GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

Stephen Forkpah
Kingdom Rest Center, LLC
7174 Martin Avenue SE
Grand Rapids, MI 49548

RE: License #: AM410418653
Investigation #: 2025A0579043
Kingdom Rest Center, LLC

Dear Stephen Forkpah:

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 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 (616) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410418653
Investigation #:	2025A0579043
Complaint Receipt Date:	06/06/2025
Investigation Initiation Date:	06/06/2025
Report Due Date:	08/05/2025
Licensee Name:	Kingdom Rest Center, LLC
Licensee Address:	7174 Martin Avenue SE, Grand Rapids, MI 49548
Licensee Telephone #:	(616) 323-4379
Administrator:	Stephen Forkpah
Licensee Designee:	Stephen Forkpah
Name of Facility:	Kingdom Rest Center, LLC
Facility Address:	7174 Martin Avenue SE, Grand Rapids, MI 49548
Facility Telephone #:	(616) 323-4379
Original Issuance Date:	04/18/2025
License Status:	TEMPORARY
Effective Date:	04/18/2025
Expiration Date:	10/17/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ ALZHEIMERS/ AGED/ TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive appropriate supervision when he eloped from the home.	No
Additional Findings	Yes

III. METHODOLOGY

06/06/2025	Special Investigation Intake 2025A0579043
06/04/2025	Special Investigation Initiated – Document Received Ashton Bryne, network180 ORR
06/05/2025	Contact – Telephone Call Received Tony Maniscalco, network180 Case Manager
06/05/2025	Face to Face Resident A Lancinet Bamba, Direct Care Woker Stephen Forkpah, Licensee Designee
06/06/2025	Contact - Document Received Ashton Byrne, network180 ORR
06/09/2025	Contact - Document Received New Intake- 205883
06/09/2025	APS Referral Heather Autsema, APS
06/17/2025	Contact- Document Received Heather Autsema, APS
06/24/2025	Contact- Document Sent Stephen Forkpah, Licensee Designee
07/14/2025	Contact- Document Received Stephen Forkpah, Licensee Designee
07/24/2025	Exit Conference Stephen Forkpah, Licensee Designee

ALLEGATION: Resident A did not receive appropriate supervision when he eloped from the home.

INVESTIGATION: On 6/6/25, I entered this referral into the Bureau Information Tracking System after being forwarded allegations that Resident A went missing for approximately 12 hours on 5/29/25. Resident A allegedly left the home around lunch meal service. Resident A is supposed to have hourly checks to ensure he has not eloped from the home and direct care workers (DCWs) were trained on this requirement by network180 staff. Resident A's elopement was not reported to his guardian for over six hours. The Sheriff's Department did not become involved until 7:30 p.m. Resident A returned to the home around midnight.

On 6/4/25, I exchanged emails with Ashton Bryne from network180 Office of Recipient Rights discussing Resident A's elopement, confirming the allegation, the home it occurred in, and confirming she was also investigating the allegation.

On 6/5/25, I received a telephone call from network180 case manager Tony Maniscalco. He expressed concern regarding DCWs and licensee designee, Stephen Forkpah's ability to follow resident service/assessment plans. He stated network180 would be reviewing whether they would continue a specialized certification program at this home due to these concerns.

On 6/5/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Lancinet Bamba (DCW), and Mr. Forkpah.

Resident A's speech was often intelligible. He was limited in the responses he provided. He stated he went out of the home and came back one day. He stated he is supposed to stay at the home and not leave. He could not express when this occurred or how long he was gone. He stated "Bamba" was working when he left the home.

Mr. Forkpah stated Resident A initially had 15–30-minute checks in his plan of service from network180 when he moved into the home due to a history of elopement. He stated this recently changed and those checks were no longer required. He denied having Resident A's current plan of service or being able to confirm current supervision requirements for Resident A. He reported that Resident A cannot go into the community independently.

Mr. Forkpah stated on 5/29/25, Mr. Bamba contacted him after dinner service to report that Resident A had left shortly before or during meal service and eloped from the home. He stated he immediately came to the home and began looking for Resident A in the neighborhood. He stated he contacted Guardian A and law enforcement after he was unable to locate Resident A, which was at approximately 7:30 p.m. He stated it was believed that Resident A was gone from 4:45 p.m. until he returned home at midnight.

I requested to review Resident A's assessment plan. There was a blank, incomplete assessment plan with a date of 2023 for the previous license at this address for Resident A. Mr. Forkpah denied having a complete and up-to-date assessment plan for Resident A under this license.

I provided consultation on the rule requirements for completing and maintaining up-to-date assessment plans for residents in the home. Mr. Forkpah acknowledged he had utilized the training resources on the LARA AFC website and attended a "New Licensee" training held virtually with staff in Lansing. I agreed to schedule a time to go through resident files with Mr. Forkpah and to complete additional training regarding resident documents to ensure compliance. He agreed to schedule a time in June or July 2025 for me to return to the home for additional training.

Mr. Bamba stated he is expected to check on Resident A approximately three times during his eight-hour shift. He stated he saw Resident A at lunch meal service on 5/29/25 and saw him in the living room prior to dinner service at some time between approximately 3:00 p.m. to 4:00 p.m. He stated he cooked dinner, served dinner, and Resident A did not come to dinner, so he called for Resident A. He stated Resident A still did not come to dinner, so he went to Resident A's room to look for him. He stated he then searched the home and yard for Resident A and could not locate him. He stated he then called Mr. Forkpah who took over attempting to locate Resident A.

On 6/6/25, Ms. Byrne provided allegations reported to her that alleged Resident A eloped on 6/3/25 and law enforcement was not contacted for three and a half hours after Resident A left the home. Resident A is supposed to have periodic supervision checks multiple times a day. I responded that Resident A, Mr. Bamba, and Mr. Forkpah only disclosed one elopement for Resident A when I completed interviews at the home on 6/5/25, but I would investigate these allegations as well.

On 6/9/25, I received an additional referral which noted Resident A eloped on 6/3/25 and law enforcement was not contacted for three and a half hours after he left the home. Guardian A was not notified either. Resident A reported walking over seven miles to visit a friend. Resident A also eloped on 5/30/25, around lunchtime. Law enforcement was not notified for six hours and Resident A returned home around midnight.

On 6/9/25, I confirmed APS worker Heather Autsema was investigating the allegations. I made her aware that I knew Resident A eloped one time on 5/29/25 but an elopement on 6/3/25 was not discussed with me when I was at the home on 6/5/25.

On 6/17/25, Ms. Autsema reported there was misinformation provided on the referral she was investigating. She stated she confirmed Resident A only eloped on 5/29/25 and not 5/30/25 or 6/3/25. She stated a referral was received on 6/3/25 stating the incident occurred "today" but it was submitted on 5/29/25 and referenced Resident

A's elopement on 5/29/25. She stated Mr. Forkpah also confirmed with her that Resident A only eloped on 5/29/25. She stated Mr. Forkpah told her Resident A's plan of service changed in March 2025 to require hourly checks on Resident A. She stated she confirmed with network180 staff that an in-service was done at the home for Resident A's supervision requirements on 6/6/25 "which noted safety checks." She stated she was not able to confirm whether hourly checks were required and not done by DCWs or if it was not specified that checks should be done hourly, just regularly. I advised I also did not get clarification and did not observe appropriate documentation confirming Resident A's supervision requirements.

On 6/24/25, I provided training resources to Mr. Forkpah regarding the documentation required for resident files. I provided a worksheet, a coversheet, and a link to on-line training resources. Mr. Forkpah and I scheduled an on-site training for 7/15/25.

On 7/14/25, Mr. Forkpah requested to reschedule our on-site training due to him being out of town. He agreed to follow up to reschedule. This did not occur during the investigation.

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:	Resident A reported he is supposed to stay in the home but left the home independently on 5/29/25. Mr. Bamba reported he checks on Resident A three times during his eight-hour shift. Mr. Forkpah reported Resident A initially had 15-30 minute checks due to a history of elopement. He reported Resident A's specific supervision requirements recently changed. He denied having a current plan of service noting Resident A's current supervision requirements. He stated Resident A cannot go into the community independently. Mr. Forkpah provided an incomplete assessment plan for Resident A, done under a different license, and dated from 2023. He denied having a current assessment plan for Resident A. Based on the interviews completed and documentation reviewed, there is insufficient evidence to support the allegation

	that Resident A did not receive supervision, protection, and personal care as specified in his assessment plan due to there not being a current assessment plan or plan of service in the home for Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

On 6/5/25, Mr. Forkpah denied having Resident A's current plan of service available in the home. He provided a blank, incomplete assessment plan form, with a date of 2023, for Resident A while he was living at a different licensed home at this address. Mr. Forkpah also denied having a completed, up to date assessment plan for Resident A for this license.

Mr. Forkpah agreed to schedule a time for me to return to the home to review resident files, to provide additional training, and ensure compliance. The meeting did not occur during this investigation.

I did not obtain or review Resident A's up-to-date plan of service or assessment plan during this investigation.

APPLICABLE RULE	
R 400.14209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident records.**
ANALYSIS:	Mr. Forkpah denied having an up-to-date plan of service or assessment plan for Resident A while I was at the home. I observed a blank assessment plan, completed for another license, and dated 2023 for Resident A. Resident A's updated plan of service and assessment plan were not made available during this investigation. Based on the interview completed and documentation reviewed, there is sufficient evidence that resident records were not maintained in the home or made available for review as required.

CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/5/25, Mr. Forkpah provided a blank, incomplete assessment plan form, with a date of 2023, for Resident A while he was living at a different licensed home at this address. He denied having a completed, up to date assessment plan for Resident A for this license.

Mr. Forkpah agreed to schedule a time for me to return to the home to review resident files, to provide additional training, and ensure compliance. The meeting did not occur during this investigation.

I did not obtain or review Resident A's up-to-date assessment plan during this investigation.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Mr. Forkpah denied having an up-to-date assessment plan for Resident A while I was at the home. I observed a blank assessment plan, completed for another license, and dated 2023 for Resident A. Based on the interview completed and documentation reviewed, there is sufficient evidence that an assessment of the resident was not completed to ensure Resident A was suitable for the amount of personal care, protection, and supervision in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/5/25, Mr. Forkpah provided a blank, incomplete assessment plan form, with a date of 2023, for Resident A while he was living at a different licensed home at this address.

Mr. Forkpah denied having a complete, up-to-date assessment plan for Resident A for this license.

Mr. Forkpah agreed to schedule a time for me to return to the home to review resident files, to provide additional training, and ensure compliance. The meeting did not occur during this investigation.

I did not obtain or review Resident A's up-to-date assessment plan during this investigation.

APPLICABLE RULE	
R 400.14316	**Resident Records**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(f) Assessment plan.**
ANALYSIS:	Mr. Forkpah denied having an up-to-date assessment plan for Resident A while I was at the home. I observed a blank assessment plan, completed for another license, and dated 2023 for Resident A. Based on the interview completed and documentation reviewed, there is sufficient evidence that a written assessment was not completed or maintained as required by the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/24/25, I completed an exit conference with Mr. Forkpah. He did not dispute my findings or recommendations at the time of report disposition.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 07/25/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 07/28/2025

Jerry Hendrick Date
Area Manager