GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

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

RE: License #:	AS250392427
Investigation #:	2023A0872012
	Welch Home

Dear Mr. Ogundipe:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250392427
Investigation #:	2023A0872012
Complaint Receipt Date:	11/29/2022
Investigation Initiation Date:	11/30/2022
Report Due Date:	01/28/2023
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	G 15 B 405 W Greenlawn Lansing, MI 48910
Licensee Telephone #:	(214) 250-6576
Administrator:	Kehinde Ogundipe
Licensee Designee:	Kehinde Ogundipe
Name of Facility:	Welch Home
Facility Address:	302 Welch Blvd. Flint, MI 48503
Facility Telephone #:	(810) 780-4222
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	03/21/2022
Expiration Date:	03/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 11/28/22, Resident A was angry. He was yelling, swearing, and making racial slurs toward staff. Staff Edward West tried to calm Resident A down. Resident A continued his verbal aggression, so Mr. West began yelling and swearing at him. Mr. West was sent home until further notice.	Yes

III. METHODOLOGY

11/29/2022	Special Investigation Intake 2023A0872012
11/30/2022	Special Investigation Initiated - On Site Unannounced
12/02/2022	APS Referral I made an APS complaint
12/19/2022	Contact - Telephone call made I interviewed staff Shaniya Martinez
12/19/2022	Contact - Telephone call made I interviewed staff Mike Page
12/19/2022	Contact - Telephone call made I interviewed staff Edward West
12/19/2022	Inspection Completed-BCAL Sub. Compliance
12/19/2022	Exit Conference I conducted an exit conference with the licensee designee, Kehinde Ogundipe

ALLEGATION: On 11/28/22, Resident A was angry. He was yelling, swearing, and making racial slurs toward staff. Staff Edward West tried to calm Resident A down. Resident A continued his verbal aggression, so Mr. West began yelling and swearing at him. Mr. West was sent home until further notice.

INVESTIGATION: On 11/29/22, I reviewed an Incident/Accident Report (IR) dated 11/28/22 regarding Resident A. According to the IR, Resident A was upset so he began to "verbally attack and throw racial slurs at clients and staff." Staff tried to calm Resident A down and redirect him, but they were unable to do so. "After continuous attempts to calm and redirect him, Staff (Edward West) used inappropriate language towards (Resident A) while trying to intervene. Staff was asked to leave the home for his choice of words towards (Resident A) until further notice." The corrective measures taken were, "employee was sent on suspension until investigation is complete."

On 11/30/22, I conducted an unannounced onsite inspection of Welch Home Adult Foster Care facility. I interviewed the home manager, Samantha Dimick and Resident A.

According to Ms. Dimick, staff Edward West has been working at this facility for approximately three months. He used to be Resident A's one-on-one staff, but he was switched several weeks ago. On 11/28/22, Mr. West came to work and was distracted because he had a lot of personal things happen over the weekend. Resident A got angry about something, and he began yelling and swearing at staff. Mr. West tried to calm Resident A down, but he would not stop. Mr. West ended up getting angry with Resident A and began cussing at him. Ms. Dimick said that as soon as Mr. West began cussing at Resident A, she told him to go outside and then she suspended his employment pending an investigation. Ms. Dimick said that Mr. West did not put his hands on Resident A and did not physically harm him in any way.

Resident A said that a couple of days ago, staff Edward West began cussing at him and calling him names. He said that Mr. West also "smacked" him in the face. I asked him if anyone else was present when this occurred and he said that the home manager, Samantha Dimick was there. I told him that Ms. Dimick said that Mr. West did not put his hands on Resident A and Resident A said, "she's lying." Resident A told me that he did not receive any marks, bruises, or injuries from the incident and nobody else was present when it happened.

On 12/19/22, I interviewed staff Mike Page via telephone. Mr. Page said that he was not working on the day this incident occurred but said that he heard about it. Mr. Page said that he heard Resident A was yelling and cussing at staff and calling them racial slurs, but he did not hear anything else about the incident.

On 12/19/22, I interviewed staff Shaniya Martinez via telephone. Ms. Martinez confirmed that she was working on 11/28/22. According to Ms. Martinez, Resident A was angry with one of the other residents, so he began yelling at staff. Ms. Martinez said that Resident A was cussing at staff and calling them the "n word." She said that staff Edward West was trying to get Resident A to calm down, but he would not calm down. Ms. Martinez told me that she did not hear Mr. West cuss at Resident A, she did not hear him call him any names and she did not see Mr. West put his hands on Resident A at any time.

On 12/19/22, I interviewed staff Edward West via telephone. Mr. West said that on 11/28/22, Resident A was angry with one of the other residents. Resident A began yelling at staff, calling them racial slurs and being verbally aggressive. Mr. West said that he tried to get Resident A to calm down and stop but he would not stop. Mr. West told me that he got upset and told Resident A to “get the fuck back” because he was getting up in Mr. West’s face. Mr. West said that he also told Resident A to “calm the fuck down” and said, “don’t do that shit.” Mr. West told me the home manager, Samantha Dimick told him to step outside so he left work for the remainder of the day. I asked Mr. West if he ever put his hands on Resident A at any time and he said no.

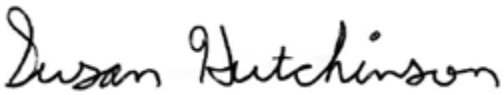
According to Mr. West, as a result of this incident, he was suspended from his job, and he also received a write up for the incident. Mr. West said that he is back to work, and he understands that what he said was wrong. He acknowledged that no matter how upset he gets, he cannot cuss at the residents.

On 12/19/22, I conducted an exit conference with the licensee designee, Kehinde Ogundipe. I told him that I concluded my investigation and explained which rule violation I am substantiating. I asked Mr. Ogundipe to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	On 11/28/22, Resident A was upset with one of the other residents. According to Resident A and staff Samantha Dimick and Edward West, Mr. West tried to get Resident A to calm down, but he would not. Resident A, Ms. Dimick, and Mr. West said that Mr. West became upset, so he cussed at Resident A. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

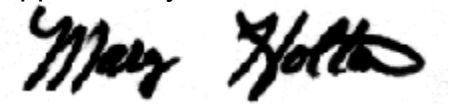
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



December 19, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



December 19, 2022

Mary E. Holton Area Manager	Date