GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

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

RE: License #:	AS250392427
Investigation #:	2022A0123026
	Welch Home

Dear Mr. Ogundipe:

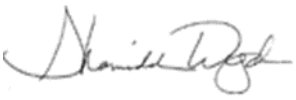
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250392427
Investigation #:	2022A0123026
Complaint Receipt Date:	03/14/2022
Investigation Initiation Date:	03/16/2022
Report Due Date:	05/13/2022
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
Facility Address:	302 Welch Blvd. Flint, MI 48503
Facility Telephone #:	(810) 410-4257
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	03/21/2022
Expiration Date:	03/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility does not have organized or accurate record keeping for resident medications. Resident A's medication list was found to have an outdated prescription. It is unknown if he has missed doses of any medication.	Yes

III. METHODOLOGY

03/14/2022	Special Investigation Intake 2022A0123026
03/14/2022	APS Referral Information received regarding APS referral.
03/16/2022	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
03/16/2022	Contact- Document Received I received documentation from Complainant 1.
03/17/2022	Inspection Completed On-site I conducted an unannounced on-site visit.
04/01/2022	Contact - Telephone call made I made an attempted call to Guardian 1. There was no answer. The voicemail box was full.
04/01/2022	Contact - Telephone call made I made a call to Parkview House in an attempt to interview Resident A.
04/01/2022	Contact - Telephone call made I made a call to the licensee designee Kehinde Ogundipe.
04/01/2022	Contact - Document Sent I sent a follow up email to Mr. Ogundipe requesting documentation.
04/01/2022	Contact - Document Received I received documentation via fax.
04/18/2022	Contact - Telephone call made I spoke with Guardian 1 via phone.

04/20/2022	Contact - Telephone call made I spoke with home manager Ethen Walton via phone.
04/27/2022	Contact- Document Sent I sent a follow up text to Staff Walton requesting the remainder of Resident A's medication order sheets.
05/02/2022	Contact- Telephone call made I spoke with licensee designee Mr. Ogundipe requesting documentation.
05/02/2022	Contact- Telephone call received I spoke with area manger Jessica Ortiz via phone.
05/02/2022	Contact- Document received I received requested information from Staff Ortiz.
05/03/2022	Exit Conference I conducted an exit conference with Mr. Ogundipe.

ALLEGATION: The facility does not have organized or accurate record keeping for resident medications. Resident A's medication list was found to have an outdated prescription. It is unknown if he has missed doses of any medication.

INVESTIGATION: On 03/16/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that the facility's records are very disorganized. Complainant 1 stated that Clozaril/Clozapine was discontinued but was still on the medication sheets. Clonazepam was still listed as well, which could have easily caused a medication error. Complainant 1 stated that Resident A's Colace prescription was left at the pharmacy, and that it was a minor medication but could have easily been a psych med. Complainant 1 stated that PRN's were not in Resident A's medication administration records, and there were no standing orders for PRN's. Complainant 1 stated that Resident A's moved out of county to another adult foster care home, and his prescriptions were transferred and filled at a new pharmacy, and this is how these issues were uncovered. Complainant 1 stated that Resident A has a guardian.

On 03/16/2022, I received requested documentation from Complainant 1. The documentation was copies of Resident A's March medication administration sheets, his Genesee Health Systems (GHS) medication list, and his VPA medication history. The GHS Medication Log Summary dated 03/09/2022 does not detail Resident A's start and end dates for the medications listed. It should be noted that it also does not have a Colace prescription listed. Resident A's *VPA Patient Health Summary* has

Colace 100 mg capsule, take 1 capsule(s) oral every day, 30 days is listed but has “completed Rx.” noted next to the medication. I did not observe any PRN’s noted on the documentation.

On 03/17/2022, I conducted an unannounced on-site visit to the facility. Home manager Ethen Walton and staff Cynthia Ferguson were present. They stated that all Resident A medications were at the home, and they use a pharmacy that delivers the medications directly to the home. They denied that Resident A ever missed a dose of medication. They stated that Resident A was in the hospital for about a month, and his medications stacked up, so he never ran out of medication. Staff Walton stated that he believes Resident A was in the hospital from January 15th through some time in February, and then went back into the hospital on 02/04/22 until 02/15/22. Staff Walton stated that Resident A never missed a medication or medical appointments. I observed that the current residents medications were stored neatly in a locked medication cabinet, in plastic containers clearly marked with each resident’s name and separated between morning and bedtime.

On 04/01/2022, I made a call to licensee designee Kehinde Ogundipe via phone, to follow up regarding paperwork that was requested during the on-site on 03/17/2022. He stated that Resident A was in the hospital in January and February 2022. The pharmacy sends medications directly to the facility.

On 04/01/2022, I received requested documentation via fax from the facility. Resident A’s January, February, and March 2022 medication administrator records were obtained. The Clozapine 100MG PO TAB is noted on all three months that it was discontinued by a physician on 12/21/2021. The section for the Clozapine has a line clearly written across the with “discontinued”, the doctor’s name, and the date it was discontinued is noted. This is documented for multiple other discontinued medications as well. The MARS sheets clearly indicate at the bottom the name of the pharmacy “LTC Welcome Michigan Center.”

On 04/01/2022, I made a phone call to Resident A’s current AFC placement, Parkview House, to interview Resident A via phone. I was informed by home manager Patty King that Resident A is currently in the hospital and has been in the hospital since 03/25/2022.

On 04/18/2022, I interviewed Resident A’s Guardian 1 via phone. Guardian 1 stated that Resident A’s medications were changed by McLaren Hospital in Flint, MI back in November 2021. She denied having any knowledge of the current allegations. She stated that his Clozaril prescription was not changed due to his health, it was changed because it was not covered under his insurance, and that Sanilac County found a way to get it covered. She stated that the only issue she personally had with the facility is that it was not barrier free and had stairs. Guardian 1 stated that Resident A is very sensitive to medication changes, and that he is currently in the hospital. She stated that if prescriptions are not kept stable, Resident A can get sick.

On 04/20/2022, I made a call to the facility. I spoke with home manager Ethen Walton. Staff Walton stated that the LTC pharmacy supplies their MARS sheets. He stated that during Resident A's stay at Willowbrook Manor, his medications were changed, and therefore for February 2022 his prescriptions were handwritten onto the MARS sheets. He stated that Resident A was out of the facility from 02/04/2022 to 02/14/2022 and this is when Resident A was in the hospital and then Willowbrook Manor. He stated that there was one script that Resident A received in February 2022, that had no refills and was used until it ran out (Cephalexin). He stated that the facility never received a Colace prescription for Resident A through the pharmacy. He stated that Resident A's doctor, Dr. Krueger sends Resident A's prescriptions straight to the LTC pharmacy, and the medications are dropped off at the facility's door. He stated that he has no recollection of anything being left at the pharmacy because staff do not pick medications up, as they are dropped off at the facility. He stated that the last medication order list they received for Resident A was on 02/14/2022.

On 05/02/2022, I spoke with area manager Jessica Ortiz via phone. She stated that there are still currently old medications that belonged to Resident A at the facility. She stated that the old bubble packs were not from LTC because the medication came from his prior placement. She stated that all Resident A's other medications are labeled by the LTC Pharmacy. She provided photos of the bubble packs. Some bubble packs have Willowbrook Manor noted on them and appear to be from a different pharmacy. The other bubble packs have LTC Welcome Michigan CE noted on them. I received Resident A's medication order list dated for 02/14/2022 from Willowbrook Manor from Staff Ortiz as well. There was no Colace prescription noted on the order summary. Ms. Ortiz provided photos of other resident medications in the home, and they all have the LTC pharmacy label on them, which confirms what Staff Walton said regarding all medications being from the same pharmacy.

On 05/02/2022, I compared the February and March 2022 MARS documentation with the medication order list from 02/14/2022. There were two discrepancies. The first discrepancy is that the Clonazepam-1mg take one daily was written on the MARS, but the physician order for 02/14/2022 states "*ClonazePAM Tablet 1 MG Give 1 tablet by mouth two times a day for seizures.*" The second inconsistency on the February 2022 MARS documentation is that the Vitamin D3 5000 Unit PO CAP take 1 capsule by mouth daily is not the same as what is noted on the 02/14/2022 medication order lists which states Cholecalciferol Tablet 1000 Unit (Vitamin D3)-give 5 tablets by mouth one time a day for supplemental.

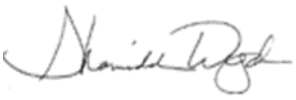
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Staff Ethen Walton reported during the investigation that Resident A had a stay at Willowbrook Manor. When Resident A returned to the facility, the facility received a medication order list. The medication order list was reviewed and compared to Resident A's February 2022 MARS documentation. There were two prescription medications that had been changed, and they were not correctly documented on the MARS sheet regarding dosages. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/03/2022, I conducted an exit conference with licensee Kehinde Ogundipe. I informed him of the findings and conclusion.

IV. RECOMMENDATION

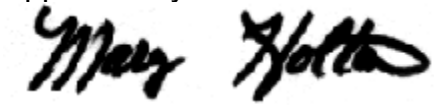
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home (capacity 6).



05/03/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/03/2022

Mary E Holton Date
Area Manager