GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 17, 2024

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

RE: License #: AS250402729
Investigation #: 2024A0779011
Welch Home I

Dear Kehinde Ogundipe:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250402729
Investigation #:	2024A0779011
Complaint Receipt Date:	11/30/2023
Investigation Initiation Date:	12/04/2023
Report Due Date:	01/29/2024
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:	Welch Home I
Facility Address:	913 Welch Blvd, Flint, MI 48503
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	08/24/2021
License **Status:**	REGULAR
Effective Date:	02/24/2022
Expiration Date:	02/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by being kicked and punched in the stomach by an unknown staff person on 11/27/2023.	No
Resident B is not being provided his required 2:1 staffing. Resident B eloped from the home on 11/21/23, and when police found him, he had frostbite on his feet.	Yes
The home is not staffed sufficiently for any of the residents.	Yes

III. METHODOLOGY

11/30/2023	Special Investigation Intake 2024A0779011
12/04/2023	APS Referral Complaint was referred to APS.
12/04/2023	Special Investigation Initiated - Telephone Spoke to Recipient rights investigator, Michelle McCormick.
12/07/2023	Contact - Telephone call made Spoke to APS worker, Kyle Whitman.
12/08/2023	Inspection Completed On-site
12/11/2023	Inspection Completed On-site
12/13/2023	Contact - Telephone call made Spoke to home manager, LaTanya Jones.
12/14/2023	Contact - Telephone call made Phone interview conducted with staff person, Cameron Davis.
01/11/2024	Exit Conference Held with licensee designee, Kehinde Ogundipe.
01/17/2024	Contact – Telephone call made. Spoke to supervisor, Jessica Ortiz.

ALLEGATION:

Resident A was assaulted by being kicked and punched in the stomach by an unknown staff person on 11/27/2023.

INVESTIGATION:

On 11/27/23, an on-site inspection was conducted, and Resident A was interviewed. Resident A stated that on 11/27/23, he left the home to go to the gas station and that staff person, Cameron Davis, followed him. Resident A claimed that Staff Davis then kicked Resident A twice and when asked where he was kicked, Resident A pointed to his chest area. Resident A reported that this happened only once and that Resident A had no marks or bruises as a result of the alleged incident. When Resident A was asked if he was sure it was Staff Davis or if it could have been a different staff, Resident A stated "No, it was Cameron". Resident A stated that there were no other staff or residents present to witness the alleged assault.

On 12/8/23, home manager, Latanya Jones was interviewed. Manager Jones stated that Resident A always has 1:1 staffing and that when Resident A walks to the local gas station, a staff person is always with Resident A. Manager Jones reported that Staff Davis was not Resident A's assigned 1:1 staff that day and that Staff Cameron called in sick on 11/27/23 and did not work. Manager Jones stated that Resident A is an attention seeker and has a history of making these types of false allegations. Manager Jones stated that Resident A did not report to any known staff that he was assaulted on 11/27/23 or by Staff Davis.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan confirmed that Resident A is quite independent and can physically do all his activities of daily living (ADL's) with prompting from staff. Resident A's Individual Plan of Service (IPOS) was also reviewed. The IPOS confirmed that Resident A will engage in attention seeking behavior such as calling EMS on himself or staff or making false allegations against staff.

On 12/14/23, a phone interview was conducted with staff person, Cameron Davis. He confirmed that he called in sick on 11/27/23 and did not work that day. Staff Davis stated that this is the first time of him hearing anything about him assaulting Resident A. Staff Davis stated that he has no issues with Resident A and denied that he has ever put his hands on Resident A or physically assaulted him in any way.

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:	Resident A is adamant that staff person, Cameron Davis, assaulted him on 11/27/23 by kicking him in the chest twice. Resident A has no known marks, bruises or injuries as a result of the alleged assault and Resident A stated that there were no staff or residents present to witness it. It is well documented in Resident A's IPOS that he engages in attention seeking behavior like making false allegations against staff. It was confirmed that Staff Davis called in sick on 11/27/23 and did not work that day. Staff Davis denies that he has ever put his hands on Resident A or physically assaulted Resident A in any way. There was insufficient evidence to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B is not being provided his required 2:1 staffing. Resident B eloped from the home on 11/21/23, and when police found him, Resident B had frostbite on his feet.

INVESTIGATION:

On 12/4/23, a phone conversation took place with recipient rights investigator, Michelle McCormick, who confirmed that she is investigating the same allegations regarding Resident B. Investigator McCormick stated that Resident B has severe mental illness, an extensive history of elopement and property destruction and is required to have 2:1 staffing. Investigator McCormick stated that she had received an incident report (IR) from this home regarding Resident B's elopement on 11/21, but the IR did not say anything about Resident B being gone for five days or about Resident B having frost bite. Investigator McCormick reported that she was not sure about Resident B's staffing at the time of the elopement, but stated that the home seems to have followed all protocols requirements once Resident B had eloped.

On 12/7/23, a phone conversation took place with APS worker, Kyle Whitman, who confirmed that he is investigating the same allegations and that he had already been to the home on 12/5/23 and attempted to interview Resident B. APS Whitman stated that due to his significant mental illness, it was not clear if Resident B even understood the questioning and Resident B did not appear to be a reliable reporter. APS Whitman confirmed that Resident B had frostbite on both feet, due to jumping out the homes window and running away without wearing any shoes. APS Whitman stated that he had spoken to Resident B's guardian, who stated that she was notified by the hospital that

Resident B was admitted there on 11/22/23, so it appears that Resident B was only missing for one day, not five. He stated that the guardian stated that Resident B has a history of elopement, that she had no concerns regarding his care at this home, and that Resident B is on a wait list for a long-term psych residential hospital placement.

On 12/8/23, an on-site inspection was conducted, and attempts were made to interview Resident B, but due to his severe mental illness, Resident B was not able to be interviewed. Resident B was clearly distressed about something and was yelling and crying during the entire length of the on-site inspection. Resident B has a history of not wanting to talk and/or be interviewed during AFC licensing investigations. Resident B was observed to be receiving his required 2:1 staffing. Resident A had bandages on both feet but was observed to be walking with no visible issues.

Resident B's Individual Plan of Service (IPOS) was reviewed. It confirmed that Resident B requires 2:1 staffing 24-hours a day. The IPOS states that staff are to stay at arms-length during waking hours and station themselves at Resident B's bedroom entrance during sleeping hours. The plan states that alarms shall be provided on the doors and windows of well-known escape areas and gives examples of bedroom and bathroom windows and front and back doors. The IPOS states that if an elopement occurs, staff are to redirect Resident B.

On 12/11/23, supervisor, Jessica Ortiz, who stated that Resident B was being provided his 2:1 staffing on 11/21/23 and at the time of the elopement. Supervisor Ortiz stated that Resident B jumped out his bedroom window, which he likes to keep open and has done before, and staff attempted to follow him but could not keep up with him. Supervisor Ortiz reported that several staff went out searching for Resident B, but could not find him, so then the police, case manager and guardian were notified of Resident B's elopement. Supervisor Ortiz stated that the hospital called her on 11/22/23 to report that Resident B was there and had been admitted. She stated that Resident A stayed in the hospital until 11/28/23 and was treated for his frostbite on both feet. Supervisor Ortiz stated that Resident B has a long history of elopement and that all staff can do is redirect, attempt to follow Resident B in the community and use verbal prompts for him to return to the home or get into the car. When asked about the section of Resident B's IPOS regarding there needing to be alarms on Resident B's bedroom and bathroom windows, Supervisor Ortiz stated that she was not aware of that. It was confirmed that there were no alarms on Resident B's bedroom window or on the window of one of the home's bathrooms.

The *AFC Licensing Division Incident/Accident Report (IR)* regarding Resident B's elopement on 11/21/23 was reviewed. The IR was written by staff person, Erik Fink, who is no longer employed at this home or for this company. The IR stated that the incident took place at 7:00am and that Resident B was sitting on his bed and then out of nowhere, he stood up and jumped out his window, which he likes to keep open. It states that staff attempted to run after Resident B and redirect him back home but Resident B would not stop running. Staff went back to the home to get a car and continued to look for Resident B. The IR indicates that police, case manager and

guardian were notified of the elopement and that several staff continued to search the neighborhood for Resident B. The corrective measures stated that the home will continue to provide Resident B with enhanced support/staffing and that the home has reached out to the case manager and responsible county to discuss Resident B's declining behaviors and the need for extra support.

On 12/14/23, a phone interview as conducted with staff person, Cameron Davis, who confirmed that he was assigned to be one of Resident B's 2:1 staffing on 11/21/23. Staff Davis stated that Resident B eloped that morning at approximately 7:00am. Staff Davis stated that the other 2:1 staff, Erik Fink, who does not work at the home any longer, was sitting on the couch in the living facing Resident B's bedroom, that Resident B was awake at the time and Resident B's bedroom door was open. Staff Davis stated that he left the living room to go wash his hands and estimated that he was only gone for a couple of minutes. Staff Davis stated that as he was walking back, he saw Resident B jumping out of his bedroom window. Staff Davis reported that he chased after Resident B on foot but he could not catch up to him. Staff Davis stated that when Staff Fink arrived in his car, he went back to the home and Staff Fink continued to look for Resident B.

On 1/17/24, a phone call was to supervisor Ortiz to check on the status of Resident A's frostbite. Supervisor Ortiz stated that Resident B has been receiving weekly visits at the home by a nurse to treat his frostbite. She reported that the nurse said that the frostbite seems to be healing nicely and that Resident B will not have any long-term damage or issues related to the frostbite.

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:	It was confirmed that Resident B jumped out of his bedroom window and eloped at approximately 7:00am on 11/21/23. Resident B's IPOS states that Resident B is to receive 2:1 staffing hours 24 hours a day. The plan states that staff are to stay at arm's length of Resident B during waking hours and are to be stationed outside of Resident B's bedroom during sleeping hours. The plan also states that alarms are to be provided on Resident B's bedroom and bathroom windows. Staff failed to meet the requirements of the IPOS when one of the 2:1 staffing, Cameron Davis, walked away from Resident B and/or Resident B's bedroom. During an on-site inspection on 12/8/23, it was confirmed that the home does not have alarms on Resident B's bedroom window or one of the home's bathroom windows. There was sufficient evidence found to warrant the citing of this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home is not staffed sufficiently for any of the residents.

INVESTIGATION:

The Individual Plan of Service (IPOS) for all six residents of this home were reviewed as part of this investigation. It was confirmed that Resident B requires 2:1 staffing 24 hours a day. The IPOS for the other five residents state that they all require 1:1 staffing. The plans for two of the residents indicate that the 1:1 staffing should be provided 24 hours a day and one residents plan states for "during the day". The plans for the other two residents do not specify when or how many hours daily the 1:1 should be provided. Therefore, this home should be providing a minimum of 7 staff during at least 1st and 2nd shift.

During an on-site inspection on 12/11/23, home manager, Latanya Jones, stated that the company's operations director, Brandon Gadberry, told her that Resident C, Resident D, and Resident E were taken off their 1:1 staffing status. Manager Jones stated that none of these three residents have been provided 1:1 staffing since she started there on 11/7/23.

During the on-site inspection on 12/11/23, a phone call was made to operations director, Brandon Gadberry. Brandon Gadberry stated that it was his understanding that there must be a behavioral treatment plan (BTP) in place in order for them to provide 1:1 staffing, and that Resident C, Resident D, and Resident D do not have an active BTP in the system. Director Gadberry could not say when those three BTPs had expired. Later

during the on-site inspection, Director Gadberry called back to state that he was mistaken and that 1:1 staffing should be provided to all three of those residents.

This home's staff schedules for between 11/27/23 and 12/24/23 were provided on 12/11/23. Per this 28-day schedule, there were 16 days where only 4 staff were scheduled during 1st and 2nd shift and there were 12-days where only 3 staff were scheduled.

On 12/13/23, a phone call was made to home manager, Latanya Jones, to discuss the staff schedule. Manager Jones confirmed that there has not been more than 4 staff scheduled per shift and sometimes only 3, for a while now. Manager Jones stated that she was told that there was a hiring freeze for the company and that she could not hire more staff.

On 12/14/23, staff, Cameron Davis, stated that he worked 3rd shift on 11/21/23. He stated that it was him and only one other staff, Erik Fink, that worked that entire shift. Staff Davis stated that Resident B had eloped during that shift and that at one point, both him and Staff Fink went outside the home chasing and/or looking for Resident B, which left no staff inside the home to supervise the other five residents.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Review of the IPOS's for all six residents of this home indicates that this home should be providing a minimum of 7 staff daily during 1st and 2nd shifts. Home manger, Latanya Jones, stated that at least between 11/7/23 and 12/11/23, Resident C, Resident D and Resident E were not provided there required 1:1 staffing. Review of this home's 28-day schedule for between 11/27/23 and 12/24/23 showed that this home did not provide more than 4 and sometimes only 3 staff per shift. Staff person, Cameron Davis, stated that on 3rd shift on 11/21/23 that he was one of only two staff that worked that shift. Staff Davis stated

	that he and other staff that shift, Erik Fink, both left the home together to chase after an eloping Resident B and that left no staff in the home to supervise the other five residents. There was sufficient evidence found to prove that for quite some time now, this home has not provided adequate enough staff to meet the required supervision needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/11/24, an exit conference was held with licensee designee, Kehinde Ogundipe. He was informed of the outcome of this investigation and that a written corrective action plan is required to address the above licensing rule violations.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, it is recommended that the status of this home's license remain unchanged.

1/17/2024

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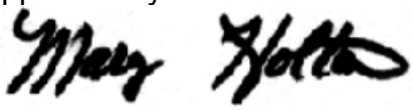
Christopher Holvey Date
Licensing Consultant

Approved By:



1/17/2024

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Mary E. Holton Date
Area Manager