GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 20, 2023

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

RE: License #: AS330411028
Investigation #: 2023A1033062
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 (517) 284-9727.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330411028
Investigation #:	2023A1033062
Complaint Receipt Date:	08/22/2023
Investigation Initiation Date:	08/24/2023
Report Due Date:	10/21/2023
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, Designee
Licensee Designee:	Kehinde Ogundipe, Designee
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:	1ST PROVISIONAL
Effective Date:	09/19/2023
Expiration Date:	03/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A requires one-on-one supervision and is not receiving this level of care from direct care staff.	No
There is not adequate food at the facility to prepare proper meals. The direct care staff run out of groceries and the groceries are not replenished in a timely manner.	Yes
The facility is dirty and kept in an unclean manner. The bathrooms do not have toilet paper for resident use.	No
The bedrooms are too small for two people to share, and there is not adequate community space for resident use.	No
The facility poses a fire hazard as it is overcrowded and there is not direct access to evacuate.	No
On 9/21/23 direct care staff took Resident A and Resident C to the local park and allowed the residents to use marijuana. Resident A had a medical event on this date related to the marijuana use.	No
Additional Findings	Yes

III. METHODOLOGY

08/22/2023	Special Investigation Intake 2023A1033062
08/23/2023	APS Referral Denied APS referral.
08/24/2023	Special Investigation Initiated - Telephone Interview with Citizen 1, via telephone.
08/28/2023	Inspection Completed On-site Interview with direct care staff/home manager, Ariel Busch, direct care staff, Tambria Baldwin & Deonna Baldwin, Resident A & B. Walk through of facility completed. Resident A resident record review initiated.
08/30/2023	Inspection Completed On-site On-site visit made to measure resident bedrooms and available living space.
09/25/2023	Contact - Telephone call made Attempt to interview Community Mental Health Therapist, Eric B. Voicemail message left, awaiting response.

09/25/2023	Contact - Document Sent Email correspondence with licensee designee, Ken Ogundipe requesting documentation. Awaiting response.
09/25/23	Contact – Telephone call made Interview with direct care staff, April Clark, via telephone.
09/28/2023	Inspection Completed On-site Interview with direct care staff, Shakiya Peters, review of Resident A resident record. Attempt to interview Resident C. Resident C was not at the facility for an interview.
09/28/2023	Contact – Telephone call made Interview with Resident A via telephone.
09/28/2023	Contact – Telephone call made Interview with Citizen 1 via telephone.
10/10/2023	Contact – Telephone call made Interview with Guardian A1's office, via telephone.
10/10/2023	Contact – Telephone call received Interview with Community Mental Health case manager, Eric Barriger, via telephone.
10/10/2023	Contact – Telephone call made Interview with direct care staff, Hannah Reyes, via telephone.
10/10/2023	Contact – Telephone call made Attempt to interview Resident C. Resident C was not at the facility to be interviewed.
10/10/2023	Contact – Telephone call made Attempt to interview direct care staff, Dephanie Young. No answer. Text message sent and awaiting a response.
10/20/2023	Exit Conference Conducted via telephone with licensee designee, Kehinde Ogundipe.

ALLEGATION:

Resident A requires one-on-one supervision and is not receiving this level of care from direct care staff.

INVESTIGATION:

On 8/22/23 I received an online complaint regarding the Bell Oaks I at Moores River adult foster care facility (the facility). The complaint alleged that Resident A requires one-on-one staff supervision and is not receiving this level of care from the current direct care staff. On 8/24/23 I interviewed Citizen 1 via telephone. Citizen 1 reported that she is aware that Resident A is required to have one-on-one direct staff supervision at the facility and has found that this is not occurring. She reported that Resident A has been free to take walks, independently, and is not receiving this level of care.

On 8/28/23 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Home Manager, Ariel Busch. Ms. Busch reported that Resident A was previously required to received one-to-one direct staff supervision and be within arms reach of direct care staff while in the community, but these requirements were changed about two months ago. She further reported that Resident A's case manager, Eric Barriger, with Clinton, Eaton, Ingham Community Mental Health (CEI-CMH) had updated her Person-Centered Plan (PCP) to support Resident A having independent access to the community and in the facility.

On 8/28/23, during on-site investigation I interviewed direct care staff, Tambria Baldwin. Ms. Baldwin reported that Resident A does not require one-to-one supervision from direct care staff members and she is able to take walks in the community on her own. She reported that Resident A does not require one-to-one supervision while in the facility or in the community at this time.

On 8/28/23, during on-site investigation, I interviewed direct care staff, Deonna Baldwin. Deonna Baldwin reported that she was told by other direct care staff members that Resident A no longer requires one-to-one supervision. She reported that the direct care staff make regular checks on Resident A, but that she is free to leave the facility and take walks in the local neighborhood, independently.

On 8/28/23, during on-site investigation, I interviewed Resident A. Resident A reported that she no longer requires one-to-one direct staff supervision. Resident A reported that she is able to come and go from the facility as she pleases and just needs to sign in and out on the sign out sheet. Resident A reported that this level of supervision was changed in the past couple of months.

On 8/28/23, during on-site investigation, I reviewed Resident A's resident record. I reviewed the document, *Assessment Plan for AFC Residents*, dated 8/22/22. On page 1, under section, *Social/Behavioral Assessment*, subsection, *Moves Independently in Community*, it states, "One on one during awake hours. Resident is delusional about being own guardian and non-compliant at times with medications."

On 8/28/23, during on-site investigation, I reviewed the document from Huron Behavioral Health, *Clinical Assessment (Initial/Annual Assessment)*, dated 5/13/22. At the time of this assessment Resident A was residing in an independent living environment and not at the facility. This was the only Community Mental Health (CMH) Assessment found in Resident A's resident record at the time of the on-site investigation. This document did not contain any directives for Resident A to have one-on-one direct care supervision.

On 9/25/23 I interviewed direct care staff, April Clark, via telephone. Ms. Clark reported that Resident A does not require one-to-one supervision at this time. Ms. Clark reported that Resident A's supervision level was changed within the past six months. She reported that Resident A is able to take walks independently.

On 9/27/23 I received an email correspondence from Eden Prairie Residential Services Program Director, Ashanti Wright, providing an updated CMH *Treatment Plan Annual/Initial* for Resident A. This CMH Treatment Plan was completed by Mr. Barriger and dated 9/12/23. It was not identified in this document that Resident A requires one-on-one direct care staff supervision.

On 10/10/23 I interviewed Guardian A1 via telephone. Guardian A1 reported that Resident A no longer requires one-on-one supervision from direct care staff. She reported that the one-on-one supervision order was discontinued around July 2023. She further reported that Resident A is able to access the community independently. Guardian A1 reported that she was informed of the change in supervision requirements from a direct care staff member at the facility, but she could not recall the name of the direct care staff who reported this change to her.

On 10/10/23 I interviewed Mr. Barriger, via telephone. Mr. Barriger reported that he began providing case management services to Resident A, through CEI-CMH, on 4/26/23. Mr. Barriger reported that he has never seen any directive that indicated Resident A required one-on-one supervision from direct care staff. Mr. Barriger reported that he has documented that Resident A has full access to the community and does go on walks and outings to a local church and the store.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(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.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Mr. Barriger, Guardian A1, Ms. Busch, Tambria Baldwin, Deonna Baldwin, & Ms. Clark, as well as review of Resident A's resident record, it can be determined that Resident A is not currently required to have one-on-one direct care staff supervision. Even though the *Assessment plan for AFC Residents* form indicated the need for one-on-one direct care staff supervision, it can be determined that this document is outdated based on the most recent CEI-CMH documentation, from Mr. Barriger, which does not denote the need for one-on-one direct care staff supervision. Mr. Barriger reported having worked with Resident A, as her case manager, since 4/26/23 and never having the directive that she requires one-on-one direct care staff supervision. All parties interviewed, with the exception of Citizen 1, were clear on their understanding that Resident A's supervision criteria changed several months ago, and she no longer requires this level of direct care staff supervision.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is not adequate food at the facility to prepare proper meals. The direct care staff run out of groceries and the groceries are not replenished in a timely manner.

INVESTIGATION:

On 8/22/23 I received an online complaint alleging that the direct care staff are not able to provide adequate quantities of nutritious food for the residents and that the facility is frequently out of food or low on food. On 8/24/23 I interviewed Citizen 1 via telephone. Citizen 1 reported that Resident A had expressed concerns to her that the facility did not have adequate food for her to eat. Citizen 1 reported that she had a conversation with Ms. Busch regarding the groceries for the facility. She reported that Ms. Busch stated there was not enough money to buy groceries.

On 8/28/23 during on-site investigation, I interviewed Ms. Busch. Ms. Busch reported that the groceries are purchased every two weeks when payroll is completed. She reported that they complete pick-up orders at Walmart. She reported that the

residents go through the food quickly due to the number of residents they are serving. Ms. Busch reported that if they run out of food before the next grocery trip, they will have direct care staff go to a local restaurant to purchase meals.

On 8/28/23 during on-site investigation, I interviewed Tambria Baldwin. Ms. Baldwin reported that the grocery shopping is completed every two weeks. She reported that by the second week the food is running low, and it becomes difficult to find items to prepare a whole meal. Ms. Baldwin reported that much of the food that is purchased is processed/frozen food and not fresh. Ms. Baldwin reported that the facility has a stocked refrigerator today as the most recent grocery shopping trip was completed on 8/24/23. Ms. Baldwin reported that there are more snack foods purchased than actual food to prepare a well-balanced meal.

On 8/28/23 I interviewed Deonna Baldwin. Ms. Baldwin reported that the food supply is frequently running low at the facility. She reported that residents are frequently hungry due to not adequate food and not many nutritious options for meals.

On 8/28/23, during on-site investigation, I interviewed Resident A. Resident A reported that the “fridge is always empty”. She reported that Ms. Busch will state to the residents that they are waiting on the budget to purchase more groceries. Resident A reported that the food is rarely fresh and mostly processed foods.

On 8/28/23, during on-site investigation, I interviewed Resident B. Resident B reported that she feels she receives adequate food to meet her needs.

On 8/28/23, during on-site investigation, I did review the food available in the refrigerator and the pantry at the facility. The refrigerator did appear to have adequate food on this date. There were not many pantry items available for a facility accommodating six residents.

On 9/25/23 I interviewed Ms. Clark, via telephone. Ms. Clark reported that within the past few weeks the grocery situation is resolving. She reported that the management has changed how the grocery orders are being placed and there is now a list to input needed items and the licensee designee, Ken Ogundipe’s, spouse, Martha Ogundipe, is handling the food orders. Ms. Clark reported that prior to this recent change she would have to bring food from her own home to be able to prepare adequate meals for the residents.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Based upon interviews with Ms. Busch, Ms. Clark, Tambria Baldwin, Deonna Baldwin, Resident A, & Resident B, as well as observations made during the on-site investigation, it can be determined that the licensee has not been providing three regular nutritious meals daily. There were multiple complaints about a lack of food in the facility and the lack of availability of fresh and nutritious options for resident consumption. Despite having a refrigerator that was stocked with food at the on-site investigation, it was reported that a recent grocery order was completed which would account for this. Ms. Clark was interviewed several weeks after the initial on-site investigation and did note a change in the grocery process at this point, but also reported that prior to this recent change there were serious concerns about resident nutrition and availability of groceries at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is dirty and kept in an unclean manner. The bathrooms do not have toilet paper for resident use.

INVESTIGATION:

On 8/22/23 I received an online complaint alleging that the facility is dirty and kept in an unclean manner. The complaint further alleged that the bathrooms are not stocked with toilet paper for resident use. On 8/24/23 I interviewed Citizen 1 via telephone. Citizen 1 reported that she had made a recent visit to the facility and noted it to be in an unclean condition. She reported that trash was found on the front porch, such as a banana peel, and the bathroom was found to have an overflowing trash can, and no toilet paper for resident use.

On 8/28/23 during on-site investigation, I interviewed Tambria Baldwin. Ms. Baldwin reported that she has arrived for work at times to find the facility in an unclean manner with fast food trash on the table and dirty dishes in the sink. She reported that the bathrooms are kept clean and stocked with toilet paper and paper towel.

On 8/28/23, during on-site investigation, I interviewed Deonna Baldwin. Ms. Baldwin reported that it is not often that the facility is found in an unclean manner. She reported that sometimes the trash cans can overflow, due to being small, but the direct care staff manage this issue. She reported that she does not have current concerns about the cleanliness of the facility and reported that the bathrooms are kept clean and stocked with toilet paper. She did report that they only keep one roll

of toilet paper in the bathroom at a time due to some residents trying to clog the toilet with toilet paper and wasting the product.

On 8/28/23, during on-site investigation, I interviewed Resident A. Resident A reported that the facility is always dirty but could not give examples of this. She did not elaborate on this issue today.

On 8/28/23, during on-site investigation, I interviewed Resident B. Resident B reported that she does not feel the facility is dirty and reported that the residents clean their own bedrooms. She reported not having issues with dirty bathrooms and has not found the bathrooms to be without toilet paper.

On 9/25/23 I interviewed Ms. Clark, via telephone. Ms. Clark reported that she did not find any issues with the facility being kept in an unclean manner. She reported that the bathrooms are neat and clean and that there is always toilet paper available for resident use.

I completed on-site investigation visits on 8/28/23, 8/30/23, & 9/28/23. During each of these unannounced on-site visits I reviewed the cleanliness of the facility. I did not find that the facility was unclean, and the resident bathrooms were always clean and stocked with toilet paper.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Resident B, Ms. Clark, Tambria Baldwin, & Deonna Baldwin, as well as observations made during three unannounced on-site investigations it can be determined that there is not substantial evidence to conclude that the home is not being kept in a comfortable, clean, and orderly manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The bedrooms are too small for two people to share, and there is not adequate community space for resident use. The facility poses a fire hazard as it is overcrowded and there is not direct access to evacuate.

INVESTIGATION:

On 8/22/23 I received an online complaint which alleged that the facility is too small to house six residents and that it does not provide ample living space or a means or evacuation in the event of an emergency. On 8/24/23 I interviewed Citizen 1 who reported that the facility is cramped and overcrowded. She reported that there does not appear to be adequate space for residents who are housed on the second floor as these resident bedrooms are too small. She further alleged that the facility is so cramped it could pose a fire hazard if there were an emergency and residents needed to evacuate.

During on-site investigation on 8/30/23 I measured Resident A's bedroom and Resident B's bedroom. I measured the total square footage of Resident A's, shared bedroom as 130.9sqft. There was 3ft 10inches of space between the two beds in Resident A's bedroom. Resident B's bedroom measured at 136.5sqft, with two beds in this bedroom. There was more than 3 feet spacing between the two beds in Resident B's bedroom. I also measured the living room at 153.18sqft, and the dining room at 112sqft. Combined, the living room and dining room account for 265.18sqft of community space, which equals 44.2sqft of living space per resident, with the facility licensed to accommodate six residents. I evaluated the two primary means of egress from the main floor. Both means of egress were clear from any obstructions and I was able to exit and enter the facility with ease. The exit, located off from the dining room, is on the other side of a large dining room table, but I was able to move around the table and utilize the exit.

During on-site investigation on 8/28/23 I interviewed Tambria Baldwin. Ms. Baldwin reported that the facility does appear cramped at times when there is a shift change and multiple direct care staff are located in the dining room to give report, but otherwise she does not see this as an issue. Ms. Baldwin reported that she has worked as a direct care staff at this facility for about three months and has not participated or observed any fire drills being conducted.

During on-site investigation on 8/28/23 I interviewed Resident A. Resident A reported that she feels her bedroom is too small. She reported that the facility feels crowded at times. She reported that she has been in attendance for conducted fire drills and feels like the fire drills are done about every 3-5 months.

During on-site investigation on 8/28/23 I interviewed Resident B. Resident B reported that she feels the facility is crowded. She reported that she has resided at

the facility since May 2023 and has not yet participated in a fire drill or observed one being conducted.

On 9/25/23 I interviewed Ms. Clark, via telephone. Ms. Clark reported that she has worked at the facility for about six months and she has yet to participate in a fire drill or witness one being conducted.

On 9/27/23 I received an email correspondence from Ms. Wright in response to my request to view the fire drill records for the past six months. Ms. Wright provided me with a document titled, Fire Drill Requirement Log. This log had the following information noted on it:

- “4/15: 7am 56secs
- 5/12: 3pm 1min 2 seconds
- 6/15: 11p 1min
- 7/11: 8am 45secs
- 8/7: 5pm 43secs
- 9/12: 1am 47secs”

APPLICABLE RULE	
R 400.14409	**Bedroom space; "usable floor space" defined.**
	(3) A multioccupancy resident bedroom shall have not less than 65 square feet of usable floor space per bed.
ANALYSIS:	The resident bedrooms in question during this investigation were the resident bedrooms on the second floor of the facility. There are two resident bedrooms on the second floor. Both bedrooms were measured and are in compliance with licensing rules to provide at least 65 square feet of useable floor space per bed for resident use.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14409	**Bedroom space; "usable floor space" defined.**
	(7) There shall not be less than a 3-foot clearance between beds in a multioccupancy bedroom.
ANALYSIS:	Based on measurements taken during the on-site investigation visit on 8/30/23 there was more than 3 feet of clearance between the resident beds in the two resident bedrooms on the second floor of the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14405	**Living space.**
	(1) A licensee shall provide, per occupant, not less than 35 square feet of indoor living space, exclusive of bathrooms, storage areas, hallways, kitchens, and sleeping areas.
ANALYSIS:	Based upon measurements taken during the on-site investigation on 8/30/23, there was found to be 265.18 square feet of living space at the facility between the living room and dining room areas. The facility has been licensed to provide care for up to six residents, which makes this at least 35 square feet of indoor living space per resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	Based upon observations made during the on-site investigations on 8/28/23, 8/30/23, 9/28/23, the two primary means of egress were never blocked during these unannounced, on-site visits and remained clear and easily accessible in the event of an emergency. There is not clear evidence to suggest that the means of egress have been obstructed in any way from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 9/21/23 direct care staff took Resident A and Resident C to the local park and allowed the residents to use marijuana. Resident A had a medical event on this date related to the marijuana use.

INVESTIGATION:

I received a verbal complaint on 9/25/23 which alleged that direct care staff, Dephanie Young, took Resident A and Resident C to the local park, on 9/21/23, where Ms. Young allowed the residents to smoke marijuana, leading to Resident A having a medical event which required Emergency Medical Services (EMS) to be called. On 9/25/23 I interviewed Ms. Clark, via telephone. Ms. Clark reported that she had been working on 9/21/23 at the time of the alleged incident. She reported

that she was at the facility when she received a telephone call from Resident C. She reported that Resident C stated Resident A had what appeared to be a seizure and they (Ms. Young & Resident C) needed assistance in contacting EMS for help. Ms. Clark reported that EMS was called, and they did an evaluation on Resident A, at the facility, as direct care staff, Hannah Reyes, had driven to the park to pick up the two residents and Ms. Young and transported them back to the facility. Ms. Clark reported that Resident A refused to go to the emergency department for evaluation and noted she felt fine when EMS staff were evaluating her. Ms. Clark reported that Ms. Young had stated that Resident A had a pen and had been smoking something but she could not determine what she had smoked. Ms. Clark reported that both Resident A and Resident C admitted to "getting high smoking weed." Ms. Clark reported that an incident report was completed regarding the event.

On 9/28/23 I conducted an unannounced on-site investigation at the facility. I interviewed direct care staff, Shakiya Peters. Ms. Peters reported that she was not working on 9/21/23 and had no knowledge of any medical event with Resident A on this date. I requested to view the incident report form for this date completed for Resident A. Ms. Peters reported that she did not have this form and could not produce it at this time. She reported that the direct care staff working on this date during the time frame of the alleged incident were Ms. Clark, Tambria Baldwin, Ms. Young, and Ms. Reyes. I attempted to interview Resident A and Resident C during this on-site investigation but neither resident was present at the facility at this time.

On 9/28/23 I interviewed Resident A via telephone. Resident A reported that on 9/21/23 she walked to the local park with Ms. Young and Resident C. She reported that Ms. Young took marijuana out of her purse and asked Resident A and Resident C to smoke it with her. Resident A reported that she smoked the marijuana because she felt pressured to do so by Ms. Young. She reported that the marijuana was in the form of a rolled marijuana cigarette. She reported that after she smoked the marijuana her "joints seized up" and she fell backwards and sideways. She reported that Resident C called the facility and spoke with Ms. Clark. She reported that Ms. Clark sent Ms. Reyes to the park with a vehicle and picked up Resident A, Resident C, and Ms. Young and transported them back to the facility. She reported that once at the facility, EMS arrived to assess her. She reported that she refused to be transported to the emergency department. She reported that she made a telephone call to Citizen 1 and explained what had occurred as she was scared.

On 9/28/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that she did receive a telephone call from Resident A on 9/21/23 reporting that she had smoked marijuana at the park with Ms. Young and Resident C and then had what appeared to be a seizure or some sort of medical event. She reported that Resident A had stated that Ms. Young had supplied the marijuana.

On 9/28/23 I requested, via email correspondence with Ms. Wright, a copy of the incident report for Resident A from 9/21/23. Ms. Wright provided the document titled, *AFC Licensing Division – Incident/Accident Report (IR)*, dated 9/21/23, completed by

Ms. Young. The report states: “I Dephanie Young took two of the clients to walk through the trails and park for about an hour, then we went and sit at the picnic table under the pavilion to rest and talk before we came back to the residence and when I turn and looked at [Resident A] I saw her gradually start lying backwards and her arms and neck seemed to be constricting, so I got up and start trying to put her down on the ground and asked the help of the other resident so she didn’t fall or hit her head because it seemed to be a seizure. Then she slowly started to sit up and myself and another resident [Resident C] stood on both sides of her to make sure that she didn’t fall and we started to tell her that we were going to have to call 911 emergency to make sure that she was fine, and [Resident A] started doing the same thing go backwards slowly with her arms and neck constricting and there was saliva the second time and [Resident C] said I have to call 911 emergency and again [Resident A] arose slowly and started saying again I’m “okay” “I’m okay” don’t call the ambulance, I’m okay so I didn’t want her getting worked up any more or stressed that I ask [Resident C] to not call 911 emergency to call the resident for them to call 911 emergency because she wouldn’t be still because [Resident A] wasn’t going to wait for the ambulance to come. As [Resident C] called the residence I was calming [Resident A] down and that’s when another DSP worker named Hannah came and we all myself, her, [Resident C] and [Resident A] got in her vehicle and she said that marijuana was being smoked, I don’t know anything about no marijuana being smoked unless it was in the form of a vapor, because she was smoking on one, but that is all that I witnessed. The ambulance came to the resident and [Resident A] refused services.”

On 10/10/23 I interviewed Ms. Reyes via telephone regarding the allegation. Ms. Reyes reported that she had been working on 9/21/23 and was requested, by Ms. Clark, to drive to the local park and pick up Ms. Young, Resident A, and Resident C as Resident A had experienced some sort of medical event. She reported that she drove to the park and transported them all back to the facility. She reported that Resident A looked clammy and pale. She reported that Resident A stated she was okay but took a fall backwards. She reported that once they were back at the facility EMS came to evaluate Resident A. She reported that EMS encouraged Resident A to go to the emergency department and get checked out, but Resident A declined. Ms. Reyes reported that she witnessed Resident A tell the EMS personnel that she had been smoking marijuana at the park. Ms. Reyes reported that Ms. Young did not state whether the residents were smoking marijuana at the park. She reported that Resident C did not state whether they had been smoking marijuana.

On 10/10/23 I interviewed Ms. Wright regarding the allegation. Ms. Wright reported that she had since spoken with Resident A regarding the incident on 9/21/23 and Resident A denied smoking marijuana at the park. I attempted to schedule a time to interview Resident C and Ms. Wright reported that Resident C is currently hospitalized, and it is unknown when she will be released. Ms. Wright reported that Ms. Young has not worked at the facility since this incident, and she believes she must have quit.

On 10/10/23 I made several attempts, via telephone calls and text messages to interview Ms. Young. I was not able to connect with Ms. Young for an interview.

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 upon interviews with Ms. Clark, Ms. Reyes, Resident A, Citizen 1, and Ms. Wright as well as review of the IR dated 9/21/23, it can be determined that there is not enough substantial evidence to conclude that Ms. Young supplied Resident A with marijuana or was aware of her using marijuana while at the park on 9/21/23. Although Resident A verbalized to multiple sources that Ms. Young supplied her with marijuana, there are no other available witnesses to corroborate this claim. I was unable to interview Resident C, due to current hospitalization status. Therefore, there is not sufficient evidence to conclude that the direct care staff were not providing for Resident A and Resident C's protection and safety on 9/21/23.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 8/28/23 I requested to view the *Resident Register* document. Ms. Busch presented this document for review. The document did not include information for Resident B & Resident C. Ms. Busch reported that this document has not been updated recently. I interviewed Resident B on this day. Resident B reported that she moved into the facility in May 2023.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.**

ANALYSIS:	Based upon review of the *Resident Register*, available in the home at the time of the on-site investigation, & interview with Resident B, the direct care staff and licensee designee are not properly updating the Resident Register when new residents admit to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation on 8/28/23 I interviewed Resident A. Resident A reported that her bedroom is very warm and she cannot open her window as she does not have a screen in her window. I observed Resident A's bedroom during this investigation and confirmed that there was no screen available in Resident A's bedroom window.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	Based upon observations made during the on-site investigation on 8/28/23, there is not currently a screen on Resident A's bedroom window.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation on 8/28/23 I reviewed Resident A's resident record. I reviewed the document, *Assessment Plan for AFC Residents*, dated 8/22/22. On page 1, under section, *Social/Behavioral Assessment*, subsection, *Moves Independently in Community*, it states, "One on one during awake hours. Resident is delusional about being own guardian and non-compliant at times with medications."

On 8/28/23 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Home Manager, Ariel Busch. Ms. Busch reported that Resident A was previously required to received one-to-one direct staff supervision and be within arm's reach of direct care staff while in the community, but these requirements were changed about two months ago. She further reported that Resident A's case manager, Eric Barriger, with Clinton, Eaton, Ingham Community

Mental Health (CEI-CMH) had updated her Person-Centered Plan (PCP) to support Resident A having independent access to the community and in the facility.

As stated above, I interviewed multiple direct care staff members as well as Resident A who all confirmed Resident A no longer required one-to-one direct care staff supervision and had not needed this level of supervision for a number of months.

On 8/28/23, during on-site investigation, I reviewed the document from Huron Behavioral Health, *Clinical Assessment (Initial/Annual Assessment)*, dated 5/13/22. At the time of this assessment Resident A was residing in an independent living environment and not at the facility. This was the only Community Mental Health (CMH) Assessment found in Resident A's resident record at the time of the on-site investigation. This document did not contain any directives for Resident A to have one-on-one direct care supervision.

On 9/27/23 I received an email correspondence from Ms. Wright, in response to an email correspondence I had sent to her requesting Resident A's current Assessment Plan for AFC Residents form. Ms. Wright sent me the same document I had reviewed during the on-site investigation on 8/28/23. There was not an updated assessment plan available to view.

On 10/10/23 I interviewed Guardian A1 via telephone. Guardian A1 reported that Resident A no longer requires one-on-one supervision from direct care staff. She reported that the one-on-one supervision order was cancelled around July 2023. She further reported that Resident A can access the community independently. Guardian A1 reported that she was informed of the change in supervision requirements from a direct care staff member in the facility, but she could not recall the name of the direct care staff who reported this change to her.

On 10/10/23 I interviewed Mr. Barriger, via telephone. Mr. Barriger reported that he began providing case management services to Resident A, through CEI-CMH, on 4/26/23. Mr. Barriger reported that he has never seen any directive that indicated Resident A required one-on-one supervision from direct care staff. Mr. Barriger reported that he has documented that Resident A has full access to the community and does go on walks and outings to a local church and the store.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based upon interviews conducted and the review of Resident A's resident record it can be determined that at the time of the on-site inspection the only available assessment documents found in Resident A's resident record were both outdated documents. The *Assessment Plan for AFC Residents* form was dated 8/22/22 and continued to denote the need for one-on-one direct care staff supervision of Resident A, even though Guardian A1 and Mr. Barriger both reported that this was not a current need and had been discontinued months prior. The CMH *Clinical Assessment* dated for 5/13/22 was outdated and an updated copy was not available, on-site, at the time of the investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation on 8/28/23 I interviewed Tambria Baldwin. Ms. Baldwin reported that she has worked as a direct care staff at this facility for about three months and has not participated or observed any fire drills being conducted.

During on-site investigation on 8/28/23 I interviewed Resident A. She reported that she has been in attendance for conducted fire drills and feels like the fire drills are done about every 3-5 months.

During on-site investigation on 8/28/23 I interviewed Resident B. She reported that she has resided at the facility since May 2023 and has not yet participated in a fire drill or observed one being conducted.

On 9/25/23 I interviewed Ms. Clark, via telephone. Ms. Clark reported that she has worked at the facility for about six months, and she has yet to participate in a fire drill or witness one being conducted.

On 9/27/23 I received an email correspondence from Ms. Wright in response to my request to view the fire drill records for the past six months. Ms. Wright provided me with a document titled, Fire Drill Requirement Log. This log had the following information noted on it:

- "4/15: 7am 56secs
- 5/12: 3pm 1min 2 seconds
- 6/15: 11p 1min
- 7/11: 8am 45secs
- 8/7: 5pm 43secs

- 9/12: 1am 47secs”

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	Based upon interviews with Resident A, Resident B, Ms. Baldwin, and Ms. Clark as well as review of the fire drill records provided by Ms. Ashanti it can be determined that, even though the fire drill records indicate three times per quarter that fire drills were conducted, there is reasonable doubt that quarterly fire drills are being conducted based upon the interviews provided noting either direct care staff, or residents, who report never participating in a fire drill.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

The current status of the provisional license for physical plant deficiencies issued 09/19/2023 shall continue, contingent upon receipt of an approved corrective action plan.

10/18/23

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Jana Lipps Date
Licensing Consultant

Approved By:

10/19/2023

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Dawn N. Timm Date
Area Manager