GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

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

RE: License #: AS630411893
Investigation #: 2023A0605039
Zenith Home

Dear Ken Ogundipe:

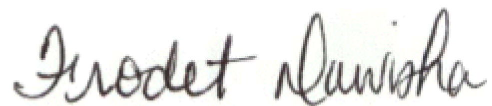
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630411893
Investigation #:	2023A0605039
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/25/2023
Report Due Date:	09/23/2023
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	G 15 B 405 W Greenlawn Lansing, MI 48910
Licensee Telephone #:	(214) 250-6576
Administrator/Licensee Designee:	Kehinde Ogundipe
Name of Facility:	Zenith Home
Facility Address:	21412 Reimanville Ferndale, MI 48220
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	12/01/2022
License Status:	REGULAR
Effective Date:	06/01/2023
Expiration Date:	05/31/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents are being evicted. Resident A was given a 30-day notice.	Yes
Direct Care Staff (DCS) Edward Wilson drove Resident B and Resident C without a valid driver's license and were in a car accident. Resident B and Resident C were injured.	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A0605039
07/25/2023	Special Investigation Initiated - Telephone Left message for reporting person (RP)
07/25/2023	Contact – Telephone call received Discussed allegations with RP
07/31/2023	Inspection Completed On-site Conducted unannounced on-site investigation
08/01/2023	Contact - Telephone call made Discussed allegations with direct care staff (DCS) Edward Wilson, James Starkey Jr., and Kamyria White Left message for DCS Jessica Loilie
08/01/2023	Contact - Telephone call made Discussed allegations with licensee designee Ken Ogundipe
08/02/2023	APS Referral Adult Protective Services (APS) made referral
08/02/2023	Contact - Telephone call received Discussed allegations with the Executive Director Kennedy Shannon
08/03/2023	Contact - Document Sent Email to APS worker Estelita Horton

08/03/2023	Contact - Document Received Email from APS worker Estelita Horton
08/09/2023	Contact – Document received Email from Office of Recipient Rights (ORR) worker Heather Shepherd
08/28/2023	Contact - Telephone call made Followed up with TTI, Greg Szopo
08/28/2023	Contact - Document Received Email from Kennedy Shannon
09/18/2023	Contact - Document Sent Email to Kennedy Shannon and Brandon Gadberry
09/18/2023	Contact - Telephone call made Followed up with the HM Abimbola Adekunle
09/18/2023	Exit Conference Conducted exit conference via telephone with licensee designee Ken Ogundipe with my findings

ALLEGATION:

Residents are being evicted. Resident A was given a 30-day notice.

INVESTIGATION:

On 07/25/2023, intake #196608 was assigned for investigation. I initiated the special investigation by contacting the reporting person (RP). About two weeks ago, the RP was alerted that Eden Prairie Residential Care, LLC terminated their contract with Macomb County Community Mental Health (MC-CMH). Eden Prairie Residential Care, LLC has about 14 individuals in their homes that received services with MC-CMH. According to the RP, a 60-notice should have been given to MC-CMH prior to terminating the contract and these individuals must remain in their homes until placement is found. However, instead Eden Prairie Residential Care, LLC began giving either a 30-day discharge notice or an emergency discharge notice to all 14 residents. In addition, Eden Prairie Residential Care, LLC dropped off three to four individuals at the hospital including Resident A. Resident A was dropped off at the hospital on 07/11/2023 and then an emergency discharge notice was issued. Resident A continues to remain at Pontiac General Hospital.

On 07/25/2023, I interviewed via telephone Resident A's support coordinator Heather Thompson with Treatment Training Innovation (TTI) regarding the allegations. Ms.

Thompson received the incident report (IR) on 07/11/2023 regarding Resident A being admitted into the hospital. Prior to that, she had only received three IRs; one in April, another one in May 2023 and on 07/11/2023. Ms. Thompson is new to Resident A, and she cannot access the prior support coordinator's emails to find out if that individual received additional IRs regarding Resident A. However, Ms. Thompson has never been contacted by the home manager Abimbola Adekunle nor any other direct care staff (DCS) from Zenith Home regarding Resident A's behaviors. She only received the IRs with no other information. Resident A had no restrictions in his individual plan of service (IPOS) or his crisis plan because according to her notes, Resident A's behaviors only began in April 2023. Ms. Thompson stated if the HM or DCS had contacted her regarding Resident A's behaviors, she would have implemented a behavioral plan. Resident A would receive an evaluation from a behavioralist and then a plan would be put in place. Prior to being contacted by staff on 07/11/2023, Ms. Thompson never received any other contact from anyone at Zenith Home regarding Resident A's behaviors nor any requests for behavior interventions.

On 07/31/2023, I conducted an unannounced on-site investigation. I interviewed assistant HM (AHM) Javontez Mitchell regarding the allegations. On 07/11/2023, AHM was working his shift when he was approached by Resident A asking for a cigarette. AHM told Resident A, "I don't have any. You have to wait until I get some. Resident A then began hitting me. He swung at me, I grabbed his arm and then Resident A broke the TV." The AHM called 911 who arrived at the home and tried to calm Resident A. The AHM then called TTI support coordinator Heather Thompson advising her what happened. Ms. Thompson stated to have the police transport Resident A to the hospital, which police did. Prior to this incident, there have been multiple IRs written regarding Resident A's behaviors that include self-harm, destruction of property, and assaulting both staff and other residents. However, the AHM stated he has never contacted Ms. Thompson advising her of these concerns nor requesting any interventions for Resident A's behaviors other than submitting to her the IRs. The AHM stated, "In the past, I usually send Heather the IRs and then she calls me, but this time she never called me whenever I sent her the IRs, but I also never called her." The AHM stated the emergency discharge was due to staff not being able to keep themselves or other residents safe if Resident A returned to Zenith Home.

I interviewed the HM Abimbola Adekunle regarding the allegations. The HM stated that Resident A was admitted to Zenith Home on 12/06/2022. The IPOS for Resident A was completed on 09/02/2022 by MC-CMH. I reviewed the IPOS and there were no statements or mention of Resident A's behaviors anywhere in the IPOS. The first incident with Resident A occurred on 04/16/2023 when Resident A assaulted another resident at Zenith Home. The IR was submitted to the support coordinator who was in place at that time, but no follow-up call was made. In April 2023, two additional IRs were submitted due to Resident A's behaviors, but again no communication was made with the support's coordinator. There were two more incidents in May 2023 regarding Resident A and these IRs were again submitted to the support's coordinator which was now Ms. Thompson, but no call was followed up by the HM or any other staff at Zenith Home. The HM stated there were no interventions put in place regarding Resident A's

behaviors. However, she reported that Eden Prairie Residential Care, LLC has been having issues with MC-CMH in receiving appropriate IPOS/crisis plans which is the reason the contract was terminated. She stated that many of the residents' IPOS do not state the behaviors, nor do they state any interventions or how staff must address these behaviors. The HM and the AHM were advised that a resident should not be accepted if the resident has behavioral issues, and their IPOS/crisis plan is not addressing these issues as the assessment plan is part of the admission process. I advised the HM and the AHM that if the group home receives an IPOS without behavior interventions then the group home must reach out to the support's coordinator and these communications must be documented.

I attempted to interview Resident B and Resident C regarding the allegations, but both stated they did not know anything about Resident A.

On 08/01/2023, I interviewed DCS Edward Wilson via telephone regarding the allegations. Mr. Wilson heard that Resident A was discharged from Zenith Home and sent to the hospital but does not know why. Mr. Wilson stated that there has been concerns with Resident A's behaviors but that he did not know of any interventions that were put in place. He never reached out to Ms. Thompson regarding Resident A.

On 08/01/2023, I interviewed DCS James Starkey Jr. via telephone regarding the allegations. Mr. Starkey Jr. has only been with this corporation for two months. He knows Resident A and has worked in the home when Resident A was living there. He stated, "Resident A had his good days, and he had his bad days." When Resident A gets mad, he becomes aggressive towards things. Resident A has never been aggressive towards Mr. Starkey Jr., and he has never witnessed Resident A become aggressive with any other staff. Mr. Starkey Jr. has observed Resident A slam doors but stated that he usually can redirect Resident A. He has never contacted Resident A's support's coordinator Mr. Thompson regarding Resident A and there are no interventions in place for Resident A's behaviors.

On 08/01/2023, I interviewed DCS Kamyria White regarding the allegations via telephone. Ms. White reported that Resident A was "happy one minute and the next minutes when Resident A doesn't get his way, he threatens residents and staff." Cigarettes were the biggest reason for Resident A's aggression. When he asks for a cigarette and staff does not have cigarettes to give him, he becomes aggressive. Although she has not seen Resident A become aggressive towards her or other staff, she has observed Resident A throwing bottles and cans around when he's mad. Ms. White has never contacted Resident A's support's coordinator but stated if anyone has it would be the AHM. She too has not seen any interventions in place for Resident A's behaviors. She tries to redirect Resident A and sometimes that works but other times it does not.

On 08/01/2023, I interviewed licensee designee Ken Ogundipe via telephone regarding the allegations. Mr. Ogundipe believes that Resident A had a psychotic episode on 07/11/2023 which resulted in his hospitalization. Resident A began attacking staff, so

the AHM called the support's coordinator Heather Thompson who advised to have the police transport Resident A to the hospital. Mr. Ogundipe stated, "TTI is not customer focused. The support's coordinators do not provide behavioral plans and for this reason, they terminated the contract with MC-CMH." Mr. Ogundipe went to MC-CMH Chief Executive Officer (CEO) about two-three months ago regarding behavioral plans for all his residents with behaviors, but he never heard back. He has been struggling with MC-CMH to get behavioral plans in place but has been unsuccessful. Initially, when the residents are admitted into Eden Prairie Residential Care, LLC homes, Mr. Ogundipe is told that these residents do not have behaviors, but then as time passes, the behaviors manifest themselves and MC-CMH does not want to update the IPOS/crisis plans nor do they want to put restrictions on the residents, so these behaviors continue. Mr. Ogundipe stated that he has reached out to MC-CMH several times for help with no avail. He believes MC-CMH was contacted regarding Resident A's behaviors too with no success so he will send me all the information he has regarding his communications with MC-CMH.

On 08/02/2023, I received a telephone call from Eden Prairie Residential Care, LLC Executive Director Kennedy Shannon regarding the allegations. Ms. Shannon advised that this corporation has had numerous issues with MC-CMH not providing behavioral plans for their residents including Resident A. Therefore, the corporation terminated their contract with MC-CMH. Ms. Shannon advised that the corporation filed a resident rights complaint regarding MC-CMH having no behavioral plans in place for these residents. She will get me the information showing that communication was made with MC-CMH for behavioral plans that includes for Resident A.

On 08/03/2023, I received an email from Adult Protective Services (APS) worker Estelita Horton stating she will be substantiating her case.

On 08/09/2023, I received an email from Office of Recipient Rights (ORR) worker Heather Shepherd. Ms. Shepherd went out to Zenith Home to conduct interviews and while she was there, she observed the floor in the living room to feel soft and kind of tilted. One area felt like it was flexing when she walked on it.

On 08/09/2023, I contacted licensee designee Ken Ogundipe regarding the floor issue. Mr. Ogundipe stated that he will be hiring a contractor to look at the floor and submit a work plan to my attention.

On 08/28/2023, I followed up with TTI and was informed that Heather Thompson was out on medical leave. Greg Szopo was covering for her regarding Resident A's case. Resident A remains at Pontiac General Hospital and Mr. Szopo will be going to the hospital to complete a behavioral plan and to assist with locating placement. Resident A has poor impulse control, has a moderate developmental disability and history of property damage. There was no crisis plan completed according to the notes. Mr. Szopo reviewed Ms. Thompson's notes and found the following regarding Resident A. On 04/17/2023, Ms. Thompson met with Resident A at Zenith Home. The staff reported that Resident A was "compliant," and "doing well with other residents." Staff also

reported, “sometimes Resident A gets upset and is hard to calm down.” Ms. Thompson recommended staff to schedule an appointment for Resident A to have his medication reviewed. On 05/15/2023, Ms. Thompson met with Resident A to assist him in finding a job. Resident A was in a good mood and according to staff, Resident A “gets along with the residents.” On 06/30/2023, Resident A told Ms. Thompson, “the staff are making things in the house stressful, so I left because I needed to walk away.” Ms. Thompson told the HM, “Resident A has zero restrictions and can come and go as he pleases.” On 07/11/2023, Ms. Thompson received a telephone call from Zenith Home stating that “The police were at the home because Resident A assaulted staff and there was property destruction and self-harm.” Resident A was taken to the hospital. Mr. Szopo stated, “Zenith Home tries to restrict their residents from doing a lot of things, which becomes an issue when there are no restrictions in their IPOS, or crisis plans.” Mr. Szopo does not show any communication regarding Resident A’s behaviors between Ms. Thompson and any staff from Zenith Home prior to 07/11/2023.

On 09/19/2023, I received a work order from Ken Ogundipe for the floor. The floor was repaired by a licensed contractor on 09/12/2023.

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: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(ii) The alternatives to discharge that have been attempted by the licensee.**
ANALYSIS:	Based on my investigation and information gathered, the alternatives to discharge were not attempted by the licensee prior to Resident A’s emergency discharge on 07/11/2023. Resident A was admitted into Zenith Home on 12/06/2022 and his unacceptable behaviors began in 04/2023-07/11/2023. His behaviors included assaulting other residents and staff, property destruction and self-harm. The staff at Zenith Home were submitting IRs to Resident A’s support’s coordinator with TTI, but staff never contacted the support’s coordinator to discuss a behavioral plan for Resident A. Resident A’s support’s

	coordinator Heather Thompson denied any communication between her and Zenith Home staff requesting behavioral interventions for Resident A’s behaviors. Several times that Ms. Thompson communicated with staff, staff reported that Resident A was “getting along with other residents,” and “doing well,” at the home. Ms. Thompson stated if staff would have contacted her prior to the emergency discharge, a behavioral evaluation would have been completed and a behavioralist would be assigned to Resident A. Instead, Resident A was sent to the hospital and then issued an emergency discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on my investigation and information gathered, interventions to address Resident A’s unacceptable behavior were not put in place to ensure Resident A’s safety and the safety of the other residents and staff. Resident A’s behavior began in 04/2023-07/11/2023, but staff never communicated with Resident A’s support’s coordinator Heather Thompson regarding Resident A’s behaviors other than submitting IRs to her attention. I reviewed Resident A’s IPOS completed on 09/14/2022, and the IPOS did not have any statements regarding any behavioral issues with Resident A. Ms. Thompson stated a behavioral plan would have been implemented for Resident A if staff would have contacted her regarding his behaviors prior to his emergency discharge on 07/11/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct Care Staff (DCS) Edward Wilson drove Resident B and Resident C without a valid driver's license and were in a car accident. Resident B and Resident C were injured.

INVESTIGATION:

On 07/26/2023, I received additional allegations regarding DCS Edward Wilson got into a car accident on 07/22/2023, with Resident B and Resident C in the car. Mr. Wilson does not have a valid driver's license. Resident B and Resident C sustained injuries.

On 07/31/2023, I interviewed the AHM Javontez Mitchell regarding the allegations. Mr. Mitchell stated on 07/22/2023, DCS Edward Wilson was the only staff member on shift. Mr. Mitchell confirmed that Mr. Wilson does not have a valid driver's license and should not be driving residents. Mr. Mitchell never received a telephone call from Mr. Wilson on 07/22/2023, advising that Mr. Wilson was driving Resident B and Resident C to the store. Mr. Mitchell stated he was not aware that Mr. Wilson was driving residents around during Mr. Wilson's shift. Mr. Mitchell stated he and DCS Kamyria White are the only staff members with valid driver's license at this home. Mr. Wilson drove Resident B and Resident C to the store and got into a car accident. He does not know all the details but stated that Resident B was complaining about his back, so he went to the hospital, but Resident C stated he was ok, so he did not go. However, the next day Resident C complained about his back, so he went to the hospital and found out he had fractured ribs. Mr. Wilson has been suspended from Zenith Home and an IR was never completed regarding this incident.

On 07/31/2023, I interviewed the HM regarding the allegations. The HM confirmed that DCS Edward Wilson does not have a valid driver's license. On 07/22/2023, Resident B and Resident C requested to purchase cigarettes from the store. Mr. Wilson drove them to the store and while at a stop light, another driver rearended them. Resident B went to the hospital, but Resident C refused to go stating he was ok. Resident C complained of back pain the next day, so he went to the hospital and learned he had fractured his ribs. Resident B was recommended to a back surgeon and Resident C to follow-up with his primary care physician (PCP). The HM stated an IR was not completed regarding this incident. Mr. Wilson has been suspended until further notice. The HM stated she too was not aware that Mr. Wilson was transporting residents in his car without a driver's license.

On 07/31/2023, I interviewed Resident B regarding the allegations. Resident B is his own guardian. He and Resident C wanted to go to the store, so they asked DCS Edward Wilson who was working the shift on 07/22/2023. Mr. Wilson agreed to take them to the store. As they were driving, they came to a stoplight and another car rearended them. Resident B complained of his throat and back hurting so he was transported to the hospital. He was told he had cracked ribs and something going on

with his back. He has to follow-up with a back surgeon. This is not the first time Mr. Wilson has transported him to the store or other places, but it is the first time they were in a car accident with Mr. Wilson. Resident B was not aware that Mr. Wilson did not have a valid drivers license.

On 07/31/2023, I interviewed Resident C regarding the allegations. On 07/22/2023, Resident C and Resident B wanted to go to the store, so DCS Edward Wilson drove them. The light turned green, so Mr. Wilson began driving but the other car hit their red light and sideswiped them. Initially, Resident C was ok, but the next day his back began hurting so he went to the hospital. He learned he had fractured his ribs. He has to follow-up with his PCP. This was the first car accident with Mr. Wilson, but it was not the first time Mr. Wilson has transported them in the car. Resident C does not know if Mr. Wilson has a driver's license or not.

On 08/01/2023, I interviewed DCS Edward Wilson via telephone regarding the allegations. Mr. Wilson has been working for this corporation for two years. He confirmed he does not have a driver's license. He stated he has been busy working, so he never had time to get his driver's license. On 07/22/2023, he was working alone on his shift when Resident B and Resident C asked him to go to the store. He drove them to the store and on the way there, he stopped at a red light. The light turned green for him, so he proceeded to drive and then was hit on the side by another driver who was on their cell phone as that driver ran their red light. Resident B complained of back pain, so he was transported to the hospital via ambulance. Resident C initially stated he was ok, but the next day he too began complaining of back pain. Both residents sustained fractured ribs. Mr. Wilson reported that he has been driving residents for about one-year and that both the HM and the AHM were aware that Mr. Wilson was transporting residents without a driver's license. Mr. Wilson stated his employment has been terminated with Eden Prairie Residential Care, LLC.

On 08/01/2023, I interviewed DCS James Starkey Jr. regarding the allegations. Mr. Starkey Jr. does not have a driver's license too. He denied transporting any residents in a vehicle and stated he does not know anything about Mr. Wilson's car accident.

On 08/01/2023, I interviewed DCS Kamiyra White regarding the allegations. Ms. White has a valid driver's license and transports residents to appointments and the store. She heard about Mr. Wilson's car accident but did not know he did not have a driver's license. She did not have any other information to offer regarding these allegations.

On 08/01/2023, I interviewed licensee designee Ken Ogundipe regarding the allegations. Mr. Ogundipe was very upset when he heard about the car accident involving Resident B and Resident C. Mr. Wilson's employment has been terminated. Mr. Ogundipe has policy regarding driving without a valid driver's license and stated that Mr. Wilson was aware of the policy but decided not to follow their policy. Mr. Ogundipe sent me the policy and it specifically indicates the "unacceptable drivers," which includes not having a valid driver's license. Mr. Ogundipe stated he will be reviewing policy with all his staff.

On 09/18/2023, I received an email from ORR Heather Shepherd stating she is substantiating her investigation for physical neglect II against DCS Edward Wilson and failure to report against the HM Abimbola Adekunle.

On 09/18/2023, I conducted the exit conference via telephone with licensee designee Ken Ogundipe. Mr. Ogundipe acknowledged the violations and agreed to submit an acceptable corrective action plan.

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:	Based on my investigation and information gathered, Resident B and Resident C safety and protection were not attended to at all times on 07/12/2023 when Mr. Wilson drove Resident B and Resident C to the store without a driver's license. Mr. Wilson confirmed he did not have a driver's license when he transported Resident B and Resident C to the store and on their way to the store, they were involved in a car accident. Resident B and Resident C sustained injuries, fractured ribs because of Mr. Wilson driving without a driver's license.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.**

	(c) The effect of the accident or incident on the person who was involved, and the care given. **(d) The name of the individuals who were notified and the time of the notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening.**
ANALYSIS:	Based on my investigation and information gathered, DCS Edward Wilson and the HM Abimbola Adekunle did not complete an IR regarding the accident on 07/22/2023 involving Resident B and Resident C. Resident B and Resident C were hospitalized due to sustaining injuries at the time of the accident. The IR was never completed nor was it submitted to Resident B, Resident C's designated representative, responsible agencies or to ORR.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/20/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:

09/20/2023

Denise Y. Nunn Date
Area Manager