GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 22, 2022

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

RE: License #: AS330408820
Investigation #: 2022A0466049
Bell Oaks At Moore 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) 284-9727.

Sincerely,

Julie Elkins, 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

I. IDENTIFYING INFORMATION

License #:	AS330408820
Investigation #:	2022A0466049
Complaint Receipt Date:	06/23/2022
Investigation Initiation Date:	06/23/2022
Report Due Date:	08/22/2022
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 At Moore River
Facility Address:	119 Moores River Dr Lansing, MI 48910
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	11/17/2021
License Status:	REGULAR
Effective Date:	04/15/2022
Expiration Date:	04/14/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATIONS

	Violation Established?
Resident A was assaulted Resident B due to supervision not being provided.	Yes
Direct care worker (DCW) Marcus White pulled a gun on Resident B.	Yes
A resident lit a cigarette in the facility using the stove, leaving the gas on and causing a gas leak.	Yes
Resident B was punched in the back twice by a staff member.	Yes
The facility is short staffed.	Yes
Resident B was raped by a female direct care worker (DCW) at the facility five weeks ago.	No
Resident B was threatened by DCW J'hon Johnson.	Yes
DCW Roy Houston was driving the residents around without a valid drivers' license.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/23/2022	Special Investigation Intake-2022A0466049.
06/23/2022	Special Investigation Initiated – Telephone call to Amber Barton, DHHS, Resident A's case manager.
06/23/2022	Contact - Document Received from Amber Barton.
06/23/2022	Contact - Telephone call received from Suzanne Hunnicutt, DHHS.
06/23/2022	Contact- telephone call made to Kehinde Ogundipe, interviewed.
06/24/2022	Contact- Document Received, additional allegations.
06/24/2022	Contact- Document Received- DHHS Variance Approval.

06/27/2022	Inspection Completed On-site with Suzanne Hunnicutt and Amber Barton.
06/27/2022	Contact- Document Received from Suzanne Hunnicutt.
06/27/2022	Contact- Document Received from Brandon Gadberry.
07/05/2022	Contact- Document Received, new allegations made.
07/07/2022	Contact - Document Received from Suzanne Hunnicutt.
07/19/2022	Contact - Document Received from Suzanne Hunicutt.
07/26/2022	Contact - Document Received from Suzanne Hunicutt.
07/27/2022	Inspection Completed On-site with APS Talaina Cummins.
08/08/2022	Contact- Document Sent to Brandon Gadberry.
08/09/2022	Contact- Document Received from Brandon Gadberry.
08/10/2022	Contact- Documents sent/received from licensee designee Kehinde Ogundipe.
08/10/2022	Contact- Documents received from Brandon Gadberry.
8/17/2022	Exit Conference with licensee designee Kehinde Ogundipe.

ALLEGATION: Resident A was assaulted by Resident B due to supervision not being provided.

INVESTIGATION:
On 06/23/2022, Complainant reported that on 06/11/2022, Resident A was punched in the back twice by Resident B. Additionally, Complainant reported a DCW had to pull Resident B off of Resident A on 6/11/22. Complainant reported the police were called to file a report, but DCWs would not allow Resident A to press charges.

On 06/23/2022, MDHHS case manager Barton reported licensee designee Ogundipe told Resident A he was not allowed to call 911 for any reason. MDHHS case worker Barton reported she addressed with licensee designee Ogundipe in an email that Resident A has the right to call 911. MDHHS case worker Barton reported DCW Houston was the only DCW on shift on 06/11/2022 when the assault took place. MDHHS case manager Barton reported licensee designee Ogundipe told her he provides all of his residents with 1:1 supervision. Case manager Barton reported that on 06/11/2022, Resident A was not provided with 1:1 supervision.

On 06/27/2022, Ms. Hunnicutt, MDHHS case manager Barton and I conducted an unannounced investigation and we interviewed Resident A who reported that on 06/11/2022, DCW Houston was working alone when Resident B assaulted him. Resident A reported that he, DCW Houston and Resident B were at the store when Resident B was upset because he thought the clerk at the store killed his mother. Resident A reported that because Resident B was rude, they left without purchasing any items. Resident A reported once they were back at the facility, Resident B punched him twice in the back. Resident A reported DCW Houston said he had to get licensee designee Ogundipe's permission before the police could be called. Resident A reported when the police were out, licensee designee Ogundipe told the police not to press charges against Resident B. Resident A reported he and Resident B are the only residents currently living at the facility.

On 06/27/2022, Ms. Hunnicutt, MDHHS case manager Barton and I interviewed DCW Houston who reported that on 06/11/2022, he was working alone when he saw Resident B hit Resident A and then tackle him. DCW Houston reported that per Resident A's request the police were contacted, and a police report was filed. DCW Houston reported he was not sure if Resident A opted to press charges or not against Resident B. DCW Houston reported he did not influence Resident A in any way as to if he should press charges or not. DCW Houston reported Resident A talked to the police officer alone. DCW Houston reported he did not remember completing an *AFC Incident/Accident Report* about the altercation. DCW Houston reported that typically Resident A and Resident B are each assigned their own 1:1 direct care staff member to provide supervision but he could not remember why he was the only DCW on shift that day. DCW Houston reported Resident A and Resident B are the only residents currently living at the facility.

On 06/27/2022, I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which did not contain specific supervision requirements nor any one-to-one supervision requirement.

On 06/28/2022, I reviewed *Lansing Police Department Case Report* dated 06/11/2022 at 4:43pm authored by Officer Tamika Lofton. Resident A was documented as the victim. In the "victim statement" of the report it stated,

> "I spoke with [Resident A] outside of the listed address. Roy took him and [Resident B] to the store. While inside the store, [Resident B] accused the cashier of murdering his mother. Once they got back in Roy's car, [Resident A] told [Resident B], you need to get a handle on your hallucinations. Once they got home, [Resident B] punched [Resident A] in the back twice and then walked away. [Resident B] then tackled [Resident A] and caused him to fall. [Resident A] punched [Resident B] in the back. Roy broke up the fight, and the two went their separate ways."

In the "victim injuries/medical treatment" section of the report it stated,

> "[Resident A] did not have any injuries, nor did he request medical attention."

In the "accused statement" section of the report it stated,

> “I spoke with [Resident B] at the listed address. Roy took him and [Resident A] to the store. While at the store, he believed the cashier was the female who murdered his mother and got mad. He told the cashier, I'll take you outside and fight you. [Resident B], Roy, and [Resident A] left the store. While in the parking lot, [Resident B] told [Resident A] don't say things like that to people. [Resident B] stated while in Roy's car, [Resident A] started yelling at him. He told [Resident A] to stop yelling or they were going to fight. Once they got to 119 Moores River Dr., [Resident A] got in [Resident B’s] face and said, your mother is dead. [Resident B] picked up [Resident A] and slammed him on the ground, then Roy broke up the incident.”

In the “witness statement” section of the report it stated,

> “I spoke with Roy at the listed address. He is an employee at the AFC home. He took [Resident A] and [Resident B] to the store. While at the store [Resident B] accused the cashier of murdering his mother and was being disrespectful to the clerk. Roy, [Resident B] and [Resident A] left the store and walked to the car. On the walk to the car, [Resident A] told [Resident B] he could not talk to people like that. The two continued exchanging words on the car ride home. Once back at 119 Moore River Dr., [Resident B] punched [Resident A] in the back of the head twice, [Resident A] fell, and [Resident B] kicked [Resident A] in the shoulder. Roy broke up the fight and separated the two. Roy stated the manager of the house wanted a police report for the incident. Roy advised he was going to keep [Resident A] separated for the evening.

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and we interviewed Resident B who reported he did hit Resident A twice on the side of his arm on 06/11/2022. Resident B reported that he was tired of Resident A talking about his mom. Resident B reported that he hit Resident A again about two to three days ago because Resident A was talking about DCW White and him having a gun at the facility.

On 07/27/2022, APS Cummings and I interviewed Resident A who reported Resident B physically hit him again about two days ago. Resident A reported Resident B was agitated with DCW Jaycee Andrews and said he was “going to beat his butt.” Resident A reported he told Resident B that the “last time a gun was pulled on him he hid” and that was when Resident B hit him. Resident A reported that staff told Resident B not to hit Resident A and redirected him. Resident A reported that he, Resident B and Resident C currently live at the facility. Resident A reported Resident C is not at the facility today as he is currently in the hospital but reported that his belongings are in his bedroom.

On 07/27/2022, I reviewed Resident B’s record which contained a written *Assessment Plan for AFC Resident’s* (assessment plan) dated 02/09/2022 and in the “controls aggressive behavior” section of the report it stated, “[Resident B] cannot control his aggressive behavior. Staff will supervise and help [Resident B] manage his aggressive behavior.” In the “gets along with others” section of the report it stated, “sometimes aggressive towards others. [Resident B] will receive 1:1

service for his safety and protection." In the "exhibits self-injurious behavior" section of the report it stated, "[Resident B] has a history of self-injury. Staff will monitor [Resident B] intensely to ensure his safety and minimize self-injurious behaviors."

On 08/10/2022, licensee designee Ogundipe reported Resident B is his own guardian and he and his community mental health case manager were both in agreement with the 1:1 supervision provision documented in the written assessment plan. Licensee designee Ogundipe reported he and Resident B both signed the written assessment plan where the supervision plan is documented. Licensee designee Ogundipe reported this supervision plan was put into place upon admission due to Resident B being unsuccessful in his previous AFC placements.

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:	Resident A and Resident B both reported that Resident A hit Resident B on 6/11/2022 and again about two days ago. DCW Houston was the only DCW on duty on 06/11/2022 and he reported Resident B hit and then tackled Resident A before he could intervene. Resident B's record contained a written *Assessment Plan for AFC Resident's* which documented "[Resident B] cannot control his aggressive behavior. Staff will supervise and help [Resident B] manage his aggressive behavior." In the "gets along with others" section of the report it stated, "sometimes aggressive towards others. [Resident B] will receive 1:1 service for his safety and protection." Resident B did not receive the required 1:1 supervision on 06/11/2022 as there was only one direct care staff member working. Resident A was hit again by Resident B in late July 2022. Resident A's protection and personal safety are not being attended to by the facility as Resident B is not being monitored per his written assessment plan even though he has a history of being aggressive with others. A violation has been established as Resident A and Resident B's protection and safety were not attended to by direct care staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker (DCW) Marcus White pulled a gun on Resident B.

INVESTIGATION:
On 06/23/2022, Complainant reported direct care worker (DCW) Marcus White pulled a gun on an unknown male resident the other day. On 06/23/2022, I interviewed Resident A's case manager Amber Barton from the Michigan Department of Health and Human Services (MDHHS) who reported Resident A told her DCW White is not working at the facility. Case manager Barton reported the facility has two residents currently and they are both male residents.

On 06/23/2022, I interviewed Suzanne Hunnicutt, MDHHS staff member, who reported that she interviewed Resident A on 06/23/2022 and Resident A reported DCW White pulled a gun on Resident B.

On 06/23/2022, I interviewed licensee designee/administrator Kehinde Ogundipe who reported DCW White was terminated due to an allegation DCW White had a gun at the facility. Licensee Ogundipe reported when he learned of the situation, the facility manager was immediately sent to the facility and DCW White was terminated that same day. Licensee Ogundipe reported there are currently two male residents living there, Resident A and Resident B.

On 06/27/2022, I conducted an unannounced investigation and I reviewed an *Adult Foster Care (AFC) Accident /Incident Report* that was completed by Roy Houston and signed on 06/23/2022. The date of the incident on the incident report was left blank. In the "explain what happened" section of the report it stated, "Marcus pulled his gun from his car because DCW threatened client with gun. Manager and HR notified right after incident." In the "action taken by staff" section of the report it stated, "All managers were notified on spot!" In the "corrective measures" section of the report it stated, "The staff was immediately terminated by HR right after incident occurred."

On 06/27/2022, I reviewed DCW White's employee record which contained a *Michigan Workforce Background Check* which was dated 05/15/2022 and documented that DCW White is eligible for employment at an adult foster care (AFC) facility. At the time of the investigation, DCW White's record did not contain a termination letter.

On 06/27/2022, I reviewed the facility's policy and procedure manual titled, "*Eden Prairie Residential Care Services Adult Foster Care Group Home Policy and Procedure Manual*." This document did not contain any rules prohibiting weapons/guns while working at the facility.

On 06/27/2022, I conducted an unannounced investigation with MDHHS staff member Ms. Hunnicutt and case manager Barton and we interviewed Resident A who reported that DCW White did have a gun in the facility but he could not

remember the date. Resident A reported DCW White let him hold the bullets but not the gun. Resident A reported he saw the gun “with my own eyes” and the gun was black. Resident A reported DCW White pulled the gun on Resident B because Resident B was upset and was going to throw the kitchen table at DCW White. Resident A reported Resident B gets upset a lot and described his behavior as “unpredictable.” Resident A reported Resident B will become verbally aggressive and extremely violent when agitated toward both him and DCWs. Resident A reported when DCW White pulled the gun on Resident B, Resident B ran out of the house onto the porch. Resident A believed that the gun scared Resident B as he talks about his mom being murdered. Resident A reported that DCW White used the gun to intimidate Resident B and manage his behaviors.

On 06/27/2022, Ms. Hunnicutt, MDHHS case manager Barton and I interviewed licensee designee Ogundipe and program director Brandon Gadberry who both reported Resident A and Resident B are both male and remain the only two residents at the facility. Licensee designee Ogundipe and Mr. Gadberry could not remember the date but reported DCW White was terminated the same day it was reported he had a gun at the facility. Mr. Gadberry reported during the internal investigation it was learned DCW White had made comments about having a concealed weapon license and that he was not afraid to use it. Mr. Gadberry reported the facility internal investigation also revealed DCW White threatened Resident B with his gun. Mr. Gadberry could not recall the dates that DCW White made comments about having a gun. Mr. Gadberry reported licensee designee Ogundipe terminated DCW White to ensure the safety of the residents. Mr. Gadberry stated it was never reported to him DCW White actually pulled out a gun rather it was reported DCW White pointed to his pocket, as in reference to his gun, as a way to intimidate or scare the residents.

On 06/27/2022, Ms. Hunnicutt, case manager Barton and I interviewed DCW J’hon Johnson who reported he was coming onto shift at 8am when DCW White told him he can handle Resident B and tapped his pocket. DCW Johnson reported DCW White told him he had a gun and kept it either in his car or his pocket, so he knew what DCW White was referring to when he touched his pocket. DCW Johnson reported that although he did not see the gun, he believed DCW White had one with him. DCW Johnson reported DCW White used the gun to intimate Resident B and manage his behaviors.

On 07/27/2022, adult protective services (APS) worker Talaina Cummins and I interviewed Resident B who reported DCW White pointed a gun at him across the room in the facility near the kitchen table. Resident B reported that after DCW White held the gun up he, Resident B, walked out of the home onto the front porch for his safety. Resident B reported at the time of this incident, DCW White was his assigned as his one-to-one DCW. Resident B reported DCW White was terminated the same day the incident with the gun occurred. Resident B reported DCW White has not worked at the facility since that date.

On 07/27/2022, APS Cummings and I interviewed DCW Roy Houston, Jr. who reported observing DCW White pull what he thought/assumed was a gun from his car and threaten Resident B with the gun which DCW White stated was in his pocket. DCW Houston reported he was working with DCW White when this occurred although he could not recall the date. DCW Houston reported he did not see the gun but DCW White kept referring to it and pointing to his pocket inferring that is where the gun was located. DCW Houston reported that although he did not see the gun, he believed DCW White had one with him. DCW Houston reported DCW White used the gun or the threat of the gun to intimate Resident B and manage his behaviors. DCW Houston reported that he immediately contacted the manager and human resources. DCW Houston reported that DCW White was terminated the same day.

On 08/04/2022, I received an email from Detective Garrett Hamilton with the Lansing Police Department, Investigation Unit, who reported making contact with Resident B. Detective Hamilton reported Resident B reported to him no one pointed a gun at him and that he did not require assistance from the police. Detective Hamilton reported the case has been unfounded per the victim and closed.

On 08/10/2022, licensee designee Ogundipe provided me with a termination letter for DCW White which was dated 06/07/2022 and documented that as the date of termination. Licensee designee Ogundipe reported DCW White has not worked at the facility since 06/07/2022.

On 08/11/2022, Kenya Crawford, human resources manager reported that DCW White was terminated on 6/15/2022 due to at will employer work policy for unsatisfactory work performance.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Complainant, Resident A and Resident B all reported DCW White pulled a gun on Resident B at the facility with the intent to intimidate Resident B. DCW Houston and DCW Johnson reported they never saw DCW White's gun but both believed he had a gun with him at the facility based on the comments he made and when he would point to his pocket inferring to the location of his gun. Licensee designee Ogundipe and program director Gadberry reported DCW White was terminated the same day it was alleged DCW White had a gun at the facility. DCW White was assigned to provide Resident B's 1:1 supervision when this occurred. There is enough evidence to support that DCW White was not suitable to meet the physical, emotional, intellectual, and social needs of each resident especially Resident B as he used the threat of a gun to manage his behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: A resident lit a cigarette in the facility using the stove, leaving the gas on and causing a gas leak.

INVESTIGATION:
On 06/23/2022, Complainant reported that yesterday a resident lit a cigarette on the gas stove, left the gas stove on causing a gas leak in the home.

On 06/23/2022, case manager Barton reported that Resident A reported to her that Resident B lit his cigarette using the gas stove and left the stove on.

On 06/27/2022, I conducted an unannounced investigation with Ms. Hunnicutt and case manager Barton and we interviewed licensee designee Ogundipe who reported Resident B is a habitual smoker who is always losing his lighter. Licensee designee Ogundipe admitted Resident B lights his cigarette by using the gas stove often. Licensee designee Ogundipe could not remember the date but reported Resident B did leave the gas stove on after lighting his cigarette. Licensee designee Ogundipe reported DCW Houston found the stove left on and turned it off. Licensee designee Ogundipe admitted the stove should not have been left on however he denied that it caused a gas leak. Licensee designee Ogundipe reported he directed DCWs that witnessed Resident B lighting his cigarette using the stove to write an Incident Report but reported that they never did.

On 06/27/2022, Ms. Hunnicutt, case manager Barton and I interviewed Resident A. Resident A reported Resident B uses the stove often to light his cigarette and he does not always remember to turn the stove off after his cigarette is lit. Resident A reported Resident B does not smoke in the house, he just lights his cigarette in the house when he cannot find a lighter. Resident A was not sure if leaving the stove on

caused a gas link but he did report DCW Houston found the stove on and turned it off.

On 06/27/2022, Ms. Hunnicutt and MDHHS case manager Barton and I did not observe any gas odor in the facility.

On 07/27/2022, APS Cummings and I interviewed conducted an unannounced investigation and I did not observe any gas odor in the facility.

On 07/27/2022 APS Cummings and I interviewed Resident B who denied that he has ever lit his cigarette using the stove. Resident B reported that he is not aware of the facility having a gas leak.

On 07/27/2022, APS Cummings and I interviewed DCW Houston who reported that Resident B has lit his cigarette in the house when he cannot find a lighter. DCW Houston reported that he has found the gas stove left on and turned it off. DCW Houston reported that he has never smelt gas in the facility and was not aware of the facility ever having a gas leak.

On 07/27/2022, I reviewed Resident B's written *Assessment Plan for Adult Foster Care (AFC) Residents* which documented that Resident B smokes. In the "gets along with others" section of the report it stated, "sometimes aggressive towards others. [Resident B] will receive 1 to 1 service for his safety and protection."

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:	Resident B did not receive the required 1:1 supervision as outlined in his written assessment plan after he used the gas stove to light his cigarette and did not turn it off. According to licensee designee Ogundipe, DCW Houston and Resident A, this is a known behavior of Resident B's, however the use of 1:1 supervision should have stopped or limited this from occurring. The required level of supervision was not provided to Resident B to ensure the safety and welfare of the residents; therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is short staffed.

INVESTIGATION:
On 06/23/2022, Complainant reported licensee designee Ogundipe is rarely checking on direct care staff members, a lot of staff quit or do not show up, leaving them shorthanded to meet Resident B's needs.

On 06/27/2022, Ms. Hunnicutt, MDHHS case manager Barton and I conducted an unannounced investigation and we interviewed licensee designee Ogundipe and Mr. Gadberry who reported two DCWs are scheduled per daytime shift and one DCW at night. Licensee designee Ogundipe and Mr. Gadberry reported there are currently two residents living at the facility who are both provided with one-to-one supervision. Licensee designee Ogundipe reported he has experienced high turnover rates with DCWs and he has had to let some DCWs workers go due to performance concerns.

On 06/27/2022, I reviewed the *Staff Schedule* that was posted in the facility at the time of the unannounced investigation titled "Welch Home Employee Schedule" dated 06/01/2022 through 06/31/2022. The Staff Schedule documented that on 06/27/2022 DCW Salina Whitby was on shift from 8am-8pm. On 06/27/2022, I was at the facility at 9am and DCW Whitby was not working, DCW Johnson was on shift which was not documented on the schedule. The scheduled did not document any DCW working from 8pm-8am on 06/01/2022-06/10/2022. The schedule documented that on 06/11/2022, only one DCW worked from 8am-8pm and 8pm-8am. The schedule documented that on 06/12/2022, no DCW was scheduled from 8am-8pm and 8pm-8am. The schedule documented that no DCW was scheduled from 8am-8pm on 06/28/2022-06/31/2022.

On 06/27/2022, Ms. Hunnicutt, case manager Barton and I interviewed Resident A who reported that there has never been a time when no DCW was at the facility. Resident A reported that there are supposed to be two DCWs per shift but that does not always occur. Resident A was not able to provide any dates or times when only one DCW has been on shift except for 06/11/2022 when he was assaulted by Resident B and DCW Houston was the only DCW on duty.

On 06/27/2022, Ms. Hunnicutt, MDHHS case manager Barton and I interviewed DCW Houston who reported that on 06/11/2022, he was the only DCW on shift. DCW Houston reported there are two residents at the facility that each have a one-to-one DCW. DCW Houston reported the facility has had shifts where a DCW does not show or after a DCW is fired, it may take a day or two to replace them. DCW Houston reported that typically there are two DCWs per shift but reported that there have been shifts where DCWs have to work alone. DCW Houston reported the night shift always works alone.

On 06/27/2022, I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which did not contain specific supervision requirements nor any one-to-one supervision.

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and I reviewed Resident B's record which contained a written *Assessment Plan for AFC Resident's* which was dated 02/09/2022 and in the "gets along with others" section of the report it stated, "sometimes aggressive towards others. [Resident B] will receive 1 to 1 service for his safety and protection."

On 07/27/2022, I reviewed the *Staff Schedule* that was posted in the facility at the time of the unannounced investigation titled "Welch Home Employee Schedule" dated July 18, 2022, through July 31, 2022. The *Staff Schedule* documented that there were two DCWs scheduled unless listed below.

- 7/18/2022, 1 DCW only 4p-12p and no DCW 12p-8am.
- 7/19/2022, 1 DCW only 4p-12p and no DCW 12p-8am.
- 7/21/2022, 1 DCW only 4p-12p.
- 7/22/2022, 1 DCW 12p-8am.
- 7/23/2022, 1 DCW 12p-8am.
- 7/24/2022, 1 DCW 12p-8am.
- 7/25/2022, 1 DCW 12p-8am.
- 7/26/2022, no DCW 4p-12p.
- 7/27/2022, no DCW 4p-12p and 1 DCW 12p-8am.
- 7/28/2022, 1 DCW 12p-8am.
- 7/29/2022, 1 DCW 12p-8am.
- 7/30/2022, 1 DCW 12p-8am.
- 7/31/2022 1 DCW 12p-8am.

On 08/09/2022, June, July and August *Staff Schedules* were provided by Mr. Gadberry and compared to the schedules that were reviewed while on site on 06/27/2022 and 07/27/2022. The schedules that were provided did not match the schedules that were posted and reviewed while on cite.

On 08/10/2022, Kenya Crawford, Human Resource (HR) Manager reported that DCW Jalisa Etchinson was terminated on 07/01/2022 for "at will employer work policy for unsatisfactory work performance." The Staff Schedule provided by Mr.

Gadberry documented that DCW Etchinson worked on 07/04/2022, 07/05/2022, 07/06/2022, 07/07/2022, 07/08/2022, 07/11/2022, 07/12/2022, 07/13/2022, 07/14/2022 and 07/15/2022.

DCW Johnson's was another terminated and his employee record was requested multiple times and was as of the writing of this report the employee record was never provided by licensee designee Ogundipe.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident B's written assessment plan documented Resident B requires 1:1 supervision but did not specify Resident B only required 1:1 supervision during waking hours. Licensee designee Ogundipe reported he schedules two DCWs per daytime shift and only one DCW at night. The schedules reviewed documented several dates when two DCWs were not scheduled/did not work. Based on the posted schedules reviewed at the time of the on-site investigation, 18 shifts in June 2022 and 16 shifts in July 2022 were not scheduled with two direct care staff members as required to meet the needs of Resident A and Resident B double staffed. A violation has been established as the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in Resident B's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B was raped by a female direct care worker (DCW) at the facility five weeks ago.

INVESTIGATION:
On 06/24/2022, Complainant reported Resident B was raped by a female DCW at the facility five weeks ago.

On 06/24/2022, I reviewed an *AFC Incident/Accident Report* dated 06/23/2022 and signed by licensee designee Ogundipe. In the "explain what happened" section of the report it stated, "Client accused the female manager of raping him 5 weeks ago. [Resident A] said he noticed this from the smelling on his body while he was taking a

shower. He stated nobody saw her raping him early in the morning while the rape occurred and he never told anyone of this 5 weeks ago. In the "action taken by staff" section of the report it stated, "Administrator immediately notified the police of this incident. The police (Officer H. Roberson #168) came back to document the report and the police IR# is 2251905731." In the "corrective measures" section of the report it stated, "continue intense enhancement care for [Resident B] and administrator will request medication review to manage his delusion and hallucinations."

On 06/27/2022, I conducted an unannounced investigation and I interviewed license designee Ogundipe who reported the manager of the facility is DCW Etchinson.

On 06/27/2022, I reviewed DCW Etchinson's employee record which contained a *Michigan Workforce Background Check* which was dated 04/22/2022 and documented that she was eligible for employment at an AFC facility.

On 07/07/2022, I interviewed APS Cummings who reported she was investigating this allegation.

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and interviewed Resident B who reported that he was not raped by any female direct care staff member, including DCW Etchinson or anyone else. Resident B reported that APS Cummings and I must be confused as he never reported that to anyone.

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and interviewed Resident A who reported that he was not aware of Resident B being raped by any female direct care staff member. Resident A reported that the facility has male DCWs that work here, DCW Etchinson is the manager and she brings in the groceries. Resident A reported Resident B can be aggressive and flirtatious with females that come to the facility.

On 07/27/202, APS Cummings and I interviewed DCW Armstrong who reported he was hired about a week ago. DCW Armstrong reported Resident B told him that he was raped when he was younger but that he never mentioned that he had been raped by DCW Etchinson or anyone else while living at the facility.

On 07/27/202, APS Cummings and I interviewed DCW Houston who reported he has worked at the facility since the end of May 2022. DCW Houston reported Resident B never reported to him that he had been raped by DCW Etchinson or anyone else while living at the facility.

On 08/10/2022, licensee designee Ogundipe reported Resident B had history of harassing females and poor relationships with them. Licensee designee Ogundipe reported this was the reason one-to-one male staff during the awake time. Licensee designee Ogundipe reported that Resident B is his own guardian and he and his community mental health case manager were both in agreement with the 1:1

supervision provision documented in the written assessment plan. Licensee designee Ogundipe reported he and Resident B both signed the written assessment plan where the supervision plan is documented. Licensee designee Ogundipe reported this supervision plan was put into place due to Resident B being unsuccessful in his previous AFC placements. Licensee designee Ogundipe reported DCW Etchinson had never been with Resident A alone and the accusations of DCW Etchinson raping him were false.

On 08/10/2022, Mr. Gadberry reported Resident B has a chronic history of delusions, and it was Mr. Gadberry's understanding Resident B recanted the same day. Mr. Gadberry reported home manager DCW Etchinson reported the police were contacted but she never obtained the police report.

APPLICABLE RULE	
R 400.14301	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	Resident B reported denied he was raped by a DCW Etchinson or any direct care staff member at the facility. DCW Etchinson's employee record documented that a *Michigan Workforce Background Check* was completed on 04/22/2022 and documented that she was eligible for employment at an AFC facility therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was threatened by DCW J'hon Johnson.

INVESTIGATION:
On 07/05/2022, Complainant reported that Resident A was threatened by DCW J'hon Johnson.

On 07/05/2022, I reviewed an *AFC Incident/Accident Report* (IR) dated 07/04/2022 and signed by licensee designee Ogundipe. In the "explain what happened" section of the IR it stated, "J'hon Johnson requested [Resident A] to move his used plate to the kitchen and [Resident A] refused and J'hon then threatened the client. The administrator went to the home to investigate the issue." In the "action taken by staff" section of the report it stated, "Staff called administrator to report the incident, after the investigation, administrator terminated the employee J'hon and requested that J'hon should leave the home immediately. Administrator called 911 to seek police assistance. The employee was removed from the property by the Lansing

police." In the "corrective measures" section of the report it stated, "Continue to provide intense 1 on 1 for [Resident A] for his safety and protection."

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and interviewed Resident A who reported DCW Johnson told him to move his plate and wash it but he was not through eating. Resident A reported DCW Johnson was yelling at him and telling him to wash the plate but DCW Johnson was not listening to what he was saying as he was willing to wash his plate after he had finished eating. Resident A reported that he was cooking a second helping of noodles and once the noodles were finished cooking, he was going to use that same plate to eat the noodles and then wash it. Resident A reported DCW Houston witnessed the altercation. Resident A reported DCW Johnson no longer works at the facility.

On 07/27/2022, APS Cummings and I interviewed DCW Houston who reported DCW Johnson was rude and disrespectful to Resident A the day he was terminated. DCW Houston reported DCW Johnson asked Resident A to wash his plate. DC Houston reported Resident A stated that he was making more noodles so once he was done eating, he would clean the plate. DCW Houston reported that was not good enough for DCW Johnson and he began yelling at Resident A. DCW Houston reported DCW Johnson was not listening to what Resident A was saying. DCW Houston reported Resident A was responding to DCW Johnson in a respectful manner and tone and DCW Johnson was not respectful to Resident A.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A and DCW Houston reported DCW Johnson did not treat Resident A with dignity when he was yelling at him about washing a plate he was still using.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: DCW Roy Houston was driving the residents around without a valid drivers' license.

INVESTIGATION:
On 07/05/2022, Complainant reported DCW Houston does not have a driver's license yet he drives the facility vehicle to take Resident A and Resident B into the community.

On 07/27/2022, APS Cummings and I conducted an unannounced investigation and we interviewed Resident A and Resident B who both reported DCW Houston drives them in the facility vehicle into the community. Resident A reported management is aware DCW Houston does not have a driver's license, but DCW Houston is allowed to transport residents.

On 07/27/2022, APS Cummings and I interviewed DCW Houston who reported he does not have a driver's license, just a state identification card. DCW Houston showed APS Cummings and I his state issued identification card. DCW Houston reported he has used the facility vehicle to take the residents into the community knowing that he did not have a driver's license. DCW Houston reported he provided his state identification card as part of the hiring process, so licensee designee Ogundipe was aware that he did not have a driver's license. DCW Houston reported many of the DCWs at the facility do not have a driver's license, so it makes it difficult when the residents want to go somewhere. DCW Houston reported that he stopped driving the residents into the community since he does not have a driver's license.

On 07/27/2022, I reviewed DCW Houston's employee record that was provided by licensee designee Ogundipe and it contained a copy DCW Houston's state identification card only but no driver's license.

My review of the Lansing Police Department Case Report dated 06/11/2022 documented DCW Roy Houston was the direct care staff member who drove Resident A and Resident to the store on 06/11/2022.

On 08/11/2022, I reviewed the facility's *Program Statement* which documented that "Eden Prairie will ensure that the resident's transportation and medical needs are met. Eden Prairie has transportation available for residents to access community-based resources and services. The facility will make provision for a variety of leisure and recreational equipment. It is the intent of this facility to utilize local community resources including public schools and libraries, local museums, shopping centers, and local parks."

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:	Resident A, Resident B and DCW Houston all reported that DCW Houston has taken Resident A and Resident B into the community using the facilities vehicle without a valid driver's license. I reviewed DCW Houston's employee record which contained a state identification card and not a driver's license therefore a violation has been established as DCW Houston was driving Resident A and Resident without a driver's license.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:
On 07/27/2022, APS Cummings and I interviewed DCW Houston who reported he was now the manager and a live-in DCW at the facility. DCW Houston reported he is the only DCW assigned to the nighttime shift and he sleeps at the facility at night. DCW Houston reported he does get up to assist the residents during the night as needed. DCW Houston reported that he moved into the facility in July 2022. I observed DCW Houston's belongings in an upstairs bedroom and DCW Houston confirmed that he slept in the home at night.

On 07/27/2022, APS Cummings and I interviewed Resident A and Resident B who reported that the DCW Houston is a live-in-staff member who does sleep at night in the home and assists them as needed. Resident A and Resident B reported that DCW Houston has lived in the home since the beginning of July 2022.

On 07/27/2022, I reviewed the original report that was written by licensing consultant Candace Colburn which stated, "Staff will remain awake during the nighttime shift."

On 08/10/2022, I did a facility search on the bureau information and technology system (BITS) which did not contain clearances nor any documentation that DCW Houston was a member of household.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	License designee Ogundipe allowed DCW Houston to move into the facility as a live-in staff without providing written notice to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 06/27/2022 and on 07/27/2022, I conducted an unannounced investigation and both times the handrail on the porch was very loose and wabbly. The handrail is not secure enough to use while climbing the porch stairs.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(8) Stairways shall have sturdy and securely fastened handrails. The handrails shall be not less than 30, nor more than 34, inches above the upper surface of the tread. All exterior and interior stairways and ramps shall have handrails on the open sides. All porches and decks that are 8 inches or more above grade shall also have handrails on the open sides
ANALYSIS:	The handrail on the porch is not secured and is in need of repair or replacement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the license status.

8/17/2022

Julie Elkins — Date
Licensing Consultant

Approved By:

08/22/2022

Dawn N. Timm — Date
Area Manager