GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 18, 2024

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

RE: License #: AS330410066
Investigation #: 2024A0790002
Bell Oaks at Ionia

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.
- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330410066
Investigation #:	2024A0790002
Complaint Receipt Date:	01/03/2024
Investigation Initiation Date:	01/03/2024
Report Due Date:	03/03/2024
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 Ionia
Facility Address:	1201 W Ionia St Lansing, MI 48915
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	06/26/2023
License **Status:**	REGULAR
Effective Date:	12/26/2023
Expiration Date:	12/25/2025
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/25/2023 direct care staff member Dareion Summerour left the residents alone from approximately 7:45 p.m. until 10:07 p.m. Mr. Summerour appeared intoxicated when he returned to the facility.	Yes
On 12/25/2023 there was not a direct care staff member working second shift trained in medication administration.	No

III. METHODOLOGY

01/03/2024	Special Investigation Intake 2024A0790002
01/03/2024	APS Referral not necessary as this special investigation originated from a denied APS referral.
01/03/2024	Contact - Telephone call made to interview Complainant. Voicemail message left requesting a return call.
01/03/2024	Special Investigation Initiated – Telephone call made. Interviewed Complainant.
01/03/2024	Contact - Telephone call made to interview recipient rights advisor Michele McCormick.
01/04/2024	Inspection Completed On-site. Interviewed DCSM Falisha VanHorn, DCSM Lutece Medina, and Resident B.
01/08/2024	Inspection Completed-BCAL Sub. Compliance
01/08/2024	Corrective Action Plan Requested and Due on 01/24/2024.
01/09/2024	Exit Conference with licensee designee Ken Ogundipe.
01/10/2024	Contact – Document Received- DCSM Ashanti Wright emailed me Darieon Summerour's Medication Administration training certificate dated 02/02/2023. Interviewed Ms. Wright.

ALLEGATION: On 12/25/2023 direct care staff member Dareion Summerour left the residents alone from approximately 7:45 p.m. until 10:07 p.m. Mr. Summerour appeared intoxicated when he returned to the facility.

INVESTIGATION:

I interviewed Complainant via phone on 01/03/2024. Complainant said she did not have any additional information regarding the complaint.

I interviewed recipient rights advisor Michele McCorrmick via phone on 01/03/2024. Ms. McCormick stated she interviewed direct care staff member (DCSM) Falisha VanHorn who functions as the home manager and Ms. VanHorn provided the following information regarding events occurring at the facility on 12/25/2023. Ms. McCormick said Ms. VanHorn disclosed Resident A called her at 8:25 p.m. and stated he needed his medication. Ms. McCormick stated Ms. VanHorn said she asked Resident A where Mr. Summerour was, and Resident A said Mr. Summerour had left the facility before he called and had not returned.

Ms. McCormick said Ms. VanHorn stated she called DCSM Lutece Medina who was scheduled to work third shift and requested Ms. Medina come to work early. Ms. VanHorn stated Ms. Medina said she would get ready and head to work immediately. Ms. McCormick said Ms. VanHorn stated she then got into her vehicle and drove to the facility. Ms. VanHorn said she arrived at the facility at approximately 9:00 p.m. Ms. VanHorn stated Ms. Medina arrived at the facility at the same time. Ms. McCormick stated Ms. VanHorn said Mr. Summerour was not at the facility when she and Ms. Medina arrived.

Ms. McCormick said Ms. VanHorn stated Mr. Summerour returned to the facility at approximately 10:07 p.m. Ms. VanHorn said Mr. Summerour acted as though nothing was wrong when returning to the facility. Ms. VanHorn said Mr. Summerour returned in the front passenger seat of a vehicle Ms. VanHorn did not recognize. Ms. VanHorn stated Mr. Summerour appeared to be intoxicated. Ms. McCormick said Ms. VanHorn stated Mr. Summerour stated he had been at a friend's house two-doors down and was in eye shot of the facility. Ms. VanHorn stated Mr. Summerour indicated he had been in eyeshot of the facility the entire time and was able to see Resident A sitting out on the front porch through the window of the home. Ms. VanHorn said Mr. Summerour thought he was providing proper supervision if he remained in eyeshot of the facility and did not believe he had done anything wrong. Ms. VanHorn stated Mr. Summerour has been terminated and no longer works at the facility or for Eden Prairie Residential Care, LLC.

I conducted an unannounced onsite investigation on 01/04/2024. I interviewed DCSM Falisha VanHorn who functions as the home manager. Ms. VanHorn statements to me were similar as those given when interviewed by recipient rights advisor Ms. McCormick with slight differences in the timeline of events.

Ms. VanHorn said she asked Resident A where Mr. Summerour was during the phone conversation and Resident A told her Mr. Summerour had left the facility. Ms. VanHorn stated Resident A did not know when Mr. Summerour had left the facility and could not provide an approximate time of departure.

Ms. VanHorn stated the two residents at the facility did not require constant line of sight supervision however still required a direct care staff member to be present in the facility. Ms. VanHorn said Resident B was approved by his guardian to spend a portion of the day on 12/25/2023 with his family and Resident B had told her he returned to the facility at approximately 6:30 p.m. She said Resident B indicated he did not see Mr. Summerour when he returned and was unsure if he was at the facility. Ms. VanHorn said Resident B informed her he went straight to his bedroom. Ms. VanHorn said after speaking to Resident A, she attempted to reach Mr. Summerour. She stated she called and texted Mr. Summerour but was unable to reach him. Ms. VanHorn stated she called DCSM Lutece Medina who was scheduled to work third shift, got in her vehicle, and headed to the facility. She said Ms. Medina agreed to come in to work early.

Ms. VanHorn stated she lives on the other side of the city, and it takes her approximately 30 minutes to get to the facility. She said she arrived at approximately 9:15 p.m. and immediately administered medication. Ms. VanHorn said Mr. Summerour was not at the facility when she arrived so she filled out two *AFC Licensing Division – Incident / Accident Reports* and called Recipient Rights.

Ms. VanHorn said Ms. Medina arrived at approximately 10:00 p.m. and Mr. Summerour pulled up in a vehicle right behind her. She stated Mr. Summerour was a passenger in the vehicle she did not recognize. Ms. VanHorn stated Mr. Summerour appeared to be under the influence of alcohol upon arrival back to the facility to continue working his schedule shift. Ms. VanHorn said Mr. Summerour appeared unsteady and was slurring his words. She said Mr. Summerour stated he had been two-doors down, in eyeshot of the facility the entire time, and was able to see Resident A sitting out on the front porch through the window of the home.

Ms. VanHorn said Mr. Summerour indicated he had left the facility at 7:45 p.m. to get food and had asked Resident A if he wanted to go with him. She stated Mr. Summerour said Resident A told Mr. Summerour he did not want to go with him. Ms. VanHorn said Mr. Summerour acted in a defiant manner and tone and did not believe he had done anything wrong by leaving the facility.

Ms. VanHorn stated Mr. Summerour must not have completed room checks because he stated Resident B had not returned prior to leaving the facility at approximately 7:45 p.m. Ms. VanHorn said according to Resident B he returned to the facility at approximately 6:00 p.m. and went directly to his bedroom.

Ms. VanHorn said Resident A had been approved and scheduled to transfer an inpatient psychiatric hospital soon after 12/25/2023. She stated Resident A transferred shortly after 12/25/2023 and will not be returning to the facility.

Ms. VanHorn stated Mr. Summerour was terminated on 12/25/2023 and no longer works at the facility or for Eden Prairie Residential Care, LLC.

I interviewed DCSM Lutece Medina. Ms. Medina said she arrived at the facility on 12/25/2023 at approximately 10:00 p.m. She stated she lives approximately 30 minutes from the facility. Ms. Medina said Mr. Summerour pulled up right behind her in a vehicle and exited from the passenger side. Ms. Medina said Mr. Summerour was speaking to Ms. VanHorn indicating he was two-doors down the entire time and was attempting to get Ms. Medina to agree with him that supervision of residents from that distance was appropriate. Ms. Medina said she had no idea where Mr. Summerour had been, so did not respond when Mr. Summerour asked for her corroboration.

I interviewed Resident B. Resident B stated he returned to the facility at approximately 6:30 p.m. on 12/25/2023. Resident B said he did not see DCSM Mr. Summerour when he returned. Resident B stated he went straight to his bedroom. Resident B disclosed seeing Mr. Summerour later that night on 12/25/2023. Resident B stated DCSMs Ms. VanHorn and Ms. Medina were at the facility when he saw Mr. Summerour. Resident B stated Ms. VanHorn administered his medication on 12/25/2023.

I reviewed two *AFC Licensing Division – Incident / Accident Reports* dated 12/25/2023. The first *AFC Licensing Division – Incident / Accident Report* indicated DCSM Falisha VanHorn who functions as the home manager arrived at the facility and DCSM Dareion Summerour was not present. The report stated Ms. VanHorn attempted to reach Mr. Summerour but received no response. The report stated Ms. VanHorn remained at the facility until the third shift DCSM Lutece Medina arrived. The report finally indicated disciplinary actions will be taken because of Mr. Summerour leaving the residents alone at the facility. The report does not say what disciplinary actions will be taken. I reviewed the second *AFC Licensing Division – Incident / Accident Report* dated 12/25/2023 and found it provided the same information as the first.

I reviewed the *medication administration records (MARs)* for Resident A and Resident B and determined Resident A and Resident B did receive their prescribed medications on 12/25/2023. I also determined DCSM Ms. VanHorn administered the residents evening medications.

I reviewed Resident A's *Assessment Plan for AFC Residents* and found while in the community Resident A requires DCSMs in line of sight.

I reviewed Resident B's *Assessment Plan for AFC Residents* and discovered Resident B requires one on one supervision because he is a significant elopement risk. I found Resident B has a history of aggressive behavior towards DCSMs and other residents. I found Resident B is a high risk for drug and ethyl alcohol (ETOH) abuse.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with recipient rights advisor Ms. McCormick, DCSM Ms. VanHorn, DCSM Ms. Medina, and Resident B, DCSM Mr. Summerour left Resident A and Resident B unsupervised from approximately 7:45 p.m. until 10:07 p.m. and appeared intoxicated upon his return.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 12/25/2023 there was not a direct care staff member working second shift trained in medication administration.

INVESTIGATION:

Ms. McCormick said Ms. VanHorn indicated DCSM Dareion Summerour was the only DCSM on shift at the time and was not trained in medication administration. Ms. VanHorn said she was already planning to head over to the facility at 9:00 p.m. to administrator medications to the residents.

Ms. McCormick said Ms. VanHorn stated she completed evening medication administration when she arrived at the facility at approximately 9:00 p.m.

Ms. VanHorn stated Resident A called her at 8:25 p.m. stating he needed his medication. Ms. VanHorn stated DCSM Dareion Summerour was the only DCSM working at the time and was not trained in medication administration, so she had already planned to arrive at the facility at approximately 9:00 p.m. to administer medication to the two residents.

I reviewed Resident A's *Assessment Plan for AFC Residents* and found Resident A requires DCSMs to administer his medication. I reviewed Resident B's *Assessment Plan for AFC Residents* and found Resident B requires DCSMs to administer his medication.

I interviewed DCSM Ashanti Wright who functions as regional manager covering the Eden Prairie Residential Care, LLC facilities in Lansing, MI on 01/10/2024. Ms. Wright provided me with a copy of DCSM Darieon Summerour's Community Mental Health (CMH) Training Unit - Medication Administration training certificate dated 02/02/2023. The document indicated Mr. Summerour had completed Medication Administration training and passed the after-training test.

Ms. Wright assured me Mr. Summerour was trained and competent in medication administration so she is unsure why a DCSM I interviewed earlier in the special investigation indicated otherwise. Ms. Wright stated Mr. Summerour worked for their company in multiple facilities for over a year administering medications. Ms. Wright said Mr. Summerour had no medication administration errors while working for Eden Prairie Residential Care LLC.

I conducted an exit conference via phone on 01/09/2024 with licensee designee Ken Ogundipe. I informed Mr. Ogundipe of the rule violation established because of this special investigation. Mr. Ogundipe indicated he would provide a Corrective Action Plan (CAP) within the allotted timeframe.

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 the information gathered during this special investigation through review of documentation and interviews with recipient rights advisor Ms. McCormick, DCSM Ms. VanHorn, DCSM Ms. Medina, Resident B, and DCSM Ms. Wright there is no evidence indicating there was not a direct care staff member working second shift trained in medication administration on 12/25/2023.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

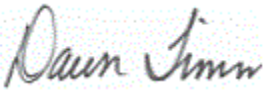
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

01/10/2024

Rodney Gill Date
Licensing Consultant

Approved By:



01/18/2024

Dawn N. Timm Date
Area Manager