GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 21, 2023

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

RE: License #: AS330411028
Investigation #: 2023A1029051
Bell Oaks I At Moores River

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330411028
Investigation #:	2023A1029051
Complaint Receipt Date:	07/27/2023
Investigation Initiation Date:	07/27/2023
Report Due Date:	09/25/2023
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	405 W Greenlawn G15B, 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:	03/14/2023
Expiration Date:	03/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by Resident B on July 26, 2023 while she was in her upstairs bedroom with her door closed. During this time Resident A was not provided with 1:1 supervision.	Yes

III. METHODOLOGY

07/27/2023	Special Investigation Intake 2023A1029051
07/27/2023	Special Investigation Initiated – Letter to complainant.
07/27/2023	APS Referral made to Centralized Intake
07/27/2023	Contact - Document Sent - Email to Rec. Rights, Alanna
07/28/2023	Contact – Email from Sarah Rupkus who sent Resident A's Treatment Plan.
08/01/2023	Inspection Completed On-site – face to face with A. Busch, Resident A, Resident B, and direct care staff members T. Greer, S. Peters, D. Similton, reviewed resident records.
08/01/2023	Contact – Document sent – email from Ariel Busch
08/16/2023	Contact – Email from Alanna Honkanen, ORR
08/23/2023	Contact – Telephone call from AFC Licensing Consultant, Leslie Herrguth.
09/12/2023	Contact -Telephone call to Easter Seals Mark Lakier and licensee designee Kehinde Ogundipe
09/12/2023	Contact – Email from Ashanti Wright and Kehinde Ogundipe
09/12/2023	Exit conference with licensee designee Kehinde Ogundipe

ALLEGATION:

Resident A was assaulted by Resident B on July 26, 2023 while she was in her upstairs bedroom with her door closed. During this time Resident A was not provided with 1:1 supervision.

INVESTIGATION:

On July 27, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A was assaulted by Resident B in her bedroom while the door was closed. According to complaint information, Resident A requires 1:1 supervision and allegedly she was not being supervised while upstairs in her bedroom and as a result Resident A was found with a black eye and several bruises due to the altercation with Resident B. According to complaint information, these concerns were also being investigated by Oakland County Office of Recipient Rights (ORR) Officer, Alanna Honkanen.

On July 28, 2023, I received an email from Adult Protective Services (APS) specialist, Robert Lindley. Mr. Lindley stated he completed an unannounced face-to-face investigation at the facility and learned direct care staff members Ms. Greer, Ms. Peters, Ms. Similton were working during the assault. Mr. Lindley stated he learned that three of the five residents required 1:1 direct care staff supervision. Mr. Lindley stated direct care staff members Ms. Greer and Ms. Peters reported residents did not require 1:1 supervision while residents were in their bedrooms and “24/7” only referred to residents being outside of the facility. Direct care staff members Ms. Greer and Ms. Peters reiterated direct care staff members did not have to provide 1:1 supervision to residents while residents were in their bedrooms even for those residents who required 1:1 supervision 24 hours per day.

On August 1, 2023, I completed an unannounced on-site investigation at Bell Oaks 1 at Moores River along with APS Mr. Lindley. Mr. Lindley and I interviewed direct care staff member, whose current role is home manager, Ariel Busch. Ms. Busch stated she did not work the day of the incident with Resident A and Resident B. Ms. Busch stated there were three direct care staff members working at the time of this incident. Ms. Busch stated there are currently six residents living in the home with three residents requiring 1:1 supervision at all times while Resident C requires 1:1 supervision during the hours of 8:00 AM to 4:00 PM. Ms. Busch stated Resident A did not have injuries from the assault but sustained a black eye because she jumped out of the car later that day. Ms. Busch stated during the altercation with Resident B, Resident A’s assigned 1:1 direct care staff member was Talisa Greer. Ms. Busch stated her understanding of 1:1 supervision is direct care staff members are not required to be with residents, including Resident A, when the resident is in their bedroom. Ms. Busch stated Resident A’s Easter Seals caseworker Laura Stern advised her direct care staff members do not have to be in the hallway supervising Resident A when she is upstairs.

Mr. Lindley and I then interviewed Resident A. Resident A stated she was in her room for “2 seconds and then I was being punched in the face” by Resident B. Resident A stated direct care staff member Ms. Similton came upstairs and realized she was being assaulted and separated them. Resident A stated she had a bump on her skull as a result of this incident. Resident A stated she no longer shares a room with Resident B and that they only shared a room for one day. Resident A stated this is the third time she has been assaulted by Resident B but could not give details regarding the other incidents. Resident A stated typically she does not know who her assigned 1:1 direct care staff member is. Resident A stated Resident B is no longer at the facility and she did not know if she will be returning.

I interviewed direct care staff member Talisa Greer. Ms. Greer stated that she was working during this time and she was assigned to provide 1:1 supervision to another resident however she noticed Resident A and B were upset with each other. Ms. Greer stated Resident B did not have a 1:1 supervision during this incident. Ms. Greer stated did she did not see the fight but she heard yelling upstairs and went upstairs to see what was going on. Ms. Greer stated it is hard to provide 1:1 supervision for Resident A because she does not like anyone by her room upstairs or in her space however someone always provides one on one supervision while she is downstairs. Ms. Greer stated when Resident A is in her room they check on her every 10 to 15 minutes. Ms. Greer stated there is no written guidelines regarding how to provide one-on-one supervision for the residents and she does not remember being trained on this protocol. Ms. Greer stated Resident B has been in the hospital since July 23, 2023 and she does not believe Resident B will be returning to the facility. According to Ms. Greer, neither Resident A nor Resident B have a history of assaulting residents.

I interviewed direct care staff member Shakiya Peters. Ms. Peters stated Resident A was upset with another resident and Resident B was “getting smart with her” so Resident A went upstairs. Ms. Peters stated after Resident A went upstairs, Resident B sat at the kitchen table with the direct care staff members and she seemed calm so there was no reason to believe she was going to assault Resident A. Ms. Peters stated shortly after Resident B went upstairs, she heard yelling. Ms. Peters stated Resident A and Resident E require 1:1 supervision and Resident C requires 1:1 supervision for the hours of 8 AM to 4 PM. Ms. Peters stated she is assigned the resident she is to supervise at the beginning of each shift. Ms. Peters stated she was trained to provide 1:1 supervision with Resident A while Resident A is outside of the facility but not when Resident A is up in her room. Ms. Peters stated there is also no chart or written guidelines for who is assigned to provide 1:1 supervision for each resident.

During the on-site investigation, I reviewed resident records and *Assessment Plan for AFC Residents* for all residents. Resident A’s *Treatment Plan* authored by April McCullum on July 10, 2023 clarified her supervision needs and stated the following:

> *“Under Individual Monitoring needs: Awake Hours: "Bell Oaks 1 Staff will provide 1:1 staffing 24 hours per day." Under Individual monitoring needs: Sleeping “Bells Oaks 1 Staff will provide 1:1 staffing 24 hours per day. Staff will monitor her during sleeping hours.” Under monitoring*

needs in the community, Bells Oak 1 Staff will provide 1:1 staffing 24 hours per day. [Resident A] must remain in eyesight of 1:1 staff at all times in the community. Staff will be within eyesight of [Resident A] at all times unless utilizing the bathroom."

According to Resident A's *Assessment Plan for AFC Residents* dated May 24, 2023, she requires *"1 to 1, 24 hours to start services. Then transition to less restrictive."*

According to Resident B's *Assessment Plan for AFC Residents* she requires 1:1 supervision however Ms. Busch stated since Resident B did not agree with this recommendation the caseworker revoked this part of her plan because Resident B is her own guardian.

I interviewed direct care staff member Damarius Similton who stated she was the one who intervened when the assault occurred. Ms. Similton stated Resident A was upstairs for about 5-10 minutes and Resident B went upstairs to put her stuff away and she heard screaming shortly afterward. Ms. Similton stated she ran up the stairs and saw Resident B on top of Resident A. Ms. Similton thought Resident A went upstairs because she was going to take a nap. Ms. Similton stated she has never observed an incident between the two of them when she was on shift in the past but she has heard there were two other incidents between Resident A and Resident B but did not know when these occurred. Ms. Similton stated the guidelines for providing one on one supervision and who they are responsible for each shift is something direct care staff members "play it by ear" to see who they are assigned to provide supervision for during that shift. Ms. Similton stated there have been staff meetings in the past which discussed how to provide 1:1 supervision and direct care staff members signed off for attending these trainings. Ms. Similton stated if Resident A goes upstairs she checks on her every half hour if she is awake and it is normal for Resident A to sleep during the day.

On August 16, 2023, I received an email from Alanna Honkanen from Oakland County ORR with information she will be substantiating her investigation because Resident A did not receive 1:1 supervision according to her plan. Ms. Honkanen stated Ms. Similton acknowledged to her she was supposed to be the 1:1 for Resident A, however, she was not upstairs with her at the time of the incident. Ms. Honkanen stated there is a lack of understanding on what the 1:1 supervision should look like at the facility since all direct care staff members thought it was fine to not be upstairs but the plan was specific to say "eyes on" was required.

On September 12, 2023, I interviewed Easter Seals behaviorist, Mark Lakier. Mr. Lakier stated he completed Resident A's *Behavioral Plan* in March 2023. Mr. Lakier stated when this plan was completed he went to Bell Oaks 1 at Moores River and trained direct care staff members on the needs of Resident A and explained the requirements of what 1:1 supervision means and how she should be in eyesight of direct care staff members at all times. Mr. Lakier stated Resident A should have had 1:1 supervision at all times including her bedroom. Mr. Lakier stated he has met with Mr. Ogundipe in the past

regarding the requirements of one on one supervision, however he did not remember the specifics of this meeting.

On September 12, 2023, I interviewed licensee designee Kehinde Ogundipe. Mr. Ogundipe stated Resident A went upstairs to her bedroom and she did not have 1:1 supervision. Mr. Ogundipe stated Resident B is her own guardian and she would not agree with 1:1 supervision so it was not required. Mr. Ogundipe stated Resident A does require 1:1 supervision and Ms. Similton did receive a written reprimanded for not providing Resident A with 1:1 supervision at the time she was assaulted by Resident B. Mr. Ogundipe stated direct care staff members know they are supposed to supervise residents with 1:1 supervision per their assessment plans and/or behavior treatment plans and he has explained to direct care staff members they have to because it is a safety issue. Mr. Ogundipe stated the agency is requesting direct care staff members are required to go upstairs into their bedrooms but the clients do not want this, so they have to contact the caseworker to let them know they are refusing it. Mr. Ogundipe stated they have learned a lesson from incidents such as this when they occur. Mr. Ogundipe stated Resident A and Resident E require 1:1 supervision 24 hours per day, Residents B, D, F do not require 1:1 supervision, and Resident C has 1:1 supervision for eight hours each day.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A was not provided supervision according to her Community Mental Health Treatment Plan which states she should have 24 hour supervision unless she is using the bathroom. Resident A was assaulted when she was upstairs by Resident B because she did not have a direct care staff member providing her 1:1 supervision while she was upstairs. During interviews with direct care staff members, they all reported they did not have to be upstairs with Resident A but only had to provide supervision when she was outside or in the community which is not what her Treatment Plan requires. Mr. Lakier from Easter Seals stated he went to the facility to train the direct care staff members regarding the requirements of Resident A's supervision needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan; I recommend no change in license status.

_____09/12/2023_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

09/21/2023

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Dawn N. Timm — Date
Area Manager