GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 13, 2023

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

RE: License #: AS630405489
Investigation #: 2024A0605003
Genesis Home

Dear Kehinde 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:

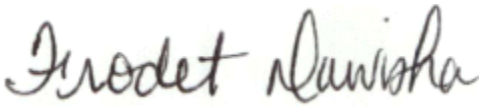
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
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(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405489
Investigation #:	2024A0605003
Complaint Receipt Date:	10/16/2023
Investigation Initiation Date:	10/16/2023
Report Due Date:	12/15/2023
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	G 15 B 405 W Greenlawn Lansing, MI 48910
Licensee Telephone #:	(214) 250-6576
Administrator/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?
Licensee designee Kehinde (Ken) Ogundipe was investigated by Dept of Labor and is ordered to pay $1.8 million in back wages. Concerns of financial capability.	Yes
DCS Allan Paylor is passing medications to residents but has not completed medication training. Administrator Dayo Ogundipe advised Allen and other staff to pass medications and to use the initials of staff that have completed medication training when completing the medication logs.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/16/2023	Special Investigation Intake 2024A0605003
10/16/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
10/16/2023	Referral - Recipient Rights Referral made to Oakland County Office of Recipient Rights (ORR) Heather Shepherd
10/17/2023	Inspection Completed On-site I conducted an unannounced on-site investigation
10/18/2023	Contact - Telephone call made Discussed allegations with licensee designee Ken Ogundipe and Eden Prairie's attorney, Kennedy Shannon
10/18/2023	Contact - Document Sent Email to Eden Prairie's certified public accountant (CPA) Bede Obasi
10/18/2023	Contact - Document Received Email from CPS Bede Obasi
10/19/2023	Contact - Document Received Email from home manager (HM) Abimbola (Ola) Adekunle

10/19/2023	Contact - Telephone call made Discussed allegations with ORR Katie Garcia and Manager of Provider Network Deana Ottman
10/23/2023	Contact - Document Received Email from CPA Bede Obasi
11/20/2023	Contact - Telephone call made Interviewed administrator Dayo Ogundipe regarding the allegations
11/20/2023	Contact - Document Received Email from Ken Ogundipe
11/30/2023	Contact - Telephone call made Interviewed DCS Edward Wilson regarding the allegations
12/04/2023	Contact - Telephone call made With Neil Wright with A Wright Construction
12/04/2023	Contact - Telephone call made Interviewed assistant home manager Javontez Mitchell regarding the allegations
12/04/2023	Exit Conference Conducted exit conference with licensee designee via telephone Ken Ogundipe with my findings.

ALLEGATION:

Licensee designee Ken Ogundipe was investigated by Dept of Labor and is ordered to pay $1.8 million in back wages. Concerns of financial capability.

INVESTIGATION:

On 10/16/2023, intake #198070 was assigned for investigation regarding licensee designee (LD) Ken Ogundipe was investigated by Department of Labor (DOL) and is ordered to pay $1.8 million in back wages and direct care staff (DCS) Allen Paylor is passing medications to residents but has not completed medication training. Administrator of Eden Prairie Residential Care, LLC Dayo Ogundipe advised Mr. Paylor and other untrained staff to pass medications and to use the initials of staff that have completed medication training when completing the medication logs.

On 10/16/2023, I initiated the special investigation by contacting the reporting person (RP) via telephone and discussed the allegations. The RP stated that the LD has not

been paying staff and staff who were paid, checks bounced. The LD and his brother Dayo are aware of checks bouncing but not addressing the issue. There is concern that staff will walk out and not care for the residents. A staff member called the DOL and filed a complaint because some staff have not been paid their overtime wages in several months.

On 10/17/2023, I conducted an unannounced on-site investigation. Present were the home manager (HM) Abimbola Adekunle, DCS Allan Paylor, assistant manager Kamyria White, Resident A and Resident B. Resident C was in the hospital after he fell down the stairs and broke both his legs. The utilities (water, electricity, and gas) were all on in the home. I observed an ample amount of food and toiletries.

I interviewed the HM Abimbola Adekunle regarding the allegations. The HM is paid salary and receives her paycheck twice monthly. She has always received her paychecks and never had a paycheck bounce. Dayo mentioned to the HM that Ken Ogundipe was being investigated by the DOL, but Dayo did not elaborate, nor did she ask any questions about the investigation. She stated no staff member complained about their checks bouncing, but there were two DCS Allan Paylor and Edward Wilson who told the HM, “I think I worked more than I’m getting paid for.” The HM called Dayo about the complaints she received, and Dayo told the HM, “I’ll talk to them.” She does not know what happened after she informed Dayo of the staff’s concerns.

On 10/17/2023, I interviewed Kamyria White regarding the allegations. Ms. White is a DCS but has the title of an assistant HM. She works Monday-Friday from 8AM-8PM and stated she attends school during the weekend. She is paid salary and is paid twice a month. Ms. White is always paid on time and her checks have never bounced. There have been times when her paycheck amount was incorrect, but corrected after she speaks with either Dayo or Ken Ogundipe. She has not received any complaints from any other staff stating they did not get paid or that their checks bounced. She does not know anything about the DOL’s investigation.

On 10/17/2023, I interviewed DCS Allan Paylor regarding the allegations. Mr. Paylor has worked for this corporation since 2021. He began working in the Flint location homes and then transferred to Genesis November 2022. His title is DCS but is paid salary, twice a month. One time he put over 200 hours but was only paid for 180 hours. He discussed this with Dayo who told Mr. Paylor, “you signed a contract agreeing to salary no matter how many hours you work.” Mr. Paylor stated he accepted this because he did sign the salary contract. His checks have never bounced, and he always got paid on time. He reported that the staff in Flint warned Mr. Paylor in the past stating, “make sure you get paid, because we’re not getting paid.” Mr. Paylor stated that has never happened at Genesis.

On 10/18/2023, I interviewed licensee designee Ken Ogundipe regarding the allegations. Mr. Ogundipe confirmed he was investigated by DOL but stated that the investigation was not because of back wages, but because of unpaid employee taxes. He owes $1.8 million. I questioned Mr. Ogundipe that according to information received,

the DOL investigation was regarding employees not getting paid for time worked and not because of employee taxes. He then stated, “yes, we weren’t paying hourly to our employees. We were paying salary to staff that should have been hourly.” Mr. Ogundipe stated he had addressed this issue before DOL became involved and now all his staff are getting paid correctly. He denied any employee payroll checks bouncing. Mr. Ogundipe stated he does not have $1.8 million to pay but will work with DOL to agree upon an amount. He will keep me updated. Mr. Ogundipe would like for me to speak with Eden Prairie Residential LLC’s attorney Kennedy Shannon and Certified Public Account (CPA) Bede Obasi regarding their bank accounts and payroll.

On 10/18/2023, I contacted Eden Prairie Residential LLC’s attorney Kenndey Shannon regarding the allegations. Ms. Shannon advised that there were concerns about staff being paid salary when they should have been paid hourly. This has been since corrected. The DOL conducted their investigation, and their findings were that Mr. Ogundipe must pay double the amount as part of his penalty for back wages totaling $1.8 million. Ms. Shannon heard that staff were complaining about missed paychecks, paydays being moved and bounced checks. She suggested speaking with CPA Bede Obasi regarding Eden Prairie’s bank accounts as she was unable to provide any details.

On 10/18/2023, CPA Bede Obasi emailed bank statements for three bank accounts, ELGA 078 (10/2022-09/2023), ELGA 442 (10/2022-09/2023) and Lake Trust Bank. I reviewed the bank statements and there are significant withdrawals of large amounts being transferred from one account to another account. ELGA 078 had frequent withdrawal transfers to Dayo in various large amounts sometimes made on the same day. With all three bank statements, there were many transactions, withdrawals, and deposits made by both Dayo and Mr. Ogundipe that it is difficult to get a clear understanding of where the money was going and what it was going to.

On 10/19/2023, the HM emailed me several grocery receipts (Sam’s Club 10/03/2023 $661) showing that Genesis Home is always stocked up with food and there are no issues purchasing food with Eden Prairie funds.

On 10/19/2023, I contacted Deanna Ottman, the manager of provider network with OCHN. Ms. Ottman stated that there have been multiple issues with Eden Prairie regarding investigations that have been substantiated. Due to these investigations, Eden Prairie has been put on a referral moratorium until 09/30/2024. There are a total of about 33 individuals residing in Eden Prairie homes. Much of the issues are due to staff not being trained properly to provide the services to the individuals which then results in investigations. This has been an ongoing issue regarding staff not knowing how to meet the needs of these individuals. For this reason, it’s unlikely that OCHN will be placing any other individual in any of Eden Prairie’s homes.

On 10/23/2023, a Zoom meeting was held with Kennedy Shannon, CPA Bede Obasi along with AFC licensing consultants from Genesee County and Ingham County. Ken and Dayo Ogundipe have a total of six bank accounts for Eden Prairie Residential Care, LLC. Dayo has three accounts and Mr. Ogundipe has three accounts. ELGA 078

belonged to Dayo and ELGA 442 belonged to Mr. Ogundipe. In June 2023, it was discussed with Mr. Ogundipe to create a payroll account to prevent any checks from bouncing or staff not getting paid. The account was created but staff throughout the company continued to complain about their paychecks bouncing. About two weeks ago, there was insufficient funds in the payroll account and some of the staff checks were rejected. The bank was contacted, and additional deposits were made to cover the payroll. OCHN is most of their income, but they have stopped placing any more individuals in any of Eden Prairie homes and have been trying to move residents out. Due to lack of placements, it is taking OCHN longer to move their residents out of the homes. OCHN as well as a few other county CMH's continue to pay Eden Prairie for their services, which should be more than enough to pay staff's salaries but there is concern that Eden Prairie is trying to grow too fast by purchasing additional homes instead of focusing on the current homes they have. There was not enough payroll going out due to Eden Prairie having most of their employees as salary, which resulted in employees not being paid for all hours worked. The DOL's findings after their investigation was that Eden Prairie owed employees $900,000 in back wages. After penalty fees from the DOL of another $900,000, Eden Prairie owes 1.8 million. It is believed that this amount is required to be paid in six-months; however, Mr. Ogundipe is proposing to DOL that he is given five-seven years to pay.

On 11/20/2023, I contacted Dayo Ogundipe, the administrator of Eden Prairie Residential Care, LLC and discussed the allegations. Dayo stated that all of Eden Prairie's employees have always been paid and their checks never bounced. He stated there was an employee who attempted to cash her check at a local grocery store and was unsuccessful, so that is why the employee filed the complaint with the DOL. He stated he has encouraged and requested all Eden Prairie employees to get direct deposit to avoid this issue moving forward. Dayo also advised that many of the employees were salary, but then changed to hourly because these staff were DCW's and not managers before DOL began their investigation. Dayo is confident that Eden Prairie can pay the $1.8 million within three years beginning the first payment in 02/2024 and then must pay $43,000 per month after that until the $1.8 million is paid off. Dayo stated the multiple withdrawals made from his account ELGA 078 were for "repairs," to the homes. He stated, "we pay cash to the Mexican workers because they prefer cash." Dayo stated the workers are employed by a licensed contractor that is contracted with Eden Prairie. He will email the name of the contractor.

On 11/20/2023, I received an email from Ken Ogundipe stating that Neil Wright of A Wright Construction Company is their licensed builder on property development. Mr. Wright is licensed under the State of Michigan as a licensed builder.

On 11/30/2023, I contacted DCS Edward Wilson via telephone regarding the allegations. Mostly works days 8A-8PM but sometimes also works nights from 8PM-8AM. He is a DCS and is paid salary, twice monthly. There have been a couple of times where more taxes were taken out of his paycheck then he should have had taken out. His paychecks have never bounced, and he has direct deposit. He has not heard staff

complain about not getting paid or checks bouncing. He has no knowledge of DOL's investigation.

On 12/04/2023, I contacted Neil Wright with A Wright Construction who stated he only services Eden Prairie homes in Ingham County. Mr. Wright does not have any staff who are "Mexicans," and does not get paid by "cash." He only receives checks from Eden Prairie Residential Care, LLC for all work completed. Mr. Wright stated he does not send any staff to service any of Eden Prairie homes in Oakland County.

On 12/04/2023, I contacted assistant HM Javontez Mitchell regarding the allegations. Mr. Mitchell is paid salary twice a month. He has always been paid for hours worked and stated that the only time his check has bounced was two years ago. Since then, he has never had a check bounce because he now has direct deposit. Mr. Mitchell stated there has not been any staff from Genesis.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.
ANALYSIS:	Based on my investigation, licensee designee Ken Ogundipe did not have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application. Eden Prairie Residential Care, LLC has contracts with OCHN and a few other counties receiving a significant amount of monetary compensation for servicing individuals placed in Eden Prairie homes by OCHN. However, Mr. Ogundipe was paying his Eden Prairie employees' salary when DCS should have been paid hourly. Staff were not getting paid for their overtime hours. Mr. Ogundipe has corrected the issue with paying his hourly waged employees' salary and there has been a bank account created just for payroll to ensure staff receive payment. Although the payroll bank account was created, many staff within Eden Prairie continued to complain about not getting paid for hours worked. Therefore, staff reported these issues to the Department of Labor and Wages. The Department of Labor and Wages investigated, and their findings were that Mr. Ogundipe must pay $1.8 million which included a penalty to his employees who were affected by not getting paid for hours worked. A settlement was agreed, and Mr.

	Ogundipe must pay the $1.8 million in three years beginning 02/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

DCS Allan Paylor is passing medications to residents but has not completed medication training. Administrator Dayo Ogundipe advised Allen and other staff to pass medications and to use the initials of staff that have completed medication training when completing the medication logs.

INVESTIGATION:

On 10/16/2023, the RP stated there are a several of DCS that had not completed medication administration training but were allowed to administer medications to resident because Dayo allowed them.

bouncing, but there were two DCS Allan Paylor and Edward Wilson who told the HM, “I think I worked more than I’m getting paid for.” The HM called Dayo about the complaints she received, and Dayo told the HM, “I’ll talk to them.” She does not know what happened after she informed Dayo of the staff’s concerns.

On 10/17/2023, I interviewed the HM Ola Adekunle regarding the medication allegations. The staff members that have completed their medication training at this home are Kamyria White, Edward Wilson, and Javontez Mitchell. The DCS that have not completed medication training are Allan Paylor, James Starkey who is currently suspended because of not completing his medication training and Shakira D. When the HM was out of the country in June 2023, she received a call from Kamyria White informing her that Allen Paylor passed medications during the months of May 2023 and June 2023 when he had not completed medication training. The HM called Mr. Paylor and advised him that he cannot pass medication if he has not completed his medication administration training. Since then, Mr. Paylor has not passed medication. The HM stated that there are two staff per shift: 8AM-8PM and 8PM-8AM. There is usually a staff member that has completed their medication training to pass medications during each shift; however, during the weekends if there are no staff members that have completed medication training working, then Kamyria White or the HM come to the home and administers medication to the residents. The HM denied any staff member coming to her advising her that Dayo informed them to initial someone else’s initials who have completed medication training instead of the staff member who passed medications.

On 10/17/2023, I interviewed Kamyria White regarding the allegations. Ms. White has completed her medication administration training. During her shifts, she is the only person who administers medications. There are about two-three staff per shift depending on how many residents are residing in the home. Ms. White stated when

there are two staff working a shift and both have not completed medication training, then she comes to the home and passes medications during the weekends. She has never observed DCS Allan Paylor pass medication, nor has she reported that to the HM. She has never been told by Dayo to initial the medication logs after staff who have not been trained pass medications.

On 10/17/2023, I interviewed DCS Allan Paylor regarding the allegations. Mr. Paylor has completed most of his training except for medication administration. Around June 2023, he stated, “I took initiative to pass medications but then Ola (HM) told me I couldn’t pass medications, so I stopped.” He has never been told by Dayo or anyone else to pass medications and another staff who completed medication training will initial the medication logs. During the weekends, he always works with staff that can pass medications. He stated, “quite frequently Kamyria and Ola have to come to the home to pass medications if there is no staff trained on medications.”

On 10/17/2023, I interviewed Resident A regarding the allegations. Resident A is his own guardian. He is unsure how many residents live at this home. He takes several medications and states that DCS Allan Paylor passes his medications and passed them last night to him. Resident A does not recall who was working with Mr. Paylor.

On 10/17/2023, I interviewed Resident B regarding the allegations. Resident B has lived here almost one year and has a guardian. He stated that there are three residents living here including him, but that Resident C was in the hospital. He too stated that DCS Allan Paylor passed his medications last night. He too does not recall who was working with Mr. Paylor last night.

On 10/17/2023, I reviewed Resident A’s, Resident B’s, and Resident C’s medications, August 2023-October 2023 medication logs and found the following errors:

- Resident A’s **Fluoxetine HCL 40MG CAPS**: take one capsule by mouth everyday was not given at 8AM on 10/15/2023, but staff initialed the medication logs.
- Resident A’s **Trazadone 150MG Tablet**: take one tablet by mouth every day before sleeping was given at 9PM on 08/31/2023, 10/08/2023, 10/14/2023, and on 10/15/2023 but staff did not initial the medication logs. In addition, Kamyria White initialed the medication log for 10/17/2023 when she has yet to pass this medication until tonight at 8PM.
- Resident B’s **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was modified to daily from 10/01/2023-10/17/2023 without a written script from the prescribing physician.
- Resident B’s **Hydroxyzine 25MG**: take one tab by mouth twice a day was initialed by Kamyria White on 10/17/2023 at 8PM, when this medication was not scheduled to be administered until tonight at 8PM.
- Resident B’s **Benztropine 2MG**: take one tab at bedtime at 8PM on 10/17/2023 was initialed by Kamyria White when this medication has not been passed yet as it is scheduled to be administered tonight at 8PM.

- Resident C's **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was modified to daily from 09/01/2023-09/13/2023 and 10/05/2023-10/09/2023 without a written script from the prescribing physician.

I also reviewed and compared September 2023 medication logs to the September 2023 staff schedules. I found that staff's initials on the September 2023 medication logs do not match the staff who were scheduled to work that day in September 2023. For example, Resident A's Trazadone for 8PM had Kamyria White's initials for 09/03/2023, but Ms. White was not scheduled to work this date. DCS Edward Wilson worked these dates according to the staff schedule. I verified that Mr. Wilson completed his medication training by reviewing his certificate of completion dated 03/21/2022; therefore, Kamyria White did not need to pass medications because according to Ms. White and the HM, the only time that Ms. White and the HM assist with medication passing is when staff who are working have not completed their medication training. I asked both the HM and Ms. White why Ms. White's initials are on 09/03/2023 when she was not working that shift. The HM stated that sometimes staff "call off," and she has Ms. White work that schedule, but has not updated the September 2023 staff schedule. I requested the updated schedule several times and only received the one I was provided at the home, which is the one I reviewed. Another example is on 09/09/2023 and 09/10/2023, the initials "DO," for Dayo Ogundipe were initialed on Resident A's medication log for all his medications at 8AM and 8PM; however, for Resident B's medications on 09/09/2023 and 09/10/2023 at 8AM, "KW," Kamyria White's initials were on the medication logs for all the medications and "DO," initials were on Resident B's 12PM and 8PM medications. Ms. White was not scheduled to work on 09/09/2023 and 09/10/2023. It is unclear why two different staff are passing medications during the same time as evident by two different initials on the medication logs. According to the staff schedule, Javontez Mitchell and Shakira Dortch worked on 09/09/2023 and 09/10/2023 from 8AM-8PM and then Allan Paylor and Edward Wilson worked from 8PM-8AM. Each shift had a staff member who successfully completed medication training; therefore, there was no need for Kamyria White or Dayo Ogundipe to administer medications on these days.

Note: There are numerous discrepancies of which staff worked the specific date and the staff that was on the schedule for September 2023. I requested October 2023 staff schedule, but it was not available at the home. The HM will email the schedule.

On 10/18/2023, I interviewed Ken Ogundipe regarding the allegations. Mr. Ogundipe is not aware of any staff passing medications that have not completed medication training and stated that the HM is responsible for all medications at Genesis. Mr. Ogundipe denied that Dayo or any other manager has asked medication trained staff to initial for the untrained medication staff and that the untrained medication staff know they cannot pass medication until they are fully trained. Mr. Ogundipe will be following up with the HM regarding these issues.

On 10/19/2023, I contacted Office of Recipient Right (ORR) worker Katie Garcia. Ms. Garcia stated she will be investigating the allegations regarding the medication errors. I

emailed her Resident A's, Resident B's, and Resident C's medication logs from 08/2023-10/2023.

On 11/20/2023, I interviewed Dayo Ogundipe regarding the allegations. Dayo denied advising any staff at Genesis who have not completed medication training to pass medications and have another staff who has completed medication training to initial the medication logs. Dayo stated the HM is the person responsible for all the medication logs and responsible to ensure that the staff schedule is updated to reflect the staff that is working.

On 11/30/2023, I discussed the allegations with DCS Edward Wilson. Mr. Wilson reported there are about two-three staff per shift. There has never been a time on his shift that an untrained staff passed medication. He stated, "Not that I know of," when asked if anyone has asked him to initial on the medication log when he did not pass medications. Mr. Wilson never observed DCS Allan Paylor pass medication while working with Mr. Wilson. Mr. Wilson stated sometimes when a staff calls off, he may contact Kamyria White to assist with medication pass. He cannot explain why both he and Ms. White's initials were on Resident A's medication log for 09/24/2023 at 8PM specifically Clonazepam and Trazadone medications. On 09/24/2023, at 8PM, Mr. Wilson's initials are on the Clonazepam and Ms. White's initials were on the Trazadone medication. Mr. Wilson was scheduled to work on 09/24/2023, but Ms. White was not.

On 11/30/2023, I reviewed the October 2023 staff schedule with Resident A's, Resident B's, and Resident C's medication logs and there were no errors.

On 12/04/2023, I interviewed assistant HM Javontez Mitchell regarding the allegations. Mr. Mitchell stated whenever he worked with a staff that has not completed medication training, he is the only one who passes medications. He stated he always initials the medication logs when he administers medication and has never been asked by anyone to initial the medication log when he did not pass medication. Mr. Mitchell has never observed any staff who has not completed medication administration training pass medication. He stated if he is on the staff schedule and his initial is not on the medication log, then he must have called in, but the staff schedule was never updated.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(e) Any scheduling changes.**

ANALYSIS:	Based on my investigation and review of September 2023 staff schedule, there were inconsistencies with staff that worked during that month verses staff's initials on Resident A's September 2023 medication logs. For example, Resident A's Trazadone for 8PM had Kamyria White's initials for 09/03/2023, but Ms. White was not scheduled to work this date. DCS Edward Wilson worked these dates according to the staff schedule. The schedule was never updated to reflect the staff that worked.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the on-site investigation on 10/17/2023, I reviewed Resident B's and Resident C's medications and medication logs and found the following errors: • Resident B's **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was not given pursuant to label instructions from 10/01/2023-10/17/2023 as this medication was given daily instead of as needed. • Resident C's **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was not given pursuant to label instructions from 09/01/2023-09/13/2023 and 10/05/2023-10/09/2023 as this medication was being given daily instead of as needed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0605004, CAP dated 12/28/2021; LSR dated 03/31/2022, CAP dated 04/13/2022**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Based on my investigation and interview with DCS Allan Paylor, Mr. Paylor confirmed he did not complete his medication administration training, but stated he took initiative and passed medications to Residents A, B, and C in June 2023. Mr. Paylor stated since he was informed by the home manager Abimbola (Ola) Adekunle that he cannot give medication to residents until he completes his medication training, Mr. Paylor has stopped administering medications to the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0605004, CAP dated 12/28/2021**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the on-site investigation on 10/17/2023, I reviewed Resident A's and Resident B's medications and medication logs and found the following errors: • Resident A's **Fluoxetine HCL 40MG CAPS**: take one capsule by mouth everyday was not given at 8AM on 10/15/2023, but staff initialed the medication logs. • Resident A's **Trazadone 150MG Tablet**: take one tablet by mouth every day before sleeping was given at 9PM on 08/31/2023, 10/08/2023, 10/14/2023, and on 10/15/2023 but staff did not initial the medication logs. In addition, Kamyria White initialed the medication log for 10/17/2023 when she has yet to pass this medication until tonight at 8PM. • Resident B's **Hydroxyzine 25MG**: take one tab by mouth twice a day was initialed by Kamyria White on 10/17/2023 at 8PM, when this medication was not scheduled to be administered until tonight at 8PM. • Resident B's **Benztropine 2MG**: take one tab at bedtime at 8PM on 10/17/2023 was initialed by Kamyria White

	when this medication has not been passed yet as it is scheduled to be administered tonight at 8PM.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0605004, CAP dated 12/28/2021; LSR dated 03/31/2022, CAP dated 04/13/2022**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	During my on-site investigation on 10/17/2023, I reviewed Resident B's and Resident C's medications and medication logs and found the following errors: • Resident B's **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was modified to daily from 10/01/2023-10/17/2023 without a written script from the prescribing physician. • Resident C's **Loratadine 10MG Tab**: take one tablet daily as needed for seasonal allergy symptoms was modified to daily from 09/01/2023-09/13/2023 and 10/05/2023-10/09/2023 without a written script from the prescribing physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site investigation on 10/17/2023, I observed the kitchen countertop separating from the kitchen island. I also observed the cabinet next to the refrigerator in need of repair as the cabinet molding is bubbling and the floor near the dining room table is chipped.

On 10/17/2023, the HM stated that “Mexicans,” complete the repairs at Genesis home and that they do not know if they are licensed or not. She suggested I contact Dayo or licensee designee Ken Ogundipe regarding these issues.

On 11/20/2023, I interviewed Dayo regarding the allegations. Dayo stated he has “Mexicans,” complete the repairs at Genesis if their cosmetic but that they do have a licensed contractor who completes all plumbing and electrical repairs. Dayo stated he will address these physical plant issues.

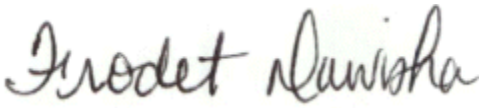
On 12/04/2023, I conducted the exit conference via telephone with licensee designee Ken Ogundipe with my findings. He is hiring an administrator, Sonia McKeown who has had over 16 years of experience as a licensee designee to oversee all his homes, specifically Oakland County. Mr. Ogundipe is looking to retire and step back from Eden Prairie. He believes Ms. McKeown will come up with strategies regarding the medication errors that continue to occur at Genesis. Mr. Ogundipe acknowledged the violations and stated that he will work closely with Ms. McKeown when she begins on 01/04/2024. Mr. Ogundipe received the final settlement from the Department of Labor and Wages. In 02/2024, he is required to pay about $200,000 and then must pay $43,000 per month for the next three years. He is confident that he can pay the full amount of the $1.8 million in three years. Mr. Ogundipe stated he will be hiring a licensed contractor for his Oakland County homes to complete all repairs to avoid further repeat violations. I advised Mr. Ogundipe that due to multiple repeat medication and physical plant violations, my recommendation will be to modify the license to a provisional. Mr. Ogundipe stated that he understands and acknowledges my findings. He agreed to submit a corrective action plan and then stated he will accept the provisional license and will submit his acceptance in writing along with the corrective action plan.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During my on-site investigation on 10/17/2023, I observed the kitchen countertop separating from the kitchen island. I also observed the cabinet next to the refrigerator in need of repair as the cabinet molding is bubbling.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0605004, CAP dated 12/28/2021; LSR dated 03/31/2022, CAP dated 04/13/2022**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	The laminate floor near the dining room table is chipped.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend modifying the license to a six-month provisional.



12/07/2023

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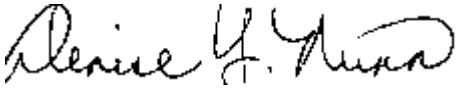
Frodet Dawisha Date
Licensing Consultant

Approved By:



12/13/2023

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Denise Y. Nunn Date
Area Manager