GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 26, 2023

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

RE: License #: AS630405489
Investigation #: 2023A0465032
Genesis 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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405489
Investigation #:	2023A0465032
Complaint Receipt Date:	07/24/2023
Investigation Initiation Date:	07/24/2023
Report Due Date:	09/22/2023
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:	Genesis Home
Facility Address:	21004 Reimanville Ferndale, MI 48220
Facility Telephone #:	(248) 951-2616
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	10/14/2022
Expiration Date:	10/13/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 7/14/2023, the facility had Resident A transported to the hospital and refused to allow him to return to the facility.	Yes
On 7/14/2023, staff member Edward Wilson, attempted to sexually assault Resident B.	No

III. METHODOLOGY

07/24/2023	Special Investigation Intake 2023A0465032
07/24/2023	Special Investigation Initiated - Letter Email exchange with APS Worker, Marcie Fincher
07/24/2023	APS Referral Assigned to Taniesha Sims for investigation
07/25/2023	Contact - Document Received I spoke to Office of Recipient Rights Officer, Alanna Honkanen, via email exchange
07/27/2023	Contact - Document Received Facility documents received via email
07/28/2023	Contact - Telephone call made I spoke to Guardian B1 via telephone
07/31/2023	Inspection Completed On-site I conducted a walkthrough of the home, interviewed Resident C and Resident D, reviewed resident files and interviewed direct care staff, Ola Adekunle and Allan Paylor
07/31/2023	Contact - Document Received Facility documents received via email
08/04/2023	Contact – Telephone call made I spoke to direct care staff, Edward Wilson, via telephone

08/04/2023	Contact - Telephone call made I spoke to Sherry Vanhulle, Easter Seals Case Manager for Resident B
08/09/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
08/11/2023	Contact - Telephone call made I left a voice mail for CMH Case Manager, Amber Hayes, case manager for Resident A
08/15/2023	Contact - Telephone call made I spoke to Guardian C1 via telephone
09/14/2023	Contact - Document Received Email exchange with APS Worker, Marcie Fincher. Ms. Fincher
09/21/2023	Contact - Document Received Email from Ms. Fincher from APS, with information related to police investigation specific to the complaints in this investigation
09/21/2023	Contact – Document received I spoke to Office of Recipient Rights Officer, Evan George, via email exchange
09/21/2023	Exit Conference I conducted an Exit Conference with licensee designee, Kehinde Ogundipe, via telephone

ALLEGATION:

On 7/14/2023, the facility had Resident A transported to the hospital and refused to allow him to return to the facility.

INVESTIGATION:

On 7/24/2203, a complaint was received, alleging that on 7/14/2023, the facility had Resident A transported to the hospital and refused to allow him to return to the facility.

On 7/23/2023 and 9/21/2023, I spoke to Adult Protective Services Worker, Marcie Fincher, via email. Ms. Fincher stated that the allegation contained in this report were investigated and unsubstantiated. Ms. Fincher stated that this investigation is now closed.

On 7/25/2023 and 9/21/2023, I spoke to Office of Recipient Rights Officers, Alanna Honkanen and Evan George, via email exchange. On 9/22/2033, Mr. George stated that he has investigated the allegations in this complaint and will not be substantiating any rule violations.

On 7/31/2023, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were four residents residing in the home, and Resident A was no longer residing at the facility. I completed a walk-through of the home, interviewed Resident C and Resident D, reviewed resident files, and interviewed direct care staff, Ola Adekunle.

I reviewed Resident A's file. The *Face Sheet* stated that Resident A resided at the facility from 10/27/2022 – 7/14/2023 and has a legal guardian, Guardian A1. The *Resident Registrar* listed his forwarding address as Providence Hospital. The *Health Care Appraisal* listed his medical diagnosis as Intellectual Cognitive Delay. The *Assessment Plan for AFC Residents* stated that Resident A required supervision in the community, has a history of aggressive behavior, independently completes self-care tasks, and did not require use of assistive devices for mobility. The *Incident/Accident Report,* dated 7/14/2023, stated that following:

> *7/14/2023 at 11:50am; Completed by Allan Paylor and Edward Wilson: Resident A came down from his room, accusing staff of taking something out of his room. Before staff could say a word, Resident A punched Mr. Wilson in the face. The police were called and Resident A was transported to the hospital. Resident A will be getting an emergency discharge from the home.*

I reviewed the *Emergency Discharge Notice*, dated 7/14/2023, which stated the following:

> *We are issuing an Emergency Discharge Notice for your adult foster care services due to issues related to maintain your health and safety, as well as, behavioral/mental stability in a community-SRS setting. You are being discharged as a result of the following concerns: Serious physical assault to a staff causing injury. As a result, you must make proper arrangements with your guardian and case manager to find alternative living arrangements immediately.*

I interviewed direct care staff, Ola Adekunle, who stated that she is familiar with Resident A and provided care to him during the time that he resided at the facility. Ms. Adekunle stated, "Resident A had a history of aggressive behavior and would attack staff verbally and physically when he didn't get his way. I was working on 7/14/2023, when Resident A punched Mr. Wilson in the face. Resident A was upset because he said something was missing from his room. He came downstairs and began accusing staff of stealing from him. Mr. Wilson attempted to redirect him, and Resident A punched him in the face. We called the police, and they showed up along with EMS. Resident A was transported to the hospital. On this same day, we issued an emergency

discharge notice to Resident A. I was told by Ken Ogundipe that Resident A could not return to the facility and that he could not come back here. Resident A never returned here after that." Ms. Adekunle acknowledged that this allegation is true.

On 8/9/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "Resident A has a long history of aggressive and defiant behavior. On 7/14/2023, he accused staff of stealing items from his room, and he punched Mr. Wilson in the face. The staff called 911 and he was transported to the hospital. The facility informed the hospital and community mental health that they would not allow Resident A to return to the facility. They discharged him, knowing that he had no where else to go. Resident A remained in the hospital for several days while a new placement was located. The home did not properly discharge Resident A and they did not allow him to return to the home after he was transported to the hospital on 7/14/2023. Resident A is now living in a new adult foster care facility and is no longer in need of placement."

On 9/21/2023, I spoke to licensee designee/administrator, Kehinde Ogundipe, via telephone. Mr. Ogundipe stated that the facility did discharge Resident A from the home on 7/14/2023, the same day that he was transported to the hospital. Mr. Ogundipe stated that this was the best plan to ensure the safety of his staff and the other residents in the home. Mr. Ogundipe stated, "I understand that was an unfortunate event. We took a risk due to Resident A's increasing aggressive behavior and we felt he was unsafe in the home. We know it was not ideal plan and we know better, and we will do better. There is no excuse and hopefully we do not have this type of situation happen again." Mr. Ogundipe acknowledged that this action is a licensing rule violation.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:**

	(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.
ANALYSIS:	On 7/14/2023, Resident A punched Mr. Wilson in the face. Resident A was subsequently transported to the hospital for evaluation. According to the Emergency Discharge Notice and Resident Registrar, Resident A was issued an emergency discharge and discharged from the home on 7/14/2023, with his forwarding address documented as the hospital. According to Ms. Adekunle and Mr. Ogundipe, upon Resident A's transport to the hospital, Mr. Ogundipe made the decision to issue and emergency discharge and was unwilling to allow Resident A to return to the home. Mr. Ogundipe acknowledged that this complaint is true. Based on the information above, there is sufficient information to confirm that this allegation is true.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 7/14/2023, staff member Edward Wilson, attempted to sexually assault Resident B.

INVESTIGATION:

On 7/24/2203, a complaint was received, alleging that on 7/14/2023, staff member Edward Wilson attempted to sexually assault Resident B. The complaint indicated the following: On 7/14/2023, Resident B eloped from the home, walked to a local Kroger, and called 911. Resident B reported that direct care staff, Edward Wilson, had attempted to rape him. Resident B passed away on 7/23/2023 due to a possible drug overdose. Resident B was born a female but identified as a transgender male.

On 7/23/2023 and 9/21/2023, I spoke to Adult Protective Services Worker, Marcie Fincher, via email. Ms. Fincher stated that the allegation contained in this report were investigated and unsubstantiated. Ms. Fincher stated that this investigation is now closed. On 9/21/2023, Ms. Fincher also provided me with email documentation from Michigan State Police Sergeant, Jeffrey Rodgers, which stated that this incident was investigated, and it was determined that Resident B had made a false allegation and the investigation is now closed.

On 7/25/2023 and 9/21/2023, I spoke to Office of Recipient Rights Officers, Alanna Honkanen and Evan George, via email exchange. On 9/22/2033, Mr. George stated that he has investigated the allegations in this complaint and will not be substantiating any rule violations.

On 7/31/2023, during my onsite investigation, I reviewed Resident B's file and interviewed Mr. Paylor and Ms. Adekunle. The *Resident Registrar* indicated that Resident B resided at the facility from 4/20/2023 – 7/23/2023. The *Face Sheet* stated that Resident B has a legal guardian, Guardian B1. The *Health Care Appraisal* listed Resident B's medical diagnosis as Schizoaffective Disorder – Bipolar Type, Anti-Social Personality Disorder, Borderline Personality Disorder, with a history of substance use, elopement and inappropriate calling of emergency services. The *Assessment Plan for AFC Residents* stated that Resident B required supervision in the community, had a history of making false allegations, independently completed self-care tasks and did not require use of assistive devices. I reviewed the *Incident/Accident Reports*, which indicated the following:

> *7/14/2023 at 6:00pm; Completed by Allan Paylor and Edward Wilson: Resident B was upset because staff told him that he has some restrictions in place and cannot use his phone without staff supervision. Resident B left the facility and went to Kroger to call the police. Resident B made a report that staff attempted to rape him. Police came over to the house to investigate. Staff answered all questions asked by police. Staff will continue to monitor and redirect Resident B.*
>
> *7/23/2023 at 12:45pm; Completed by Allan Paylor and Edward Wilson: Resident B was in his room all day. Staff came to give him meds in his room, and he was laying on his bed. Around 12:30pm, staff went to Resident B's room to ask if he wanted lunch and to give him his noon meds. Staff found Resident B on the floor, unresponsive. Staff called 911. Staff gave CPR; Staff called to inform case manager of the incident and left a voice message for Guardian B1.*

I interviewed Resident C, who stated that he has been living at the facility for seven months. Resident C stated, "I don't have any concerns. Staff are good to us. No one has ever tried to hurt me or do anything that made me uncomfortable. I don't know about any issues here."

I interviewed Resident D, who stated that he like likes living at the facility. Resident D stated, "Resident B was my friend. We got along good. I am sad he is gone, and I don't know what happened. Staff are nice and they take care of us and help when I need something. Staff have not been mean to me or done anything to hurt me."

I interviewed direct care staff, Allen Payor, who stated that he has worked at the facility for one year. Mr. Paylor stated, "I was working on 7/14/2023 and 7/23/2023, when both incidents occurred. Resident B had a history of substance use and making false allegations. He would often get mad if they didn't get what he wanted. On 7/14/2023, I

was working at the facility, along with Edward Wilson. Resident B asked to use his phone and we told him that he could, but that we wanted to ensure he was not going to unnecessarily call 911. He became very upset and left the home. A short while later, Resident B returned, and the cops also showed up at the facility. They said that Resident B reported that Mr. Wilson had tried to rape him. But I was here the entire time and Mr. Wilson never was alone with Resident B and nothing like this ever happened. The police interviewed me and Mr. Wilson and took down information and then they left. When the police left, Resident B went up to his room and was for the rest of the day. On 7/23/2023, Resident B stayed in his room all morning. We went to his room around 8:00am to ask him if he wanted breakfast and to administer his morning meds. He seemed fine and he did take his morning meds. But he said he was tired and wanted to continue to lay in bed. Around 10:30am, I checked on him again and he still seemed fine. He was lying in bed but responded, “Fine” when I asked him if he was okay. At 12:30pm, Mr. Wilson went upstairs to check on Resident B again, and he found him on the bedroom floor, and he was unresponsive. Mr. Wilson called for help, and I immediately ran upstairs. We called 911 and performed CPR until the paramedics arrived. The paramedics tried to resuscitate Resident B but were unsuccessful and he passed away. I do not know the cause of death. But I know we did not do anything to cause or harm Resident B.” Mr. Paylor denied this allegation is true.

I interviewed direct care staff, Ola Adekunle, who stated that she is familiar with Resident B and provided care to him during the time that he resided at the facility. Ms. Adekunle stated, “Resident B would often call 911 when he was upset or didn’t get his way. He would sometimes call 911 daily and it was becoming a huge issue. Guardian B1 and the case manager asked us to begin supervising his calls to the best of our ability to prevent calls to 911. We did the best we could, but Resident B would get mad when we told him we had to monitor him. I never had mistreated a resident and I have never observed any other staff mistreat or harm a resident. I don’t believe this allegation is true.”

On 8/4/2023, I spoke to direct care staff, Edward Wilson, via telephone. Mr. Wilson stated, “I am familiar with Resident B, and I did provide direct care to him when he lived here. Resident B would get mad easily if he didn’t get what he wanted. And he would threaten us by calling 911 because he thought it would get is in trouble. He called 911 all the time. I was working on 7/14/2023, along with Mr. Paylor. Resident B seemed to be doing okay but then he asked to use his phone and I reminded him that he needed to be monitored to prevent him from calling 911 unless it was really an emergency. Resident B got really upset and ran out of the home. A little while later he came back, and the cops showed up. We found out at that time, he had gone to Kroger, called 911 and made an allegation that I had tried to sexually assault him. But this was absolutely not true. I was working along with Mr. Paylor the entire time and there was never a moment that I was alone with Resident B. And I would never do something like this. On 7/23/2023, Resident B stayed in his room all morning. We went to his room around 8:00am to ask him if he wanted breakfast and to administer his morning meds. He seemed fine and he did take his morning meds. But he said he was tired and didn’t want to get up. We checked on him again around 10:30am and he seemed fine still. At

12:30pm, I went upstairs to check on Resident B again, and he found him on the bedroom floor, and he wasn't awake. I called for help, and Mr. Paylor came to assist me. We called 911 and performed CPR until the paramedics arrived. The paramedics tried to resuscitate Resident B, but he passed away. We don't know the cause of death." Mr. Paylor denied this allegation is true.

On 8/4/2023, I spoke to Easter Seals Case Manager, Sherry VanHulle, via telephone. Ms. VanHulle stated, "I was Resident B's case manager for 4 years prior to their passing. Resident A was a female that identified as a male. Resident B had a long history of substance abuse/seeking, panhandling, inappropriate sexual behavior and making false allegation to law enforcement. Resident B frequently made false accusations when people didn't do what he wanted or if staff attempted to redirect him. He frequently called 911 and was on a phone monitoring restriction in attempt to reduce these calls to law enforcement. I do not believe that any staff attempted to rape Resident B. I believe this was a reaction of them being redirected and acting out. Resident B passed away on 7/23/2023, but the autopsy results have not yet been received. I was told by the coroner's office that they believe their cause of death was a heart attack related to ongoing medical issues of extreme obesity and refusal to obtain consistent medical care. I am also the case manager for Resident E and I feel they are providing adequate care to him as well. I do not have any concerns related to the staff's care and treatment of Resident B during the time that they resided at the facility."

On 8/9/2023, I spoke to Guardian B1 via telephone. Guardian B1 stated, "Resident B had a lot of mental health and physical health issues. He had a history of lying and making false allegations all of the time. He was calling 911 so often that I had to request staff to monitor his calls to avoid law enforcement being continually called. When Resident B did not get his way, he would immediately call 911. I do not believe this allegation is true and I did not have any concerns about the care that staff were providing to him. I have not received a death certificate as of yet so I am unsure of the exact cause but there is no concern of foul play on the part of staff."

On 8/15/2023, I spoke to Guardian C1, via telephone. Guardian C1 stated that he feels the staff are providing adequate care to Resident C. Guardian C1 did not vocalize any concerns.

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:	According to the *Assessment Plan for AFC Residents* and Guardian B1 and Ms. Vanhulle, Resident B had a long history of making false allegations to law enforcement as a form of retaliation against others. According to Mr. Wilson, he has never mistreated, or attempted to cause harm to any resident, including Resident B. Mr. Wilson denied this allegation is true. According to Resident C and Resident D, they feel comfortable living at the facility. Resident C and Resident D denied being mistreated, or observing any other resident, being mistreated by staff. According to Mr. Paylor and Ms. Adekunle, they have never mistreated or caused harm to any resident, including Resident B., nor observed any other staff mistreat a resident. Mr. Paylor and Ms. Adekunle denied this allegation is true. Based on the information above, there is not sufficient information to confirm that this allegation is true.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Stephanie Gonzalez 9/26/2023

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 09/26/2023

Denise Y. Nunn Date
Area Manager