GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2022

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

RE: License #: AS330411028
Investigation #: 2022A1033011
Bell Oaks I At Moores River

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) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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 #:	AS330411028
Investigation #:	2022A1033011
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/03/2022
Report Due Date:	08/02/2022
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:	Bell Oaks I At Moores River
Facility Address:	123 Moores River Lansing, MI 48910
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	05/03/2022
License **Status:**	TEMPORARY
Effective Date:	05/03/2022
Expiration Date:	11/02/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/27/2022, the direct care staff (DCS) at the home refused to sit with Resident A and dropped her off at Sparrow Hospital. DCS are not providing for her supervision while Resident A is in Sparrow Emergency Department. Resident A states DCS have been "cussing her out."	Yes
Additional Findings	Yes

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A1033011
06/03/2022	Special Investigation Initiated - Telephone Interview with MDHHS worker Suzanne Hunnicutt.
06/06/2022	Inspection Completed On-site Interview Licensee Designee, Kehinde Ogundipe and direct care staff, Brandon Gadberry, with CPS - MDHHS worker, Suzanne Hunnicutt. Initiated resident record review, requested employee files, inspected facility.
06/06/2022	Contact - Face to Face Interview with direct care staff, JaLisa Etchison, with MDHHS worker, Suzanne Hunnicutt
06/06/2022	Contact - Face to Face Interviewed Resident A, at Sparrow Hospital Lansing, with MDHHS worker Suzanne Hunnicutt.
06/07/2022	Contact - Telephone call received Call received from DCS Gadberry. Additional interview with DCS Gadberry via telephone.
06/09/2022	Contact - Telephone call made Attempt to interview Service Specialist with MDHHS Tayler Jasper. Left voicemail message.
06/10/2022	Contact - Document Sent Attempt to interview Service Specialist with MDHHS, Tayler Jasper. Email sent requesting a call back.

06/16/2022	Contact - Telephone call made Interview, MDHHS Service Specialist, Tayler Jasper.
06/16/2022	Contact - Telephone call made Interview with direct care staff, Salina Whitby.
06/16/2022	Contact - Telephone call made Interview with direct care staff, Aurrion Summerour.
06/16/2022	Contact - Telephone call made Interview with Citizen 1, via telephone.
06/24/2022	Contact - Telephone call made Attempt to interview direct care staff, DeAsia Whitt. Left voicemail message.
06/24/2022	Contact - Telephone call made Attempt to interview direct care staff, Rahnesha Bowden. Left voicemail message.
06/24/2022	Contact - Telephone call made Attempt to interview direct care staff, Kiara Ngugi. Left voicemail message.
06/24/2022	Contact - Telephone call made- Attempt to interview Citizen 2. Text message sent requesting call back.
06/27/2022	Contact - Telephone call received- Interview with Citizen 2, via telephone.
06/28/2022	Inspection Completed-BCAL Sub. Compliance
07/27/2022	APS Referral- not required as resident is not an adult.
07/29/2022	Exit Conference with licensee designee Ogundipe

ALLEGATION:

On 05/27/2022, the direct care staff (DCS) at the home refused to sit with Resident A and dropped her off at Sparrow Hospital. DCS are not providing for her supervision while Resident A is in Sparrow Emergency Department. Resident A states DCS have been "cussing her out."

INVESTIGATION:

On 6/3/22 I received an online complaint related to stated allegations. I interviewed MDHHS worker Suzanne Hunnicutt, via telephone. Ms. Hunnicutt reported she had received a complaint related to the status Resident A who currently resides at the Bell Oaks I adult foster care facility. According to Ms. Hunnicutt, on 05/27/22 direct care staff members were unable to reach Resident A's guardian and direct care staff members refused to sit with Resident A so she was dropped off at Sparrow Hospital. Ms. Hunnicutt stated Resident A was currently without proper care and custody sitting at the hospital. Ms. Hunnicutt reported Resident A has the cognitive capacity of a 7-year-old child. Ms. Hunnicutt reported she interviewed Resident A, at Sparrow Hospital Emergency Department, on 6/1/22, while she was awaiting admission. She reported direct care staff member (DCS), Salina Whitby, present with Resident A. She reported DCS Whitby identified herself as an employee of the Bell Oaks I facility and noted that today was her first day. Ms. Hunnicutt reported she interviewed Resident A, alone, and Resident A reported she had been left alone at the hospital by facility staff. Ms. Hunnicutt reported Resident A stated a direct care staff member was with her at the hospital from 5/27/22 at 10pm thru 5/28/22 at 6am. She reported that another staff did not return to the hospital to sit with her until 5/28/22 at 10pm. Ms. Hunnicutt reported Resident A identified, Licensee Designee, Ken Ogundipe, arrived at the hospital at 10pm on 5/28/22 and stayed at the hospital until Monday, 5/30/22. Resident A further reported to Ms. Hunnicutt that from this point she was supervised by another male direct care staff, but she could not recall his name. Resident A reported to Ms. Hunnicutt that this male direct care staff continuously left her bedside, and the hospital, even though he was to be providing supervision to her. Ms. Hunnicutt reported Resident A reported DCS have threatened her and have been trying to fight her. Resident A reported to Ms. Hunnicutt a staff by the name of Ariana, last name unknown, cussed her out and threatened to hit her. She stated this staff called her racist names like "white cracker" and called her a "fucking bitch." She stated Ariana called her stupid for self-harming and trying to kill herself and stated she told her she was just trying to get attention.

On 6/6/22 I completed a joint onsite investigation of the Bell Oaks I facility with Ms. Hunnicutt. Present for this investigation were licensee designee (LD) Ogundipe and Program Director for Eden Prairie, Brandon Gadberry. LD Ogundipe reported that Resident A is currently the only resident receiving care at this facility. LD Ogundipe

reported Resident A was taken to the Sparrow Emergency Department on the evening of 5/27/22. He further reported direct care staff, Damora Jackson, was present with Resident A on 5/28/22 while she was at the hospital. LD Ogundipe reported that he arrived at the hospital to provide supervision for Resident A on 5/28/22 at 10pm and found the resident alone in her room. There was not a direct care staff to relieve when LD Ogundipe arrived on this date. LD Ogundipe reported that he remained with Resident A from 5/28/22 at 10pm thru 5/30/22 at 8am. LD Ogundipe reported they have worked out a plan with Sparrow Hospital staff that when their staff need a meal break or restroom break that they will alert the hospital staff, who will then try to locate a hospital staff to sit with Resident A. LD Ogundipe reported that on 6/3/22 they instituted a sign in and out sheet that will be left in Resident A's hospital room so that they are able to keep track of staff coming and going to provide supervision to Resident A. LD Ogundipe reported he has been staffing direct care staff at Sparrow Emergency Department with Resident A since she was admitted on 5/27/22.

On 6/6/22 Ms. Hunnicutt and I completed a joint interview with direct care staff, Jalisa Etchison, at a residence on 514 N. Pine St., Lansing, MI. DCS Etchison identified herself as the Home Manager for three Eden Prairie adult foster care facilities. DCS Etchison reported, "everyone is quitting on me" as she discussed current staffing for Resident A at Sparrow Hospital. DCS Etchison reported Resident A is currently alone at the hospital at the time of this interview as she has no direct care staff able to cover this shift. DCS Etchison reported it was not communicated to her that Resident A would need continued supervision if she were taken to the emergency department. She reported struggling to find adequate staffing to staff this need, despite the fact that Resident A is the only resident of the facility. She reported Resident A has been alone in the emergency department several times since she was taken to Sparrow on 5/27/22. Ms. Etchison reported DCS Jackson was with Resident A at Sparrow from 5/27/22 thru 5/28/22 at 10am. She further reported the staff who was scheduled to relieve DCS Jackson at 10am called in for their shift. DCS Etchison reported this staff member was replaced by DCS Rahnesha Bowden, who stayed with Resident A on 5/28/22 from 10:30am until 8pm. DCS Etchison reported she is not sure who replaced DCS Bowden but she believes it was LD Ogundipe, but reported she has no verification that this is accurate. DCS Etchison reported there is now a sign in/out sheet at the hospital to keep track of when DCS are present with Resident A. She reported the sign in/out sheets are being kept in a red folder in the hospital room with Resident A.

On 6/6/22, at approximately 12:45pm, Ms. Hunnicutt and I completed an onsite visit with Resident A in the Sparrow Hospital Emergency Department. Resident A was alone in her room when we arrived. Resident A reported LD Ogundipe was with her the previous evening and left this morning. Resident A reported there has not been a DCS to replace LD Ogundipe yet on this date. Resident A reported she has not had consistent supervision since being taken to the emergency room on 5/27/22. Resident A reported her supervision at the Bell Oaks I facility was not consistent either. She reported direct care staff members would leave her alone at the facility

for 30-to-60-minute periods of time. She reported the staff would leave the facility and go next door to the adjacent facility. Resident A reported direct care staff members at Bell Oaks I "cuss me out." She reported she would not repeat what they have said to her as she did not feel comfortable. She reported that the staff swear at her and yell at her.

While in Resident A's room at Sparrow Hospital I reviewed the *Working With Client at Sparrow Hospital,* sign in/out sheets, that LD Ogundipe and DCS Etchison had referred to. On 6/3/22 DCS Deyonce Johnson signed in at 8pm, but there was no sign out time indicated on the log. On 6/4/22 DCS Dasianae Ray signed in at 8pm, but there was no sign out time indicated on the log. On 6/5/22 LD Ogundipe signed in at 8pm and signed out at 7am with the following note, "Have a meeting on 6/6/22 with CPS at 8am. Had to leave at 7am to be ready for the meeting." There was not a replacement for LD Ogundipe on 6/6/22 when he left the hospital at 7am. There was one additional log to review that had LD Ogundipe's name on it but did not have a clear beginning and ending time and there was no date for this event.

On 6/7/22 I interviewed Eden Prairie Program Director, Brandon Gadberry. Mr. Gadberry reported that the facility has given notice to Resident A's MDHHS worker Taylor Jasper, that they will no longer be staffing supervision for Resident A at the Sparrow Hospital Emergency Department. Mr. Gadberry reported that this has been a staffing hardship for their facility, and they can no longer provide this level of supervision. It was noted to Mr. Gadberry that Resident A is the only resident of this facility at this time. He reported Ms. Jasper has not been provided with a 30-day discharge notice for Resident A.

On 6/7/22, I received an email from Mr. Gadberry stating the 30-day discharge notice was submitted to MDHHS with the following text, "Ann Forman at DHHS has documented on June 6th, 2022, she will be assuming staffing responsibilities and accepting our notice immediately."

On 6/16/22, I interviewed DCS, Aurrion Summerour, via telephone. DCS Summerour reported she has worked for the Bell Oaks I facility since 5/15/22. DCS Summerour reported she was familiar with Resident A and had worked with her at the facility. She reported she was instructed Resident A required 1:1 supervision as she had a history of attempted self harm, including swallowing batteries. DCS Summerour reported this level of staffing was difficult to provide if a DCS needed to use the restroom or have any regular break schedule as the facility only staffed one DCS per shift. DCS Summerour reported that she was not aware of any staff members using offensive language or speaking to Resident A in a derogatory manner. DCS Summerour reported that on one occasion, while providing care to Resident A, she began to cut herself with a broken bottle she had found on the street. She further reported Resident A "likes the hospital" and would say and do things in front of police officers in attempts to be taken to the hospital for admission.

On 6/16/22, I interviewed Citizen 1 via telephone. Citizen 1 reported being a former employee of the Bell Oaks I adult foster care facility. Citizen 1 reported having worked with Resident A while she was employed at the facility. Citizen 1 reported that it was expected of the staff to provide 1:1 direct supervision of Resident A. She reported this was difficult to manage as many staff members were quitting on a regular basis. Citizen 1 reported direct care staff had to stay beyond their scheduled shifts to manage the staffing crisis. Citizen 1 reported DCS Etchison had stated, "The bitch might as well kill herself" when discussing Resident A's suicidal ideations. Citizen 1 reported being present for this statement as well as DCS, Kiara Ngugi. Citizen 1 reported she does not believe Resident A heard this statement. Citizen 1 reported she did not directly observe any staff using derogatory language in the presence of Resident A.

On 6/16/22 I interviewed MDHHS Service Specialist, Taylor Jasper via telephone. Ms. Jasper reported LD Ogundipe was given information pertaining to the needs of Resident A via email, telephone conversations and Zoom meetings, prior to Resident A's placement at the Bell Oaks I facility on 5/18/22. Ms. Jasper reported she sent, via email on 5/4/22, Resident A's *Trauma Assessment* and *Behavior Plan* to LD Ogundipe for his review. She reports receiving an email response from LD Ogundipe acknowledging receipt of these documents and understanding the level of care required for Resident A. This email response, from LD Ogundipe, was received by Ms. Jasper on 5/4/22 and read as follows, "Taylor, thank you for sending me the information on [Resident A]. I have read the *Trauma Assessment* and *Behavior Plan*. She will need intense support enhancement care for her safety protection and caring. Also, she has a history of anger, high anxiety and elopement, self-injury behavior, strong trauma issues, etc." Ms. Jasper also reports going over the DHHS 3307 document with DCS Etchison on 5/18/22 when Resident A moved into the Bell Oaks I facility. Ms. Etchison signed this form acknowledging receipt of this information.

On 6/27/22 I interviewed Citizen 2 via telephone. Citizen 2 reported that she did cover shifts with Resident A at Sparrow Hospital. She reported that many staff would "no call no show" their shift to sit with Resident A so it was difficult to staff supervision at all times. She further reported that due to staffing shortages, Resident A would be left at the hospital for hours, unsupervised. Citizen 2 did not work with Resident A in the Bell Oaks I facility and denied having any knowledge of staff being verbally abusive toward Resident A.

On 6/30/22 I interviewed Citizen 3 via telephone. Citizen 3 has been employed by the Eden Prairie organization and has worked for DCS Etchison at another residence. Citizen 3 reported DCS Etchison speaks in a derogatory manner to other residents in her care and has made statements such as, "You're going to do what you're fucking told!" Citizen 3 reported being concerned about this language and approach to resident care.

I reviewed the *Children's Trauma Assessment Group* document for Resident A, dated 3/4/22. This document was emailed to LD Ogundipe, by Ms. Jasper, on 5/4/22. On page 1, under section, *Reason for Referral,* it reads, "[Resident A] was referred for a trauma assessment by Jessica Poulsen of DHHS. [Resident A] was allegedly sexually abused and was separated from her mother for several months, living in a facility which was unable to meet her needs. She has had multiple elopement attempts, she self-harms as a coping mechanism and she has been transported to the hospital by the police on numerous occasions. [Resident A] reports feeling depressed and she has reported hearing voices which inform her to hurt herself or others."

I reviewed the *DHHS 3307* document. Under section 4. *All known emotional and psychological factors relating to the care of the child,* it reads, "Her current diagnosis are ADHD combined presentations, intellectual disability (mild), generalized Anxiety disorder, trauma/stress related disorder. She has a history of self-harm including overdosing on medications, cutting, hitting herself, ripping her hair out. She has verbally threatened others that she wants to harm them when agitated. She has said she wants to burn her mother's house down. She yells, screams, cusses, and has a history of eloping often from her home and school. She gets overwhelmed and bored very easy and it's preferred if there are activities to keep her busy."

On 6/6/22 I reviewed the June 2022 staff schedule for the facility. On the dates 6/3/22, 6/4/22, 6/5/22 there were no staff members scheduled to work from 8am-8pm. On the date 6/5/22 there were no staff members scheduled to work from 8pm through 8am the following morning of 6/6/22.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on interviews with Resident A, Ms. Hunnicutt, LD Ogundipe, Mr. Gadberry, Ms. Jasper, DCS Etchison, DCS Summerour, Citizens 1, 2, and 3, findings from onsite investigation and review of sign in sheets at Sparrow Hospital, *Children's Trauma Assessment Group* document, *DHHS 3707 f*orm, and Staff Schedule for the month of June 2022, it can be determined that the direct care staff were not able to provide for Resident A's personal needs, including protection and safety. Resident A has a documented history of self-harm and elopement attempts and direct care staff members left her unattended on multiple occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While conducting onsite investigation of the Bell Oaks I facility on 6/6/22 I requested to review all employee files. I was told by Mr. Gadberry and LD Ogundipe that the files were kept with their human resources representative, Kenya Crawford. They further reported that DCS Etchison had some of the files with her at another location where she was currently providing care to another client. Ms. Hunnicutt and I made an in-person visit to Ms. Etchison to obtain the employee records she had on hand. The additional records were emailed by Ms. Crawford.

I reviewed the employee files and found that the following files were missing evidence of a completed Michigan Workforce Background Check:

- JaLisa Etchison
- Dasianae Ray
- Salina Whitby

I inquired, via email to Ms. Crawford and Mr. Gadberry on 6/6/22, whether this was the entirety of the employee files available for review. It was reported, by Mr. Gadberry, during an interview on 6/7/22 that the employee files that were provided for review are complete as of this date.

I received an email response from Ms. Crawford on 6/7/22 that there are currently no employee records to review for direct care staff, Dasianae Ray and Salina Whitby.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(6) If an adult foster care facility determines it necessary to employ or independently contract with an individual before receiving the results of the individual's criminal history check or criminal history record information required under this section, the adult foster care facility may conditionally employ the individual if all of the following apply: **(a) The adult foster care facility requests the criminal history check or criminal history record information required under this section, upon conditionally employing the individual.** **(b) The individual signs a written statement indicating all of the following:** **(i) That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) to (g) within the applicable time period prescribed by subsection (1)(a) to (g).** **(ii) That he or she is not the subject of an order or disposition described in subsection (1)(h).** **(iii) That he or she has not been the subject of a substantiated finding as described in subsection (1)(i).** **(iv) The individual agrees that, if the information in the criminal history check conducted under this section does not confirm the individual's statement under subparagraphs (i) to (iii), his or her employment will be terminated by the adult foster care facility as required under subsection (1) unless and until the individual can prove that the information is incorrect.** **(v) That he or she understands the conditions described in subparagraphs (i) to (iv) that result in the termination of his or her employment and that those conditions are good cause for termination.** **(c) Except as otherwise provided in this subdivision, the adult foster care facility does not permit the individual to have regular direct access to or provide direct services to residents in the adult foster care facility without supervision until the criminal history check or criminal history record information is obtained and the individual is**

	eligible for that employment. If required under this subdivision, the adult foster care facility shall provide on-site supervision of an individual in the facility on a conditional basis under this subsection by an individual who has undergone a criminal history check conducted in compliance with this section. An adult foster care facility may permit an individual in the facility on a conditional basis under this subsection to have regular direct access to or provide direct services to residents in the adult foster care facility without supervision if all of the following conditions are met: **(i) The adult foster care facility, at its own expense and before the individual has direct access to or provides direct services to residents of the facility, conducts a search of public records on that individual through the internet criminal history access tool maintained by the department of state police and the results of that search do not uncover any information that would indicate that the individual is not eligible to have regular direct access to or provide direct services to residents under this section.** **(ii) Before the individual has direct access to or provides direct services to residents of the adult foster care facility, the individual signs a statement in writing that he or she has resided in this state without interruption for at least the immediately preceding 12-month period.** **(iii) If applicable, the individual provides to the department of state police a set of fingerprints on or before the expiration of 10 business days following the date the individual was conditionally employed under this subsection.**
ANALYSIS:	Based upon review of the employee files, interview with Mr. Gadberry, and correspondence with Ms. Crawford, the facility employed direct care staff and had them working with Resident A prior to obtaining proper fingerprinting or background checks on DCS Etchison, DCS Whitby and DCS Ray. There was no available evidence that the facility attempted to complete the required fingerprint process.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During review of employee records, it was identified that the following direct care staff did not have evidence of current TB testing in their employee file.

- Aurrion Summerour
- De'Asian Whitt
- Rahnesha Bowden
- Damora Jackson
- Kiara Ngugi
- Deyonce Johnson
- Dasianae Ray
- Salina Whitby

On 6/7/22 I interviewed Mr. Gadberry. Mr. Gadberry reported that as of this date these are the complete employee files available for review.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Based on review of employee records there is evidence that the facility employed multiple direct care staff and had them providing direct care to Resident A prior to receiving a negative TB test.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 I reviewed the available employee records for the Bell Oaks I facility. There were no employee records available for the following direct care staff:

- Salina Whitby
- Dasianae Ray

These two direct care staff had been assigned to work with Resident A and had no employee records for review on this date.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a)Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	There were not any employee files to review for DCS Whitby and DCS Ray. Licensee designee Ogundipe had not gathered and/or maintained this information as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 I conducted a review of employee records. It was identified that the following direct care staff did not have documentation of required trainings prior to providing for Resident A's care needs.

- Aurrion Summerour
- De'Asian Whitt
- Rahnesha Bowden
- Demora Jackson
- Kiara Ngugi
- Deyonce Johnson

During interview with DCS Etchison on 6/6/22 she reported that she is responsible for the training of new DCS at the Bell Oaks I facility. DCS Etchison reported she was not given information on Resident A's care needs until after she was admitted to the facility. DCS Etchison reported she did not recall receiving a copy of the *DHHS 3707* form, which highlights information the facility would need to know about how to provide care to Resident A. DCS Etchison reported that it was her signature at the bottom of Resident A's *DHHS 3707* form but she did not recall when she received this form.

On 6/16/22 I interviewed DCS Salina Whitby, via telephone. DCS Whitby reported that she began working for the Bell Oaks I facility on 6/1/22. She reported that on this date she was hired and immediately went to sit with Resident A at Sparrow Hospital. DCS Whitby reported she received some training prior to her shift but no training related to Resident A's care needs. DCS Whitby had no employee record available to review when I conducted my review of employee files. No evidence of training could be found during my review.

On 6/16/22 I interviewed Citizen 1 via telephone. Citizen 1 reported she was not given training prior to beginning her first shift at the facility. She reported regarding Resident A's care needs she was given a "run down about her" but no formal training to the AFC facility or resident care.

On 6/27/22 I interviewed Citizen 2 via telephone. Citizen 2 reported she did not receive training prior to working her first shift with Resident A. Citizen 2 reported she applied for the job and expected she was going for an interview which turned into being hired and sent to provide supervision to Resident A on the same day. She reported she did not receive any orientation or training to AFC or this Resident's needs.

On 6/30/22 I interviewed Citizen 3 via telephone. Citizen 3 works for another residence operated by the Eden Prairie organization. Citizen 3 reported she was hired the same day she went for her interview and was put to work that day providing care for a resident. Citizen 3 reported she did not receive any training to the facility or the resident's care needs prior to beginning this shift.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e)Verification of experience, education, and training.**

ANALYSIS:	Based on review of employee records and interviews with DCS Whitby, Citizen 1, 2, & 3 it can be clearly established required trainings were not completed prior to direct care staff assuming care responsibilities for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 I reviewed the employee records for the Bell Oaks 1 facility. The following employee records did not contain evidence of reference checks or attempts of reference checks:

- JaLisa Etchison
- Aurrion Summerour
- De'Asia Whitt
- Rahnesha Bowden
- Demora Jackson
- Kiara Ngugi
- Deyonce Johnson

On 6/7/22 I interviewed Mr. Gadberry. Mr. Gadberry reported that as of this date these are the complete employee files they have available for review.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f)Verification of reference checks.**
ANALYSIS:	Based on review of the employee files and interview with Mr. Gadberry there was no documentation of completed reference checks for the above employees at the time of this review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 I reviewed the employee files for Bell Oaks I facility. The following employee files were missing evidence of verification of receipt of personnel policies and job descriptions:

- JaLisa Etchison
- Aurrion Summerour
- De'Asia Whitt
- Rahnesha Bowden
- Demora Jackson
- Kiara Ngugi

On 6/7/22 I interviewed Mr. Gadberry. Mr. Gadberry reported that as of this date these are the complete employee files they have available for review.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(i)Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	Based on review of employee records and interview with Mr. Gadberry, there is no evidence direct care staff were given personnel policies and job descriptions upon hire.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 I reviewed the employee files for Bell Oaks I facility. The following employee files were missing evidence of a valid driver's license:

- Aurrion Summerour
- De'Asia Whitt
- Rahnesha Bowden
- Damora Jackson
- Kiara Ngugi
- Deyonce Johnson
-

On 6/6/22 I reviewed documents found in Resident A's record titled, *Eden Prairie Residential Care Services – Progress Notes.* These notes identified four occasions where direct care staff transported Resident A in a car with a direct care staff member who does not have a copy of a valid driver's license in their employee record.

- *Eden Prairie Residential Care Services – Progress Notes* dated 5/19/22, completed by DCS Summerour, reports “car ride” in the 3pm time slot on this form.
- *Eden Prairie Residential Care Services – Progress Notes* dated 5/24/22, completed by DCS Bowden, reports “car ride” in the 12pm, 12:30p and 1pm time slots with a notation, “Ice Cream”.
- *Eden Prairie Residential Care Services – Progress Notes* dated 5/24/22, completed by DCS Jackson, reports “car ride” in the 4:30p and 5pm time slots on this form.
- *Eden Prairie Residential Care Services – Progress Notes* dated 5/27/22, completed by DCS Jackson, report states in section, *Coping Skills Applied*, “Went for a ride today to get fresh air.”

On 6/27/22 I interviewed Citizen 2 via telephone. Citizen 2 reported she was aware of staff that have been driving Resident A on outings and they do not have a driver’s license. She could not recall staff names at the time of this interview.

On 6/30/22 I interviewed Citizen 3 via telephone. Citizen 3 works for another residence run by the Eden Prairie organization. Citizen 3 reported she was aware there are staff transporting a client she works with and several of these staff members do not have a valid driver's license.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.**
ANALYSIS:	Based on review of employee records, *Eden Prairie Residential Care Services – Progress Notes* dated 5/19/22, 5/24/22, 5/27/22 and interviews with Citizens 2 and 3, it can be established licensee designee Ogundipe did not have proof of a valid driver’s licenses for DCS Jackson, DCS Bowden, & DCS Summerour, and they were noted to be transporting Resident A, by car, on four occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/6/22 Ms. Hunnicutt and I completed an onsite investigation of the Bell Oaks I facility and interviewed LD Ogundipe. LD Ogundipe reported Resident A was

currently at Sparrow Hospital Emergency Department being observed for psychiatric care. LD Ogundipe reported he did not feel Resident A was a good match for the Bell Oaks I facility. He reported she requires more supervision than their staff can manage. LD Ogundipe reported he did not know the level of care Resident A was going to require before she was admitted to the facility on 5/18/22. LD Ogundipe reported MDHHS worker Ms. Jasper had not been able to provide him with all Resident A's pertinent information due to confidentiality purposes. LD Ogundipe reported that he did not receive information about Resident A's needs until she moved into the facility on 5/18/22. LD Ogundipe reported he did have phone conversations and Zoom meetings with Ms. Jasper prior to 5/18/22. LD Ogundipe further reported that he did not know the name of Resident A's guardian until 6/5/22 when he requested this information from Ms. Jasper. LD Ogundipe reported that Resident A has not been established with a primary care physician and at this time he is uncertain which physician will reorder Resident A's medications when they are due for refill. LD Ogundipe reported that he has not issued a 30-day discharge notice for Resident A at this time. He further reported that he does not have plans to issue this notice at this point. LD Ogundipe reported that Resident A is currently the only resident of this facility.

On 6/6/22 Ms. Hunnicutt and I interviewed DCS Etchison. DCS Etchison reported Resident A's care needs were not properly communicated to her when she admitted to the facility on 5/18/22. DCS Etchison reported her signature is on the *DHHS 3707* form in Resident A's file, dated for 5/18/22, but she denied having seen this form before today. DCS Etchison reported she was unaware if Resident A were to go to the emergency department that facility staff would be expected to provide for her supervision there, since Resident A is a minor and the facility has accepted responsibility for her care. DCS Etchison reported she does not feel the facility is able to manage Resident A's care needs. She reported, "We do not have CPI training". She further reported, "She elopes and we cannot manage that behavior. I feel she needs to be in a locked facility. I have been saying this from the get-go." DCS Etchison reported she has expressed these concerns to LD Ogundipe.

On 6/16/22 I interviewed Ms. Jasper via telephone. Ms. Jasper reported that she and LD Ogundipe began conversations about potential placement for Resident A on 3/23/22. Ms. Jasper reported that she had telephone, email and Zoom communications with LD Ogundipe from 3/23/22 onward about placement and needs of Resident A. Ms. Jasper reported that on 5/4/22 LD Ogundipe was emailed Resident A's Trauma Assessment and Behavior Plan. She reported that on 5/4/22 LD Ogundipe replied that he had received and reviewed the information. Ms. Jasper had copy of the email verification for this information. Ms. Jasper reported that it was never stated LD Ogundipe could not have access to information pertaining to Resident A due to confidentiality purposes. Ms. Jasper reported that it was discussed with LD Ogundipe that Resident A has a history of suicidal behavior and self-harm. She further reported that there was an email exchange, on 5/5/22, between herself and LD Ogundipe with the following exchange:

"Jasper, Tayler, 5/5/22, 9:48am: "Hello Ken, Would [Resident A] have her own bedroom and what would the staff to client ratio be?...being that she needs intense supervision. – Tayler

Ogundipe, Ken, 5/5/22, 11:01am: "Good morning Tayler, Yes our mutual client will have her own room and also 1 on 1 intense support enhancement. The rate for that is $600 plus $60 for Covid-19 PREMIUM. Totaling $660. Please let me know who is the client's guardian who will be responsible for her room and board payment. Please let me know if you have any questions on this." – Ken Ogundipe, Administrator.

On 6/16/22 I interviewed DCS Whitby via telephone. DCS Whitby reported she had worked with Resident A. She reported she had received no training pertaining to Resident A's care needs and was sent to provide supervision to Resident A while she was in the Sparrow Hospital Emergency Department.

On 6/16/22 I interviewed DCS Summerour via telephone. DCS Summerour reported that Resident A's care needs were relayed to her by staff at the Bell Oaks I facility. DCS Summerour reported it was relayed to her that Resident A would require 1:1 supervision due do previous suicidal behaviors. She reported she was made aware Resident A had previously swallowed batteries. DCS Summerour reported there was only one staff member available in the facility at a time. Resident A was the only resident in the facility but was not able to be seen when direct care staff would need to use the restroom or have a break. DCS Summerour reported Resident A had exit seeking behaviors. She reported one minute Resident A would be fine and the next minute she would want to leave the facility. DCS Summerour reported Resident A found a broken glass bottle and began cutting herself with the glass while walking down the street.

On 6/16/22 I interviewed Citizen 1. Citizen 1 reported that it was expected that Resident A would have 1:1 supervision due to history of self-harm and suicidal behaviors. Citizen 1 reported the facility did not have adequate staff to manage Resident A's needs due to multiple staff quitting and other staff having to stay longer to cover shifts.

On 6/8/22 Ms. Hunnicutt interviewed Citizen 1. Citizen 1 reported to Ms. Hunnicutt that she does not believe the Bell Oaks I staff are equipped to handle Resident A and stated they are not watching her like they should be. She stated they let [Resident A] wander around and do whatever she wants. She stated there is so much turnover, it's hard to say if staff are trained properly.

I reviewed *AFC Licensing Division – Incident/Accident Reports* (IR) for Resident A. On 5/20/22 and IR was completed and signed by DCS Etchison and LD Ogundipe. In section, *Facts of the Incident*, subsection, *Explain What Happened*, it read, "Client had a melt down after she had stomach pains, on and off all through out the day, which the client cut herself and decided to take off walking down the street." In

subsection, *Action taken by Staff*, it read, “Clients DCW followed client to be sure of her safety asked client to come back (client refused) then the DCW (Aurrion) called the home manager and was advised to call 911.”

On 5/21/22 an IR was completed and signed by LD Ogundipe. In section, *Facts of the Incident*, subsection, *Explain what Happened*, it read, “[Resident A] had high anxiety due to her transition to the new environment. She was verbally and physically abusive to her caregiver and cut herself slightly with a broken glass that she obtained from braking [sic] the room window.” In subsection, Action taken by Staff, it read, “Staff took [Resident A] to Sparrow Hospital for care. She was treated and discharged to the staff. Staff searched [Resident A’s] to remove any foreign object that she can use to harm herself. Staff redirected [Resident A] and had a conversation with her to assure her they are there for her when she needs them.”

On 5/22/22 an IR was completed and signed by direct care staff, DeAsia Whitt, and LD Ogundipe. In section, *Facts of the Incident*, subsection, *Explain What Happened*, it read, “Mad because I made a phone call due to her cutting herself. She cut her finger. She walked out had to call the police.”

On 5/22/22 an IR was completed and signed by direct care staff, Aurrion Summerour, and LD Ogundipe. In section, *Facts of the Incident*, subsection, *Explain What Happened*, it read, “[Resident A] said she didn’t feel safe with staff. She then called 911 then walked up the street.”

On 5/27/22 there was a completed IR for Resident A. This IR was signed by LD Ogundipe and DCS Etchison. This IR stated under section, *Facts of the Incident,* subsection, *Explain What Happened,* it read, “Client was asked what did she overdose on, client stated she had pills from her previous home and that she had been hiding her meds in her cheek at med time, client also stated she had drank bleach at some point of the day.” Under subsection, *Action Taken by Staff,* it read, “Sparrow ran test to see what all was in the client’s system which they stated she had traces of bleach. Administrator (Ken) was notified of this incident and the hospitals decision was to admit client.” Under subsection, *Corrective Measure Taken to Remedy and/or Prevent Recurrence*, it read, “Staff has searched and removed liquids, sprays, etc. from client’s room and staff has also put all cleaning supplies, and other harmful substances away from client access with a lock.”

On 5/27/22 there was a second completed IR for Resident A. This IR was signed by LD Ogundipe and DCS Jackson. This IR stated under section, *Facts of the Incident,* subsection, *Explain What Happened,* it read, “Stomach hurted [sic], couldn’t walk, but walked down Washington had to call police for help she was drinking bleach and that she had taken a lot of her medication.” Under subsection, *Action Taken by Staff,* it read, “Called police to assist, followed behind her.” Under subsection, *Corrective Measures Taken to Remedy and/or Prevent Recurrence,* it read, “Patient’s mouth will be checked after medication administration and client will not have any access to any liquids/cleaning supplies.”

I reviewed the *Children's Trauma Assessment Group* document for Resident A, dated 3/4/22. This document was emailed to LD Ogundipe, by Ms. Jasper, on 5/4/22. On page 1, under section, *Reason for Referral,* it reads, "[Resident A] was referred for a trauma assessment by Jessica Poulsen of DHHS. [Resident A] was allegedly sexually abused and was separated from her mother for several months, living in a facility which was unable to meet her needs. She has had multiple elopement attempts, she self-harms as a coping mechanism and she has been transported to the hospital by the police on numerous occasions. [Resident A] reports feeling depressed and she has reported hearing voices which inform her to hurt herself or others."

I reviewed the *DHHS 3307* document. Under section 4. *All known emotional and psychological factors relating to the care of the child,* it reads, "Her current diagnosis are ADHD combined presentations, intellectual disability (mild), generalized Anxiety disorder, trauma/stress related disorder. She has a history of self-harm including overdosing on medications, cutting, hitting herself, ripping her hair out. She has verbally threatened others that she wants to harm them when agitated. She has said she wants to burn her mother's house down. She yells, screams, cusses, and has a history of eloping often from her home and school. She gets overwhelmed and bored very easy and it's preferred if there are activities to keep her busy."

On 6/6/22 I reviewed the June 2022 staff schedule for the facility. On the dates 6/3/22, 6/4/22, 6/5/22 there were no staff members scheduled to work from 8am-8pm. On the date 6/5/22 there were no staff members scheduled to work from 8pm through 8am the following morning of 6/6/22.

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:	Based on interviews with LD Ogundipe, Ms. Jasper, DCS Etchison, DCS Whitby, DCS Summerour, DCS Jackson, review of IR's, the *Children's Trauma Assessment Group* document and the *DHHS 3307* document, it can be determined that substantial information was provided to LD Ogundipe regarding the needs of Resident A and her high-risk behaviors and requirement for supervision. LD Ogundipe agreed to provide for Resident A's care although LD Ogundipe did not assure adequate staffing was available for Resident A's supervision and protection despite her well documented history of suicidal behaviors, self-harm and elopement tendencies.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/3/22 I interviewed Ms. Hunnicutt, via telephone. Ms. Hunnicutt reported that she had received a complaint related to the status of Resident A currently residing at the Bell Oaks I adult foster care facility. Ms. Hunnicutt reported that the allegation is Resident A was able to gain access to bleach at the facility. Ms. Hunnicutt reported that it is alleged that Resident A drank bleach at the Bell Oaks I facility. Ms. Hunnicutt reported that she interviewed Resident A, at Sparrow Hospital Emergency Department on 6/1/22 and Resident A reported to her, "[Resident A] stated she drank bleach and took pills. She stated staff wasn't watching her and she was able to just go get the bleach and drink it. She stated she didn't remember what kind of pills she took and stated she "just grabbed them and took them"."

On 6/6/22 Ms. Hunnicutt and I completed a joint investigation of the Bell Oaks I facility. At this time LD Ogundipe was interviewed. LD Ogundipe reported the household cleaners and chemicals are kept locked at the top of the basement stairs. He demonstrated that there is a door, leading to the basement, that locks and the chemicals are kept on the other side of the door. I was able to observe this on this date. I inspected the facility and did not find evidence of chemicals being stored in other areas at the time of this investigation.

On 6/6/22 Ms. Hunnicutt and I interviewed DCS Etchison. DCS Etchison reported that the chemicals at the Bell Oaks I facility are kept locked behind the basement door. DCS Etchison reported Resident A told DCS Jackson that on 5/27/22 she had drunk bleach and taken pills at the facility. DCS Etchison confirmed Resident A also told the police the same statement and was then taken to Sparrow Hospital Emergency Department. DCS Etchison reported she is the only one with keys to the chemical storage and is uncertain how Resident A would have been able to obtain chemicals at the facility.

On 6/16/22 I interviewed Ms. Jasper via telephone. Ms. Jasper reported that she had spoken with the staff at Sparrow Hospital but could not recall the date or the

staff member she had spoken with. She reported that it was stated to her, by this staff, that Resident A could not have drunk bleach at the facility as she would have exhibited other physical problems such as a burned esophagus and this was not present in her physical examination.

On 6/16/22 I interviewed Citizen 1 via telephone. Citizen 1 reported that she had previously worked with Resident A as a direct care staff at the Bell Oaks I facility. Citizen 1 reported that it is entirely possible that Resident A could have gained access to bleach at the facility because she had witnessed the bleach and other cleaning products, being left out in the bathroom and under the kitchen sink. Citizen 1 reported these products were not difficult to gain access to and readily accessible in the facility prior to Resident A being hospitalized for claims of drinking the bleach.

On 6/8/22 Ms. Hunnicutt interviewed Sheila (last name not identified) with Sparrow Behavioral Health Services. Sheila reported to Ms. Hunnicutt that Resident A's ammonia level was high when she arrived at the emergency department on 5/27/22 and has since come down to a normal level. This would be consistent with [Resident A] stating she drank bleach prior to her arrival at the emergency department and would explain why it came down with no medical intervention. Sheila further reported to Ms. Hunnicutt that on 6/04/22 there was a note from the doctor and nurse that [Resident A] stated she did not actually drink bleach and she just stated that to get the AFC home shut down because she does not feel safe with them.

On 6/8/22 Ms. Hunnicutt interviewed DCS Ranesha Bowden. DCS Bowden reported to Ms. Hunnicutt, that the bleach and cleaning products, at Bell Oaks I facility, were kept in the laundry room, under the kitchen sink and in the bathroom, but were moved after [Resident A] drank the bleach. DCS Bowden denied she had direct knowledge of [Resident A] drinking the bleach, and stated it was entirely possible as it is her understanding that other caregivers do not always watch [Resident A] like they are supposed to.

On 6/21/22 Ms. Hunnicutt interviewed DCS Aurrion Summerour. DCS Summerour reported to Ms. Hunnicutt, that cleaning supplies like bleach products were kept in the back closet where the laundry machines were, at the Bell Oaks I facility. She stated that these chemicals were not locked up.

I reviewed all available *AFC Licensing Division – Incident/Accident Reports* (IR) for Resident A. On 5/27/22 there was a completed IR for Resident A. This IR was signed by LD Ogundipe and DCS Etchison. This IR stated under section, *Facts of the Incident,* subsection, *Explain What Happened,* it read, "Client was asked what did she overdose on, client stated she had pills from her previous home and that she had been hiding her meds in her cheek at med time, client also stated she had drunk bleach at some point of the day." Under subsection, *Action Taken by Staff,* it read, "Sparrow ran test to see what all was in the client's system which they stated she had traces of bleach. Administrator (Ken) was notified of this incident and the hospitals decision was to admit client." Under subsection, *Corrective Measure Taken*

to Remedy and/or Prevent Recurrence, it read, “Staff has searched and removed liquids, sprays, etc. from client’s room and staff has also put all cleaning supplies, and other harmful substances away from client access with a lock.”

On 5/27/22 there was a second completed IR for Resident A. This IR was signed by LD Ogundipe and DCS Jackson. This IR stated under section, *Facts of the Incident,* subsection, *Explain What Happened,* it read, “Stomach hurted [sic], couldn’t walk, but walked down Washington had to call police for help she was drinking bleach and that she had taken a lot of her medication.” Under subsection, *Action Taken by Staff,* it read, “Called police to assist, followed behind her.” Under subsection, *Corrective Measures Taken to Remedy and/or Prevent Recurrence,* it read, “Patient’s mouth will be checked after medication administration and client will not have any access to any liquids/cleaning supplies.”

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based on interviews with Ms. Hunnicutt, Citizen 1, Ms. Jasper, LD Ogundipe, DCS Etchison, statements from DCS Bowden, DCS Summerour and review of available IR forms for Resident A there is not substantial evidence to prove that Resident A drank bleach at the Bell Oaks I facility. However, there is evidence to demonstrate that the facility was not keeping poisons, caustics and other dangerous materials safeguarded in nonresident areas for the protection of Resident A based on multiple statements from former and current staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

07/27/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

07/27/2022

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Dawn N. Timm Date
Area Manager