GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2022

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

RE: License #:	AS250392427
Investigation #:	2022A0872032
	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.
- 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) 284-9700.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS250392427
Investigation #:	2022A0872032
Complaint Receipt Date:	04/20/2022
Investigation Initiation Date:	04/20/2022
Report Due Date:	06/19/2022
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?
On 4/18/22, staff encouraged Residents A and B to physically fight, threatening that they would shoot them if either quits or gets knocked out. Staff reportedly had guns on their hips. Resident A was arrested for assault. Resident B received 12+ stiches in his head as a result of the incident.	No
Additional Findings	Yes

III. METHODOLOGY

04/20/2022	Special Investigation Intake 2022A0872032
04/20/2022	Special Investigation Initiated - Telephone I interviewed the Adult Protective Services Worker, Monica Voltz
04/20/2022	APS Referral This complaint was referred by APS
04/26/2022	Inspection Completed On-site Unannounced
04/26/2022	Contact - Telephone call made I spoke to Ms. Voltz
04/28/2022	Contact - Document Sent I emailed the home manager, Ethen Walton requesting information about this complaint
05/05/2022	Contact - Telephone call made I interviewed Resident A via telephone
05/06/2022	Contact - Document Sent I emailed the licensee designee requesting additional information
05/18/2022	Contact - Telephone call made I interviewed staff Jamareo Riggs
05/25/2022	Contact - Telephone call made I interviewed Resident B's CMH case manager, Sherry Van Holle

05/27/2022	Inspection Completed-BCAL Sub. Compliance
05/27/2022	Exit Conference I conducted an exit conference with the licensee designee, Ken Ogundipe via telephone

ALLEGATION: On 4/18/22, staff encouraged Residents A and B to physically fight, threatening that they would shoot them if either quits or gets knocked out. Staff reportedly had guns on their hips. Resident A was arrested for assault. Resident B received 12+ stiches in his head as a result of the incident.

INVESTIGATION: On 4/20/22, I spoke to Adult Protective Services Worker, Monica Volz via telephone. Ms. Volz said that she interviewed Resident B and saw a cut on his forehead and by his eye. Resident A was still in jail. Ms. Volz also interviewed staff Marlow Harris, the assistant manager, Ethen Walton, and Resident C. She said that Mr. Harris, Mr. Walton, and Resident C denied the allegations.

On 4/26/22, I conducted an unannounced onsite inspection of Welch Home Adult Foster Care facility. I interviewed staff Marlow Harris, assistant manager, Ethen Walton, and Residents C and D. Mr. Harris said that he has worked at this facility for approximately two months. He said that on 4/18/22, he and staff Jamareo Riggs were working at the facility. Residents A and B were arguing about clothes. Resident A went outside and confronted Resident B. Resident B said, “Do something about it.” Mr. Harris said that he and Mr. Riggs tried to diffuse the situation, but Resident B called Resident A “bitch” and they began fist fighting in the garage. Mr. Harris said that he and Mr. Riggs broke it up and all four of them started walking back to the front of the house. At that time, neither of the residents had any injuries. Mr. Harris said that he heard “two smacks” and when he turned around, Resident B was bleeding from the forehead and kept saying, “What the fuck?” At that time, Mr. Harris saw a flashlight in Resident A’s hand which he confiscated from him. Mr. Riggs took Resident B to the hospital, staff called the police, and police came to the facility and arrested Resident A. Mr. Harris said that at no time did he or Mr. Riggs threaten the residents or make them fight. He also said that he has never brought a gun to work and has never seen or heard any of the other staff talk about bringing a gun to work.

Resident C said that he has lived at this facility for approximately 2.5 years. He said that Resident B has caused a lot of trouble since moving in. Resident B has a “high temper” and he tried to start a fight with him on one occasion. According to Resident C, he did not witness the fight between Residents A and B, but he did see that Resident B had a cut on his head. When Resident C asked him what happened, he said, “I got in a fight.” Resident C told me that he does not believe staff would encourage the residents to fight. He also said that he has never seen any of the staff bring weapons to work nor has he ever heard them talk about weapons.

Resident D said that she has lived at this facility for just over a month. She said that Resident B is always stealing or ruining the other resident's belongings. Resident D said that she was present when Resident A and B got into a fight and was looking out the window. She said that she saw Resident A hit Resident B with something who then began bleeding from the head. Resident D told me that both residents were yelling at each other and were egging each other on, and staff went and broke it up. She said that she did not hear staff prompting the residents to fight and she did not see either of the staff with a gun or any other weapon.

Assistant Manager, Ethen Walton said that he did not witness the fight between Residents A and B, but he heard about it. He said that Resident A hit Resident B with a tactical flashlight. Resident A was arrested, and Resident B was taken to the hospital. According to Mr. Walton, he spoke to both staff, and they denied encouraging the residents to fight. I asked Mr. Walton what the facility's policy is on weapons, and he said that staff are not allowed to bring weapons to the facility. He said that he does not believe that Mr. Harris or Mr. Riggs would bring weapons to the facility, and he does not believe that they would encourage the residents to fight.

At my request, Mr. Walton took me out to the garage. I looked around and did not see any evidence of blood or a struggle. Mr. Walton told me that if it is raining, residents will smoke in the garage but that is all it is used for. Mr. Walton said that Resident A is on an outing and Resident B is currently in a state hospital for mental health issues and he does not know if he will be returning to this facility.

On 5/05/22, I interviewed Resident A via telephone. Resident A told me that Resident B, "Was always taking my shit so I told him to go in the garage and box it out." Resident A said that he and Resident B went outside and Resident B "backed me up against the fence" so he defended himself by hitting Resident B with a flashlight that he had in his pocket. Resident A said that Resident B "called the cops on me and I went to jail for three days." I went over the allegations with Resident A and he said that none of that happened. He said that he heard that Resident B told police that staff had guns and were making them fight but that is not true. Resident A said that staff broke up the fight. He said that staff did not encourage them to fight, and they did not have guns.

On 5/06/22, I reviewed AFC paperwork related to Residents A and B. Resident A was admitted to Welch Home AFC on 3/13/22. According to Resident A's Assessment Plan, he controls aggressive behaviors. According to Resident A's Behavioral Assessment dated 01/21/21, he is diagnosed with attention deficit hyperactivity disorder, mild intellectual disability, other pervasive developmental disorders, oppositional defiant disorder, and psychotic disorder. He engages in self-injurious behaviors and staff are to do hourly checks on him.

Resident B was admitted to Welch Home AFC on 04/11/22. According to Resident B's Assessment Plan, he requires staff assistance with controlling aggressive behavior, getting along with others, and not self-harming.

On 5/18/22, I interviewed staff Jamareo Riggs via telephone. Mr. Riggs said that he has worked at Welch Home AFC for almost two years. He said that on the date of the incident, he heard Residents A and B yelling at each other, outside, on the side of the house. He went outside and convinced them to stop arguing. Shortly after, Resident B approached him with a cut on his head, yelling that Resident A had hit him with a flashlight. Mr. Riggs said that he transported Resident B to the hospital while other staff remained at the facility with Resident A. Mr. Riggs later found out that Resident A had been arrested. I reviewed the allegations with Mr. Riggs, and he denied them all. He said that while Resident B was a resident of Welch Home AFC, he used to lie and cause trouble. Mr. Riggs said that he has never brought a weapon to work and said that he has never encouraged residents to fight each other. He told me that it is his job to keep the residents calm, not get them upset.

On 5/25/22, I interviewed Resident B's Easter Seals case manager, Sherry Van Hulle via telephone. Ms. Van Hulle said that Resident B is still in the hospital, and it is unknown where he will be placed when he is released. Ms. Van Hulle said that Resident B is very difficult, he is non-compliant with medications, and he elopes. Ms. Van Hulle said that she spoke to Resident B about the incident that happened on 4/18/22 and he told her that he was "shot in the head." Ms. Van Hulle said that she knew this was not the case, but Resident B is very delusional, and he does not give honest accounts of incidents. I reviewed the allegations with Ms. Van Hulle and she said that she has no reason to believe that any of that took place.

I attempted to contact Guardian B1 on two separate occasions. Her voicemail box was full both times and I was unable to leave a message.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS	Resident B gave several different accounts of what happened on 4/18/22: he told the referral source that he was encouraged to fight by staff and was threatened, he told APS Worker, Monica Voltz that he received 175 stitches from the incident, he told Resident C that he got in a fight, and he told his case manager that he was "shot in the head."

	Staff Marlow Harris, Ethen Walton and Jamareo Riggs said that Residents A and B got into a fight and Resident A hit Resident B in the head with a flashlight. Mr. Harris, Mr. Walton, and Mr. Riggs said that staff did not encourage the residents to fight, they did not threaten them, and they did not bring weapons to work. Residents C and D said that they have never heard staff encourage the residents to fight and have never seen staff bring weapons to work. Resident A said that he and Resident B got into a fight, and he hit Resident B in the head with a flashlight. Resident A said that he heard Resident B tell the referral source that staff encouraged them to fight and had weapons, but the allegations are untrue. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my investigation, I obtained AFC paperwork related to Resident A and Resident B. Resident A was admitted to Welch Home AFC on 3/13/22 and Resident B was admitted on 4/11/22. On 05/06/22, I exchanged emails with the area manager, Jessica Ortiz. Ms. Ortiz said that she does not have signed Resident Care Agreements or Assessment Plans for Residents A or B. She also said that she does not have a Health Care Appraisal completed for Residents A or B. She said that the facility is in the process of hiring a new home manager. Ms. Ortiz said that she has completed new Assessment Plans for both residents and she sent them to their guardians/case managers to be signed. Ms. Ortiz sent me the unsigned AFC paperwork and will send me the signed paperwork once she receives it.

On 05/09/22, Ms. Ortiz sent me signed copies of Resident A and Resident B's Assessment Plans and Resident Care Agreements.

I reviewed an Incident/Accident Report dated 4/18/22 regarding Residents A and B. According to the report, "Client A argued with Client B about items. Residents A and B started to fight, staff separated the two, Resident B returned and hit Resident A with a flashlight. Resident A was taken to the hospital for treatment." This IR was not sent to me as required according to licensing rules.

Renewal LSR dated 1/27/22 found violation to Rule 400.14301(10). At the time of my inspection, a resident was admitted to Welch Home AFC on 7/16/21 yet their Health Care Appraisal was dated 9/29/20. The corrective action plan dated 2/13/22, and signed by the licensee designee, Kehinde Ogundipe indicated that resident Health Care Appraisal's will be dated within 90 days prior to or 30 days after their admission.

Renewal LSR dated 1/27/22 found violation to Rule 400.14301(4). At the time of my inspection, a resident Assessment Plan that I reviewed was not signed or dated by the resident and guardian. The corrective action plan dated 2/13/22, and signed by the licensee designee, Kehinde Ogundipe indicated that resident Assessment Plans will be signed and dated by residents and/or guardians.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A was admitted to Welch Home on 3/13/22 and Resident B was admitted to Welch Home on 4/11/22. As of 5/06/22, neither resident had a signed Health Care Appraisal on file which is a direct violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal LSR dated 1/27/22, CAP dated 2/13/22**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A was admitted to Welch Home on 3/13/22 and Resident B was admitted to Welch Home on 4/11/22. As of 5/06/22, neither resident had a signed Assessment Plan on file which is a direct violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal LSR dated 1/27/22.**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.
ANALYSIS:	Resident A was admitted to Welch Home on 3/13/22 and Resident B was admitted to Welch Home on 4/11/22. As of 5/06/22, neither resident had a signed Resident Care Agreement on file which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	On 5/06/22, I reviewed an Incident/Accident Report dated 4/18/22 regarding Residents A and B. According to the report, "Client A argued with Client B about items. Resident A and B started to fight, staff separated the two, Resident B returned and hit Resident A with a flashlight. Resident A was taken to the hospital for treatment." Resident A was taken to jail. This IR was not sent to me according to licensing rules which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/27/22, I conducted an exit conference with the licensee designee, Kehinde Ogundipe via telephone. I discussed the results of my investigation and explained which rule violations I am substantiating. Mr. Ogundipe agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Susan Hutchinson June 1, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton June 1, 2022

Mary E Holton Area Manager	Date