GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

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

RE: License #: AS330408820
Investigation #: 2023A0783024
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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330408820
Investigation #:	2023A0783024
Complaint Receipt Date:	08/01/2023
Investigation Initiation Date:	08/04/2023
Report Due Date:	09/30/2023
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?
Resident A did not have 1:1 staffing on June 3, 2023 when his assessment plan calls for 1:1 staffing at all times.	Yes
On June 3, 2023 staff members at the facility did not assist Resident A with trimming his beard, clipping his nails, nor brushing his teeth.	No
On June 3, 2023 Resident A's iPad and iPad charger were missing, it is unknown if a staff member took possession of those items.	No
On June 3, 2023 Resident A's bedroom floor was observed dirty with some type of white flakes.	No
On June 3, 2023 Resident A had no clean clothing.	No
On June 3, 2023 Resident A's bedroom window was observed painted shut.	No
On June 3, 2023 Resident A was observed laying in his bed with no sheets.	No

III. METHODOLOGY

08/01/2023	Special Investigation Intake - 2023A0783024
08/02/2023	Contact - Telephone call made to Complainant, unsuccessful
08/04/2023	Special Investigation Initiated – Letter - Email from Complainant
08/04/2023	Contact - Document Received - Resident A's *Individualized Plan of Service*
08/28/2023	Inspection Completed On-site
08/28/2023	Contact - Face to Face interview with direct care staff member Myron Chandler
08/28/2023	Contact - Document Received - Resident A's written *Assessment Plan for AFC Residents*
09/19/2023	Contact - Telephone call made to Guardian A1, unsuccessful
09/20/2023	Contact - Telephone call made to Guardian A1, unsuccessful
09/20/2023	Exit Conference with Ken Ogundipe

ALLEGATION:

Resident A did not have 1:1 staffing on June 3, 2023 when his service plan calls for 1:1 staffing at all times.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 Guardian A1 observed that Resident A did not have a 1:1 staff, even though he was supposed to according to his plan of service.

On August 28, 2023 I conducted an unannounced onsite investigation and observed Resident A in his bedroom without a staff member present.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, “There appeared to be only two workers there with six clients. [Resident A] did not have a one-on-one, contrary to what we've been told.” The written statement indicated direct care staff member “Myrun”, last name unknown, was working on June 3, 2023.

On August 28, 2023 I interviewed direct care staff member Myrun Chandler who stated he has worked at the facility for five months and is familiar with Resident A. Mr. Chandler said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said Resident A requires 1:1 line of sight staffing and added that he is typically assigned to work as Resident A’s 1:1 staff member when he works at the facility. Mr. Chandler said the facility is “short staffed” and direct care staff members do not provide 1:1 line of sight staffing to Resident A when he is in his bedroom, rather only when he is in the common area of the home. Mr. Chandler stated Resident A frequently stays in his bedroom until 12:00 noon or even 1:00 – 2:00 pm without a direct care staff member present.

On August 4, 2023 I received a written copy of Resident A’s written *Individualized Plan of Service* (IPOS) dated May 16, 2023, which stated, “[Resident A] is scheduled to move into the Eden Prairie home in Lansing. Clinician has updated safeguards to include information for enhanced staffing that is being requested through the end of IPOS year. This writer will present this request for staffing at BTPRC scheduled 5/15/23. Writer has amended safeguard to include rational for this enhanced staffing as well as the fade plan. Fade plan will also be included in behavioral health goal. Authorizations updated to reflect BTPRC. FADE PLAN/CRITERIA FOR REDUCTION/DISCONTINUATION OF STAFFING: [Resident A’s] ability to display self-control, respond to verbal redirection, refrain from property destruction and

aggression towards other that pose a health/safety risk. Fading 1:1 supports can be done via a few different ways. Gradually over 6 weeks, the 1:1 caregiver steps away but remains in eye contact to record episodes of a behavior of great concern. Staff number one will then fade from [Resident A] (not in sight, go into another room, attempt not to interact, for 5 minutes three times per day. 2. Gradually over the next 6 weeks (and only if [Resident A] has been successful with staff reduction outlined in number 1), have the 1:1 staff position themselves a further number of feet away from the individual while maintaining eye contact so that the individual gains confidence with working independently. 3. Gradually over the weeks when there has not been any significant behaviors of concern (that necessitates a 1:1), then the 1:1 caregiver can begin to work with two individuals at a time for a limited amount of time per shift (i.e. 10-15 minutes) (i.e., the enhanced staffing ratio decreases so that 2 or three people are sharing a single enhanced staff person rather than 2 or 3 people each having their own 1:1). Try to find individuals in the environment that your individual is more likely to accept or at least less bothered by. Initially, have the second individual present for just 15 minutes daily, then 30 minutes, then 45 minutes, then 1 hour, then 1.5 hours, etc."

On August 28, 2023 I received Resident A's written *Assessment Plan for AFC Residents* dated May 10, 2023. The written assessment plan stated Resident A requires assistance from staff members in the community but was not signed by Guardian A1 nor Resident A's placing agency.

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:	Based on statements from Complainant, Mr. Chandler, and written documentation obtained during the special investigation I determined that Resident A requires “enhanced” or 1:1 line of sight staff supervision and has a written plan to reduce that staffing level which he did not receive on June 3, 2023 when Guardian A1 observed him at the facility, nor on August 28, 2023 when I observed him at the facility, nor regularly according to Mr. Chandler when he is left alone in his bedroom. Based on statements from Complainant, Mr. Chandler, and written documentation obtained during the special investigation I determined that Resident A requires “enhanced” or 1:1 line of sight staff supervision and has a written plan to reduce that staffing level which he did not receive on June 3, 2023 when Guardian A1 observed him at the facility, nor on August 28, 2023 when I observed him at the facility, nor regularly according to Mr. Chandler when he is left alone in his bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On June 3, 2023 staff members at the facility did not assist Resident A with trimming his beard, clipping his nails, nor brushing his teeth.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 the facility staff members had not assisted Resident A with trimming his beard, clipping nails, or his brushing teeth.

On August 28, 2023 I completed an unannounced onsite investigation at the facility and noted that Resident A’s beard and nails appeared trimmed and his teeth appeared brushed.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, “[Relative A1] also couldn't find any evidence that [Resident A] had been brushing his teeth, as she had to open up a new toothbrush for him to use. She also had to open up a new deodorant, wondering if he had used any prior to this shower. After the shower, [Relative A1] trimmed [Resident A’s] beard and clipped his nails, as they hadn't been done.”

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said Resident A had not gotten up for the

day and completed his activities of daily living for the day by the time Guardian A1 and Relative A1 arrived, which was Resident A's choice.

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:	Based on statements from Complainant, Guardian A1, and Mr. Chandler Resident A's had not been assisted with his activities of daily living such as grooming, personal hygiene and bathing when Guardian A1 and Relative A1 arrived unannounced on June 3, 2023 because Resident A had not chosen to get up for the day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On June 3, 2023 Resident A's iPad and iPad charger were missing, it is unknown if a staff member took possession of those items.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 Resident A's iPad and iPad charger were missing, it is unknown if staff took possession of these items.

On August 28, 2023 I completed an unannounced onsite investigation and observed Resident A's iPad and iPad charger near his bed.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, "We asked about [Resident A's] iPad, but no one knew what happened to it. Both it and the charger were missing. It has still not been found as of the writing of this e-mail."

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said Resident A has an iPad and iPad charger that "came up missing" at some point but were later found and now Resident

A has the items. Mr. Chandler said he has “no idea” who took the items or when they were taken but he does not believe the items were taken by a staff member. Mr. Chandler said Resident A has an activation code on the iPad and staff members do not know the code. Mr. Chandler said Resident A is very active and constantly moving around the facility and frequently misplaces the iPad and charger which is most likely what happened.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on statements from Complainant and Mr. Chandler as well as my observation at the unannounced onsite investigation there is no evidence to indicate that a staff member took possession of Resident A’s belongings.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On June 3, 2023 Resident A’s bedroom floor was observed dirty with some type of white flakes.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 Resident A’s bedroom floor had not been swept and was dirty with some kind of white flakes.

On August 28, 2023 I completed an unannounced onsite inspection and observed that Resident A’s bedroom floor was clean.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, “The floor wasn't swept and was dirty with some kind of white flakes.”

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said the floors might have needed “a quick sweep,” but denied that they were excessively dirty.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my observation at the unannounced onsite inspection and a statement from Mr. Chandler and also based on the written statement from Guardian A1 there is lack of documentation to indicate that Resident A’s bedroom was regularly nor excessively dirty
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On June 3, 2023 Resident A had no clean clothing.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 the washing machine had been broken and was just replaced, so none of Resident A’s clothing was washed.

On August 28, 2023 I completed an unannounced onsite investigation at the facility and noted that Resident A had plenty of clean clothing and the facility washer and dryer were functioning properly.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, “We were told that the washing machine had been broken and was just replaced, so none of his clothes were washed.”

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said the facility washer was broken for approximately two to five days and a part had to be ordered but the machine was operable again at the time of the interview.

APPLICABLE RULE	
R 400.14404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Based on statements from Complainant, Guardian A1, and Mr. Chandler the facility washer needed repair for several days, however, it appears it was handled quickly and appropriately, and the washer was functioning at the time of my onsite investigation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On June 3, 2023 Resident A's bedroom window was observed painted shut.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 Resident A's bedroom was hot but the bedroom window could not be opened due to it being painted shut.

On August 28, 2023 I completed an unannounced onsite inspection at the facility and noted that Resident A's bedroom window was open.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, "We arrived unannounced at about 3:00 pm. We found [Resident A] in his bed, wrapped up in a heavy blanket. His upstairs room, which is shared with another client, was very hot, as it has no air conditioning, and the windows are painted shut. We tried to open them with some tools that we had but were unsuccessful."

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said Resident A's window was painted shut for a time but it was fixed once it was brought to the licensee designee's attention and the window is functioning properly at this time.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	Based on statements from Complainant, Guardian A1, and Mr. Chandler Resident A's bedroom window was painted shut for a time, however, it appears it was handled quickly and appropriately, and the window was open at the time of my onsite investigation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On June 3, 2023 Resident A was observed laying in his bed with no sheets.

INVESTIGATION:

On August 1, 2023 I received a complaint via centralized intake that stated on June 3, 2023 Resident A was observed laying in his bed, but the bed had no sheets on it.

On August 28, 2023 I completed an unannounced onsite investigation and observed Resident A lying in his bed and the bed had a top sheet and bottom sheet. I noted that the other residents also had a top and bottom sheet on their beds as well.

On August 4, 2023 I received a written email from Complainant that contained a written statement from Guardian A1 dated June 5, 2023 indicating he had concerns based on an unannounced visit to Resident A at the facility on June 3, 2023. The written statement said, "[Resident A's] bed had no sheets on it and was turned sideways so that his pillows would fall off onto the floor."

On August 28, 2023 I interviewed direct care staff member Myron Chandler who said he was working on June 3, 2023 when Guardian A1 and Relative A1 came to the facility to visit Resident A. Mr. Chandler said Resident A likes to spend a lot of time in bed and staff members can only make the bed when Resident A gets out of the bed, which they do at each opportunity. Mr. Chandler said sheets are always

available to Resident A, he chooses to remove them and stay in his bed without them.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Based on my observations at the unannounced onsite investigation and a statement from Mr. Chandler there is lack of evidence to indicate that Resident A regularly goes without bed sheets on his bed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth 09/20/2023

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 09/20/2023

Dawn N. Timm Date
Area Manager