GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2023

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

RE: License #:	AS250412203
Investigation #:	2023A0872030
	Bell Oaks At Thomas

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

I. IDENTIFYING INFORMATION

License #:	AS250412203
Investigation #:	2023A0872030
Complaint Receipt Date:	03/15/2023
Investigation Initiation Date:	03/15/2023
Report Due Date:	05/14/2023
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 Thomas
Facility Address:	2705 Thomas St. Flint, MI 48504
Facility Telephone #:	(810) 820-3190
Original Issuance Date:	01/12/2023
License Status:	TEMPORARY
Effective Date:	01/12/2023
Expiration Date:	07/11/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The staff in the home has been physically abusing Resident A. On 3/13/23, Resident A had abrasions on the right side of her face and swelling to her forehead from the abuse.	No
Additional Findings	Yes

III. METHODOLOGY

03/15/2023	Special Investigation Intake 2023A0872030
03/15/2023	Special Investigation Initiated - Telephone AFC Licensing Consultant, Chris Holvey spoke to APS Worker, Shwanda Lee
03/15/2023	APS Referral This complaint was referred by APS. Shwanda Lee is the APS Worker
03/22/2023	Inspection Completed On-site Unannounced
03/30/2023	Inspection Completed On-site Unannounced
04/04/2023	Contact - Document Sent I emailed Brandon Gadberry and Melissa Root requesting information related to Resident A
04/04/2023	Contact - Document Received I received AFC documentation regarding Resident A
04/05/2023	Contact - Telephone call made I interviewed Resident A's case manager, Joe Keller
04/05/2023	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
04/05/2023	Contact - Document Sent I emailed APS Worker, Shwanda Lee regarding this complaint

04/06/2023	Contact - Document Received I received an email from the licensee designee, Kehinde Ogundipe
04/07/2023	Contact - Document Received I received an email and photographs from APS Worker, Shwanda Lee
04/10/2023	Contact - Telephone call made I interviewed Resident A's public guardian, Guardian A
04/11/2023	Inspection Completed-BCAL Sub. Compliance
04/11/2023	Contact – Document received I received IRs regarding Resident A
04/11/2023	Exit Conference I conducted an exit conference with the licensee designee, Kehinde Ogundipe

ALLEGATION: The staff in the home has been physically abusing Resident A. On 3/13/23, Resident A had abrasions on the right side of her face and swelling to her forehead from the abuse.

INVESTIGATION: On 03/15/23, Adult Foster Care (AFC) Licensing Consultant Christopher Holvey called Adult Protective Services Worker, Shwanda Lee. Ms. Lee said that she spoke to the home manager of Bell Oaks at Thomas who is denying the allegations. The home manager said that Resident A has marks on her face, but they occurred during an altercation with another resident. The home manager also said that Resident A has been hospitalized five times over the past two days.

On 03/22/23, I conducted an unannounced onsite inspection of Bell Oaks at Thomas AFC. According to the home manager, Artecia Howard, Resident A is currently in the hospital. She is supposed to be discharged back to the facility on 3/23/23. I reviewed the allegations with Ms. Howard, and she said that the allegations are not true. She said that on 03/13/23, Resident A was upset while up in her room. She began slapping the blinds off her windows and banging her head against the wall. Ms. Howard said that whenever Resident A gets upset and does not get her own way, she acts out physically. Ms. Howard told me that to her knowledge, staff has never hit Resident A or harmed her in any way. Resident A seeks attention, and she threatens to run away or kill herself when she gets upset. According to Ms. Howard, Resident A met a guy at the hospital and now, she keeps acting out in hopes of being able to go to the hospital to see him.

While at the facility, I interviewed Resident B. Resident B said that Resident A “goes off a lot.” She said that Resident A will become upset and will start hitting things or herself. According to Resident B, she has never seen any of the staff hit Resident A or harm her

in any way. Resident B told me that she and Resident A have “gotten into it” and she does not like her living at this facility with her.

On 03/30/23, I conducted another unannounced onsite inspection of Bell Oaks at Thomas AFC. Staff Kenyata Berrien said that Resident A is again in the hospital. She said that to her knowledge, Resident A is supposed to be discharged back to the facility on 03/31/23.

On 04/05/23, I interviewed Resident A’s case manager, Joe Keller via telephone. Mr. Keller said that he has been Resident A’s case manager since July 2022. He is in Washtenaw County and is trying to coordinate services to have Resident A’s case transferred to a county closer to her. According to Mr. Keller, Resident A has an extensive history of acting out and making allegations against staff and other residents. Mr. Keller said that Resident A resided at Eisenhower Center, which is a specialized AFC, but her behaviors became too much to handle so she was transferred to Bell Oaks at Thomas AFC in January 2023. Mr. Keller told me that while a resident of this facility, Resident A has been hospitalized more often than she has been stable at the facility.

Mr. Keller told me that AFC staff has not been good about communicating with him about Resident A. He said that he knows that Resident A has been experiencing severe behaviors and she is being sent to the hospital frequently. According to Mr. Keller, Resident A has a history of self-harm, suicidal ideation, impulsive behaviors, elopements, and attention seeking behavior. Mr. Keller said, “There is nothing she won’t do to get attention.” Mr. Keller said that he suspects that Resident A is not getting the kind of services she needs at Bell Oaks at Thomas AFC which is why her behaviors have significantly increased. He said that he, Resident A’s guardian, and her treatment team are trying to come up with a more successful placement for her.

On 04/05/23, I reviewed Adult Foster Care paperwork related to Resident A. She was admitted to Bell Oaks at Thomas AFC on 01/24/23. According to her Assessment Plan dated 01/23/23, she has a history of physical aggression and property destruction. She also has a history of head banging and cutting. Resident A “struggles with engagement” and she “benefits from strong, supportive staffing.”

According to her Health Care Appraisal dated 02/17/22, she is diagnosed with disruptive mood, post-traumatic stress disorder, obesity, and impaired cognition.

I reviewed Resident A’s Eisenhower Center Individualized Plan of Service (IPOS) dated 09/02/22. According to this document, before being admitted to Eisenhower Center, she had significant contact with the police, usually due to calling 911 and reporting she was suicidal. She requires a lot of attention and engagement with staff. “Resident goes through periods where she reports elevated suicidality and thoughts and attempts to access emergency services or request a 1:1 staff member to be with her.” This document does not state that she requires 1-on-1 supervision at this time.

On 04/07/23, I received an email and photographs from APS Worker, Shwanda Lee. The photographs were taken by Ms. Lee on 03/17/23 of Resident A's hands and face, while Resident A was in the hospital. The photographs showed some small scabs/abrasions on Resident A's left hand, near her wrist. I did not see any marks or bruises on her face.

Ms. Lee said that she interviewed Resident A on 04/07/23 at the hospital. Resident A told her that the staff at Bell Oaks at Thomas "are abusing me with their hands." Ms. Lee asked for further information, but Resident A was unable to provide details. Resident A did tell Ms. Lee that she received the marks on her hands and face from an incident that occurred with Resident B. Resident A told Ms. Lee that she and Resident B were fighting, and they fell down in the street. She said that when she fell, she received scratches on her nose and hand. Ms. Lee noted that Resident A said that she is experiencing visual and auditory hallucinations and she "blacks out" and when she wakes up, she does not remember what was going on.

On 04/10/23, I interviewed Resident A's public guardian, Guardian A via telephone. Guardian A confirmed that Resident A was admitted to Bell Oaks at Thomas in January 2023. According to Guardian A, AFC staff has not done a good job of communicating with her regarding Resident A's needs. She said that she is aware that Resident A has been hospitalized on multiple occasions and said that Resident A is currently at Genesys Ascension Hospital, and it is not known if she will return to Bell Oaks at Thomas.

I reviewed the allegations with Guardian A, and she said that she was told that on 03/13/23, Resident A received injuries to her hands and face due to an altercation with another resident. According to Guardian A, she does not have any information that staff has abused or mistreated Resident A.

Guardian A said that Resident A is extremely vulnerable, and she exhibits a lot of problematic symptoms. She said that she does not believe that Resident A's needs are being met at this AFC facility, but she does not have specific information which indicates she is being mistreated. Guardian A told me that since Resident A has services through three different counties, it is difficult to find a suitable placement for her. She said that she is going to petition the court to have a new guardian appointed for Resident A in Genesee County.

On 04/11/23, I conducted an exit conference with the licensee designee, Kehinde Ogundipe. I discussed the results of my investigation and explained which rule violations I am substantiating. Mr. Ogundipe agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 03/13/23, Resident A and Resident B got into a physical altercation, resulting in injuries to Resident A's hand and face. Staff Artecia Howard said that staff did not physically abuse Resident A or injure her in any way. Resident B said that she never witnessed staff harm Resident A in any way. Resident B also said that she and Resident A have "gotten into it." Resident A's case manager, Joe Keller said that he does not have any evidence that staff has physically abused Resident A. He said that Resident A has significant behavioral problems, and she has extensive needs. Adult Protective Services Worker, Shwanda Lee said that she interviewed Resident A on 03/17/23. Resident A told her that Bell Oaks at Thomas staff are "abusing me with their hands." However, when Ms. Lee asked her about the injuries to her hands and face, she said that she got into a physical altercation with one of the other residents which is how she received the injuries. Resident A's public guardian, Guardian A said that she heard about the incident from 03/13/23 and she was told that Resident A got into a physical altercation with another resident, which resulted in her injuries. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/04/23, I reviewed Resident A's Health Care Appraisal dated 02/17/22. Resident A was admitted to Bell Oaks at Thomas AFC facility on 01/24/23.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On 04/04/23, I reviewed Resident A's Health Care Appraisal dated 02/17/22. Resident A was admitted to Bell Oaks at Thomas AFC facility on 01/24/23. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: Resident A was admitted to the hospital on 03/13/23 due to an altercation with another resident. She was also experiencing suicidal ideation. On 04/06/23, I received an email from the licensee designee, Kehinde Ogundipe. Mr. Ogundipe said that the previous home manager did not have staff complete an Incident/Accident Report (IR) regarding Resident A's behaviors and hospitalization on 03/13/23.

In addition, Resident A has been admitted and released from the hospital on multiple occasion since her admittance to Bell Oaks at Thomas AFC on 01/24/23. Facility staff has not completed and submitted IRs for all of her hospitalizations.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Resident A was admitted to the hospital on 03/13/23 due to an altercation with another resident. She was also experiencing suicidal ideation. According to the licensee designee, Kehinde Ogundipe, the home manager did not have staff complete and submit an Incident/Accident Report (IR) regarding this incident. In addition, Resident A has been admitted and released from the hospital on multiple occasion since her admission to Bell Oaks at Thomas AFC on 01/24/23. Facility staff has not completed and submitted IRs for all of her hospitalizations as required by this rule. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

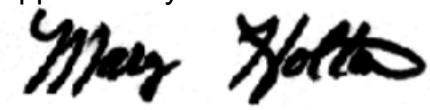
IV. RECOMMENDATION

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

April 11, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



April 11, 2023

Mary E. Holton Area Manager	Date