. Ogunedo adamantly denied yelling at the residents or being physically aggressive. She denied leaving marks on any of the residents. Mrs. Ogunedo recalled that Employee #1 would sometimes not utilize the gait-belt when assisting Resident C, as Employee #1 stated she (Employee #1) was strong. Mrs. Ogunedo explained to Employee #1 that this would cause her to be tired sooner. In addition, this would cause the resident to have bruising (if Employee #1 did not utilize the gait belt). Mrs. Ogunedo informed that she would know if Employee #1 did not follow the protocol, as there would be bruising underneath Resident C's arms.

I attempted to interview Resident C; however, she just stared straight forward. She did not answer any of my questions or talk to me. It should be noted that I previously observed Resident C navigating through the facility with the rollator, talking to the other residents, and enjoying a snack.

On June 27, 2022, I spoke with Guardian C. He appeared to be surprised by the allegations. He stated that Resident C has dementia, and nothing has been reported to him. He also mentioned that Responsible Agency A has on-going contact with Resident C. He stated that since his mother has been there, she has received "top notch" care and he had no concerns. Guardian C also stated that he would keep my phone number, should he have any concerns in the future.

During the course of this investigation, I spoke with APS Worker #1. I was also provided with a copy of the contacts from her investigation. Resident A was interviewed and denied anyone pushing, hitting, or yelling at him. It was noted that she contacted Resident A's guardian and Responsible Agency A.

Resident B denied that anyone hits, pokes, or physically hurts her. APS Worker #1 asked Resident B about having bruises on her legs in the fall of 2021 and Resident B pointed to her thighs on top. When APS Worker #1 asked how the bruising occurred, Resident B stated she fell. According to APS Worker #1, the area of the bruising reported did not appear to be consistent with a fall. APS Worker #1 asked several questions and inquired if Resident B was comfortable or if she was afraid of anyone. Resident B denied being physically abused or fearing anyone. APS Worker #1 also contacted the case manager for Resident B and informed her of the allegations. It was also noted that Resident B was timid and quiet during the interview. She was hesitant before answering some questions. After APS Worker #1 spoke with the case manager and guardian, it was found that this was Resident B's demeaner.

APS Worker #1 informed me that she did not substantiate the cases.

On June 28, 2022, I conducted the exit conference with Mrs. Ogunedo. She stated she was surprised by the allegations and concurred with the recommendations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Resident A reported that Mrs. Ogunedo has not gotten upset and pushed him. Resident A reported that the staff treated him "good," and he did not have any concerns to report. Resident B reported that things were pretty good. Resident B did not provide any information to confirm or refute the allegations regarding how she was treated by Mrs. Ogunedo. Resident B did not report that she had any concerns. Resident C did not provide any information to confirm or refute the allegations. Guardian C stated that since his mother has been there, she has received "top notch" care and he had no concerns. Mrs. Ogunedo adamantly denied yelling at the residents or being physically aggressive. She denied leaving marks on any of the residents. APS Worker #1 conducted an investigation and did not substantiate the cases. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Mrs. Ogunedo yells at residents and is physically aggressive with the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Resident A and Resident B are fed expired food.

INVESTIGATION:

On May 4, 2022, I spoke with APS Worker #1. She informed me that she would check and see if Resident A and Resident B received food stamp assistance. APS Worker #1 later informed me that day that they did not receive food stamps. APS Worker #1 interviewed Resident A and Resident B. Both residents reported to be hungry between meals. Mrs. Ogunedo reported that their residents receive snacks between meals.

During the on-site inspection, Mr. Ogunedo stated that they have plenty of options for food and they would not intentionally serve expired food. Staff are supposed to check the dates and get rid of any food that has expired. While walking through the

home, I also noticed that the kitchen counters were cluttered, and the general conditions were unkempt. Mr. Ogunedo stated they would address this matter. I also observed the food in the home and checked the expiration dates. The expiration date on the milk had passed (5/15/22) and Mr. Ogunedo discarded the milk; however, he later informed that the milk was frozen (prior to expiration) and was not spoiled. I provided technical assistance and encouraged him to document the date the milk was opened when it is frozen prior to the expiration date. The food observed in the home was not expired, with the exception of an unopened jar of peanut butter, which expired on May 5, 2022.

The resident medications are kept in a cabinet in the kitchen. When I entered the kitchen, the keys to the medication cabinet were observed to be in the cabinet lock. When brought to his attention, Mr. Ogunedo locked the cabinet and removed the keys.

While in the home, I noticed that the dining room table was cluttered with papers, a laptop and other school related items. Mr. Ogunedo stated that all those items are removed, and the residents utilize the table for mealtimes.

I reviewed Resident A's recent weight records and no significant changes were noted. During my interview with Resident A, he reported to get enough food to eat and had no concerns about the meals he was served.

Resident B reported that the food was "pretty good." She reported to get enough to eat.

While in the home, I also observed Mr. Ogunedo prepare and provide snacks to the residents. The servings were adequate. The residents appeared to be happy with the snacks provided.

On June 27, 2022, I observed an adequate amount of food in the home. I did not observe any spoiled food. It was noted that there were several boxes of food stacked in the home. Mrs. Ogunedo stated that she likes to cook and is trying to find a way to organize all the beans, rice, and other food items so they are accessible. I recommended additional shelving. While I was in the home, I noted there was a small box of expired mashed potatoes. Mrs. Ogunedo discarded them. I inquired about what was provided for lunch. Mrs. Ogunedo reported to serve sandwiches, grapes, and refreshing lemonade. I also observed these food items in the home.

During the course of this investigation, I spoke with APS Worker #1. I was also provided with a copy of the contacts from her investigation. It was noted that she contacted Resident A's guardian, who had observed mealtimes, and they were adequate. In addition, the caseworker for Responsible Agency A reported that the dietitian was very happy with Resident A's weight loss since being admitted into the home, and that he is maintaining a healthy weight. It was also noted that the food in the freezer was outdated, but not spoiled. The licensee also recently replaced their

freezer, and they were in the process of switching freezers during her (APS Worker #1) on-site investigation.

During the exit conference with Mrs. Ogunedo, she thanked me for the technical assistance provided. She also stated that they do not know everything, and they are open to following recommendations.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Mr. Ogunedo stated that they have plenty of options for food and they would not intentionally served expired food. Staff are supposed to check the dates and get rid of any food that has expired. An adequate amount of food was observed in the home during each of the unannounced on-site inspections. During the on-site inspections, two expired items were found, which were discarded. There was no spoiled food observed in the home. Resident A reported to get enough food to eat and had no concerns about the meals he was served. Resident B reported that the food was “pretty good.” She reported to get enough to eat. While in the home, I also observed Mr. Ogunedo prepare and provide snacks to the residents. The servings were adequate. The residents appeared to be happy with the snacks provided. Technical assistance was also provided to Mr. Ogunedo. Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that the residents are served expired food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On May 26, 2022, upon arrival to the facility, I noticed that the home was equipped with a ramp. There was rainwater pooling on the landing of the ramp. According to Mr. Ogunedo, none of the residents utilize a wheelchair, and the ramp is utilized for a rollator.

While in the home, I noticed that the dining room table was cluttered with papers, a laptop and other school related items. Mr. Ogunedo stated that all those items are removed, and the residents utilize the table for mealtimes.

During the on-site inspection, I noticed that the kitchen counters were cluttered, and the general conditions were unkempt. Mr. Ogunedo stated they would address this matter.

It was also noted that Resident A's bedroom door had been colored on with markers and needed to be repaired.

The trim in the living room, which was no longer attached to the wall, also required repair.

On June 27, 2022, I interviewed Mrs. Ogunedo in the kitchen area of the home. I noted that the kitchen still appeared to be somewhat cluttered and brought this to her attention. I also explained that the established violations would require a written corrective action plan.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	While Mr. Ogunedo reports that none of the residents utilize wheelchairs, it is important to note that while the home is equipped with a wheelchair ramp, it is not licensed to accommodate individuals who utilize wheelchairs. In addition, there was water pooling on the landing of the ramp. The licensee shall ensure that the ramp is kept and maintained in good condition. The dining room table and kitchen counters were observed to be cluttered and unkempt. Resident A's bedroom door needed to be repaired or repainted. The trim in the living room required repair. During the second on-site investigation, the kitchen area still appeared to be unkempt.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On May 26, 2022, it was noted that there was a baby-gate installed, blocking the second means of egress. Mr. Ogunedo was informed that the gate needed to be removed.

On June 27, 2022, I noted that the front screen door was not equipped with non-locking-against-egress- hardware. I discussed this with Mrs. Ogunedo and explained why it was a safety hazard. During the on-site investigation, I observed that the baby-gate had been removed.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	The second means of egress was obstructed as the licensee was utilizing a baby-gate, blocking the direct path to the exit door. The front screen door was not equipped with non-locking-against-egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The resident medications are kept in a cabinet in the kitchen. On May 26, 2022, when I entered the kitchen, the keys to the medication cabinet were observed to be in the cabinet lock. When brought to his attention, Mr. Ogunedo locked the cabinet and removed the keys.

On June 27, 2022, I interviewed Mrs. Ogunedo in the kitchen area of the home. I also observed the keys to the medication cabinet in the lock. The medication cabinet was not locked. Mrs. Ogunedo locked the medication cabinet and removed the keys once this was brought to her attention. I explained that this would be a rule violation.

During the exit conference, I explained to Mrs. Ogunedo that I would be requesting a written corrective action plan to address this established rule violation.

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 {333.1101 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:	On two separate occasions, the keys to the medication cabinet were observed to be in the medication cabinet lock. The medications were not safeguarded as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.

Mahtina Rubritius 06/28/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 06/29/2022

Ardra Hunter Date
Area Manager