GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 22, 2025

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

RE: License #: AS410417965
Investigation #: 2025A0579059
Kingdom Rest Center

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.

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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AS410417965
Investigation #:	2025A0579059
Complaint Receipt Date:	09/26/2025
Investigation Initiation Date:	09/26/2025
Report Due Date:	11/25/2025
Licensee Name:	Kingdom Rest Center, LLC
LicenseeAddress:	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
Facility Address:	5252 Kimball Avenue SE, Kentwood, MI 49508
Facility Telephone #:	(616) 323-4379
Original Issuance Date:	02/12/2024
License Status:	REGULAR
Effective Date:	08/12/2024
Expiration Date:	08/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ ALZHEIMERS/ AGED/ TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B do not receive adequate supervision at the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/26/2025	Special Investigation Intake 2025A0579059
09/26/2025	Special Investigation Initiated - Letter Jeannie Haff, ORR
09/26/2025	Contact - Document Sent Complainant 1
09/26/2025	Contact - Document Received New Intake- Additional Allegations
09/26/2025	Contact - Document Sent Complainant 2
09/30/2025	Contact - Document Sent Request for records from KPD.
10/02/2025	Contact- Telephone Call Received Sargent Wierenga, Kentwood Police Department
10/02/2025	Contact- Document Received Complainant 1
10/02/2025	Contact- Face to Face Resident B Stephen Forkpah, Licensee Designee
10/02/2025	Contact- Telephone Call Made Resident B & Guardian B
10/02/2025	Contact- Telephone Call Made Stacy Delmark, Case Manager
10/02/2025	Contact- Telephone Call Made Abraham Solunteh, Direct Care Worker

10/13/2025	Contact- Document Sent Stephen Forkpah, Licensee Designee
10/15/2025	Contact- Document Received Stephen Forkpah, Licensee Designee
10/22/2025	Exit Conference Stephen Forkpah, Licensee Designee

ALLEGATION: Resident A and Resident B do not receive adequate supervision at the home.

INVESTIGATION: On 9/26/25, I received this referral which alleged Resident A and Resident B are often left alone. It was additionally alleged that on 9/23/25, Resident A had a "violent episode" where he threw trash cans and was punching the trash cans and trees. Resident A was screaming he was going to "kill the neighborhood dogs, kill himself and take others with him." Law enforcement responded. Resident A was removed from the home but returned to the home within 24 hours. Resident A was previously arrested for running around the neighborhood, throwing a shovel, and breaking a neighbor's window. Resident A and Resident B are often alone in the neighborhood, so they talk to children inappropriately, ask to go into neighbor's homes, knock on windows and doors, and yell profanities.

On 9/26/25, I inquired with Jeannie Haff (network 180 Office of Recipient Rights) whether network180 contracts with this home. She reported they do not.

On 9/26/25, I contacted Complainant 1 to confirm my receipt of the allegations and to discuss the process and limitations of licensing investigations. I advised that residents of adult foster care homes may have unsupervised access to the community contingent upon their assessment plan. I reported I would review documentation to see if that was the case for Resident A and Resident B. I advised Complainant 1 that if Resident A and Resident B were observed in the community breaking the law, to contact law enforcement for assistance as one would if any individual was observed breaking the law within the community.

On 9/26/25, I received a second referral which alleged on 9/23/25, Resident A was throwing and punching a garbage can. Resident A was heard talking of killing dogs and "taking others down with him." Law enforcement arrived at the home. Law enforcement is often at the home. When law enforcement comes to the home, direct care workers ("DCWs") leave or hide. Resident A was unsupervised and attempted to enter a neighbor's backyard through a gate. The neighbor went inside their home and Resident A repeatedly knocked on the front door, so the neighbor called law enforcement. On 9/18/25, law enforcement arrived at the home and Resident B discussed how he had previously "almost murdered" someone. It is believed Resident A and Resident B are left unsupervised daily and they wander the

neighborhood without supervision. Resident B attends children's softball games unsupervised. Resident A and Resident B fight with each other in the front yard and are unsupervised.

On 9/26/25, I contacted Complainant 2 to confirm my receipt of the allegations and to discuss the process and limitations of licensing investigations. I advised Complainant 2 that residents of adult foster care homes may have unsupervised access to the community contingent upon their assessment plan. I reported I would review documentation to see if that was the case for Resident A and Resident B. I advised Complainant 2 that if Resident A and Resident B were observed in the community breaking the law, to contact law enforcement for assistance as one would if any individual was observed breaking the law within the community.

On 9/30/25, I submitted a written records request to Kentwood Police Department to confirm their involvement at this home.

On 10/2/25, I received a voicemail message from Sergeant Wierenga with the Kentwood Police Department. He inquired if I wished to speak to someone or would like documentation sent to me. That same day I placed a return phone call and left a voicemail message for Sergeant Wierenga advising I will speak to someone if they have concerns about the license at this address and would receive records if records were available for this address. I provided my contact information and advised I am the consultant who oversees the license at this address should anyone ever have concerns and need to speak with me. Neither a return phone call nor records were received as of the date of this report's disposal.

On 10/2/25, I received an email from Complainant 1 who reported "it is clear these caretakers are not caring for these residents according to license requirements." Complainant 1 reported Resident A and Resident B have "violent outbursts", have damaged property, and threatened women and animals and DCWs do not appear to manage their behaviors. Complainant 1 expressed fear regarding Resident A and Resident B living at the home.

On 10/2/25, I responded to Complainant 1 reporting their concerns were noted. I advised of the limitations of my role and potential outcomes of the investigation.

On 10/2/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident B and Licensee Designee, Stephen Forkpah. Mr. Forkpah reported Resident A was incarcerated and would not be returning to the home until 10/6/25 at the earliest.

Mr. Forkpah reported he or Mr. Sulonteh were always present when law enforcement was called to the home. He denied that DCWs leave or hide when law enforcement contacts Resident A and Resident B. He stated that although he and all DCWs are trained in Mandt physical management, due to Resident A and Resident B's physical and mental health diagnoses, they sometimes cannot be de-escalated

or physically managed by DCWs, and law enforcement must be contacted to assist. He stated contacting law enforcement is supported by Resident A and Resident B's caseworker who reports they need to be incarcerated when they assault someone. Mr. Forkpah stated he contacted law enforcement when Resident A was assaulting him and could not be physically managed, which is why Resident A is currently incarcerated.

Mr. Forkpah stated Resident A and Resident B appear to be doing well in this home, compared to Resident A's two prior placements which Mr. Forkpah was the licensee designee for and Resident B's prior placement which Mr. Forkpah was the licensee designee for. He stated it is intended that Resident A will return to this home once he is released from incarceration. He stated Resident A has a medication review on 10/7/25, and he is going to inquire about an increase in Resident A's psychotropic medication to see if that assists with his incidents of escalating behaviors.

Mr. Forkpah stated Resident B moved into this home in May 2025 and Resident A moved in in July 2025. He stated since that time, he believes law enforcement has been at the home four times. He stated there was one incident when Resident A was running after Mr. Sulonteh attempting to hit him with a shovel he had found. He stated during that incident, Resident A threw the shovel, and it ended up breaking a neighbor's window. He stated he agreed to pay to replace the window, but the neighbor has not discussed the window replacement with him since the incident. He stated there have been no other incidents with neighbors that he is aware of. He stated the next-door neighbor even allows the residents into her home unsupervised. He stated three additional incidents with law enforcement were related to things that occurred in the home, not in the community, with the most recent being Resident B calling law enforcement because Mr. Forkpah would not drive him to St. Joseph.

Mr. Forkpah stated Resident A and Resident B are always supervised by DCWs in the home and the community. I inquired about their assessment plans to confirm their level of supervision. Mr. Forkpah reported he does not have their assessment plans available at this home but agreed he would send me a copy.

Resident B reported he and Resident A have both had contact with law enforcement at this home and each time, a DCW has been present. He denied that DCWs hide or leave when law enforcement comes to the home. He stated he recently called law enforcement because Mr. Forkpah would not drive him to St. Joseph and he wanted to be admitted to the hospital but changed his mind. He stated he stood in the driveway of the home during this contact with law enforcement.

Throughout the interview, Resident B was fixated on going to St. Joseph to see his fiancée. He requested I give Mr. Forkpah permission to drive him to St. Joseph. I advised I could not be involved with that. Resident B discussed that when he goes to St. Joseph on 10/7/25, if he does not see his fiancée, he will have assaultive behaviors. Mr. Forkpah stated he was following the instruction of community mental health who requested Resident B not to have contact with his fiancée, in addition to

Mr. Forkpah not having the ability to regularly drive Resident B that far. Resident B asserted Guardian B would decide if he could see his fiancée or not, not his case worker. Resident B insisted on calling Guardian B while I was present and placed her on speakerphone. Guardian B gave Resident B permission to see his fiancée on 10/7/25 but stated DCWs must keep line-of-sight supervision of Resident B at Resident B's fiancée's home because Resident B requires supervision in the community. Mr. Forkpah reported they typically allow Resident B into his fiancée's home unsupervised because her parents are present. Guardian B reported Resident B must always be supervised by DCWS when in the community and DCWs must be in Resident B's fiancée's home with him if he goes there.

Resident B stated he is left alone in this home. He stated this occurred one time on 10/2/25 when Mr. Sulonteh had to drop his child off at school and overnight staff had already left. He stated it only occurred one time. Later in the interview, he stated he is left alone "sometimes" when he does not want to wake up and Mr. Sulonteh must leave briefly in the morning. He stated since he can go into the community independently, he thinks he should be allowed to stay home independently. Resident B reported he can and does go into the community independently without DCW's present.

I requested to review the staff schedule for this home. Mr. Forkpah informed me he does not maintain a staff schedule for this home.

I requested to review the "Incident/Accident Report" forms regarding the incidents of serious hostility, property destruction, or harm to self or others that required law enforcement involvement for Resident A and Resident B. Mr. Forkpah informed me that incident reports were not completed for the incidents.

On 10/2/25, I completed a telephone interview with caseworker Stacy Delmark. I informed Ms. Delmark that I witnessed the conversation between Resident B, Mr. Forkpah, and Guardian B and heard Resident B threatening to have assaultive behaviors if he is not allowed to visit his fiancée on 10/7/25. She reported she would become involved with Guardian B and Mr. Forkpah to address this. She stated she is the caseworker for Resident A and Resident B. She stated she does not have concerns regarding Resident A and Resident B not being appropriately supervised and is not aware of them being unattended in the home and in the community. She stated they are not allowed to move independently within the community and must have staff present with them.

Ms. Delmark stated Resident A and Resident B are related and have the same physical and mental health diagnoses. She stated Resident A, especially, is on an extensive number of medications. She stated their diagnoses are not responsive to medications and their behaviors are due to "never having consequences." She stated she is supportive of Mr. Forkpah and DCWs contacting law enforcement and Resident A and Resident B being incarcerated due to their assaultive behaviors. She

stated as is evident by Resident B threatening to have assaultive behaviors on 10/7/25, he can have control over his behavior.

Ms. Delmark stated she feels this placement is the best option for Resident A and Resident B at this time because both are “tough placements” and have been moved from several previous placements. She stated Mr. Forkpah is “doing the best he can with what he has”, and goes beyond standard AFC care to do a lot for Resident A and Resident B. She stated she feels Resident A and Resident B would have better placement outcomes if DCWs in the home were more consistent with following Resident A and Resident B’s plan of service though. She stated there are some challenges with the language barrier since DCWs speak English as a second language. She gave an example of a prior medication order that was a bit confusing for her to read as a registered nurse that was put on the medication administration record for Resident B. She stated given that DCWs speak English as a second language, the order was likely extremely confusing for them and led to them not giving the medication correctly. She stated she had the order clarified and ensured DCWs understood it. She stated since that time, Resident B has had a decrease in behaviors because he is receiving his medication correctly. She stated she does not blame the DCWs though, because even with her education and background, it was initially confusing to read.

On 10/2/25, I completed a telephone interview with Mr. Sulonteh. He stated Mr. Forkpah had already spoken to him. He apologized stating he did not know that he could not leave Resident B alone while he was in bed. He stated he thought it was okay to briefly leave the home. He reported this has only occurred once and it will not occur again now that he knows it is not allowed.

Mr. Sulonteh stated he has been present two to three times when law enforcement has come to speak to Resident A or Resident B. He stated he is present and speaks to law enforcement, he does not leave or hide. He stated on one occasion; Resident A was chasing him attempting to hit him with a shovel and Resident A threw the shovel breaking a neighbor’s window. He stated one time a neighbor called and reported Resident A was threatening animals and children and was in their yard, so law enforcement responded and told Resident A to stay in the yard of the home. He stated law enforcement has responded to assist when Resident A and Resident B are exhibiting assaultive behaviors that DCWs cannot physically manage. He stated he is Mandt trained and feels he is competent to work with Resident A and Resident B. He stated approximately once a month; Resident A escalates to the level of not responding to redirection or not being able to be physically managed by DCWs.

On 10/13/25, I requested copies of the assessment plan for Resident A and Resident B. Mr Forkpah provided the assessment plans. It was noted Resident A moves independently within the community, however on the comment line it stated, “with supervision”. It was noted Resident B does not move independently within the community and needs supervision.

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:	Complainant 1 and Complainant 2 reported Resident A and Resident B are unsupervised in the community. Resident B reported he can and does go into the community independently. Resident B reported he was left in the home unattended on 10/2/25. Mr. Forkpah and Mr. Sulonteh reported Resident A and Resident B do not go into the community without supervision, although Mr. Forkpah discussed Resident A and Resident B going to the home next-door unsupervised and Resident B visiting his fiancée unsupervised. Mr. Sulonteh acknowledged he did leave Resident B unattended in the home on 10/2/25. Ms. Delmark reported she does not have knowledge of Resident A or Resident B not being supervised appropriately by direct care workers and that Resident A and Resident B require supervision within the community. Guardian B stated Resident B requires supervision within the community. Resident A and Resident B's assessment plan noted Resident A and Resident B require supervision in the community. I attempted to review a staff schedule to confirm staffing in the home. Mr. Forkpah reported he did not maintain a staff schedule. I attempted to review incident reports to confirm which staff were involved when law enforcement interacted with Resident A and Resident B. Mr. Forkpah reported incident reports were not completed for the incidents. Based on the interviews completed, there is sufficient evidence that Resident B did not receive supervision as specified by his assessment plan and defined by the act when he was left unattended in the home or unsupervised in the home of his fiancée. In addition, Resident A and Resident B are not supervised in the community when they go to the next-door neighbor's home.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

On 10/2/25, Resident B reported he was left unattended in the home on 10/2/25.

On 10/2/25, Mr. Sulonteh acknowledged he did briefly leave Resident B unattended at the home on one occasion. He stated he was not aware he could not do that and reported it would not occur again.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department; to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Resident B reported he was left unattended in the home on 10/2/25. Mr. Sulonteh acknowledged he left Resident A unattended in the home on 10/2/25. Based on the interviews completed, there is sufficient evidence the direct care staff to resident ratio was not maintained in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/2/25, I requested to review the staff schedule for the home. Mr. Forkpah acknowledged he does not maintain a staff schedule.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.**

	(c) Hours or shifts worked. **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	I requested to review the staff schedule in the home. Mr. Forkpah denied maintaining a staff schedule in the home. Based on the interview completed, there is sufficient evidence that a staff schedule was not maintained in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/2/25, I requested to review the assessment plan for Resident A and Resident B. Mr. Forkpah reported he did not have the assessment plans available in the home.

On 10/15/25, I received Resident A and Resident B's assessment plans. Resident A's assessment plan was signed by Mr. Forkpah on 4/21/25 and by Guardian A on 10/14/25, after I had requested to review it. Resident B's assessment plan was signed by Mr. Forkpah on 4/28/25 and by Guardian B on 10/15/25, after I had requested to review it.

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:	I requested Resident A and Resident B's assessment plan on 10/2/25. Mr. Forkpah reported it was not available in the home. Mr. Forkpah later provided assessment plans signed by Guardian A on 10/14/25 and Guardian B on 10/15/25. Based on the documentation reviewed, there is sufficient evidence that resident records are not appropriately maintained in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/2/25, I requested to review the "Incident/Accident Report" forms regarding the incidents of serious hostility, property destruction, or attempts of harm to self or others that required law enforcement involvement for Resident A and Resident B. Mr. Forkpah acknowledged incident reports were not completed for the incidents.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (i) Displays of serious hostility. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.
ANALYSIS:	I requested the “Incident/Accident Report” forms regarding the incidents of serious hostility, property destruction, or harm to self or others that required law enforcement involvement for Resident A and Resident B. Mr. Forkpah acknowledged incident reports were not completed for the incidents. Based on the interview completed, there is sufficient evidence that incident reports were not completed appropriately during incidents of serious hostility, property destruction, and attempts of harm to others.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/22/25, I completed an exit conference with Mr. Forkpah. He discussed that it is challenging to maintain compliance with licensing rules because there are four operators of Kingdom Resident LLC but since he is the licensee designee, licensing holds him responsible. He gave the example that one of the other partners should be maintaining the schedules in the home, and he has advised them of this, but they were not, and now he is responsible for the violation. He stated since I was at the home, he has again reminded his business partners that they must maintain daily schedules and they are now posted in the home.

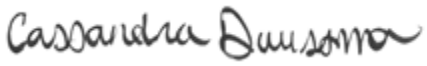
Mr. Forkpah reported due to Resident A and Resident B’s behaviors and their being very manipulative, DCWs will advise them they need to remain in the home, but they threaten DCWs or simply leave stating it is their right to leave the home when they want to. He stated he does not know how to address that with DCWs as they likely feel it is easier to let them go than them becoming assaultive especially when they advise it is their right to leave and DCWs cannot make them stay. I advised if they refuse to remain in the home and leave without supervision, it would be appropriate to contact law enforcement and report their elopement. It was discussed that Ms.

Delmark might be willing to assist with plans of service relating to their elopement and supervision in the community if they are not willing to comply.

I advised that I was willing to provide resources to support an achievable corrective action plan. I advised I was willing to provide consultation and training to his business partners to help them better understand licensing rules if he thought that would be helpful. I advised the importance of not receiving continued reports of Resident A and Resident B being unsupervised in the community, observing missing paperwork in the home, and the licensing actions that could be taken should there be repeat violations substantiated. Mr. Forkpah expressed understanding. He did not dispute my findings or recommendations.

IV. RECOMMENDATION

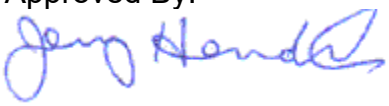
Contingent upon receipt of an acceptable plan of corrective action, the department recommends the status of the license remain the same.



10/22/2025

Cassandra Duursma — Date
Licensing Consultant

Approved By:



10/22/2025

Jerry Hendrick — Date
Area Manager