GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

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

RE: License #: AS250392427
Investigation #: 2022A0576058
Welch Home

Dear Mr. Ogundipe:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS250392427 |
| | |
| **Investigation #:** | 2022A0576058 |
| | |
| **Complaint Receipt Date:** | 09/25/2022 |
| | |
| **Investigation Initiation Date:** | 09/27/2022 |
| | |
| **Report Due Date:** | 11/24/2022 |
| | |
| **Name:** | Eden Prairie Residential Care, LLC |
| | |
| **Licensee Address:** | 405 W Greenlawn, G 15 B, Lansing, MI 48910 |
| | |
| **Licensee Telephone #:** | (214) 250-6576 |
| | |
| **Administrator:** | Kehinde Ogundipe |
| | |
| **Licensee Designee:** | Kehinde Ogundipe |
| | |
| **Name of Facility:** | Welch Home |
| | |
| **Facility Address:** | 302 Welch Blvd., Flint, MI 48503 |
| | |
| **Facility Telephone #:** | (810) 780-4222 |
| | |
| **Original Issuance Date:** | 03/21/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/21/2022 |
| | |
| **Expiration Date:** | 03/20/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A suffers from Bipolar, Schizophrenia, Asthma, Anxiety, Depression, and COPD. Today, Resident A ran away from the AFC home and reported that staff are not protecting her from Resident B. Resident B threatened Resident A with a gun, burnt her with a cigarette, hit her, punched her, and threw her into a wall. The staff blows her off when she tells them her concern. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/25/2022 | Special Investigation Intake<br>2022A0576058 |
| 09/25/2022 | APS Referral |
| 09/27/2022 | Special Investigation Initiated - Letter<br>Sent email to Susan Hutchinson, AFC Licensing Consultant |
| 09/27/2022 | Contact - Document Received<br>Received Incident Report |
| 10/13/2022 | Inspection Completed On-site<br>Interviewed Assistant Manager, Shaniya Martinez, Resident A, Resident B, Resident C, Staff, Edward West and Mike Page, and Home Manager, Samantha Dimick |
| 11/17/2022 | Contact - Telephone call made<br>Interviewed Licensee Designee, Kehinde Ogundipe |
| 11/17/2022 | Exit Conference<br>Exit Conference conducted with Licensee Designee, Kehinde Ogundipe |

### ALLEGATION:

Resident A suffers from Bipolar, Schizophrenia, Asthma, Anxiety, Depression, and COPD. Today, Resident A ran away from the AFC home and reported that staff are not protecting her from Resident B. Resident B threatened Resident A with a gun, burnt her

with a cigarette, hit her, punched her, and threw her into a wall. The staff blows her off when she tells them her concern.

**INVESTIGATION:**

On September 27, 2022, I received an email from AFC Licensing Consultant, Susan Hutchinson who provided an AFC Licensing Division – Incident / Accident Report (IR) and advised it is related to the current investigation. Ms. Hutchinson advised that Resident A can present problematic behaviors and may have been provided a discharge notice. Additionally, Resident A and Resident B "have been on and off in terms of a relationship".

On September 27, 2022, I reviewed an IR dated for September 26, 2022, and authored by Samantha Dimick. The IR indicated that on September 26, 2022, Resident A wrote a letter indicating that she was feeling suicidal and was threatening to harm another client and herself. Resident A was sent to the hospital and was not admitted. Staff contacted Resident A's case manager for guidance.

On October 13, 2022, I completed an unannounced on-site inspection at Welch Home and interviewed Assistant Home Manager, Shaniya Martinez. Ms. Martinez denied the allegations and advised that staff do not allow Resident B to harm Resident A. Ms. Martinez reported Resident A and Resident B will sometimes get along with each other and then they do not. Resident B only talks with Resident A when he wants something from her. Resident B was in a relationship with another person and when that ended Resident A "tries to talk to" Resident A.

According to Ms. Martinez, Resident B has never punched or thrown Resident A into a wall. Resident A has never told Ms. Martinez she was hit or pushed by Resident B. Resident B does not have a gun in the home and was never allowed to have a gun at the home. Male residents are not allowed to go in Resident A's bedroom and Ms. Martinez has never seen Resident B in Resident B's bedroom. Ms. Martinez denied being aware of or witnessing Resident B attack Resident A. According to Ms. Martinez, Resident A is not always credible and says things that are not true.

Ms. Martinez reported Resident A got burned by a cigarette about 4 weeks ago. Resident A reported that Resident B burned her with the cigarette on purpose and Resident B says the burn was the result of an accident. Resident B explained to staff that an ash got on Resident A and caused the burn. At the time, Resident A and Resident B were both required to have 1 on 1 staff supervision (Resident A currently requires 2 on 1 supervision due to elopement and self-harm concerns) however no one witnessed the incident when Resident A was burned.

On October 13, 2022, I interviewed Resident A who reported she has resided at the home since March 2022, and Resident A and Resident B have had an "on and off friendship". Resident A has a guardian, and she is looking for a new home for Resident

A. Regarding being burned, Resident A reported Resident B put a marijuana cigarette out on her arm. Resident A does not know why Resident B put the cigarette out on her arm. Resident B was smoking on the side of the garage, and she was sitting in a chair by the garage. Resident A explained that her eyes were shut, and she was resting however she was not asleep. Resident A felt a burning sensation on her arm and asked Resident B what he did. Resident B did not answer, and Resident A's arm began to blister. Resident A did not see Resident B burn her. There was no staff present with Resident A and Resident B when this incident occurred, and it was only Resident A and Resident B outside by the garage. Resident A's arm was viewed. Resident A had a circular mark on her right forearm. The mark was healed and appeared to be an old burn mark.

Regarding Resident B threatening her with a gun, Resident B will say "want to see my gun" and has said he has a gun however Resident A has never seen a gun. According to Resident A, staff do not let Resident B in her room. No males are allowed in her room and the only time Resident A was in her room was during an incident in September 2022. Resident A reported that at the end of September 2022, Resident B pushed her as she was standing the doorway to her bedroom. Resident A had Covid-19, was supposed to stay in her bedroom and she wanted to go outside. Resident B pushed Resident A when she was trying to reach for the doorknob from inside her room. Resident A reported she and Resident B will call each other names and once after she called Resident B "the N-word" he punched her.

On October 13, 2022, I interviewed Resident B who reported he has lived at his home for 7 months and he likes his home. Regarding the allegations, Resident B reported Resident A "lies on him". Resident B reported he does not own a gun, he does not have a gun in the home, and he never threatened Resident A with a gun. Resident B reported he has a tool, a drill and Resident A may have thought it was a gun.

Regarding Resident A being burned, Resident B reported he did not purposely burn Resident A with a cigarette. Resident B explained he was putting out a rolled cigar and an ash flew and accidently burned Resident A. Resident B denied ever punching or hitting Resident A and stated he does not "hit females". Resident B denied he goes in Resident A's bedroom and advised staff do not allow Resident B into Resident A's bedroom.

On October 13, 2022, I interviewed Staff, Edward West. The allegations were discussed with Mr. West, and he explained Resident A exaggerates. Mr. West denied Resident B has a gun in the home. Mr. West denied being aware of or witnessing Resident B threaten Resident A with a gun. According to Mr. West, staff do not allow Resident B or any other residents into Resident A's bedroom. Mr. West has never witnessed Resident B hit or punch Resident A. Mr. West believes staff are keeping Resident A safe and free from harm. Mr. West explained there was an occasion when Resident A had Covid-19 and was quarantined to her room. Resident A would come out of her room unmasked and would not keep her door shut. Resident A became

aggressive with Resident B after he went to shut her door. Resident A pushed Resident B and tried to grab his arm however Resident B fell backwards in her bedroom.

On October 13, 2022, I interviewed Staff, Mike Page. Mr. Page has never witnessed Resident B with a gun, and he does not have a gun in the home. Staff complete room checks twice daily and there has never been a gun found in Resident B's bedroom. Resident A has never complained to him that Resident B pushed or hit her. Mr. Page has never seen Resident B in Resident A's bedroom. No residents are allowed into Resident A's bedroom and only staff go into her room to clean or complete room checks. According to Mr. Page, staff keep Resident A safe and free from harm and Resident B does not say anything to Resident A.

On October 13, 2022, I interviewed Resident C who reported he has lived at the home for 3 months. Resident C reported Resident A "is the worst and hollers 'rape'" and calls him names. Resident B does not have a gun in the home and Resident C never seen Resident B with a gun. Resident C stated Resident A and Resident B may have been boyfriend and girlfriend however he does not know for sure. Resident C never seen Resident B hit or punch Resident A. Resident C did see a burn mark on Resident A however he does not know how this burn happened. Resident A was asleep and said she got burned and he does not know what occurred. According to Resident C, Resident A is not known to burn others with his cigarettes. Resident C explained that Resident B is mischievous and steals. Resident C has never witnessed Resident B behave in an aggressive manner with anyone. According to Resident C, Resident A and Resident B are "story-tellers".

On October 13, 2022, I interviewed Home Manager, Samantha Dimick. Ms. Dimick reported Resident A had a burn mark on her arm. Resident B said that he was smoking, and an ash fell on Resident A's arm. Resident A was sleeping at the time of being burned and the resident's respective 1 on 1 staff were not outside with the residents. The 2 staff were written up and one terminated due to this incident. Regarding a gun, Ms. Dimick has never known Resident B to have a gun. Room checks are completed, and no gun have ever been found. Ms. Dimick is not aware of Resident B hitting, pushing, or threatening Resident A. Staff do not allow Resident B in Resident A's room and she has never seen Resident B in Resident A's room. There was an incident where Resident A's bedroom was messy, and she ended up falling due to tripping over items on her floor and this was not caused by Resident B pushing her. Ms. Dimick reported staff are protecting Resident A and keeping her safe from others.

On October 13, 2022, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated for September 19, 2022, and authored by Aireyanna Taylor. The IR documented that on September 17, 2022, Resident A and Resident B were in the backyard. Resident A came to staff and said she was burned by Resident B on her arm with a cigar. Staff applied ointment and bandage to the burn. Staff were given a written violation for not having eyes on her client at all times.

On October 13, 2022, I reviewed Resident A and Resident B respective AFC Assessment Plans and Individual Plan of Service (IPOS). Resident A's plan(s) revealed Resident A is a 27-year-old female with active diagnosis of Schizoaffective Disorder, Bipolar Type, Unspecified Intellectual Disability, and Borderline Personality Disability among other physical health conditions. Resident A has a 1 on 1 staff person that is with her daily. Resident B's plan revealed he is a 23-year-old male that requires support and supervision 24 hours daily. Resident B denied depression and continues to need staff intervention when he is upset. Resident B will punch walls or other objects and can become verbally aggressive.

| **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:** | It was alleged that Resident A is pushed, hit, burned, and threatened by Resident B and staff are not protecting her. After completion of an unannounced on-site inspection, interviews of staff and residents, and a review or documentation there is not a preponderance of evidence to conclude a rule violation.<br><br>Resident A reported that she was burned by Resident B. Resident A was noted to have a circular mark on her arm that was healed and appeared to be a scar from being burned. Resident A did not witness Resident B burn her as she reported her eyes were closed. Resident B denied purposely burning Resident A and stated an ash fell onto her arm causing the burn. No witnesses were present at the time of this incident.<br><br>Resident A advised Resident B has hit her after she called him a vulgar name and also pushed her in her room. Resident B denied ever hitting or harming Resident A in any manner. Staff were interviewed and denied ever witnessing Resident B hit or push Resident A. Resident C was interviewed and advised he has never witnessed Resident B hit Resident A.<br><br>Resident B denied having a gun or threatening Resident A with a gun. Routine room searches are completed, and no gun has been discovered. According to Resident A, Resident B has asked her if she wanted to see his gun. |

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|---|---|
| | There is not a preponderance of evidence to conclude a rule violation. It was alleged that Resident A's safety and protection was not being adhered to by staff and Resident B demonstrated assaultive behavior toward Resident A. Staff denied that Resident B has harmed Resident A or threatened her. Resident B denied purposely harming Resident A and advised Resident A "lies on him". Although Resident A did receive a burn injury, there were no witnesses to the incident that would indicate if the cause was accidental or done intentionally. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On October 13, 2022, I interviewed Assistant Manager, Shaniya Martinez. Ms. Martinez reported Resident A got burned by a cigarette about 4 weeks ago. Resident A reported that Resident B burned her with the cigarette on purpose and Resident B says the burn was the result of an accident. At the time, Resident A and Resident B were both required to have 1 on 1 staff supervision (Resident A currently requires 2 on 1 supervision due to elopement and self-harm concerns) however no one witnessed the incident when Resident A was burned.

On October 13, 2022, I interviewed Resident A who reported Resident B put a marijuana cigarette out on her arm. Resident B was smoking on the side of the garage, and she was sitting in a chair by the garage. According to Resident A, there were no staff present with Resident A and Resident B when this incident occurred, and it was only Resident A and Resident B outside by the garage. Resident A reported at the time of this incident, she was required to have 1 on 1 staffing.

On October 13, 2022, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated for September 19, 2022, and authored by Aireyanna Taylor. The IR documented that on September 17, 2022, Resident A and Resident B were in the backyard. Resident A came to staff and said she was burned by Resident B on her arm with a cigar. Staff applied ointment and bandage to the burn. Staff were given a written violation for not having eyes on her client at all times.

On October 13, 2022, I reviewed Resident A AFC Assessment Plan and Individual Plan of Service (IPOS). Resident A's plan(s) revealed Resident A has a 1 on 1 staff person that is with her daily.

On November 17, 2022, I interviewed Licensee Designee, Kehinde Ogundipe. Mr. Ogundipe reported Resident A was provided a discharge notice however her county

cannot find a placement for her, and she is now on a 2 on 1 staffing due to behaviors she presents. Resident A is doing okay however continues to exhibit elopement behaviors. The hope is for Resident A to be moved to an all-female home in the near future.

| **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:** | Resident A obtained a burn injury, and no one was witness as to how it occurred. An IR was obtained regarding this incident and documented that staff was "given a written violation for not having eyes on Resident A at all times". Per Resident A's IPOS, she is to have 1 on 1 staffing at all times due to behavior issues she presents. Resident A was not provided the supervision as specified in her written assessment plan. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On November 17, 2022, I conducted an Exit Conference with Licensee Designee, Kehinde Ogundipe. I advised Mr. Ogundipe I would be requesting a corrective action plan for the cited rule violation.

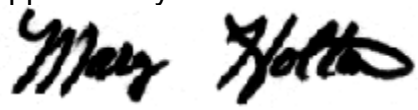
## IV. RECOMMENDATION

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

11/17/2022

Christina Garza Date
Licensing Consultant

Approved By:



11/17/2022

Mary E. Holton Date
Area Manager