GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

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

RE: License #: AS330410063
Investigation #: 2023A0783020
Bell Oaks at Lyons

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 #:	AS330410063
Investigation #:	2023A0783020
Complaint Receipt Date:	07/03/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	09/01/2023
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 Lyons
Facility Address:	1435 Lyons Ave Lansing, MI 48910
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	04/20/2023
License Status:	TEMPORARY
Effective Date:	04/20/2023
Expiration Date:	10/19/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not supervised according to his written assessment plan and eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/03/2023	Special Investigation Intake - 2023A0783020
07/03/2023	Special Investigation Initiated – Telephone call with Guardian A1
07/03/2023	Contact - Telephone call made to adult protective services (APS) investigator Rob Lindley
07/05/2023	APS Referral- Not required as APS already investigating.
07/05/2023	Inspection Completed On-site
07/05/2023	Contact - Face to Face interview with direct care staff member Marlow Harris
07/05/2023	Contact - Face to Face observation/attempted interview with Resident A
07/05/2023	Contact - Document Received - Resident A's resident record
07/05/2023	Contact - Telephone call made to direct care staff member Guy Ross, unsuccessful
07/16/2023	Contact - Telephone call made to licensee designee Ken Ogundipe
07/16/2023	Contact - Telephone call made to direct care staff member Guy Ross, unsuccessful
08/08/2023	Contact - Telephone call made to direct care staff member Guy Ross, unsuccessful
08/16/2023	Contact - Document Sent - FOIA request to Lansing Police Department

08/17/2023	Contact - Telephone call made to program director Ashanti Wright
08/21/2023	Contact - Telephone call made to direct care staff member Guy Ross, unsuccessful
08/21/2023	Contact - Telephone call made to direct care staff member Diana Bingham
08/28/2023	Contact - Telephone call made to direct care staff member Guy Ross, unsuccessful
08/29/2023	Contact - Telephone call made to Rob Lindley
08/29/2023	Contact - Telephone call made to Oakland County Mental Health Provider Service Specialist Deana Ottman
08/29/2023	Exit Conference with Ken Ogundipe

ALLEGATION:

Resident A was not supervised according to his written assessment plan and eloped from the facility.

INVESTIGATION:

On July 3, 2023 I received a complaint via centralized intake from Complainant that stated Resident A was found wondering on July 2, 2023 at 7:22am by law enforcement. The written complaint stated Resident A has delayed speech and has the verbal skills of a 4-year-old. The written complaint stated Resident A told law enforcement officers he lives in AFC home, but law enforcement contacted the AFC homes in the area and he did not reside in any of them. The written complaint stated it is unknown where Resident A resides, and law enforcement officials took Resident A to Sparrow Hospital because they had nowhere else to take him.

On July 3, 2023 I spoke to Guardian A1 who stated Resident A has eloped before and direct care staff members were aware of that and for that reason Resident A was assigned 1:1 staffing, however he eloped from his bedroom as facility direct care staff members do not provide 1:1 staffing when Resident A is in his bedroom. Guardian A1 reported Resident A gets up for the day at 6:00 am and he was found wandering in the streets at approximately 7:30 am. Guardian A1 said Resident A eloped during third shift and there are only two direct care staff members working during third shift and they were occupied with another resident's behavior. Guardian A1 stated Resident A's elopement was a "freak accident." Guardian A1 stated she has been very "impressed with" the direct care staff members at the facility.

On July 3, 2023 I spoke to assigned adult protective services (APS) investigator Rob Lindley who said he went to the facility and spoke with Resident A who understands that he is not supposed to leave the facility without a direct care staff member and agreed that he would not. On August 29, 2023, I spoke to Mr. Lindley and he stated that he substantiated the neglect of Resident A by direct care staff members Guy Ross and Marlow Harris as they were the two direct care staff members working when Resident A eloped from the facility and they did not provide the supervision that Resident A required, which is 1:1 line of sight supervision, due to a history of elopement, which both staff members were or should have been aware of.

On July 5, 2023 I completed an unannounced onsite investigation at the facility and attempted to interview Resident A. He appeared almost completely nonverbal and was unwilling or unable to answer any questions pertaining to the allegation.

On July 5, 2023 I interviewed direct care staff member Marlow Harris who stated he arrived at work at 7:00 am on July 2, 2023 and was told Resident A was in his bedroom. Mr. Harris stated Resident A has a history of eloping and for that reason he has been assigned 1:1 staffing however direct care staff members have been instructed not to provide 1:1 staffing while residents are in their bedrooms. Mr. Harris said when he arrived, he was told Resident A was in his bedroom. Mr. Harris stated approximately twenty minutes after he arrived at work, he noted that Resident A was not there and he asked another direct care staff member Guy Ross, who was the last to see Resident A, to look for Resident A in his vehicle, which he did. Mr. Harris said he did not contact police for assistance locating Resident A, but the police telephoned him shortly thereafter stating they had Resident A in their custody and were bringing him home.

On August 21, 2023 I spoke to direct care staff member Diana Bingham who stated she worked first shift on July 2, 2023 and she arrived to work at 7:00 am and she asked Mr. Ross where Resident A was and he told her Resident A was asleep in his bedroom. Ms. Bingham stated she began making breakfast and the rest of the residents got up to eat at approximately 8:30 am but Resident A did not get up however it is not unusual for him to “sleep in” so staff members did not go into Resident A’s bedroom to check on him until 9:00 am and Resident A was not in his bedroom. Ms. Bingham said at that time she checked the entire house and grounds but could not locate Resident A. Ms. Bingham stated she telephoned direct care staff member Guy Ross who already left for the day and he told her Resident A was asleep in his bed when he left at 7:00 am. Ms. Bingham stated at that time she telephoned facility manager Ashanti Wright and was told that Resident A had already been found by the police at 5 to 6 am at the CATA station. Ms. Bingham stated Resident A requires line of sight 1:1 staffing which direct care staff members do not provide while residents are in their bedrooms to respect their privacy. Ms. Bingham stated Resident A eloped out of his bedroom window and direct care staff member Guy Ross told her he made visual contact with Resident A at 7:00 am.

On July 16, 2023 I spoke to licensee designee Ken Ogundipe who stated Resident A requires 1:1 staffing but he was alone with no direct care staff member at the time he eloped. Mr. Ogundipe said direct care staff members cannot go into residents' bedrooms even when providing 1:1 supervision to respect resident rights to privacy. Mr. Ogundipe said when Resident A eloped direct care staff members followed him and reported his elopement to the police.

On August 29, 2023 I spoke to Deana Ottman who is an Oakland County Mental Health Provider Service Specialist and is responsible for contract compliance between the placing agency and the licensee. Ms. Ottman said if Resident A's IPOS stated he required enhanced staffing and 24-hour supervision that is intended to include supervision and 1:1 line of sight supervision in his bedroom, which is what the licensee is being paid to provide.

On August 17, 2023 I spoke to facility program director Ashanti Wright who stated she is responsible for making the facility schedule and she schedules three staff members in the morning, three staff members in the afternoon, and two staff members at night. Ms. Wright stated at the time Resident A eloped he was one of four residents in total and one of three residents who required 1:1 staff supervision. Ms. Wright stated at the time Resident A eloped,
Guy Ross and Marlow Harris were on the schedule for third shift and direct care staff member Diana Bingham was coming onto first shift. Ms. Wright stated Resident A went into the bathroom and then sneaked out the back door while staff members were going over shift change documentation. Ms. Wright said staff members realized Resident A left immediately and Mr. Ross "chased" after Resident A on foot until he lost sight of him and then police were called.

On July 5, 2023 I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated June 16, 2023 which indicated Resident A requires supervision in the community and stated, "staff 1 on 1 supervision at all times due to elopement."

On July 5, 2023 I received and reviewed Resident A's *Individualized Plan of Service* (IPOS) dated May 18, 2023 which stated, "[Resident A] needs a 24 hour supported environment: he needs and is approved for enhanced staffing for health and safety, including aggressive behaviors and elopement. [The licensee] is responsible to provide the level of supports and services outlined in this IPOS as well as monitor for health and safety. [The licensee] supports [Resident A] by providing direction in many of his daily living tasks as well as actual physical assistance for taking medication and some hygiene tasks. They also provide assistance for meal preparation, laundry, housekeeping tasks and social/recreational activities. They provide safety for [Resident A]. [Resident A] requires assistance with activities of daily living including personal care (bathing, grooming)(recognizing survival signs, telling time, reading/ writing, using transportation, leisure choice and participation, shopping, using telephone, money management), and personal care routines due to cognitive limitation. [Resident A] continues to need a 24-hour supported

environment: he is approved for enhanced staffing for health and safety, including aggressive behaviors and elopement.

On August 16, 2023 I submitted a request for information to the Lansing Police Department via the Freedom of Information Act (FOIA) and received a response that there was no written documentation available for that address on the date referenced concerning Resident A.

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 Guardian A1, Mr. Lindley, Mr. Harris, Ms. Bingham, Ms. Wright, Mr. Ogundipe, and Ms. Ottman as well as written documentation at the facility, Resident A requires 1:1 line of sight supervision from direct care staff member due to aggression and elopement. The same interviews confirmed Resident A does not receive the supervision he requires per his written *Assessment Plan for AFC Residents* and IPOS which both stated he needs 1:1 line of sight supervision by a staff member always. This was not provided when Resident A was left alone in his bedroom from at least 7:00 am when direct care staff member Guy Ross left for the day until 9:00 am when direct care staff members Marlow Harris and Diana Bingham looked for Resident A. Hence, Resident A eloped and was later found by local police.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 5, 2023 I requested Resident A's written *Health Care Appraisal* and was presented with a blank document. I reviewed Resident A's entire record and there was nothing noting that he was an emergency admission. Direct care staff member Marlow Harris stated Resident A was recently admitted and all his paperwork had not been completed.

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:	Based on a review of Resident A's written resident record and an interview with direct care staff member Marlow Harris there is sufficient evidence to indicate that no written Health Care Appraisal was obtained for Resident A within the 90 -day period before Resident A's admission to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On July 5, 2023 I interviewed direct care staff member Marlow Harris who was at the facility when it was discovered that Resident A eloped from the facility on July 2, 2023. Mr. Harris denied that he telephoned the police nor Resident A's guardian or placing agency. Rather, Mr. Harris contacted direct care staff member Guy Harris who was off duty to come back to the facility and look for Resident A. Mr. Harris denied that Mr. Ross located Resident A but stated shortly thereafter he was notified that the police had Resident A.

On August 21, 2023 I spoke to direct care staff member Diana Bingham who said when she arrived at work at 7:00 am on July 2, 2023 and was told by direct care staff member Guy Ross that Resident A was in his bedroom. Ms. Bingham stated she discovered two hours later that Resident A eloped from the facility and she stated she telephoned direct care staff member Guy Ross and facility manager Ashanti Wright and was told the police found Resident A at approximately 5:00 to 6:00 am. Ms. Bingham denied she telephoned the police nor Resident A's guardian or placing agency when she discovered Resident A eloped.

On August 16, 2023 I completed a FOIA request which returned no results, indicating the police were not called to the facility on July 2, 2023.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b) Contact the local police authority.**
ANALYSIS:	Based on information received from the two direct care staff members present when it was discovered Resident A eloped from the facility and the Lansing Police Department, Mr. Harris and Ms. Bingham did not call the police, Resident A's guardian, nor Resident A's placing agency to report Resident A's elopement immediately, even though they know he had been gone for some time and instead decided to call other people who work for the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/29/23

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Leslie Herrguth Date
Licensing Consultant

Approved By:

08/30/2023

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Dawn N. Timm Date
Area Manager