



STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 9, 2023

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

RE: License #:	AS250392427
Investigation #:	2023A0872033
	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.
- 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 (517) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Susan Hutchinson". The signature is written in a cursive style with a large initial "S".

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS250392427
Investigation #:	2023A0872033
Complaint Receipt Date:	03/27/2023
Investigation Initiation Date:	03/27/2023
Report Due Date:	05/26/2023
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:	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

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED
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II. ALLEGATION(S)

	Violation Established?
Staff Edward West punched Resident A in the ribs. The home manager called the police, fired Mr. West, and took Resident A to the hospital to be examined.	Yes

III. METHODOLOGY

03/27/2023	Special Investigation Intake 2023A0872033
03/27/2023	Special Investigation Initiated - Letter I emailed the program director, Melissa Root requesting information related to these complaints
03/27/2023	Contact – Telephone call received I interviewed the program director, Melissa Root
03/30/2023	Inspection Completed On-site Unannounced
04/05/2023	Contact - Document Received AFC documentation received
04/06/2023	APS Referral I made an APS complaint via email
05/01/2023	Contact - Document Sent I emailed the Flint City Police Department requesting a copy of the assault report
05/05/2023	Contact - Document Received I received a copy of the police report
05/05/2023	Contact - Telephone call made I attempted to call former staff, Edward West on numerous occasions but his phone will not accept calls
05/05/2023	Contact - Telephone call made I interviewed Resident A's supports coordinator, Miranda Gedmin

05/09/2023	Exit Conference I conducted an exit conference with the licensee designee, Kehinde Ogundipe
05/09/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff Edward West punched Resident A in the ribs. The home manager called the police, fired Mr. West, and took Resident A to the hospital to be examined.

INVESTIGATION: On 03/27/23, I interviewed the senior program manager for Eden Prairie Residential Care, Melissa Root. According to Ms. Root, the home manager (Tyresha Webster) of Welch Home Adult Foster Care facility had a staff meeting earlier today. After the meeting, one of the staff took Ms. Webster aside and told her that a couple days ago, she witnessed staff Edward West punch Resident A in the ribs. She also witnessed Mr. West push Resident A into a chair so forcefully that the chair broke.

Ms. Root said that Resident A is nonverbal so he could not be interviewed. However, Ms. Webster and the area supervisor, Latonya Jones immediately questioned Mr. West about the allegations which he denied. Ms. Root said that based on the information, Mr. West was fired on the spot. As he was leaving the facility, he was very angry, and he threatened Ms. Webster and Ms. Jones. Once Mr. West left, staff called the police to report the assault and another staff transported Resident A to the hospital to be examined.

According to Ms. Root, Flint City Police officers responded to the facility to take the assault complaint. While they were at the facility, Mr. West came back and walked into Resident A's room, yelling at him, and telling him, "Tell them I didn't do anything to you!" Ms. Root said that Resident A became very agitated and upset and based on all the information provided, officers arrested Mr. West and transported him to the Flint City Police Department, charging him with assault.

On 03/27/23, I reviewed an Incident/Accident Report (IR) dated 03/25/23 completed by staff India Collins regarding Resident A. According to the IR, Resident A wanted some chocolate milk, but Ms. Collins asked him to wait. Resident A went to the refrigerator and got the milk out of the fridge. Staff Edward West told him to "put that shit back" and took the milk from him. Resident A sat down at the dining room table and kept saying "milk." He got up, went to the refrigerator, and got the milk again. Mr. West took it from him and told him to "get his ass" in his room. Resident A became upset, so he went in his room and slammed his door. Mr. West followed Resident A into his room and began "picking at him." Resident A started screaming and swinging his covers at Mr. West, so Mr. West began hitting/punching Resident A in the ribs. Resident A fell back on his bed and tried to knock his dresser over, spilling papers onto the floor. Mr. West told Resident A to "pick that shit up now!" The corrective measures taken were, "The employee, Edward West that was abusive to the client was terminated immediately, the

area supervisor was told of the abusive incident and [it] was also reported to the police. Law enforcement came over and arrested the employee, Edward West.”

I received another IR dated 03/27/23 regarding Resident A. According to the IR, staff India Collins took Resident A to the hospital as a result of the assault. He was examined by doctors and released back to the facility.

On 03/30/23, I conducted an unannounced onsite inspection of Welch Home Adult Foster Care facility. I observed Resident A who was lying in bed looking through a book. Resident A is diagnosed with autism, and he was unable to communicate with me. He appeared to be clean and dressed appropriately. The home manager, Tyresha Webster confirmed that staff Edward West has been fired and is no longer employed at this facility.

On 04/05/23, I received AFC documentation regarding this complaint. Resident A was admitted to Welch Home AFC on 03/07/22. According to his Health Care Appraisal and easterseals plan of service, he is diagnosed with insomnia, anxiety, ADHD, pseudobulbar, psoriasis, self-injurious behaviors, and autism spectrum disorder. He “displays discomfort by verbally yelling, telling, and/or physically pointing to the area that is bothering him.” He understands only simple messages and gives one-word responses. He has limited understanding due to his cognitive ability.

On 05/05/23, I reviewed a police report from the Flint City Police Department regarding this incident. According to the report, on 03/27/23, officers responded to Welch Home AFC in response to a welfare check. Officers Girardin and Arthur interviewed staff India Collins who reported that Resident A was physically assaulted by staff Edward West on two separate occasions. Officers were unable to interview Resident A due to his cognitive disability. EMS arrived at the facility and Resident A was transported to Hurley Medical Center. While at Welch Home AFC, officers arrested staff Edward West and charged him with Vulnerable Adult Abuse 4th degree. Mr. West was released from jail on 03/28/23.

On 05/05/23, I interviewed Resident A’s Easter seals Supports Coordinator, Miranda Gedmin via telephone. Ms. Gedmin said that Resident A is his own guardian, but she has been his supports coordinator for several years. She confirmed that Resident A is unable to communicate effectively due to his autism diagnosis. According to Ms. Gedmin, she was notified of the abuse allegations regarding Resident A. She said that she was told that the alleged perpetrator, Edward West was fired, and Resident A was transported to the hospital where he was examined and released. Ms. Gedmin said that she or her assistant meets with Resident A monthly, and she has no concerns about the care he is receiving at Welch Home AFC.

I attempted to telephone former staff, Edward West on multiple occasions. As of this date, 05/09/23, his telephone is not working, and it cannot accept messages.

On 05/09/23, I conducted an exit conference with the licensee designee, Kehinde Ogundipe. I discussed the findings of my investigation and told him which rule violation I am substantiating. Mr. Ogundipe agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	<p>Staff India Collins reported that on 3/25/23, she witnessed staff Edward West physically abuse Resident A by punching him in the ribs several times. Mr. West was also cussing at Resident A and being disrespectful.</p> <p>Management learned of this incident on 03/27/23. On that date, Edward West was fired, the police were contacted, and Resident A was taken to the hospital for a physical examination.</p> <p>On 03/27/23, Flint City Police arrested Edward West and charged him with Vulnerable Adult Abuse 4th degree.</p> <p>I conclude that there is sufficient evidence to substantiate this rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Susan Hutchinson

May 9, 2023

Susan Hutchinson Licensing Consultant	Date
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Approved By:

Mary Holton

May 9, 2023

Mary E. Holton Area Manager	Date
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