GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2023

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

RE: License #: AS330408820
Investigation #: 2023A0790031
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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, 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 #:	AS330408820
Investigation #:	2023A0790031
Complaint Receipt Date:	02/25/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/26/2023
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:	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. ALLEGATION(S)

	Violation Established?
Direct care staff members (DCSMs) Dareion Summerour and Jeremy Bates used physical force on Resident A.	Yes
DCSM Dareion Summerour locked Resident A out of the facility and threw his belongings down the stairs.	No

III. METHODOLOGY

02/25/2023	Special Investigation Intake 2023A0790031
02/28/2023	Special Investigation Initiated - On Site- Interviewed direct care staff member (DCSM) Guy Ross and Resident A.
02/28/2023	Inspection Completed On-site
03/02/2023	Contact - Telephone call made to interview DCSM Ashanti Wright who functions as the regional manager.
03/02/2023	Exit Conference with licensee designee Kehinde Ogundipe.
03/06/2023	Contact - Document Sent- Emailed Ms. Wright requesting additional information and documentation.
03/06/2023	Contact - Document Received- Ms. Wright emailed the requested information and documentation.
03/07/2023	Contact - Telephone call made to interview DCSM Dareion Summerour. Left voicemail message requesting a return call.
03/07/2023	Contact - Telephone call made to interview DCSM Jeremy Bates.
03/07/2023	Inspection Completed-BCAL Sub. Compliance.
03/07/2023	Corrective Action Plan Requested and Due on 03/22/2023.
03/08/2023	APS Referral called into Centralized Intake.

ALLEGATION:

Direct care staff members (DCSMs) Jeremy Bates and Dareion Summerour used physical force on Resident A.

INVESTIGATION:

I reviewed an AFC Licensing Division – Incident / Accident Report dated 02/24/2023. The report explained the following happened at the facility on 02/23/2023: "[Resident A] said he called the police from a neighbor's home. [Resident A] said when he got back into the house, Mr. Summerour kicked him in the head."

The Action taken by Staff / Treatment Given states: Mr. Summerour denied the incident ever happened.

The Corrective Measures Taken to Remedy and/or Prevent Recurrence were as follows: Mr. Bates was terminated; police report was made regarding the accusations and the Office of Recipient Rights was notified of the allegations.

I reviewed a second AFC Licensing Division – Incident / Accident Report dated 02/24/2023. The report explained the following happened at the facility on 02/23/2023: Resident A told the house supervisor on 02/24/2023 the day prior Resident A and DCSM Jeremy Bates got into an argument and Mr. Bates pushed Resident A.

The Action taken by Staff / Treatment Given states: "The house supervisor asked Mr. Bates about the allegations and Mr. Bates admitted to pushing [Resident A] because [Resident A] was in his face threatening him. The house supervisor reminded Mr. Bates he should have walked away, and it is never okay to put his hands on a resident."

The Corrective Measures Taken to Remedy and/or Prevent Recurrence were as follows: Mr. Bates was terminated, and the Office of Recipient Rights was contacted and notified of the allegations.

I reviewed a statement written by Resident A on 02/24/2023 outlining what happened at the facility on 02/23/2023. The statement, in part, indicated the following: Resident A came downstairs and DCSM Jeremy Bates said he had something for somebody and Resident A asked if it was for him. Resident A said Mr. Bates' tone of voice became loud, and Mr. Bates began cursing at Resident A, so Resident A threatened Mr. Bates. Resident A said Mr. Bates told him if Resident A threatened him again, he was going to "fuck" Resident A up. Resident A said Mr. Bates then got in his face so he told Mr. Bates he was "going to kill" him. Resident A stated Mr. Bates pushed him. Resident A said he went back to the facility, went inside, sat down, and put his head down. He stated Mr. Bates pushed the table on him so Resident A flipped the table over and asked to speak to a "higher up" supervisor.

I conducted an unannounced onsite investigation on 02/28/2023. I interviewed DCSM Guy Ross. Mr. Ross said he normally works the night shift but today was his first time working a day shift. He said he did not know anything about DCSMs Dareion Summerour and Jeremy Bates using physical force against Resident A. Mr. Ross stated he was not working on 02/23/2023 when the altercations allegedly happened. He said he was informed of the allegations by other DCSMs but has no firsthand knowledge.

I interviewed Resident A who stated he cannot recall the sequence in which the events happened on 02/23/2023 but can recall much of what occurred. Resident A said he came downstairs and DCSM Jeremy Bates began yelling at him for having a stogie in his dresser. Resident A said Mr. Bates kept yelling at him repeatedly about this, so he threatened to stab Mr. Bates. He stated Mr. Bates said, “Do not threaten me again or I will beat your ass.” Resident A said then Mr. Bates pushed him.

Resident A said when he got back inside after being locked out of the facility, he sat down on the couch and had his head down. He stated Mr. Bates again began yelling at him and pushed the coffee table over on him. Resident A said he was unsure if anyone else saw this. He stated the other residents were in their rooms when this happened.

Resident A stated DCSM Dareion Summerour, who Resident A refers to as “little brother”, took his phone. He said Mr. Summerour then went upstairs and began throwing Resident A’s clothes all over and throwing his shoes down the stairs. Resident A stated he ran upstairs to get his clothes and Mr. Summerour kicked him in the head. Resident A said he would not put his hands on Mr. Summerour or Mr. Bates. He stated he tried to end the situation. Resident A said the police showed up and the female officer asked him to go upstairs to his room and rest. He stated the police just showed up. Resident A denied calling them because Mr. Summerour had taken his phone. Resident A said Mr. Summerour and Mr. Bates were both fired, and things have been “calm and fine” since. I attempted to interview other residents, but no one wanted to speak with me.

I interviewed DCSM Ashanti Wright who functions as the regional manager on 03/02/2023 via phone. Ms. Wright stated she was not present at the facility on 02/23/2023 and has no firsthand knowledge of what happened. She said she does believe an altercation took place and Mr. Bates admitted to pushing Resident A. Ms. Wright stated Mr. Bates had been one of their better DCSMs and the residents really liked him. I noticed Mr. Bates was wearing a tether when I visited the facility on an earlier date. Ms. Wright said Mr. Bates was eligible to work at an Adult Foster Care (AFC) home and provided me with his letter from Workforce Background Check which indicated Resident A was eligible to work as a DCSM.

Ms. Wright stated Mr. Summerour denied kicking Resident A in the head and denied anything happening between him and Resident A on 02/23/2023. She said Resident B disclosed he did not witness any altercation between Resident A and Mr. Bates or Resident A and Mr. Summerour. Ms. Wright stated Resident B indicated he was in his

room when the alleged altercations occurred, and he did not witness Mr. Bates push Resident A or Mr. Summerour kick Resident A in the head. Ms. Wright said Resident B disclosed he witnessed Resident A body slam Mr. Summerour. She stated Resident A disclosed he did body slammed Mr. Summerour because Mr. Summerour kicked him in the head. Ms. Wright stated she terminated Mr. Bates and Mr. Summerour because she believes the altercations occurred and Resident A was locked out of the facility.

I attempted to interview DCSM Dareion Summerour on 03/07/2023 via phone but he did not answer. I left a voicemail message requesting a return call.

I interviewed DCSM Jeremy Bates on 03/07/2023 via phone. Mr. Bates said Resident A woke up agitated on 02/23/2023. He stated it is normal for Resident A to wake up agitated and he recently had been more confrontational and physically violent. Mr. Bates stated Resident A had put his hands on another resident as well as DCSMs. He said he was speaking to another resident when Resident A came downstairs and got in his face. Mr. Bates stated he pushed Resident A. He said he did not push Resident A like he was fighting. Mr. Bates stated he pushed Resident A more like “get back” out of his personal space. Mr. Bates stated Resident A continued to escalate. He said Resident A was yelling and being aggressive toward other residents and DCSMs.

Mr. Bates said he and Mr. Summerour gave Resident A multiple chances to calm down. He stated Resident A called the police because he felt he was being cornered. Mr. Bates said the police came to the facility and a female officer told Resident A to go to his room to rest and relax. He said Resident A complied with the officer’s request and went to his room to cool down. Mr. Bates stated he went outside for 10 to 15 minutes and made a phone call. He said he heard some rumbling upstairs, so he went back inside, ran upstairs, and noticed Resident A’s belongings thrown around his room. Mr. Bates said this was not unusual to see because Resident A tends to get upset, go to his room, and throw his clothes and belongings all over the place. Mr. Bates said he did not see an altercation take place between Resident A and Mr. Summerour.

Mr. Bates stated he knows Mr. Summerour allowed Resident A to borrow a pair of his shoes. He said Mr. Summerour told him he allowed Resident A to borrow a pair of his shoes and had asked for them back. Mr. Bates again stated he did not witness anything physical happen between Resident A and Mr. Summerour.

Mr. Bates said DCSMs normally call Resident A’s case manager from Community Mental Health – Clinton-Eaton-Ingham (CMH-CEI) when he is agitated and aggressive. He stated Resident A had been so aggressive recently it was even hard for the case manager to calm him down.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with DCSMs Mr. Ross, Ms. Wright, Mr. Bates, and Resident A there is sufficient evidence indicating DCSMs Jeremy Bates and Dareion Summerour used physical force on Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

DCSM Dareion Summerour locked Resident A out of the facility and threw his belongings down the stairs.

INVESTIGATION:

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 02/24/2023. The report explained, in part, the following happened at the facility on 02/23/2023: Resident A brought to the house supervisor's attention that DCSM Dareion Summerour locked Resident A out of the home and threw his belongings down the stairs.

I reviewed a statement written by Resident A on 02/24/2023 outlining what happened at the facility on 02/23/2023. In the statement Resident A wrote in part that DCSM Dareion Summerour told Resident A to give Mr. Summerour back the shoes he let Resident A borrow. Resident A said he told Mr. Summerour no because he had them for a month. Resident A stated Mr. Summerour went upstairs and began throwing his shoes down the steps and stomping on Resident A's clothes. Resident A said he went outside to smoke a cigarette and Mr. Summerour locked the door for 20 minutes locking him out. Resident A stated he went to a neighbor's house to try to get help and the neighbor ignored him.

Guy Ross said he knew nothing about DCSM Dareion Summerour locking Resident A out of the facility and/or throwing Resident A's belongings down the stairs. Mr. Ross stated he was not working on 02/23/2023 when the incidents allegedly happened. He said he was informed of the allegations by other DCSMs but had no firsthand knowledge.

Resident A stated Mr. Summerour locked him out of the facility for approximately 20 minutes.

Ms. Wright said Mr. Summerour denied locking Resident A out of the facility. She said Resident B disclosed he witnessed Mr. Summerour lock Resident A out of the facility. Ms. Wright stated she will ask Resident B if he would be willing to speak with me and provide me with this disclosure directly. She said she would have Resident B call me if he is willing to speak with me. As of the date of this report, Resident B has not called. Ms. Wright stated she terminated Mr. Summerour because she believes he locked Resident A out of the facility.

Mr. Bates stated he does not remember Resident A being locked out of the facility.

I conducted an exit conference with licensee designee Kehinde Ogundipe on 03/02/2023 informing him there were violations established because of this special investigation. I requested Mr. Ogundipe provide an acceptable Corrective Action Plan (CAP).

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: **(g) Refuse the resident entrance to the home.**
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with DCSMs Mr. Ross, Ms. Wright, Mr. Bates, and Resident A there is not sufficient evidence to indicate DCSM Dareion Summerour locked Resident A out of the facility and threw his belongings down the stairs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

03/07/2023

Rodney Gill Date
Licensing Consultant

Approved By:

03/22/2023

Dawn N. Timm Date
Area Manager