GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 12, 2023

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

RE: License #: AS630411893
Investigation #: 2024A0465003
Zenith 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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630411893 |
| | |
| **Investigation #:** | 2024A0465003 |
| | |
| **Complaint Receipt Date:** | 10/16/2023 |
| | |
| **Investigation Initiation Date:** | 10/17/2023 |
| | |
| **Report Due Date:** | 12/15/2023 |
| | |
| **Licensee Name:** | Eden Prairie Residential Care, LLC |
| | |
| **Licensee Address:** | G 15 B - 405 W Greenlawn<br>Lansing, MI 48910 |
| | |
| **Licensee Telephone #:** | (214) 250-6576 |
| | |
| **Administrator:** | Kehinde Ogundipe |
| | |
| **Licensee Designee:** | Kehinde Ogundipe |
| | |
| **Name of Facility:** | Zenith Home |
| | |
| **Facility Address:** | 21412 Remainville<br>Ferndale, MI 48220 |
| | |
| **Facility Telephone #:** | (214) 250-6576 |
| | |
| **Original Issuance Date:** | 12/01/2022 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/01/2023 |
| | |
| **Expiration Date:** | 05/31/2025 |
| | |
| **Capacity:** | 4 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Licensee Designee/Administrator, Ken Ogundipe, has failed to pay proper wages to his employees. | Yes |
| Direct care staff have not completed medication administration training. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/16/2023 | Special Investigation Intake<br>2024A0465003 |
| 10/17/2023 | Inspection Completed On-site<br>I conducted a walkthrough of the facility, reviewed resident files, interviewed Resident A and direct care staff, Marcus Turner |
| 10/17/2023 | Contact - Telephone call made<br>I spoke to licensee designee, Ken Ogundipe, via telephone |
| 10/18/2023 | Contact - Document Received<br>I received facility documents via email |
| 10/18/2023 | Contact - Document Sent<br>Email exchange with Office of Recipient Rights Officer, Katie Garcia, who is assigned to investigate this complaint |
| 10/27/2023 | Contact - Document Received<br>Email exchange with ORR Officer, Katie Garcia |
| 11/02/2023 | Contact - Telephone call made<br>I spoke to direct care staff, Shakira Dortch, via telephone |
| 11/16/2023 | Contact - Telephone call made<br>I spoke to direct care staff/home manager, Ola Adekunle, via telephone |
| 11/16/2023 | Contact - Telephone call made<br>I spoke to Guardian A1 via telephone |

| | |
|---|---|
| 11/21/2023 | Contact - Document Received<br>Email received from AFC Licensing Consultant, Christopher Holvey. |
| 11/27/2023 | Contact - Telephone call made<br>I spoke to direct care staff, Javontez Mitchell, via telephone |
| 11/29/2023 | Contact - Document Received<br>Email exchange with Mrs. Garcia |
| 12/04/2023 | Contact - Document Received<br>Emailed received from AFC Licensing Consultant, Christopher Holvey, via email |
| 12/06/2023 | Exit Conference<br>I conducted an Exit Conference with Mr. Ogundipe via telephone |

**ALLEGATION:**

**Licensee Designee/Administrator, Ken Ogundipe, has failed to pay proper wages to his employees.**

**INVESTIGATION:**

On 10/16/2023, a complaint was received, alleging that Eden Prairie Residential Care, LLC, to which Ken Ogundipe, is the licensee designee/administrator, failed to pay proper wages to their employees. The complaint indicated that Mr. Ogundipe was recently investigated by the Department of Labor and Wages, and it was determined that Mr. Ogundipe failed to pay his employees fair compensation. Mr. Ogundipe has been ordered to pay 1.8 million in back wages to employees. On 10/13/2023, multiple employee checks bounced due to Mr. Ogundipe not having the necessary funds in the bank account.

On 10/17/2023, I conducted an onsite investigation. At the time of my onsite investigation, there were two residents residing in the home. I observed the home to have an adequate supply of food, working electricity and running water. I observed Resident A in the living room, watching television. I completed a walkthrough of the facility, reviewed resident files, interviewed Resident A, Resident B and direct care staff, Marcus Turner.

Resident A stated, “I like living here. There is food here and staff give us things that we need when we need it. I don’t have any concerns.” Resident A denied any concerns related to this complaint.

I spoke to direct care staff, Marcus Turner, who stated that he has worked for Eden Prairie Residential Care for several years, at least since 2020. Mr. Turner stated, “I have worked for Eden Prairie for years, but I most recently began working at this home two weeks ago. I have not any issues with getting paid. I get a check every two weeks and I have always gotten paid. If I wasn’t getting paid, I wouldn’t be here right now. I have never had an issue with not getting paid and I haven’t heard any other staff complain about this either. The home has power and running water. We have cable television and have money each week to buy groceries for the residents.” Mr. Turner denied any current financial concerns related to the daily operations of the facility.

On 10/17/2023 and 12/6/2023, I spoke to Mr. Ogundipe, via telephone. Mr. Ogundipe stated, “I did make a mistake and not pay my employees the wages they earned. I made errors in calculating employee wages and now I owe 1.8 million dollars to the Department of Labor and Wages. But what I owe is back wages, not related to employee checks bouncing. All of my employees are being paid and their checks are being cashed without any issues. I am able to continue to pay all of my employees and I am financially able to continue to operate my business. I just came to a settlement agreement with the Department of Labor and Wages, to pay $277,000 on 4/1/2024 and then $45,000 per month beginning on 6/1/2024, for three years. I am confident that I will be able to meet this financial obligation and do not have any worries about the financial stability and capabilities to continue to operate.”

On 11/2/2023, I spoke to direct care staff, Shakira Dortch, via telephone. Mrs. Dortch stated, “I don’t have any concerns with getting paid. I get paid on time every month and have not had any issues with my paycheck bouncing.”

On 11/16/2023, I spoke to direct care staff/home manager, Ola Adekunle, via telephone. Ms. Adekunle stated, “This is not true. Staff always get paid. I am not aware of any time when an employees check bounced. I get paid on time each month and have not had any concerns. We always ensure that the residents have food in the home for all meals and snacks.” Ms. Adekunle did not report any concerns related to this complaint.

On 11/27/2023, I spoke to direct care staff, Javontez Mitchell, via telephone. Mr. Mitchell stated he has worked at the facility for two years. Mr. Mitchell stated, “I get paid on time each month and I have not had any issues. The home always has ample food and the other things that residents need.” Mr. Mitchell did not report any concerns.

| APPLICABLE RULE | |
|---|---|
| **R 400.14201** | **Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of 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:** | According to Mr. Ogundipe, he owes 1.8 million dollars to the Department of Labor and Wages for improperly paying Eden Prairie Residential Care direct care staff salary wages instead of the required hourly rate.<br><br>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 various community mental health agencies. However, Mr. Ogundipe was paying his Eden Prairie employees' a 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.<br><br>Based on the information above, Mr. 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. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Direct care staff have not completed medication administration training.**

**INVESTIGATION:**

On 10/16/2023, a complaint was received, alleging that direct care staff have not completed medication administration training. The complaint stated that the home has staff that have not completed medication training but are still allowed to administer medication to residents. The complaint stated that staff were informed that they can pass medication and write the initials of other staff who have completed medication training.

On 10/18/2023, 10/27/2023 and 11/29/2023, I spoke to Office of Recipient Rights Officer, Katie Garcia via email exchange. Ms. Garcia stated that her investigation is still in process but she does not have sufficient information to substantiate a rights violation as of now.

At the time of my onsite investigation, on 10/17/2023, I determined that the facility have two staff on duty at all times. There are three direct care staff that are trained medication passers: Javontez Mitchell, Mark Turner, and Abimbola (Ola) Adekunle. I reviewed the employee files and determined that each employee completed medication training through *Training & Treatment Innovations, Inc*. in November 2021 and December of 2021. I also reviewed the *Medication Administration Logs* for October 2023 and November 2023, and I observed all MARS to be initialed by Mr. Mitchell, Mr. Turner, and Ms. Adekunle. I did not observe any errors or concerns related to medication training for staff.

I interviewed Mr. Turner. Mr. Turner stated, “I have completed medication training. I have worked for this corporation for many years, and I completed medication training a few years ago. I am trained in medication and able to pass medication to residents. I have never been told to falsify medication logs or to use the initials of another staff.” Mr. Turner denied knowledge of this complaint being true.

On 11/2/2023, I spoke to direct care staff, Shakira Dortch, via telephone. Mrs. Dortch stated, “I am not trained to pass medications but there are always two staff on duty, and one of those staff is someone that is trained and can pass medications. I have never passed medications and I have never been told that I can pass medications. I have never been told to falsify medications records.” Ms. Dortch denied knowledge of this complaint being true.

On 11/16/2023, I spoke to Ms. Adekunle, who stated that she is trained in medication administration. Ms. Adekunle stated, “I have been working at the facility for three years and I am also the home manager. I am trained in medication administration and also assist in training new staff. We always have two staff on duty at all times and there is always someone on duty that can pass medication. I have never told any staff to falsify documents or administer medications if they are not trained. This is not true.”

On 11/16/2023, I spoke to Guardian A1, via telephone. Guardian A1 stated, “I do not have any concerns related to medication management for Resident A. I think the facility is managing his medication properly. I have no reason to believe otherwise.” Guardian A1 did not vocalize any concerns related to this complaint.

On 11/27/2023, I spoke to Mr. Mitchell via telephone. Mr. Mitchell stated, “I am trained in medication administration. I took the training several years ago and I know how to properly pass meds. We always have two staff on duty, so there is always on trained medication passer on duty. We have never had any issues with staff trying to pass medications if they are not trained. And I have never been told, or heard of, other staff being told to pass medications if they are not trained.” Mr. Mitchell denied knowledge of this complaint being true.

On 10/17/2023 and 12/6/2023, I spoke to Mr. Ogundipe, via telephone. Mr. Ogundipe stated, “I always have two staff on duty at the facility. And there is always at least one staff on duty that is trained in medication administration. I, nor any of my management staff, have ever told staff to lie or falsify medication records. We have never told staff that are untrained in medication administration, to pass medications and initial another staffs’ name. This is not true.” Mr. Ogundipe denied knowledge of this complaint being true.

| **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:**<br>**(a) Be trained in the proper handling and administration of medication.** |
| **ANALYSIS:** | Mr. Mitchell, Mr. Turner, and Ms. Adekunle completed medication training through *Training & Treatment Innovations, Inc*. in November 2021, and December of 2021. The *Medication Administration Logs* for October 2023 and November 2023 were properly initialed by Mr. Mitchell, Mr. Turner, and Ms. Adekunle. I did not observe any errors or concerns related to medication training for staff.<br><br>According to Mr. Turner, Ms. Dortch, Ms. Adekunle, Mr. Mitchell, and Mr. Turner, they are trained in medication administration. Mr. Turner, Ms. Dortch, Ms. Adekunle, Mr. Mitchell, and Mr. Turner stated that they have never been told to falsify medication logs or to use the initials of another staff.” Mr. Turner, Ms. Dortch, Ms. Adekunle, Mr. Mitchell, and Mr. Turner denied knowledge of this complaint being true. |

| | |
|---|---|
| | According to Mr. Ogundipe, he has never advised direct care staff to falsify documents or administer medication if not properly trained. Mr. Ogundipe denied knowledge of this allegation being true.<br><br>Based on the information above, there is not sufficient information to confirm that direct care staff, that are not trained in medication administration, are passing prescribed medications to residents. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 10/17/2023, I arrived at the facility at approximately 10:00am. While onsite at the facility, Mr. Turner informed me that he did not have the key to access residents' medications. Mr. Turner stated, "I am the only staff here right now. The other staff, Mr. Mitchell, left at 8:00am, to take Resident B to an appointment. And he should be back by 2:00pm. But he accidently took the medication cabinet key with him, and I don't have any way to access the residents' medications until he gets back. But no residents need medication until this evening, so it isn't a problem. This hasn't happened before. He just forgot to leave it." Mr. Turner acknowledged that, if a resident required medication, he would be unable to administer it accordingly.

On 10/17/2023, I spoke to Mr. Ogundipe via telephone while onsite at the facility. I notified Mr. Ogundipe that Mr. Turner was at the home without proper access to resident medications. Mr. Ogundipe stated, "I am so sorry that this happened. I will contact staff right away and ensure that the key is at the home immediately."

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | On 10/17/2023, I arrived at the facility at 10:00am and left the home at approximately 10:40am. During this time, Mr. Turner was on duty at the facility and did not have the key to access residents' prescribed medications. |

| | |
|---|---|
| | According to Mr. Turner, Mr. Mitchell left the facility at 8:00am and accidently took the medication cabinet key with him. Mr. Turner stated that he had been at the facility for approximately two hours, unable to access or administer resident medications if needed.<br><br>Based on the information above, on 10/17/2023, the facility did not have sufficient staff on duty to provide adequate personal care to residents, including the ability to administer prescribed medications if needed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 10/18/2023, I reviewed the *Staff Schedule* and the *Medication Administration Record* for October 2023. My review of these documents determined that the staff schedule did not properly document scheduling changes and the hours/times worked. I observed the following discrepancies:

- 10/2/2023 - 10/3/2023: The schedule has no staff listed as working from 8:00am – 8:00pm, but Mr. Mitchell's initials are on the MAR as having administered the 8:00am and 8:00pm medications
- 10/6/2023 – 10/8/2023: Ola Adekunle is not listed on the staff schedule on these dates. However, Ms. Adekunle's initials are listed on the MAR as having passed residents' 8:00am and 8:00pm medications

On 11/16/2023, I spoke to Ms. Adekunle, who stated, "There were staff on duty on 10/2/2023 and 10/3/2023. Mr. Mitchell worked on these days along with Mr. Turner. We made an error on the staff schedule, and it should have reflected that Mr. Mitchell and Mr. Turner worked on these days. On the dates of 10/6/2023 – 10/8/2023, we had some staffing issues with staff calling off from work, so I had to cover those shifts with other staff. But I did not update the staff schedule to reflect that I worked on those dates. This was an error." Ms. Adekunle acknowledged that the staff schedule was not correct and did not reflect scheduling changes.

On 11/27/2023, I spoke to Mr. Mitchell, who stated, "I did work on 10/2/2023 and 10/3/2023. I was asked to work last minute, so I was not originally on the schedule. I am not sure if the schedule was updated because I do not oversee the schedule."

On 10/17/2023 and 12/6/2023, I spoke to Mr. Ogundipe via telephone. Mr. Ogundipe stated, “We make the staff schedule, but if any staff call in sick or quit or don’t show up, we have to pull another staff in to work. However, we have not been updating the schedule to reflect those staffing changes. I did not realize we needed to update it to show these changes. We will make these changes moving forward.”

On 12/6/2023, I conducted an exit conference with Mr. Ogundipe. Mr. Ogundipe stated that he is in agreement with the findings of this report.

| **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:**<br>**(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.**<br>**(b) Job titles.**<br>**(c) Hours or shifts worked.**<br>**(d) Date of schedule.**<br>**(e) Any scheduling changes.** |
| **ANALYSIS:** | The *Staff Schedule* for October 2023 did not reflect that Mr. Mitchell and Mr. Turner worked on 10/2/2023 and 10/3/2023 from 8:00am – 8:00pm. The staff schedule did not accurately reflect that Ms. Adekunle worked on 10/6/2023, 10/7/2023 and 10/8/2023 from 8:00am – 8:00pm.<br><br>According to Ms. Adekunle and Mr. Ogundipe, the facility has not been updating the staff schedule to reflect scheduling changes as required.<br><br>Based on the information above, the facility has not maintained an accurate staff schedule that includes staff scheduling changes. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

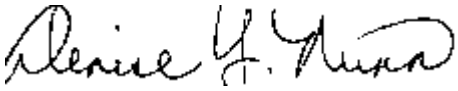
## IV. RECOMMENDATION

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

12/8/2023

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:



12/12/2023

Denise Y. Nunn — Date
Area Manager