GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 10, 2023

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

RE: License #: AS250402729
Investigation #: 2023A0779028
Welch Home I

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250402729
Investigation #:	2023A0779028
Complaint Receipt Date:	03/14/2023
Investigation Initiation Date:	03/14/2023
Report Due Date:	05/13/2023
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 I
Facility Address:	913 Welch Blvd, Flint, MI 48503
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	08/24/2021
License **Status:**	REGULAR
Effective Date:	02/24/2022
Expiration Date:	02/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 3/8/23, staff De'Quino Cox hit Resident A in the eye leaving a bruise.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/14/2023	Special Investigation Intake 2023A0779028
03/14/2023	Special Investigation Initiated - Telephone Interview conducted with home manager, Chinanna Brown.
03/14/2023	APS Referral Complaint was referred to APS centralized intake.
03/16/2023	Inspection Completed On-site
03/16/2023	Contact - Telephone call made Interview conducted with staff person, De'Quino Cox.
03/20/2023	Exit Conference Held with licensee designee, Kehinde Ogundipe.
03/23/2023	Contact - Telephone call made Interview conducted with staff person, Kendrick Turner.
04/10/2023	Inspection Completed – BCAL Sub. Compliance.

ALLEGATION:

On 3/8/23, staff De'Quino Cox hit Resident A in the eye leaving a bruise.

INVESTIGATION:

On 3/14/23, a phone interview was conducted with home manager, Chinanna Brown, who confirmed that she saw that Resident A had a bruised eye when she arrived to work the morning of 3/8/23. She stated that Resident A claims that staff person, De'Quino Cox, punched him in the eye during the previous night. She stated that Mr. Cox denied anything took place between him and Resident A that night. Ms. Brown reported that there were two other staff working that night and that staff person, Martez Turner, claims that he did not see or hear any altercation take place between Resident

A and Mr. Cox. Mr. Turner told Ms. Brown that he did not see the bruise on Resident A's eye until the end of the shift at 8:00am. Ms. Brown stated that the third staff, Kendrick Turner, originally denied knowing anything about Resident A's black eye, but then changed his story. She stated that when a different staff told her that Kendrick Turner told him that he heard Resident A and Mr. Cox in Resident A's room fighting, she confronted Kendrick Turner again. Ms. Brown reported that Kendrick Turner then told her that when Resident A and Mr. Cox were in the bedroom alone, he heard Resident A throwing things around and that the door hit Resident A in the eye. Ms. Brown stated that none of the three staff working that night reported anything to her about Resident A having behaviors that night or that Resident A had an injured eye. She stated that staff took Resident A to a local Urgent Care clinic, but the clinic stated that they did not feel that Resident A required any treatment. She reported that staff then attempted to take Resident A to the hospital, but Resident A refused to go.

Ms. Brown provided a copy of an *AFC Licensing Division Incident/Accident Report* (IR) regarding Resident A obtaining a bruised eye on 3/8/23. The information recorded on the IR matches the information obtained during the interview with Ms. Brown. The IR stated that a call was made to the police and APS. The corrective measures listed on the IR was for the home to continue providing Resident A with enhanced support at all times and that the staff involved in the incident were terminated.

Resident A's Assessment Plan for AFC Residents was reviewed. The plan stated that Resident A has problems controlling aggressive and sexual behaviors and can display some self-injurious behavior. It stated that Resident A is physically able to complete all his activities of daily living with prompting from staff to do so.

On 3/16/23, an on-site inspection was conducted, and Resident A was interviewed. Resident A confirmed that a staff person had punched him "full force" in his eye. Resident A could not remember the name of the staff person who hit him.

On 3/16/23, Ms. Brown stated that staff person, Kendrick Turner, changed his story again about what happened the night of 3/8/23. She stated that the only part of Kendrick Turner's story that has not changed is the fact that Mr. Cox and Resident A were in Resident A's bedroom alone while Resident A was having behaviors. Ms. Brown stated that she called the police on 3/8/23 and reported the physical assault on Resident A. She stated that the employment of De'Quino Cox and Kendrick Turner has been terminated.

On 3/16/23, a phone interview was conducted with staff person, De'Quino Cox. Mr. Cox admitted that he got into a physical altercation with Resident A during the night of 3/8/23 and that he had punched Resident A in the eye. Mr. Cox claims that Resident A was being physically aggressive and that he was protecting himself. He stated that he was alone in the bedroom with Resident A, that he does not know where the other two staff were at the time or if they witnessed any of the altercation.

On 3/23/23, a phone interview was conducted with staff person, Kendrick Turner. He stated that on 3/8/23, he heard Resident A throwing things around in his bedroom like always does but denied that he saw any physical altercation between Resident A and Mr. Cox. Kendrick Turner reported that he and staff person, Martez Turner, were upstairs during this time and did not see Resident A and Mr. Cox fighting. He stated that he saw Resident A later during that shift and that it didn't look like anything happened.

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:	It was confirmed that on 3/8/23, Resident A had a bruised eye. When asked about how he obtained the bruised eye, Resident A stated that a staff person had punched him in the eye, but he could not remember the staff person's name. It was confirmed that De'Quino Cox was a staff assigned to Resident A during the early morning hours of 3/8/23. Mr. Cox stated that Resident A was being physically aggressive, and he admitted to punching Resident A in the eye.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/14/23, home manager, Ms. Brown stated that Resident A is required to have 2-on-1 staffing. She stated that staff persons, De'Quino Cox and Kendrick Turner were assigned to be those staff during the early morning of 3/8/23. Ms. Brown reported that staff person, Kendrick Turner, told her that during the early morning hours on 3/8/23, Resident A was in his bedroom alone with staff person, De'Quino Cox. She stated that Kendrick Turner told her that he was with staff person, Martez Turner, in the upstairs of the home and that Mr. Cox was downstairs alone with Resident A in Resident A's bedroom, while Resident A was having behaviors. Ms. Brown reported that Martez Turner confirmed this to be true. Ms. Brown stated that the police were not called while Resident A was displaying his aggressive behaviors.

On 3/16/23, Ms. Brown provided a copy of Resident A's CMH Individual Plan of Service (IPOS). The plan states that Resident A is be provided 2-on-1 staffing at all times. Resident A's IPOS also states that staff are to call the police if Resident A engages in physical aggression for 10 minutes or more.

On 3/16/23, Mr. Cox stated that on 3/8/23, he was alone with Resident A in Resident A's bedroom, while Resident A was throwing things around and being physically aggressive. Mr. Cox reported that he thought that the other two staff working with him that shift, Kendrick, and Martez Turner, may have been in the living room at that time, but admitted that he was not sure where the other staff were. Mr. Cox stated that neither Kendrick nor Martez Turner came into Resident A's bedroom to help him while Resident A was having behaviors.

On 3/23/23, Kendrick Turner, stated that he was aware that Resident A was displaying behaviors and throwing things around his room during the early morning of 3/8/23. He confirmed that Mr. Cox was the only staff person in the bedroom with Resident A during that time, as he and Martez Turner were in the upstairs of the home doing cleaning. Kendrick Turner stated that he is aware that Resident A requires 2-on-1 staffing but denies that he was told that he was assigned to be one of those two staff that shift.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's CMH IPOS states that Resident A is to be provided with 2-on-1 staffing at all times and that staff are to call the police when Resident A displays physical aggressive behavior for more than 10 minutes. It was confirmed that during the early morning hours on 3/8/23, Resident A was throwing things around his room and being physically aggressive toward staff person, De'Quino Cox. Mr. Cox and staff person, Kendrick Turner, both stated that Mr. Cox was left alone with Resident A while Resident A was displaying physically aggressive behaviors. During this time, Resident A was not provided his required 2-on-1 staffing and the police were not called to intervene with his physically aggressive behaviors. There was

	sufficient evidence found to prove that Resident A was not provided the supervision, protection and personal care as specified in his IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/20/23, an exit conference was held with licensee designee, Kehinde Ogundipe. He was informed that a written corrective action plan was required to address the above stated licensing rule violations.

IV. RECOMMENDATION

Upon receipt of an approve written corrective action plan, it is recommended that the status of this home's license remain unchanged.

4/10/2023

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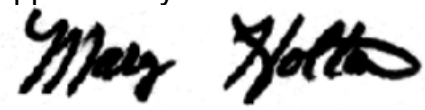
Christopher Holvey Date
Licensing Consultant

Approved By:



4/10/2023

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Mary E. Holton Date
Area Manager