GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2023

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

RE: License #:	AS250412203
Investigation #:	2023A0872047
	Bell Oaks At Thomas

Dear Kehinde 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,

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

I. IDENTIFYING INFORMATION

License #:	AS250412203
Investigation #:	2023A0872047
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/30/2023
Report Due Date:	07/24/2023
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:	Bell Oaks At Thomas
Facility Address:	2705 Thomas St. Flint, MI 48504
Facility Telephone #:	(810) 820-3190
Original Issuance Date:	01/12/2023
License Status:	TEMPORARY
Effective Date:	01/12/2023
Expiration Date:	07/11/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are not trained in First Aid and CPR.	Yes
Staff took Resident A to the park and smoked marijuana in front of her.	No
On or around 03/15/23, Resident A was cooking by herself, and she sustained a 6x1 inch burn on her stomach. Staff put unspecified ointment on the burn and did not seek medical attention for her.	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0872047
05/30/2023	APS Referral I made an APS complaint via email
05/30/2023	Special Investigation Initiated - Letter
05/30/2023	Contact - Telephone call I interviewed Resident A
06/01/2023	Contact - Document Received The licensee designee sent me copies of 30-day discharge notices for Resident A and Resident B
06/08/2023	Inspection Completed On-site Unannounced
06/12/2023	Contact - Document Received AFC documentation received via email
06/14/2023	Contact - Document Received AFC documentation received via email
06/14/2023	Contact - Telephone call made I spoke to Macomb County Recipient Rights Officer, Amber Sultes

06/14/2023	Contact - Telephone call received I received a telephone call from Eden Prairie Area Supervisor, Latonya Jones
06/29/2023	Contact - Telephone call made I spoke to Resident A
06/29/2023	Exit Conference I conducted an exit conference with the licensee designee, Kehinde Ogundipe
06/29/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff are not trained in First Aid and CPR.

INVESTIGATION: On 06/08/23, I conducted an unannounced onsite inspection of Bell Oaks at Thomas Adult Foster Care facility. I interviewed Resident A and staff Shanika Jackson.

I asked Staff Jackson if she has received training in CPR and First Aid. Staff Jackson said that she is scheduled to take CPR and First Aid next week and said that her CPR and First Aid card has expired. She said she has worked at this facility for approximately two months.

On 06/14/23, I emailed the licensee designee and his management team, requesting proof of First Aid and CPR training for the following staff/former staff: Kenyata Berrien, Artecia Howard, Pricilla Butts, Monica Evans, Branesha Green, Shanika Jackson, and Mykiyah Boston. The senior program manager, Melissa Root emailed me some documentation regarding staff CPR and First Aid training but was unable to provide me with copies of CPR and First Aid cards for any of the seven staff I requested.

APPLICABLE RULE	
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:	Staff Shanika Jackson said that she has worked at this facility for two months. She said that her CPR and First Aid training has expired, and she is scheduled to take this training during the week of 06/15/23. On 06/14/23, I emailed the licensee designee and his management team, requesting proof of First Aid and CPR training for the following staff/former staff: Kenyata Berrien, Artecia Howard, Pricilla Butts, Monica Evans, Branesha Green, Shanika Jackson, and Mykiyah Boston. The senior program manager, Melissa Root emailed me some documentation regarding staff CPR and First Aid training but was unable to provide me with copies of CPR and First Aid cards for any of the seven staff I requested. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff took Resident A to the park and smoked marijuana in front of her.

INVESTIGATION: On 05/30/23, I interviewed Resident A. Resident A told me that approximately two weeks ago, staff Shanika Jackson and Malikah Lynch asked her to go to the store with them. After the store, they all went to the park. Resident A said that while at the park, Shanika Jackson and Malikah smoked marijuana in front of her.

On 06/08/23, I conducted an unannounced onsite inspection of Bell Oaks at Thomas Adult Foster Care facility. I interviewed Resident A and staff Shanika Jackson.

I asked Resident A about the incident in the park involving staff Shanika Jackson and Malikah Lynch. She stated that approximately two weeks ago, Staff Jackson and Staff Lynch took her to the store and then they went to the park. They all got out of the vehicle and went and sat on a park bench. Resident A said that Shanika Jackson and Malikah Lynch began smoking marijuana while they were all at the park. After they finished, they all drove back to the AFC facility. Resident A said that there were other people at the park, but she does not know if they saw Shanika Jackson and Malikah Lynch smoking marijuana.

Staff Shanika Jackson said that she has worked at this facility for approximately two months, and she typically works 1st shift. I asked her if she ever took Resident A to the store, or the park and she said no. I asked her how often she worked with staff Malikah Lynch and initially, she said that she never worked with her. I told Staff Jackson that I am investigating allegations that she and former staff Malikah Lynch took Resident A to the park and smoked marijuana while there. Staff Jackson then said that on one occasion, she and former staff Malikah Lynch did take Resident A to the park for an outing. I asked her if they smoked marijuana while at the park and she said no. She said that she smokes black & mild (cigars), and Malikah Lynch smokes blacks (cigarettes) and they both smoked those while at the park but not marijuana. Staff Jackson told me that she would not smoke marijuana in front of the residents or while caring for the residents. She also said that she has never heard any of the other staff talking about smoking marijuana in front of or while caring for the residents.

On 06/14/23, I reviewed the staff schedule for the month of May 2023. I noted that according to the schedule, staff Shanika Jackson and Malikah Lynch worked on the same days, and same shifts on 10 occasions during the month of May 2023.

I attempted to interview former staff, Malikah Lynch but as of 06/30/23, she has not returned my telephone call.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(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.**
	Resident A said that on one occasion, staff Shanika Jackson and Malikah Lynch took her to the park. While at the park, they sat on a bench and Ms. Jackson and Ms. Lynch smoked marijuana in front of her. Staff Shanika Jackson said that she and staff Malikah Lynch did take Resident A to the park on one occasion but said that neither one of them smoked marijuana. I attempted to interview former staff Malikah Lynch but as of 06/30/23, she has not returned my phone call.
ANALYSIS:	I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On or around 03/15/23, Resident A was cooking by herself, and she sustained a 6x1 inch burn on her stomach. Staff put unspecified ointment on the burn and did not seek medical attention for her.

INVESTIGATION: On 06/08/23, I conducted an unannounced onsite inspection of Bell Oaks at Thomas Adult Foster Care facility. I interviewed Resident A and staff Shanika Jackson.

According to Resident A, sometime in March 2023, she was cooking hot dogs in the microwave. Resident A said that she does not remember the names of the staff who were working that day but said there were three staff present. Resident A told me that the hot dogs were in a bowl of water in the microwave and when she pulled the bowl out and went to drain the water, the hot water spilled on her shirt, burning her stomach. Resident A showed me a large horizontal scar on her stomach approximately six inches long.

I asked Resident A if staff sought medical attention for her and she said no. She said that staff went and bought some burn cream and a burn spray and after treating the wound with the cream and spray, they put a bandage on it. Resident A told me that the burn blistered up and the blister bubbles eventually popped and healed into a scar. She said that the healing process took over two weeks. I asked Resident A if staff said anything about needing to take her to the doctor and she said, “They said they didn’t want to get the state involved.” Resident A told me that she never told any of the other staff what had happened, and she never saw a doctor for the wound.

On 06/14/23, I emailed the licensee designee and his management team, requesting a copy of the staff schedule for March 2023. The senior program manager, Melissa Root said that she is unable to provide me with a staff schedule for March 2023.

On 06/14/23, I received a telephone call from Latonya Jones. Area Supervisor (AS) Jones said that she recently became the area supervisor for this facility, and she learned that sometime in March 2023, Resident A sustained a burn to her stomach. AS Jones said that she was unable to find an Incident/Accident Report (IR) completed by staff regarding the incident, so she completed an IR with the information she learned. She told me that the two staff caring for Resident A on the date of the incident are no longer working for this facility. AS Jones told me that the former home manager of this facility did not keep accurate records and documentation from her time as manager is not complete.

On 06/14/23, I received an IR dated “about 3/13” completed by AS Latonya Jones. According to the report, on or around 03/13/23, she went to Bell Oaks at Thomas AFC to do some paperwork. While there, Resident A asked her to help her get her shirt on. AS Jones wrote, “While assisting (her) I noticed a very large open wound on her stomach. I asked (her) what had happened and she stated ‘Monica told me to make me some hotdogs and to put water in the bowl add the hotdogs and put it into the

microwave. And then I burned myself.' I asked if she had been to the doctor. She replied she hadn't."

On 06/28/23, I telephoned Resident A in response to a text message from her. She told me that she is doing well and the staff she used to have problems with are no longer around. Resident A said that she was told that this facility is closing, and she is moving to a new facility on 06/30/23. Resident A said that she will be moving to a house in Flint, MI and will be living by herself, although staff will be with her 24/7.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On or around 03/15/23, Resident A sustained a 6x1 inch burn to her stomach while cooking hot dogs in the microwave. Resident A said that she does not remember the names of the staff working at the time but said that staff put burn cream, spray, and a bandage on the wound. Resident A said that staff never sought medical attention for the wound. On 06/08/23, Resident A showed me the scar from the burn. I observed it to be approximately 6x1 inches. The wound was healed but there is a very visible scar. Area Supervisor, Latonya Jones said that to her knowledge, staff did not seek medical attention for Resident A after she received a burn to her stomach. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/29/23, I conducted an exit conference with the licensee designee (LD), Kehinde Ogundipe. I discussed the findings of my investigation and told LD Ogundipe that I will be requesting a corrective action plan upon the receipt of my investigation report. LD Ogundipe said that Resident A is the only resident remaining at Bell Oaks of Thomas AFC and she will be moving out on 07/01/23. LD Ogundipe told me that once Resident A moves out and once I close out this special investigation report, he will be closing the license at this facility.

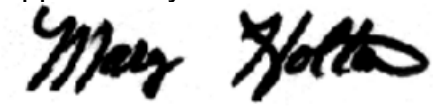
IV. RECOMMENDATION

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

June 30, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



June 30, 2023

Mary E. Holton Area Manager	Date