GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 15, 2024

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

RE: License #: AS630411893
Investigation #: 2024A0465006
Zenith Home

Dear Mr. Ogundipe:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630411893
Investigation #:	2024A0465006
Complaint Receipt Date:	11/20/2023
Investigation Initiation Date:	11/22/2023
Report Due Date:	01/19/2024
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:	Zenith Home
Facility Address:	21412 Remainville 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?
On an unknown date in October 2023 or November 2023, the facility smelled of marijuana. There is concern that staff are smoking weed while on duty.	No
In October 2023 and November 2023, Resident A was engaging in self-harm behavior, while also having 1:1 staffing. There is concern that the facility was not providing adequate 1:1 care and that the facility did not obtain needed medical care timely.	Yes

III. METHODOLOGY

11/20/2023	Special Investigation Intake 2024A0465006
11/20/2023	APS Referral APS Referral denied
11/22/2023	Special Investigation Initiated - Letter I spoke to Complainant via email
11/22/2023	Contact - Document Sent Email exchange with Erica Smith from Office of Recipient Rights
11/27/2023	Inspection Completed On-site I conducted a walk-through of the facility, reviewed resident files and interviewed direct care staff, Marcus Turner, Javontez Mitchell and Ola Adekunle
12/08/2023	Contact - Document Received Email exchange with Erica Smith from Office of Recipient Rights
12/11/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
12/20/2023	Contact - Telephone call made I left a voice message for CMH Case Manager, Michelle Ingersoll
12/20/2023	Contact – Telephone call made I spoke to Guardian B1 via telephone
12/27/2023	Contact - Telephone call made I spoke to direct care staff, Shakira Dortch-Coleman, via telephone

01/14/2024	Contact - Telephone call made I left a voice message for CMH Case Manager, Michelle Ingersoll
01/15/2024	Contact - Document Sent Email exchange with Erica Smith from Office of Recipient Rights
01/15/2024	Exit Conference I conducted an Exit Conference with licensee designee via telephone

ALLEGATION:

On an unknown date in October 2023 or November 2023, the facility smelled of marijuana. There is concern that staff are smoking weed while on duty.

INVESTIGATION:

On 11/20/2023, a complaint was received, alleging that, on an unknown date in October 2023 or November 2023, the facility smelled of marijuana. The complaint stated that there is concern that staff are smoking weed while on duty.

On 11/22/2023, I spoke to Complainant via email. Complainant confirmed that the information contained in the complaint is accurate.

On 11/22/2023, 12/8/2023 and 1/15/2024, I spoke to Recipient Rights Officer, Erica Smith, via email exchange. Ms. Smith stated that she has completed an investigation of this complaint. Ms. Smith stated that she will not be substantiating this allegation.

On 11/27/2023, I conducted a walk-through of the facility. While onsite at the facility, I did not observe alcohol or drugs in the home, and I did not smell the odor of marijuana in the home. At the time of my onsite investigation, Resident A was no longer residing at the facility. There was one resident residing at the facility, Resident B. I interviewed Resident B and direct care staff, Marcus Turner, Javontez Mitchell, and Ola Adekunle.

Resident B stated that he likes living at the facility. Resident B stated, “Staff help me with things that I need. I haven’t had any problems here. I have not seen any staff use drugs here or smoke weed.” Resident B denied knowledge of this complaint being true.

I interviewed direct care staff, Marcus Turner, who stated that he has worked at the facility for three months. Mr. Turner stated, “I have never used drugs or alcohol at work and have never smoked weed at work. And I’ve never seen anyone else use

drugs or alcohol while at work." Mr. Turner denied knowledge of this complaint being true.

I interviewed direct care staff, Javontez Mitchell, who stated that he has worked at the facility for 2 ½ years. Mr. Mitchell stated, "I have never smoked weed or used any drugs while working at the facility. I have never seen any other staff use drugs while working and I have never smelled weed in the facility." Mr. Mithcell denied knowledge of this complaint being true.

I interviewed direct care staff, Ola Adekunle, who stated that she has worked at the facility for three years. Ms. Adekunle stated, "I have never used drugs or alcohol while at work and I have never observed any other staff do anything like this either." Ms. Adekunle denied knowledge of this complaint being true.

On 12/11/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "There was a day I visited the facility and smelled the strong odor of marijuana. I do not know where the odor came from, nor did I observe marijuana in the home. But I did smell it. I did not mention the odor to staff and Resident A no longer resides in the home. But I do think staff were possible smoking marijuana in the home."

On 12/20/2023, I spoke to Guardian B1 via telephone. Guardian B1 stated, "I do not have any current concerns related to the care staff are providing to Resident B. I have not observed, nor smelled marijuana odor, when I have visited the facility." Guardian B1 did not vocalize any concerns related to this complaint.

On 12/27/2023, I spoke to direct care staff, Shakira Dortch-Coleman, via telephone. Ms. Coleman stated, "I have never used alcohol or drugs while I was on duty. I never did anything like that. I haven't seen anything like this happening at work." Ms. Coleman denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	On 11/27/2023, I conducted a walk-through of the facility. I did not observe alcohol or drugs in the home, and I did not smell the odor of marijuana in the home. According to Resident B, he has not seen any staff use drugs here or smoke weed." Resident B stated that staff are meeting his care needs. Resident B denied knowledge of this complaint being true.

	According to Mr. Turner, Mr. Mitchell, Ms. Adekunle, and Ms. Dortch-Coleman, they have never used drugs or alcohol at work and have never seen anyone else use drugs or alcohol while at work." Mr. Turner, Mr. Mitchell, Ms. Adekunle, and Ms. Dortch-Coleman denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that this allegation is true.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

In October 2023 and November 2023, Resident A was engaging in self-harm behavior, while also having 1:1 staffing. There is concern that the facility was not providing adequate 1:1 care and that the facility did not obtain needed medical care timely.

INVESTIGATION:

On 11/20/2023, a complaint was received, alleging that during the months of October 2023 and November 2023, Resident A was engaging in self-harm behavior. The complaint stated that Resident A was eating food out of the garbage, raw food from the refrigerator, smearing and eating his own feces, drinking his own urine, smearing feces on the wall, and picking and eating his own skin. The complaint stated that during this time, Resident A was supposed to have a 1:1 staff. The complaint stated that there is concern as to how Resident A has been able to engage in continuous self-harm behavior with 1:1 staffing. The complaint stated that there is concern that the facility is not providing adequate 1:1 staffing. The complaint stated that staff blocked the front door with a couch, so they didn't have to provide 1:1 to Resident A. The complaint stated that the facility allowed Resident A to engage in self-harm behavior for three weeks prior to seeking medical care.

On 11/22/2023, 12/8/2023 and 1/15/2024, I spoke to Recipient Rights Officer, Erica Smith, via email exchange. Ms. Smith stated that she has completed an investigation of this complaint and determined that there was a preponderance of evidence to support that this allegation is true. Ms. Smith stated that she will be substantiating this allegation.

On 11/27/2023, at the time of my onsite investigation, Resident A was no longer residing at the facility. I reviewed Resident A's file, and interviewed direct care staff, Mr. Turner, Mr. Mitchell, and Ms. Adekunle.

The *Face Sheet* stated that Resident A was resided at the facility from 10/3/2023 – 11/17/2023 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed

Resident A's medical diagnosis as Disorganized Schizophrenia, Impaired Cognition and Limited Insight/Judgement. The *Assessment Plan for AFC Residents* stated that Resident A required 1:1 staffing 12 hours per day (8:00am – 8:00pm), supervision in the community, has limited verbal communication skills, history of inappropriate sexual comments and aggressive behavior, difficulty following directions, needs assistance with self-care tasks, including changing of briefs every two hours, history of wandering, and does not require use of assistive devices. I reviewed the *Staff Schedule* for the months of October 2023 and November 2023, at which time the facility had two residents residing in the home, Resident A and Resident B. The staff schedule reflected that the facility had two staff on duty daily from 8:00am – 8:00pm from 10/3/2023 – 11/17/2023, during the time that Resident A was residing in the home. However, the October 2023 schedule did not specify which staff was assigned as the 1:1 for Resident A for each shift. The November 2023 schedule did specify which staff on duty was assigned to provide 1:1 staffing to Resident A. I reviewed the Incident/Accident Reports for Resident A, which stated the following:

> *10/23/2023; Completed by Marcus Turner and Shakira Dortch-Coleman: Resident A peed in a cup and drank it. Staff tried getting the cup away from him, but he was very aggressive. Resident A has been making damages to his room wall by peeling off the paint. He walks around the house, slams doors, and he does not listen to redirection. Resident A tries to snatch food from residents and staff aggressively. He also takes food out of the trash and tries to pick up hot food while cooking. Staff redirected Resident A out of the kitchen. The kitchen might require some lock for safety measures.*
>
> *11/7/2023 at 11:00am; Completed by Javontez Mitchell and Shakira Dortch: Resident A tries to walk out of the home at every slight opportunity. Resident A is still incontinent, and he spread {feces} on walls in house. Staff redirects Resident A. Staff has tried to make Resident A use the bathroom instead. However, there hasn't been 100% success yet. Staff will continue to redirect and monitor.*
>
> *11/9/2023 at 11:00am; Completed by Javontez Mitchell and Shakira Dortch-Coleman: Resident A was caught peeing in the living room vent. He also spits in it and in the kitchen sink. He always puts his hands in his pants and tries to grab food from the fridge without washing his hands. Staff redirected him to wash his hands and use the bathroom. Staff will continue to monitor and redirect.*
>
> *11/10/2023 at 2:00pm; Completed by Javontez Mitchell and Edward Wilson: Resident A came out of room. Staff noticed he got poop on his face and hands. Resident A had poop in his brief and put it in his mouth. Staff redirected Resident A and cleaned him up. Staff will continue to monitor and redirect.*
>
> *11/14/2023 at 12:00am; Completed by Javontez Mitchell and Edward Wilson: Staff noticed some redness and rashes on Resident A's butt yesterday and the rashes got worse by this morning. Staff took Resident A to ER. Staff will continue to monitor.*

11/17/2023 at 12:00am; Completed by Javontez Mitchell and Shakira Dortch-Coleman: Resident A is peeling his skin, and he is putting it in his mouth. Some parts of his body are sore as a result of him peeling. Staff tried to stop him and redirect. However, he is not complying. We are not to touch him or forcefully redirect per rights. Staff will continue to try to redirect. He might also require changes in his plan advising how to deal with the situation.

11/17/2023 at 2:00pm; Completed by Javontez Mitchell and Shakira Dortch-Coleman: Staff called Guardian A1, and she asked for Resident A to be checked into a hospital for mental health evaluation due to self-harm. Staff called EMS to help transport to the hospital. Resident A will need to be evaluated and a follow-up will be scheduled with his psychiatrist for medication review.

I interviewed Mr. Turner, who stated, “We provided 1:1 staff to Resident A 12 hours a day, from 8:00am – 8:00pm. Resident A lived here for about a month. Resident A was having a lot of issues when he lived here, and he was doing a lot of harmful stuff. He was playing with his feces, but I didn’t see that personally. But I was working the day that he peed into a cup and began drinking it. Me and the other staff didn’t know he was doing that until we turned around and saw him peeing in the cup. I intervened but we are not allowed to physically restrain residents, so all we can do is redirect. The day that he drank urine, I saw him pee in a cup and then proceed to drink it. I and Ms. Coleman immediately grabbed the cup and took it away from him. He also would snatch food and other items from people aggressively. He was doing a lot of harmful things to himself and all we could do was redirect him. He was incontinent and he was having issues with playing with his feces. Resident A did like to wander and often tried to leave the home, that’s why he had a 1:1. We always had two staff on duty to ensure Resident A received 1:1 services for 12 hours a day. I never blocked the front door with the couch, and I never observed any other staff do this either. We did provide 1:1 staffing for Resident A. When we observed that he was picking his own skin and trying to eat it, we notified his guardian, and she told us to take him to the hospital.” I asked Mr. Turner if he contacted Resident A's primary care physician or sought medical care for Resident A during the time that he observed the self-harm behavior. Mr. Turner stated, “No, I never called Resident A's primary care physician and I never called 911 or took Resident A to the hospital. Resident A went to the hospital on 11/17/2023, at the request of Guardian A1.”

I interviewed Mr. Mitchell, who stated, “Resident A received 1:1 supervision during the time that he lived here. It was 12 hours of 1:1 from 8:00am – 8:00pm daily. We provided the 1:1 to make sure he was safe and to prevent elopement. Even though we provided 1:1, there were times when Resident A might have been alone for a minute or two in his room or another area of the home. Resident A was engaging in self-harm behavior. He was trying to eat food out of the garbage, and he also began playing with his feces. Resident A is incontinent and one day he began putting his hands down his brief and was pulling his feces out and smearing it on the wall. I immediately redirected him and cleaned him up and changed his brief. I also

observed him one time with feces in his mouth. Each time I redirected him and cleaned him. But we are not allowed to physically restrain residents, so all we could do was redirect and assist Resident A the best we could. I never put the couch in front of the door. I never have done that, and I have never seen any other staff do that either. On 11/17/2023, Resident A was observed picking his skin and trying to eat it. We notified Guardian A1, and she told us to transport him to the hospital and we did." When asked if medical care was sought for Resident A prior to 11/17/2023, Mr. Mithcell stated that he did not call Resident A's primary care physician to seek medical advice and did not have Resident A transported to a medical facility for evaluation. Mr. Mitchell stated, "I don't believe we did seek medical care for Resident A prior to 11/17/2023. I never called 911 or called his physician. We didn't have Resident A taken to the hospital until Guardian A1 requested it."

I interviewed Ms. Adekunle, who stated, "Resident A had 1:1 supervision when he lived here to make sure he was safe. He had a history of wandering and attempting to leave the home. When I worked, I never blocked the front door with the couch, and I never seen any other staff do this either. Resident A was displaying self-harm behavior, and we were constantly redirecting him. He was trying to eat food out of the trash, playing with/eating his feces and was peeing into cups and vents in the home. He also began picking his skin and trying to eat it. There were a lot of issues, and we did our best to redirect Resident A each time we observed these behaviors, but we can only redirect. We were not allowed to stop him. We cannot physically intervene or restrain residents. We notified Guardian A1 of the ongoing issues, but we never called Resident A's primary care physician and we did not take him to the hospital prior to 11/17/2023. We had him taken to the hospital on 11/17/2023 because he had begun picking his skin and trying to eat it, and we knew he was getting worse. And Guardian A1 told us to have him taken to the hospital." Ms. Adekunle denied knowledge of this complaint being true.

On 12/11/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "Resident A lived at the facility from 10/3/2023 – 11/17/2023. He was supposed to have 1:1 supervision and I do not believe the facility as providing it. If they had been, I don't believe Resident A would have been engaging in all the self-harm behavior that he was. On one occasion, I visited the home and there was a couch blocking the doorway. I believe the couch was there to prevent Resident A from leaving the home and to allow staff to not have to fully monitor him. I received the incident reports, and I interpreted them to mean that he was being left alone or unsupervised for short periods of time. The incident reports mentioned that he was playing with and eating his feces, and that he had drank his own urine and was trying to eat food from the trash can. I was very concerned and when I read the incident report in November that said he was picking his skin, I immediately told the staff to have him transported to the hospital. When he arrived at the hospital, he was confused and in an altered state. He was admitted to the hospital and once he was ready for discharge, I moved him to a different adult foster care facility. I do not believe the facility provided adequate 1:1 supervision to Resident A and they should have sought medical care sooner."

On 12/27/2023, I spoke to Ms. Dortch-Coleman, via telephone. Ms. Dortch-Coleman stated, “We were providing 1:1 staff to Resident A when he lived at the facility. We did our best to redirect him, but we also were not allowed to physically stop him or restrain him when he was doing things that were harmful. He was displaying unusual behavior. He was eating playing with and smearing his feces. He was also attempting to drink urine and he then he began picking at his skin and trying to eat it. We did monitor him. When I worked with him, I made sure I kept an eye on him to make sure he was safe. I never blocked the front door with a couch. I can’t speak to what other staff did when they were working. I did not call Resident A’s primary care physician and I never had Resident A transported to the hospital prior to 11/17/2023. I am not sure who would have made that decision.”

On 1/15/2024, I conducted an Exit Conference with licensee designee/administrator, Kehinde Ogundipe. Mr. Ogundipe stated that Resident A was receiving 1:1 supervision as specified in his assessment plan. Mr. Ogundipe stated, “We were waiting for further direction from community mental health, and I was having staff do the best could while figuring how to manage these behaviors, as it was the first time we had dealt with something like this. We dropped the ball by not following proper medical protocol and this could have been a lot worse than it was. In the future, we will handle this differently.” Mr. Ogundipe acknowledged that, given Resident A’s behaviors, staff should have sought medical care sooner. Mr. Ogundipe also acknowledged that, based on the incident reports, there were possibly times when staff were not providing 1:1 supervision/line of sight for Resident A. Mr. Ogundipe stated he plans to implement corrective measures to ensure immediate care is provided to residents as needed. Mr. Ogundipe is in agreement with the findings of this report.

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:	According to the *Assessment Plan for AFC Residents*, Resident A was supposed to have 1:1 staff supervision 12 hours per day, from 8:00am – 8:00pm. However, according to the *Incident/Accident Reports*, Mr. Turner and Mr. Mitchell, there were moments during shifts when staff did not have Resident A in line of sight at all times as required per the assessment plan. According to Mr. Turner, Mr. Mitchell, Ms. Adekunle and Ms. Dortch-Coleman, from 10/23/2023 – 11/17/2023, Resident A engaged in significant self-harm behavior, including ingesting

	bodily fluids and raw/disposed food. Mr. Turner, Mr. Mitchell, Ms. Adekunle and Ms. Dutch-Coleman stated that they attempted to verbally redirect Resident A but did not provide any further interventions to assist in ensuring Resident A's supervision, protection and personal care needs were met. Based on my review of Resident A's file, the facility did not implement any additional protocols or services to assist in ensuring that Resident A's supervision, protection and personal care needs were met. Based on the information above, there is sufficient information to confirm that the facility did not provide adequate supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	According to the *Incident/Accident Reports*, from 10/23/2023 – 11/17/2023, Resident A displayed significant self-harm behavior, including ingesting bodily fluids and raw/disposed food. According to Mr. Turner, Mr. Mitchell, Ms. Adekunle and Ms. Dortch-Coleman, they attempted to verbally redirect Resident A but did not obtain medical care from a primary care physician or medical facility until 11/17/2023, when Guardian A1 requested they transport Resident A to the hospital for a mental health evaluation. Based on the information above, there is sufficient information to confirm that the facility did not obtain needed care immediately for Resident A when he began displaying self-harm behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez 1/17/2024

_____

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

_____

Denise Y. Nunn Date
Area Manager