GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 6, 2023

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

RE: License #: AS630405489
Investigation #: 2023A0993023
Genesis Home

Dear Mr. Ogundipe:

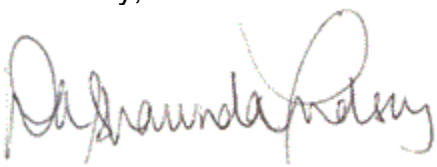
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405489
Investigation #:	2023A0993023
Complaint Receipt Date:	04/13/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/12/2023
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:	Genesis Home
Facility Address:	21004 Reimanville Ferndale, MI 48220
Facility Telephone #:	(248) 951-2616
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	10/14/2022
Expiration Date:	10/13/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Per an incident report, on 04/12/2023, Resident S asked staff to take him to the store around 4:30am. Staff said it was too early and to wait. Around 5am, staff checked on Resident S, and he was nowhere to be found.	Yes

III. METHODOLOGY

04/13/2023	Special Investigation Intake 2023A0993023
04/17/2023	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Brittany Navetta
04/18/2023	Special Investigation Initiated - Telephone Telephone call made to home manager Ola Adekunle
04/19/2023	Inspection Completed On-site Conducted an unannounced onsite inspection
04/20/2023	Contact - Telephone call made Telephone call made to Easter Seals case manager Sherry VanHulle. Left a message.
05/22/2023	Contact - Telephone call made Telephone call made to Easter Seals case manager Sherry VanHulle. Left a message.
05/22/2023	APS Referral Forwarded allegations to adult protective services (APS). The assigned APS specialist is Tina Edens.
05/22/2023	Contact - Document Sent Requested a copy of a police report from Livonia Police Department.
05/23/2023	Contact - Telephone call made Telephone call made to Easter Seals case manager Sherry VanHulle. Left a message.

05/23/2023	Contact - Document Received Received a copy of a police report from Livonia Police Department.
05/23/2023	Contact - Telephone call made Telephone call made to Easter Seals case manager Sherry VanHulle
05/25/2023	Exit Conference Attempted to hold exit conference with licensee designee Kehinde Ogundipe. Left a message.

ALLEGATION:

Per an incident report, on 04/12/2023, Resident S asked staff to take him to the store around 4:30am. Staff said it was too early and to wait. Around 5am, staff checked on Resident S, and he was nowhere to be found.

INVESTIGATION:

On 04/17/2023, I received an incident report (IR). Per an incident report, on 04/12/2023, Resident S asked staff to take him to the store around 4:30am. Staff said it was too early and to wait. Around 5am, staff checked on Resident S, and he was nowhere to be found.

On 04/17/2023, I forwarded the allegations to recipient rights advocate Brittany Navetta.

On 04/18/2023, I conducted a telephone interview with home manager Ola Adekunle. She stated Resident S returned to the facility on Saturday morning around 2am. Ms. Adekunle did not provide the date of Resident S's return. Staff Allan Paylor was working in the facility when Resident S eloped. Per Ms. Adekunle, Resident S does not have a guardian and can move independently in the community.

On 04/19/2023, I conducted an unannounced onsite investigation. I interviewed staff Allan Payor and Resident S.

Mr. Paylor verified he was working when Resident S eloped from the facility. Mr. Paylor stated Resident S left on 04/15/2023 around 4:30am. Prior to leaving, Resident S asked Mr. Paylor for a cigarette. Mr. Paylor told him it was not anymore. Resident S went back to his bedroom. When Mr. Paylor went to check on Resident S about 30 minutes later, Resident S was not in the facility. Mr. Paylor stated he searched the porch, side of the

facility as well as the basement. He contacted the home manager and called 911. Resident S was transported back to the facility by Livonia Police Department around 2am. Mr. Paylor stated he has worked in the facility for about six months, and that was the first time Resident S eloped. Per Mr. Paylor, Resident S has community access.

Resident S confirmed he eloped from the facility while Mr. Paylor was working. Resident S stated he went to the gas station to get a coffee, pop, and cigarettes. He did not tell staff he was leaving. Resident S stated he does not have a guardian, and he does not have community access. Resident S could not recall who transported him back to the facility.

During the unannounced onsite investigation, I reviewed Resident S' adult foster care (AFC) assessment plan. Per the plan, dated and signed in January 2022, Resident S cannot move independently in the community. Staff is to assist Resident S with supervision while moving in the community. Per Resident S' Individual Plan of Service (IPOS), dated and signed in September 2022, the facility will provide ratio of one staff to six residents during awake and sleeping hours. Staff will always accompany Resident S in the event of personal safety risk.

On 05/23/2023, I received a copy of the police report from Livonia Police Department. Per the report, police observed Resident S sleeping at a gas station around 1:40am on 04/15/2023. Per the police LEIN, Resident S had walked away from his group home. Police transported Resident S back to the facility and turned him over to Mr. Paylor without incident.

On 05/23/2023, I conducted a telephone interview with Easter Seals case manager Sherry VanHulle. She verified Resident S eloped from the facility. According to Ms. VanHulle, Resident S elopes often. She stated Resident S is used to "coming and going" as he pleases. She confirmed Resident S does not have a guardian. However, he cannot move independently in the community. Per Ms. VanHulle, Resident S lacks insight, is not able to make appropriate decisions, and is very impulsive.

On 05/25/2023, I attempted to conduct an exit conference with licensee designee Kehinde Ogundipe with no success. I left a message.

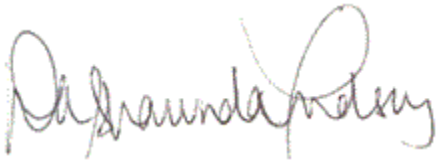
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Per the IR, Resident S eloped from the facility on 04/12/2023 sometime before 5am. Livonia Police Department transported him back to the facility on 04/15/2023 around 1:40am. Per the assessment plan, dated and signed in January 2022, Resident S cannot move independently in the community. Staff is to assist Resident S with supervision while moving in the community. Per Resident S' Individual Plan of Service (IPOS), dated and signed in September 2022, the facility will provide ratio of one staff to six residents during awake and sleeping hours. Staff will always accompany Resident S in the event of personal safety risk. Ms. Adekunle and Mr. Paylor both stated Resident S has community access.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Per the IR, Resident S eloped from the facility on 04/12/2023 sometime before 5am. Livonia Police Department transported him back to the facility on 04/15/2023 around 1:40am. According to Ms. VanHulle, Resident S elopes often. She stated Resident S is used to "coming and going" as he pleases. She confirmed Resident S does not have a guardian. However, he cannot move independently in the community. Per Ms. VanHulle, Resident S lacks insight, is not able to make appropriate decisions, and is very impulsive.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

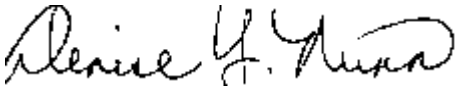
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



05/31/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



06/06/2023

Denise Y. Nunn Date
Area Manager