GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 25, 2022

Kehinde Ogundipe
Eden Prairie Residential Care, LLC
G 15 B
405 W Greenlawn
Lansing, MI 48910

RE: License #: AS330411028
Investigation #: 2022A0466051
Bell Oaks I At Moores River

Dear Mr. Ogundipe:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330411028
Investigation #:	2022A0466051
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	08/26/2022
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	G 15 B 405 W Greenlawn Lansing, MI 48910
Licensee Telephone #:	(214) 250-6576
Administrator:	Kehinde Ogundipe
Licensee Designee:	Kehinde Ogundipe
Name of Facility:	Bell Oaks I At Moores River
Facility Address:	123 Moores River Lansing, MI 48910
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	05/03/2022
License Status:	REGULAR
Effective Date:	05/03/2022
Expiration Date:	11/02/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS:

	Violation Established?
Resident B was admitted to facility even though she does not meet the criteria for admission.	Yes
The facility does not have a resident record for Resident B.	Yes
Direct care workers are not properly trained.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/27/2022	Special Investigation Intake- 2022A0466051.
06/27/2022	Special Investigation Initiated - On Site with DHHS worker Suzanne Hunnicutt.
08/18/2022	Contact - Document Sent to licensee designee Kehinde Ogundipe.
08/18/2022	Contact - Document Received from licensee designee Kehinde Ogundipe.
08/22/2022	Contact - Document Sent to case manager Tayler Jasper.
08/22/2022	Contact - Document Received from case manager Tayler Jasper.
08/23/2022	Contact- Document sent/recevied from assigned licensing consultant Rodney Gill.
8/25/2022	Exit Conference with licensee designee Kehinde Ogundipe.

ALLEGATION: Resident B was admitted to facility even though she does not meet the criteria for admission.

INVESTIGATION:
On 06/27/2022, Complainant reported Resident B is a minor, under the age of 18 years, and was admitted to facility by licensee designee Kehinde Ogundipe even though she does not meet the facility's age requirement. Additionally, Complainant reported licensee designee Ogundipe did not have approval for a minor in placement from the Department of Health and Human Service, (DHHS) and/or Licensing and Regulatory Affairs (LARA) for Resident B to live at the facility which is licensed to care for adults.

On 06/27/2022, I conducted an unannounced investigation with DHHS staff member Suzanne Hunnicutt and we interviewed Resident B. Resident B reported she is under the age of 18 years old and she could not remember the exact date when she was admitted to the facility but reported that she has been living at the AFC facility for a couple of weeks as of the date of the onsite investigation. Resident B reported she was originally going to be admitted to a facility in Flint, however the facility did not have running water, so she was brought to this AFC facility by DHHS case manager Tyler Jasper. Resident B reported DCW Salina Whitby has been living at the facility and taking care of her 24-hours a day, seven days a week. Resident B reported that she is never left alone at the facility and that DCW Whitby takes her in the community when she wants to go places. Resident B reported she does not take any medications.

On 06/27/2022, DHHS staff member Hunnicutt and I interviewed DCW Whitby who reported Resident B has been at the facility about two weeks. DCW Whitby reported she is the DCW that has been on duty with Resident B since her admission. DCW Whitby reported she was not aware of what Resident B's care plan is because case manager Tyler Jasper did not provide any paperwork about Resident B at the time of admission or since. DCW Whitby reported Resident B has been provided 1:1 supervision since admission. DCW Whitby reported Resident B has not exhibited any behavioral concerns or problems since admission. DCW Whitby reported Resident B is not being administered any medications and therefore does not have a medication administration record.

On 06/27/2022, DHHS staff member Hunnicutt and I interviewed licensee designee Ogundipe who reported he could not remember the exact date Resident B was admitted but reported it was an "emergency admission." Licensee designee Ogundipe reported Resident B was supposed to be admitted to a non-licensed facility he owns in Flint but upon arrival to the Flint facility, Resident B and case manager Jasper did not like the facility, so Resident B was brought this AFC facility. Licensee designee Ogundipe reported he immediately began the request/process for a minor in placement however the request was denied. Licensee designee Ogundipe confirmed Resident B was admitted to the facility prior to starting the process/request for the minor in placement with DHHS or LARA.

On 08/18/2022, licensee designee Ogundipe reported Resident B lived at the facility from 6/13/2022 to 7/4/2022 as an emergency placement. Licensee designee Ogundipe reported Resident B's placing agency immediately applied for a variance request to allow Resident B to live in an AFC facility and according to Mr. Ogundipe the variance request was initially approved by the DHHS however LARA did not recommend the minor placement so that variance request was denied. Licensee designee Ogundipe reported Resident B moved out on 07/04/2022.

On 08/22/2022, case manager Jasper reported Resident B lived at the facility from 06/13/2022 thought 07/05/2022. Case manager Jasper reported being unable to

find any other documents that were provided to licensee designee Ogundipe upon admission. Case manager Jasper reported he reviewed Resident B's DHHS form 3307 (Placement Outline) DHS 3762, consent to medical treatment and Resident B's safety plan with licensee designee Ogundipe. Case Manager Jasper reported licensee designee Ogundipe should have those documents.

On 08/23/2022, licensee designee Ogundipe provided a copy of the facility's program statement which stated, "Eden Prairie Residential Care Services will provide 24-hour supervision, protection and personal care to six (6) female ambulatory adults, who are 18 - 99 years old, whose diagnosis is aged, mentally ill, and/or developmentally disabled in the least restrictive environment possible. We will accept clients with severely mentally and aggressive behavior issues. We will not admit clients that will require skilled nursing care, non-ambulatory, incontinence, non-verbal, medically fragile and hearing impaired. We will not also admit clients that have violent behaviors, fire starters and sexual misconduct behaviors."

On 08/23/2022, assigned licensing consultant Rodney Gill reported licensee designee Ogundipe applied and was granted approval for a minor in placement previously. This approval was not regarding the minor involved in this investigation. Licensing consultant Gill reported licensee designee Ogundipe was aware of the procedure and the requirement to obtain the approval for the minor in placement prior to admission.

On 08/23/2022, I interviewed licensing consultant Candace Coburn who reported she received a request for a minor in placement for Resident B on 6/15/2022. Licensing consultant Coburn reported that on 06/16/2022, licensee designee Ogundipe's request for a minor in placement was denied.

Special Investigation # 2022A1033011, dated 07/27/2022, established rule violation of R 400.14301 (2)(a) because substantial information was provided to licensee designee Ogundipe regarding the needs of Resident A prior to Resident A's admission to facility. This information included her high-risk behaviors and requirement for supervision and the fact Resident A was a minor child. Licensee designee Ogundipe agreed to provide for Resident A's care. During the course of Resident A's admission to the facility, licensee designee Ogundipe did not assure adequate staffing was available for Resident A's supervision and protection despite her well documented history of suicidal behaviors, self-harm and elopement tendencies. Licensee designee Ogundipe submitted a corrective action plan on 08/09/2022 and the corrective action plan was approved on 08/09/2022 by licensing consultant Jana Lipps. The corrective action stated, "Program director and licensee designee with gather intake documents and complete AFC assessment prior to accepting resident. Program director will coordinate with supports coordinator, home manager and staff IPOS training." This corrective action will be maintained through "quarterly quality assurance reviews of resident intakes and IPOS trainings."

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	The licensee's program statement documented only individuals older than 18 years of age would be admitted to the facility. However, on 06/13/2022, licensee designee approved the admission of Resident B, who is a minor child, to be admitted to the facility. Licensee designee Ogundipe did this prior to seeking approval from the Michigan Department of Health and Human Services and/or Licensing and Regulatory Affairs despite having experience in seeking approval for placement of minors in AFC facilities in the past. By admitting Resident B without approval, licensee designee Ogundipe did not assure the amount of personal care, supervision, and protection needed by Resident B was available in the home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2022A1033011 AND CAP DATED 08/09/2022].**

ALLEGATION: The facility does not have a resident record for Resident B.

INVESTIGATION:
On 06/27/2022, Complainant reported there is no paperwork/records for Resident B located at the facility.

On 06/27/2022, I conducted an unannounced investigation with Ms. Hunnicutt and we interviewed DCW Whitby who reported that the facility does not have a resident record for Resident B. DCW Whitby reported having not received the required documents from Resident B's case manager Tyler Jasper. DCW Whitby reported there were no documents available for review. DCW Whitby reported Resident B does not take any medications and therefore she does not have a medication administration record (MAR).

On 06/27/2022, Ms. Hunnicutt and I interviewed licensee designee Ogundipe who reported there was not a resident record for Resident B available for review because

it was an “emergency placement” and they have not received the required documents back from case manager Jasper yet.

On 08/22/2022, case manager Jasper reported Resident B lived at the facility from 06/13/2022 thought 07/05/2022. Case manager Jasper reported being unable to find any documents that were provided to licensee designee Ogundipe upon admission. Case manager Jasper reported providing licensee designee Ogundipe with the following documents for Resident B: DHHS 3307 (Placement Outline), DHHS 3762, (consent to medical treatment) and a safety plan. Case Manager Jasper reported those documents should be at the facility. Case manager Jasper was not able to confirm that any of the required AFC documents were completed for Resident B upon admission. Case manager Jasper confirmed Resident B was not prescribed any medications while she was living at the facility.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician’s instructions; health care appraisal.**
	(5) If a resident is referred for emergency admission and the licensee agrees to accept the resident, a written assessment plan shall be completed within 15 calendar days after the emergency admission. The written assessment shall be completed in accordance with the provisions specified in subrules (2) and (4) of this rule. **(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:** **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**

	(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission. **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	DCW Whitby and licensee designee Ogundipe both reported that the facility did not have a resident record for Resident B. Even though Resident B was an emergency admission, Resident B's written assessment plan and resident care agreement should have been available for review at the time of admission and/or prior to her discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care workers are not properly trained.

INVESTIGATION:
On 06/27/2022, Complainant reported that DCWs at the facility are not properly trained.

On 06/27/2022, Ms. Hunnicutt and I interviewed Resident B and DCW Whitby who both reported DCW Whitby provides transportation to Resident B into the community by car. DCW Whitby reported she recently started working at the facility when Resident B was admitted and that she has had some training, but she could not explain/describe what training she has completed.

On 06/27/2022, Ms. Hunnicutt and I interviewed licensee designee Ogundipe who reported Kenya Crawford was the Human Resource and Training manger and she could provide DCW Whitby's employee record. Licensee designee Ogundipe reported the facility has experienced of employee turnover.

On 08/11/2022, Ms. Crawford reported DCW Whitby completed her finger printing and tuberculosis (TB) test, both were completed on 06/29/2022. Ms. Crawford acknowledged that those were the only documents that she had in DCW Whitby's employee record. Ms. Crawford reported that not all of the required trainings, verifications and reference checks had been completed for DCW Whitby.

Special Investigation # 2022A1033011 dated 07/27/2022, established rule violation of R 400.14208 (1) because licensee designee Ogundipe had not gathered and/or maintained required employee records for two direct care staff members including DCW Whitby. Licensee designee Ogundipe submitted a corrective action plan that was received on 08/09/2022 and approved on 08/09/2022 by licensing consultant Jana Lipps. The corrective action plan documented "all employee records will be stored electronically and physically maintained at central office." This corrective action will be maintained through "quality assurance audits using QA tool will take place quarterly. Human resource director will register/participate in HR training courses/certifications."

R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	DCW Whitby's employee record did not contain documentation that she had been trained or was competent in the following required direct care staff trainings: reporting requirements, first aid, Cardiopulmonary resuscitation (CPR) personal care, supervision, and protection, resident rights and safety and fire prevention.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	DCW Whitby's employee record did not contain a statement that was signed by a licensed physician attesting to the physician's knowledge of DCW Whitby's physical health which was required to be obtained within 30 days of assumption of duties or occupancy in the home, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c)A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.**

	(d) Verification of the age requirement. **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	All of the above listed items/documents were not contained in DCW Whitby's employee record. Additionally, DCW Whitby's employee record did not contain a driver's license. Resident B and DCW Whitby both reported that DCW Whitby provided transportation to Resident B into the community by car.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2022A1033011 AND CAP DATED 08/09/2022].**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 06/27/2022, Ms. Hunnicutt and I interviewed DCW Whitby who reported she was now the manager and a live-in DCW at the facility. DCW Whitby reported she is the only DCW assigned to the nighttime shift and she sleeps at the facility at night. DCW Whitby reported she is willing to get up and assist Resident B during the night as needed. DCW Whitby reported she moved into the facility when Resident B was admitted. I observed DCW Whitby 's belongings in an upstairs bedroom and DCW Whitby confirmed that she slept in the home at night.

On 06/27/2022, I reviewed the original report that stated, "Staff will remain awake during the nighttime shift."

On 08/10/2022, I did a facility search on the bureau information tracking system (BITS) which did not contain criminal history clearances nor any documentation DCW Whitby was a member of household.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	License designee Ogundipe allowed DCW Whitby to move into the facility as a live-in staff without written notice to the department within five days after that change occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/27/2022, Hunnicutt and I interviewed licensee designee Ogundipe who confirmed Resident B was admitted to the facility prior to starting the minor in placement process. Licensee designee Ogundipe reported he has had minors living in his AFC facilities previously so he was aware approval for Resident B's placement was required to be obtained prior to Resident B living in the AFC facility. Licensee designee Ogundipe reported that this was an "emergency situation" and that is why he admitted Resident B prior to having authorization. Licensee designee Ogundipe reported he had obtained approval for another minor to live at this facility a couple of months ago but that resident has since moved out.

On 08/22/2022, case manager Jasper reported that Resident B lived at the facility from 06/13/2022 thought 07/05/2022.

On 08/23/2022, I conducted a review of the bureau information tracking system (BITS) which documented that license designee Ogundipe has been a licensee designee/administrator since 2018. License designee Ogundipe is currently the licensee designee/administrator for five other licensed AFC facilities.

On 08/23/2022, I interviewed licensing consultant Candace Coburn who reported that she received a request for a minor in placement for Resident B on 6/15/2022. Licensing consultant Coburn reported that on 06/16/2022, licensee designee Ogundipe's request for Resident B's minor in placement was denied.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

ANALYSIS:	Licensee designee/administrator Ogundipe willfully admitted Resident B, who is a minor child, without authorization from DHHS and LARA. Licensee designee/administrator Ogundipe is a seasoned licensee designee/administrator who has successfully gone through the minor placement protocol previously. On 06/13/2022, even though Mr. Ogundipe did not have approval to admit Resident B, he did so anyway. Resident B resided in the facility from 06/13/2022 thought 07/05/2022 according to case manager Jasper. Licensing consultant Candace Coburn received a request for a minor in placement for Resident B on 6/15/2022, two days after Resident B was admitted to the facility. This same request for placement was denied on 06/16/2022 yet licensee designee Ogundipe allowed Resident B to continue to reside at the AFC facility until 07/03/2022, a full 18 days past the date of denial of placement. Based on the decisions made by licensee designee/administrator Kehinde Ogundipe in Resident B's case, he is not administratively capable to provide the level of care for the programs for which he is licensed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional status due to the quality of care violations cited in the report.

08/25/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

08/25/2022

Dawn N. Timm Date
Area Manager