GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 23, 2024

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

RE: License #:	AS250402729
Investigation #:	2024A0872014
	Welch Home I

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250402729
Investigation #:	2024A0872014
Complaint Receipt Date:	12/13/2023
Investigation Initiation Date:	12/15/2023
Report Due Date:	02/11/2024
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:	Welch Home I
Facility Address:	913 Welch Blvd Flint, MI 48503
Facility Telephone #:	(214) 250-6576
Original Issuance Date:	08/24/2021
License Status:	REGULAR
Effective Date:	02/24/2022
Expiration Date:	02/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 12/10/23, staff provided Resident A with alcohol. Staff drank alcohol with Resident A while they were working.	No
Additional Findings	Yes

III. METHODOLOGY

12/13/2023	Special Investigation Intake 2024A0872014
12/15/2023	APS Referral This complaint was referred by APS but was not assigned for investigation
12/15/2023	Special Investigation Initiated - Letter I emailed the home manager requesting information about this complaint
12/18/2023	Contact - Document Received AFC documents received
01/04/2024	Inspection Completed On-site Unannounced
01/17/2024	Contact - Telephone call made I interviewed staff Michael Owens
01/22/2024	Contact - Telephone call made I interviewed Guardian A1
01/23/2024	Contact - Telephone call made I interviewed Relative A1
01/23/2024	Inspection Completed-BCAL Sub. Compliance
01/23/2024	Exit Conference I conducted an exit conference with the licensee designee, Kehinde Ogundipe

ALLEGATION: On 12/10/23, staff provided Resident A with alcohol. Staff drank alcohol with Resident A while they were working.

INVESTIGATION: On 12/18/23, I received Adult Foster Care paperwork related to Resident A. Resident A was admitted to Welch Home I Adult Foster Care facility on 06/10/22. According to Resident A's health care appraisal, Resident A is diagnosed with schizophrenia. According to Resident A's assessment plan, Resident A requires staff supervision when in the community. Resident A has a history of aggressive and sexually inappropriate behaviors. Resident A also has a history of not getting along with others, self-injurious behaviors, and alcohol use. Resident A requires staff prompts with bathing, grooming, dressing, and personal hygiene.

According to his Oakland County individualized plan of service (IPOS) dated 09/16/22, Resident A requires 2:1 staffing, Resident A has a history of sexually and physically inappropriate behaviors and property destruction.

I reviewed an Incident/Accident Report (IR) dated 12/10/23 completed by staff Latonya Jones. According to the IR, Staff Jones returned to Welch Home I AFC at approximately 6:30pm-7pm on 12/10/23 because she forgot her phone charger. When she got inside, she heard Resident A on the phone with his sister, stating that he was intoxicated. When Resident A got off the phone, Staff Jones asked him if he had consumed alcohol and he said yes. Staff Jones asked him where Resident A got the alcohol, and Resident A told Staff Jones that Staff Michael Owens and Michri Owens had bought him "three big things" of alcohol. Resident A told Staff Jones that both Staff Owens' have purchased and provided him with alcohol on numerous occasions "so I don't run off." Staff Jones asked Resident A to go to the hospital for an exam, but he refused. Staff Jones asked if she could have EMS come to the home to assess him and he refused. Staff Jones contacted management, Resident A's guardian, recipient rights, Adult Protective Services and AFC Licensing. Staff Jones was instructed to suspend both Michael Owens and Michri Owens pending this investigation which she did. The corrective measures taken were, "We will continue to closely observe him. We will continue to ensure his health and safety. We will also continue enhanced 2:1 staffing. We will continue to encourage him not to consume alcohol especially with medications."

On 01/04/24, I conducted an unannounced onsite inspection of Welch Home I AFC. I interacted with Resident A and Resident C, interviewed Resident B, and interviewed staff Georgia Young, Keondre Betts, and Rayshawn Williams. Resident A was taking a nap in his room when I conducted my onsite inspection. I attempted to interview him but at first, Resident A would not wake up and when Resident A did wake up, I was unable to understand what Resident A was saying.

According to staff Georgia Young, she has worked at this facility for several years. Staff Young said that she is aware of the incident that took place between Resident A and staff Michael Owens and Michri Owens but said that she was not working that day. Staff Young said that she has worked with both staff, and she did not have any concerns

about their interaction with the residents. Staff Young said that to her knowledge, both staff have been suspended and/or fired because of the incident.

Staff Keondre Betts said that he has been working at this facility for approximately one year and he has worked with both Owens, staff. Staff Betts said that none of the staff he has worked with has ever said or done anything inappropriate with the residents.

Staff Rayshawn Williams said that he has worked at this facility for over a year, and he has worked with both Owens staff. Staff Williams said that he worked 1st shift on 12/10/23 and although he worked with staff Michael Owens and staff Michri Owens, he left work at 4pm that day. When Staff Williams got to work on 12/11/23, he was told that both Staff Owens got Resident A drunk on 12/10/23. Staff Williams said that he was told that Resident A asked both Staff Owens to take him to the store and buy him alcohol, so they did.

Staff Young, Staff Betts, and Staff Williams said that Resident A has a history of alcohol use, and he often asks staff to take him to the store to buy alcohol or asks for alcohol. All three staff said that Resident A has a mental health condition, and he should not be drinking alcohol and said that they would never purchase alcohol for Resident A or allow Resident A to drink alcohol in the home without prompting him not to and notifying management.

Resident B told me that he has lived at this facility for approximately seven months. Resident B said that staff Michael Owens and Michri Owens did work at this facility until recently and said that “they were nice people.” I asked Resident B if he ever observed either staff say or do anything inappropriate with any of the residents and he said no. I asked Resident B if he ever witnessed any of the staff purchase alcohol for any of the residents and he said no. I asked Resident B if he ever witnessed Resident A drinking alcohol and he said no. Resident B said that Resident A “has a lot of problems” and he is always “causing trouble” but he has never witnessed staff say or do anything inappropriate to him.

I interacted with Resident C, but he had just moved into this facility, and he was never provided care by staff Michael Owens or Michri Owens.

On 01/17/24, I interviewed staff Michael Owens (Staff Owens 1) via telephone. Staff Owens 1 said that he began work at this facility in September 2023 and his employment was recently terminated. Staff Owens 1 confirmed that on 12/11/23, he and his brother, Michri Owens (Staff Owens 2) were working at the facility. He said that Resident A wanted to go to the store to buy a soda, so Staff Owens 1 took him to the store while Staff Owens 2 stayed at the facility with the other residents. Staff Owens 1 said that while at the store, in addition to purchasing a soda, Resident A also bought a small bottle of alcohol. I asked Staff Owens 1 if he purchased the alcohol for Resident A and he said no. I asked him if he tried to discourage Resident A from purchasing the alcohol and he said, “I tried to talk him out of it, but he bought it anyway.” Staff Owens 1 said that Resident A drank the alcohol before they got back to the facility and “that was it.”

Staff Owens 1 told me that when they got back to the facility, Resident A sat on the couch and watched television and said, “he was fine.”

I asked Staff Owens 1 if he ever bought or drank alcohol with any of the residents and he said no. I asked him if he ever drank alcohol while working and he said no. I asked him if he is aware of any of the other staff buying alcohol for the residents, drinking alcohol with the residents, or drinking alcohol while working and he said no.

On 01/22/24, I interviewed Resident A’s public guardian, Guardian A1, via telephone. Guardian A1 confirmed that Resident A resides at Welch Home I and he has for over a year. Guardian A1 said that Resident A has had a public guardian since 1993. He suffers from mental illness and has been in an inpatient psychiatric setting on several occasions. I reviewed the allegations with Guardian A1 and she said that she was told about this incident although she did not receive an Incident/Accident Report that she is aware of. She said that Resident A has a history of alcohol seeking behaviors and property destruction. According to Guardian A1, Resident A has been somewhat successful in this placement, but she receives numerous IRs about his aggression and destruction of property. Guardian A1 said that to her knowledge, Resident A’s case manager has authorized 2:1 staffing for Resident A, and they are attempting to secure another inpatient psychiatric placement for him.

On 01/23/24, I interviewed Relative A1 via telephone. I reviewed the allegations with her, and she said that she was not aware Resident A had made these allegations. I asked her if she recalls talking to Resident A on the phone on or around 12/11/23 and/or whether he ever told her he was intoxicated or was supplied alcohol by staff, and she said no. Relative A1 said that Resident A tends to exaggerate and lie about things to get attention, so she never knows if he is telling the truth or not. She said that she is aware that his CMH case manager and his guardian are trying to find a new placement for him but thus far, they have been unsuccessful.

I attempted to contact staff Michri Owens on several occasions but the phone number I have for him has been disconnected. As of 01/23/24, I have not been able to reach him for an interview.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(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.**
	According to an Incident/Accident Report (IR) dated 12/10/23 completed by staff Latonya Jones, she overheard Resident A talking to Relative A1 on the phone, stating that he was intoxicated. Staff Jones questioned Resident A who told her that staff Michael and Michri Owens gave him alcohol and he was intoxicated.

	Staff Georgia Young, Keondre Betts, and Rayshawn Williams said that they heard about this incident but said that they never witnessed staff give any of the residents alcohol and did not see any staff drinking alcohol while working. I attempted to interview Resident A but he was unwilling/unable to talk to me. Resident B said that he has never witnessed any of the staff provide any of the residents with alcohol and he has never seen any of the staff consume alcohol while working. Former staff Michael Owens said that on 12/10/23, Resident A purchased a small bottle of alcohol despite him discouraging Resident A from doing so. Staff Owens said that he never provided any of the residents with alcohol and never drank alcohol while working. As of 01/23/24, I have been unable to reach staff Michri Owens for an interview. Guardian A1 said that she was told about this incident, but she does not know if staff provided Resident A with alcohol. Relative A1 said that Resident A never told her that he was intoxicated or that staff provided him with alcohol. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of my investigation, I reviewed Resident A's Assessment Plan dated 06/27/22. Resident A was admitted to Welch Home I on 06/10/22. Assessment plans must be completed at least annually or more often if necessary.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	During the course of my investigation, I reviewed Resident A's Assessment Plan dated 06/27/22. Resident A was admitted to Welch Home I on 06/10/22. Assessment plans must be completed at least annually or more often if necessary. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

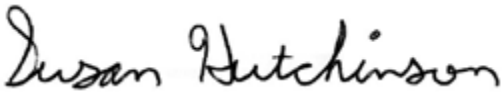
INVESTIGATION: During my investigation, I conducted an unannounced onsite inspection of Welch Home I on 01/04/24. I observed Resident A who was lying in bed. He was laying on a dirty mattress with no sheets and had a pillow with no pillowcase.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	During my investigation, I conducted an unannounced onsite inspection of Welch Home I on 01/04/24. I observed Resident A who was lying in bed. He was laying on a dirty mattress with no sheets and had a pillow with no pillowcase. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/23/24, I conducted an exit conference with the licensee designee, Kehinde Ogundipe. I explained the results of my investigation and which rule violations I am substantiating. I asked him to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

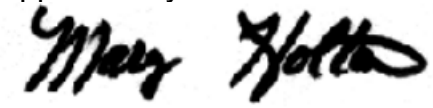
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



January 23, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



January 23, 2024

Mary E. Holton Area Manager	Date