GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2024

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

RE: License #: AS250402729
Investigation #: 2024A0779028
Welch Home I

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. 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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250402729
Investigation #:	2024A0779028
Complaint Receipt Date:	03/19/2024
Investigation Initiation Date:	03/21/2024
Report Due Date:	05/18/2024
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?
Staff is not providing Resident A with his required nebulizer or oxygen.	No
Additional Findings	Yes

III. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A0779028
03/19/2024	APS Referral Complaint was received from APS centralized intake.
03/21/2024	Special Investigation Initiated - On Site
03/21/2024	Contact - Telephone call made Spoke to nurse practitioner.
03/21/2024	Contact - Telephone call made Interview conducted with staff person, Martez Turner.
04/03/2024	Exit Conference Held with licensee designee, Kehinde Ogundipe.

ALLEGATION:

Staff is not providing Resident A with his required nebulizer or oxygen.

INVESTIGATION:

On 3/21/24, an on-site inspection was conducted and Resident A was interviewed. Resident A confirmed that he does sometimes have a harder time breathing, mostly at night. Resident A stated that his nurse practitioner told him that his Albuterol, which is given through a nebulizer, is supposed to be 3x daily as needed. Resident A acknowledged that he understands that he has to ask for the medication when he feels he needs it. Resident A claims that he has asked for it a few times but that staff has never given it to him. Resident A could not say how many times he has asked for his Albuterol or when the last time was that he had asked for it. Resident A stated that he has not had any significant incident/episode related to not being able to breath, since he has lived at this home. When asked if he is prescribed oxygen, Resident A stated that he used to use oxygen a long time ago, but not since he has been at this home. Resident A stated that he gets all his other medications.

On 3/21/24, home manager, Anthon Lewis, stated that Resident A is not prescribed oxygen. Manager Lewis stated that nurse practitioner, Lisa Lindsay, told both staff and Resident A that the Albuterol was an “as needed” medication and that Resident A had to ask it for it. Manager Lewis stated that there is one primary med passer on 1st shift and one on 2nd shift that handle the medication administration for the week and they are saying that Resident A has never asked to receive his Albuterol. Manager Lewis reported that the home has had the Albuterol medication and the nebulizer machine in the home for Resident A since it was prescribed in February 2024.

During the on-site inspection on 3/21/24, an interview was conducted with staff person, Rashawn Williams, who confirmed that he is the primary med passer all week during 1st shift. Staff Williams stated that Resident A has never asked for his Albuterol or to use his nebulizer; therefore, he has never given Resident A Albuterol. Staff Williams stated that he would definitely give Resident A that medication if Resident A asked for it or if he ever saw Resident A having trouble breathing.

On 3/21/24, a phone interview was conducted with staff person, Martez Turner, who confirmed that he is the primary med passer 5-6 nights a week for 2nd shift. Staff Turner claims that Resident A has never asked him for his Albuterol and/or to use his nebulizer. Staff Turner stated that he has never given Resident A his Albuterol. Staff Turner stated that he would have no reason not to give Resident A his Albuterol if he asked for it.

A review of Resident A’s Medication Administration Record (MAR) confirmed that Resident A has been prescribed Albuterol Sulfate 0.083%. The prescription is written as “use one vial via nebulizer machine 3x a day as needed.” It was confirmed that the home had filled a 1-month supply of Albuterol for Resident A on 2/14/24 and then another 3-month supply on 3/12/24. The entire 4-month supply was present in the home on 3/21/24.

On 3/21/24, a phone conversation took place with nurse practitioner (NP), Lisa Lindsay, who confirmed that she had prescribed Albuterol for Resident A. NP Lindsay stated that the medication is prescribed to be taken up to 3x daily on an “as needed” basis, because every time she examines Resident A, his lungs appear to be perfectly clear. NP Lindsay stated that she has recently made it clear to Resident A that he will not be given the Albuterol unless he feels he needs it and that he has to ask staff for it. NP Lindsay stated that she is not aware of any time when Resident A has asked for this medication and the staff have refused to give it to him.

APPLICABLE RULE	
R 400.14310	**Resident Health Care**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications**
ANALYSIS:	Resident A claims that he has asked to use his nebulizer (Albuterol medication) on a few occasions and that staff have never given it to him, but Resident A could not say how many times he has asked for his Albuterol or when the last time was that he had asked for it. Resident A stated that he has not had any significant incident/episode related to not being able to breath, since he has lived at this home. The two primary medication passers for this home have stated that Resident A has never asked to get the Albuterol and/or to use his nebulizer; therefore, they confirmed that they have never passed that medication to Resident A. The home was viewed to have a nebulizer machine and a full 4-month supply of the Albuterol medication in the home for Resident A. There was insufficient evidence found to prove that the licensee has failed to follow physician recommendations regarding having a nebulizer and Albuterol medication available for Resident A to use.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/21/24, a review of Resident A's Medication Administration Record (MAR) took place. The same prescription for Albuterol was listed and worded the same on two separate places on the MAR. On one of the listings, the two med passers for this home, Staff Williams, and Staff Turner, initialed on the MAR indicating that they had given the medication Albuterol to Resident A on multiple occasions in March 2024. The other listing had no staff initials on it. The entire 4-month supply of Albuterol was observed to be in the home.

On 3/21/24, both Staff Williams and Staff Turner stated that they have never given Resident A his Albuterol medication. Neither staff had an explanation as to why they initialed the MAR when not actually passing the medication.

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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Staff persons, Rashawn Williams, and Martez Turner have initialed the Medication Administration Record (MAR) indicating that they had given the medication Albuterol to Resident A on multiple occasions in March 2024. Staff Williams and Staff Turner stated that they have never given Resident A his Albuterol medication. The full 4-month supply of the Albuterol medication was observed to be present in the home. Staff Williams and Staff Turner failed to accurately document the administration of Resident A's medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/3/24, an exit conference was held with licensee designee, Kehinde Ogundipe. Kehinde Ogundipe was informed of the outcome of this investigation and that a corrective action plan is required.

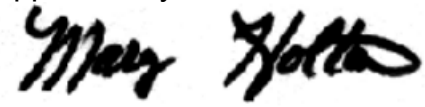
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

4/3/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



4/3/2024

Mary E. Holton Date
Area Manager