GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 6, 2023

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

RE: License #: AS630411893
Investigation #: 2023A0605020
Zenith Home

Dear Mr. Ogundipe:

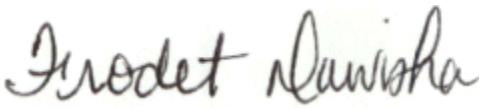
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630411893
Investigation #:	2023A0605020
Complaint Receipt Date:	02/02/2023
Investigation Initiation Date:	02/02/2023
Report Due Date:	04/03/2023
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	G 15 B 405 W Greenlawn Lansing, MI 48910
Licensee Telephone #:	(214) 250-6576
Administrator/Licensee Designee:	Kehinde Ogundipe
Name of Facility:	Zenith Home
Facility Address:	21412 Reimanville Ferndale, MI 48220
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	12/01/2022
License Status:	TEMPORARY
Effective Date:	12/01/2022
Expiration Date:	05/31/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A waited until 11:00 AM to receive breakfast this morning 02/01/2023.	No
Clothes are not being washed and Resident A is given other residents clothes to wear.	Yes
Resident A's bed is not leveled.	No
Additional Findings	Yes

III. METHODOLOGY

02/02/2023	Special Investigation Intake 2023A0605020
02/02/2023	Special Investigation Initiated - Letter Email sent to Oakland County Office of Recipient Rights (ORR) worker Brittany Navetta regarding the allegations.
02/02/2023	Contact - Telephone call made Attempted to reach the reporting person (RP) at the number provided, but the woman who answered stated there was no one by that name at their agency.
02/03/2023	Contact – Document received Email from ORR Brittany Navetta
03/06/2023	Contact - Telephone call received Discussed allegations with DCS Justin Martin
03/15/2023	Contact - Face to Face Conducted an unannounced follow-up investigation.
03/29/2023	APS referral Adult Protective Services (APS) referral made.
03/29/2023	Contact – Document received APS denied referral

03/29/2023	Contact – Telephone call made Discussed allegations with Resident A's legal guardian, George Heitmanis' office.
03/29/2023	Exit Conference Conducted exit conference via telephone with licensee designee Ken Ogundipe with my findings.

ALLEGATION:

Resident A waited until 11:00 AM to receive breakfast this morning 02/01/2023.

INVESTIGATION:

On 02/02/2023, intake #193086 was assigned for investigation regarding Resident A not receiving breakfast until 11AM on 02/01/2023. I initiated the special investigation by making a referral to Oakland County Office of Recipient Rights (ORR).

On 02/03/2023, I received an email from ORR worker Brittany Navetta she searched for this individual in their system, and it does not appear that Resident A is open for services with Oakland County Housing Network (OCHN), which means he's out of OCHN-ORR jurisdiction.

On 02/07/2023, I conducted an unannounced on-site investigation at Zenith Home. Resident A was not present as he was hospitalized, and Resident D had been discharged from the home. Resident B and Resident C were present with direct care staff (DCS) Edward Wilson III.

On 02/07/2023, I interviewed Resident B regarding the allegations. Resident B stated he and other residents such as Resident A wake up late. Staff try to wake them up, but he wakes up around 11AM and because it is too late for breakfast, he eats lunch around 12PM. Resident B stated he is offered breakfast when he wakes up early, but he likes sleeping in. He gets enough food to eat.

On 02/07/2023, I interviewed Resident C regarding the allegations. Resident C was sleeping when I arrived at the home which was around 10:30AM. He woke up and answered my questions. Resident C stated he likes sleeping in and eats when he wakes up. Resident C gets enough food to eat and reported no concerns.

On 02/07/2023, I interviewed DCS Edward Wilson III regarding the allegations. Mr. Wilson has been working for this corporation for a year and has been at Zenith Home since they were licensed in December 2022. Mr. Wilson stated he attempts to wake the residents up around 7:30AM-8AM for their medications and offers them breakfast, but they all want to return to bed after receiving their medications. He stated that Resident A, Resident B and Resident C wake up around 11AM or later and then after they wake

up, Mr. Wilson prepares lunch for them. Resident A was always the first one up and first one to eat breakfast. Mr. Wilson advised there is always enough food in the home for all the residents.

On 02/07/2023, I interviewed the home manager (HM) Ola Adekunle who arrived shortly after at Zenith Home. The HM stated all the residents, including Resident A like to sleep in. She stated that staff wake the residents up in the morning around 7:30AM-8AM for their morning medications and offer them breakfast. Almost always, the residents including Resident A refuses breakfast and returns to bed. The residents wake up around 11AM and eat. The HM stated the residents have never complained to her about not getting breakfast or there not being enough food in the home.

On 02/07/2023, DCS Kamyria White also arrived shortly after to Zenith Home. I interviewed her regarding the allegations. Ms. White stated when she works her shift usually 8AM-8PM, she has a structured schedule for Resident A, Resident B, and Resident C. She wakes them up around 8AM for their medications and gives them breakfast immediately because all of them like to go back to sleep. After the residents eat breakfast, they sleep until around 11AM, especially Resident A. Ms. White reported that no resident has come to her and complained they did not get breakfast or that they did not get enough food to eat.

On 03/06/2023, I contacted via telephone DCS Justin Martin regarding the allegations. Mr. Martin reported that Residents A, B, and C get woken up by staff other than him because he does not pass medications to give residents their morning medications. At that time, breakfast if offered but sometimes they refuse and then return to bed. He stated that the residents are usually awake around 11AM and that is when they eat. Residents A, B, nor C have complained to him about not getting food to eat.

On 03/15/2023, I conducted another unannounced on-site investigation. Present were DCS Edward Wilson II and Justin Martin and assistant HM Javontez Mitchell. Resident A was hospitalized again and then discharged from the home given he required a higher level of care. I observed ample amount of food in the home for Resident B and Resident C.

On 03/29/2023, I contacted Resident A’s guardian’s office George Heitmanis and spoke with the office manager Angela Mancuso. Ms. Mancuso stated that Resident A is currently in jail. Resident A has been in and out of hospitals for a very long time. He has also been in numerous placements but due to his behavioral needs, he has been discharged from group homes many times too. Ms. Mancuso stated she has not received complaints about Zenith Home from Resident A; however, Resident A had not been at Zenith Home long. She stated, “Resident A complains about everything and it’s usually things that are not concerning to them, but if he had complained about Zenith Home, it’s unlikely true because he hasn’t been there long enough.”

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation, Resident A, Resident B, and Resident C were provided a minimum of three regular meals daily. The staff would wake the residents up around 7:30AM-8AM for their morning medications and offer them breakfast. Almost always, they would refuse and return to sleep. However, they were receiving lunch soon after they woke up which was usually around 11AM. I observed ample amount of food in the home for the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Clothes are not being washed and Resident A is given other residents clothes to wear.

INVESTIGATION:

On 02/07/2023, I interviewed Resident B in his bedroom. I observed a pile of dirty clothes on the floor in the corner of the bedroom. Resident B has asked DCS Mr. Wilson to wash his clothes, but Mr. Wilson has not so they have been piling up in the corner of the bedroom. Resident B stated that Resident A was in the hospital. Resident A refuses to shower and smells. Resident B had to share his clothes with Resident A because clothes were not being laundered.

On 02/07/2023, I interviewed Resident C regarding the allegations in his bedroom. Resident C did not have any dirty clothes in his bedroom. He had clean clothes in his dresser and reported that staff wash his clothes, and he has never had to wear someone else's clothes. Resident C reported no concerns.

On 02/07/2023, I interviewed DCS Edward Wilson III regarding the allegations. Mr. Wilson reported that he washes clothes two-three times per week. He did not know that Resident B had a pile of dirty clothes sitting in the corner of his bedroom but stated he will wash them today. Mr. Wilson denied there being a schedule of laundry day and when each residents' clothes are washed. He does not know why Resident A had to borrow Resident B's clothes and believes that Resident A "threw his clothes away." Mr. Wilson observed Resident A throw his shoes in the garbage for no apparent reason.

On 02/07/2023, I interviewed the home manager (HM) Ola Adekunle regarding the allegations. The HM believed DCS Mr. Wilson was washing residents' clothes and did not know there were dirty clothes piled on the floor. She advised she will be addressing this issue with Mr. Wilson and all the other staff.

On 02/07/2023, I interviewed DCS Kamyria White regarding the allegations. Ms. White stated that Mr. Wilson is good about laundry and maintaining the home. She stated that when she works, she does laundry when she sees clothes piled up or when residents ask her. Ms. White denied any complaints from both Resident A or Resident B about dirty clothes or that Resident A was borrowing Resident B's clothes.

On 03/06/2023, I contacted via telephone DCS Justin Martin regarding the allegations. Mr. Martin stated that DCS Edward Wilson was put in charge of laundry last month, but after the on-site investigation on 02/07/2023, Mr. Martin is currently in charge of the laundry. He stated he has been doing laundry every other day and that the HM verifies this by visiting the home.

On 03/15/2023, I conducted another unannounced on-site investigation. I observed DCS Edward Wilson folding residents' clothes and DCS Justin Martin in the basement washing clothes. I went into Resident B's bedroom and there were no dirty clothes piled on the floor.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions, when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	Based on my unannounced on-site investigation on 02/07/2023, staff were not affording Resident B with opportunities to launder his clothing. Resident B asked DCS Edward Wilson to assist in washing his clothes, but Mr. Wilson did not. I observed a pile of dirty clothes sitting on the floor in the corner of Resident B's bedroom. However, during a follow-up unannounced on-site investigation on 03/15/2023, I observed DCS Edward Wilson folding residents' clothes and DCS Justin Martin doing laundry. I observed no dirty clothes on the floor of Resident B's bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's bed is not leveled.

INVESTIGATION:

During the unannounced on-site inspection on 02/07/2023, I observed Resident A's bed in his bedroom. The bed was appropriate and leveled. I did not observe any concerns with the bed.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During my unannounced on-site investigation on 02/06/2023, I observed Resident A's bed to be leveled and orderly in appearance.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced on-site investigation on 02/07/2023, I arrived at the home around 10:30AM. I knocked several times on the door and there was no answer. I drove to this corporation's other adult foster care (AFC) home, Genesis Home that is on the same street. I was advised by assistance HM Javontez Mitchell that DCS Edward Wilson is at Zenith Home but was in the bathroom. I drove back to Zenith Home and was greeted at the door by Mr. Wilson. Mr. Wilson stated there should be two DCS on shift always and that DCS Justin Martin stepped out to go to Genesis Home to use the bathroom, leaving only Mr. Wilson with Resident B and Resident C. Mr. Wilson stated he was in the bathroom when there was a knock on the door and when he came out, I had already left. Mr. Wilson stated this was an isolated incident that Mr. Martin left the home leaving Mr. Wilson alone.

On 02/06/2023, the HM stated there should always be two DCS on shift and Mr. Martin should have never left the home. The HM stated she will be providing an in-service to Mr. Martin. The HM had the assistant HM Mr. Mitchell come to the home to ensure there are sufficient staff on shift for Resident B and Resident C.

On 03/06/2023, I interviewed DCS Justin Martin regarding the allegations. Mr. Martin stated the toilet upstairs did not work and Mr. Wilson was using the toilet downstairs, so he stepped out to go use the bathroom at Genesis Home. He stated that this was an isolated incident and he understood that he cannot leave his shift without having another staff member cover while he steps out.

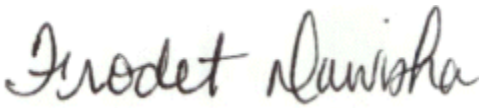
On 03/15/2023, I conducted a follow-up on-site investigation and checked the toilet upstairs. The toilet was in working order.

On 03/29/2023, I conducted the exit conference via telephone with license designee Ken Ogundipe with my findings. Mr. Ogundipe stated he is addressing all these concerns with staff and will be submitting a corrective action plan.

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:	Based on my unannounced on-site investigation on 02/07/2023, there was insufficient DCS on duty for Resident B and Resident C. DCS Edward Wilson and DCS Justin Martin were scheduled to work. Mr. Martin stepped out to use the bathroom at their other AFC home on the same street, Genesis Home leaving Mr. Wilson alone during their shift. According to Mr. Wilson and the HM there should always be two DCS per shift due to both Resident B's and Resident C's behavioral needs. This was an isolated incident. I followed up with another unannounced on-site visit on 03/15/2023 and there were three staff members on shift during this time for Resident B and Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

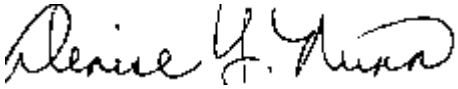
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



03/29/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:



04/06/2023

Denise Y. Nunn Date
Area Manager