GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2024

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

RE: License #: AS330410066
Investigation #: 2024A0790014
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
"THIS REPORT CONTAINS QUOTED PROFANITY"

I. IDENTIFYING INFORMATION

License #:	AS330410066
Investigation #:	2024A0790014
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:	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?
Direct care staff member (DCSM) Malaysha Love smoked marijuana with Resident A at her home while on an outing.	Yes
A DCSM is providing Resident A with THC pens and cigarettes.	No
On 03/21/2024 Resident A was locked out of the facility for an undetermined amount of time.	Yes
There is no house phone, and it is impossible to reach Resident B. Resident B's medical insurance company and several medical professionals are unable to reach Resident B as needed.	No
There is no vehicle available to transport residents to medical or other appointments and activities.	Yes

III. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A0790014
03/21/2024	Special Investigation Initiated - On Site- Interviewed Resident A, direct care staff members (DCSMs) Bertha Cager, and Briena Moore.
03/21/2024	Inspection Completed On-site
03/21/2024	APS Referral not necessary because this is a denied APS complaint.
03/25/2024	Contact - Face to Face- Interviewed DCSM Alexianna Cain and Resident A.
03/28/2024	Contact - Telephone call made. Interviewed Guardian B1.
03/28/2024	Contact - Telephone call made. Interviewed DCSM Ashanti Wright who functions as the regional manager for Eden Prairie Residential Care, LLC.
03/28/2024	Contact - Document Received. Ms. Wright emailed receipt for the new landline phone for the facility.
03/28/2024	Contact – Telephone call made. Interviewed Guardian B1.
03/28/2024	Contact - Document Received- Guardian B1 provided requested information via email.
04/09/2024	Contact - Face to Face- Interviewed DCSM Teria Young and Resident B.

04/09/2024	Contact - Telephone call received. Interviewed DCSM Falisha VanHorn who functions as the home manager.
04/11/2024	Inspection Completed-BCAL Sub. Compliance
04/11/2024	Exit Conference / Interview with licensee designee Kehinde Ogundipe.
04/11/2024	Corrective Action Plan Requested and Due on 04/25/2024.

ALLEGATION: Direct care staff member Malaysha Love smoked marijuana with Resident A at her home while on an outing.

INVESTIGATION:

I reviewed a denied Adult Protective Services (APS) referral dated 03/18/2024. The referral stated Resident A resides at Bell Oaks at Ionia. The referral indicated Resident A has been diagnosed with attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), disruptive mood dysregulation disorder (DMDD), Autism, bipolar, and substance abuse treatment. The referral indicated Resident A has a guardian and receives services through Easter Seals.

The referral stated approximately two weeks ago, Resident A was taken out of the facility to run errands with a direct care staff member (DCSM) named Malaysha Love. While running the errands, the two of them allegedly visited Ms. Love's home and got "high" together. It is unknown what substances were used. Ms. Love has not returned to work since the alleged incident and an internal investigation is being conducted. The referral indicated during the alleged incident, Resident A lost his glasses and has since been unable to locate them.

I conducted an unannounced onsite investigation on 03/21/2024 and interviewed Resident A. Resident A admitted he went on an outing with direct care staff member (DCSM) Malaysha Love to run some errands approximately two weeks ago. Resident A said during the outing, Ms. Love stopped at her home and he and Ms. Love smoked marijuana together and they both “got high”. Resident A said he last saw Ms. Love at the facility a couple of days ago. He stated he believes Ms. Love is still working at the facility. Resident A stated he has not smoked marijuana with Ms. Love or any other DCSM since smoking marijuana with Ms. Love while on the outing a couple of weeks ago. Resident A said he told his mother and DCSM Falisha VanHorn who functions as the home manager about smoking marijuana with Ms. Love while on the outing two weeks ago.

I interviewed DCSM Bertha Cager. Ms. Cager stated she was unaware and has no knowledge of the incident involving Resident A smoking marijuana with DCSM Malaysha Love while at Ms. Love's home when on an outing a couple of weeks ago. Ms. Cager said Ms. Love has been terminated and is no longer working at the facility.

I interviewed DCSM Briena Moore. Ms. Moore said she does not know DCSM Malaysha Love and was unaware of the incident involving Resident A smoking marijuana with Ms. Love at Ms. Love's home while on an outing a couple of weeks ago.

I reviewed an Eden Prairie *Contract Change Record* dated 03/21/2024. The record indicated DCSM Malaysha Love took Resident A on an outing and smoked marijuana with him resulting in Ms. Love's immediate termination.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSMs Ms. Cager, and Ms. Moore there was sufficient evidence found indicating DCSM Malaysha Love smoked marijuana with Resident A at her home while on an outing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: A direct care staff member is providing Resident A with THC vape pens and cigarettes.

INVESTIGATION:

The APS referral dated 03/18/2024 additionally indicated someone is providing Resident A with THC vape pens and cigarettes despite him being underage. It is unknown if this person is a DCSM or a resident. The referral indicated DCSMs are aware of Resident A's substance use but do not intervene to "keep the peace."

I reviewed a denied APS referral dated 03/21/2024. The referral indicated Resident A is getting cigarettes from another resident at the facility.

Resident A stated no DCSMs or residents are supplying him with THC vape pens. He said he gets his THC vape pens on his own from an individual who does not live or work

at the facility. Resident A stated he is not going to provide the identity of his source. He said he does not feel it is a big deal. Resident A stated he is attempting to get his medical marijuana card because marijuana helps him sleep, with his depression, anxiety, and attention deficit hyperactivity disorder (ADHD).

Resident A again refused to disclose who is supplying him with THC vape pens. He assured me no one from the facility is supplying him with vape pens. Resident A specifically stated no DCSMs, or residents have supplied him with vape pens. Resident A said he will be 21 years old soon and plans to continue to smoke both THC and tobacco vape pens and cigarettes.

DCSM Ms. Cager said she just found out Resident A smokes marijuana. She stated she heard from other DCSMs Resident A has been witnessed smoking marijuana while at a previous Eden Prairie Residential Care, LLC facility. Ms. Cager said she has never witnessed Resident A smoking marijuana. Ms. Cager stated she is unaware and has no knowledge of DCSMs supplying Resident A with THC vape pens or cigarettes.

DCSM Ms. Moore stated she was aware Resident A smokes marijuana because she has witnessed him smoking marijuana while residing at a previous Eden Prairie Residential Care, LLC facility. She said when it was discovered Resident A was using a marijuana vaporizer, the vape pen was confiscated. Ms. Moore stated she is unaware and has no knowledge of DCSMs supplying Resident A with THC vape pens or cigarettes.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSM Ms. Cager, and Ms. Moore there was insufficient evidence found indicating a DCSM is providing Resident A with THC vape pens and/or cigarettes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 03/21/2024 Resident A was locked out of the facility for an undetermined amount of time.

INVESTIGATION:

The APS referral dated 03/21/2024 alleged on 03/21/2024 Brandon was outside smoking after 10:00 p.m. which is after curfew. Direct care staff members (DCSMs) told Resident A he should not be outside. The referral stated DCSMs then locked Resident A out of the facility for an unknown amount of time. According to the referral, Resident A was eventually allowed back inside the facility, began yelling, and slammed the refrigerator door. The referral said DCSMs then called law enforcement (LE) twice on 03/21/2024 because of Resident A's behaviors.

I interviewed Resident A at the facility on 03/25/2024. Resident A stated on 03/21/2024 he was locked out of the facility for an undetermined amount of time and was about to kick down the door. He said DCSM Robert Cain and DCSM Alexianna Cain locked him out. Resident A said he was out past curfew and was smoking a nicotine vape pen on the porch. Resident A stated he is unaware why Mr. Cain and Ms. Cain locked him out of the facility. Resident A said Mr. Cain told Resident A, "You either need to stay inside or stay outside." He stated he refused to come back inside because he was in the middle of smoking his vape pen. Resident A said this is when Mr. Cain and Ms. Cain locked the door. Resident A admitted he was angry after being redirected for going out after curfew and smoking his vape pen. He stated he slammed the refrigerator door hard enough to break it after DCSMs let back into the facility. Resident A said police were called after he became aggressive and slammed the refrigerator door. Resident A stated he is going to continue to go outside after curfew and smoke his vape pen. Resident A stated he has subsequently worked things out with the DCSMs. He said he feels the DCSMs are "being dicks" about the whole thing.

I interviewed DCSM Alexianna Cain. Ms. Cain said she was working second shift on 03/21/2024. She stated Resident A knows he is not supposed to go outside after curfew. Ms. Cain said Resident A went outside after curfew anyway on 03/21/2024 and was smoking a nicotine vape pen. Ms. Cain stated Resident A became angry when told he knew he was not to be outside after curfew. She said Resident A was acting angry and aggressive, so DCSMs locked the front door to allow Resident A time to calm down. Ms. Cain said Resident A was allowed back inside a few minutes later. She stated Resident A was still enraged and aggressive and slammed the refrigerator door hard enough to break it.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(g) Refuse the resident entrance to the home.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A and DCSM Ms. Cain there was sufficient evidence found indicating on 03/21/2024 Resident A was locked out of the facility for an undetermined amount of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There is no house phone, and it is impossible to reach Resident B. Resident B's medical insurance company and several medical professionals are unable to reach Resident B as needed.

INVESTIGATION:

I reviewed a Bureau of Community and Health Systems Online Complaint dated 03/25/2024. The complaint alleged there is no landline at the facility and residents cannot be reached unless a DCSM allows a resident to use their personal cell phone.

The complaint stated the facility is allegedly being closed in 05/2024 and no one is communicating with the residents' family members or guardians. I interviewed Guardian B1 via phone on 03/28/2024. Guardian B1 said she is unable to reach Resident B because there is no house phone available and DCSMs must use their own cell phones to receive or make calls for residents at the facility. Guardian B1 stated Aetna Care Management Team has been attempting to get in touch with Resident B to assist with his healthcare and have not been able to reach Resident B. Guardian B1 said Resident B was supposed to follow up with Sparrow Hospital after he was discharged regarding heart monitoring. She stated as far as she is aware DCSMs have not followed up on this. Guardian B1 stated Resident B had not received his monthly injection for his mental illness. Guardian B1 said as of today she was informed by DCSM Ashanti Wright scheduled an appointment was scheduled for 04/01/2024 at 2:15 p.m.

I interviewed DCSM Ashanti Wright who functions as the regional manager for Eden Prairie Residential Care, LLC via phone on 03/28/2024. Ms. Wright stated she does have to replace the landline phone at the facility because a resident broke the old one. Ms. Wright emailed me a receipt for a new landline phone she purchased for the facility after our phone interview. Ms. Wright said she scheduled Resident B's monthly injection for his mental illness on 04/01/2024. She stated she will contact Guardian B1 and inform her the appointment has been scheduled. Ms. Wright stated she would also ensure Resident B is able to access the new landline phone to contact Aetna Care Management Team and follow up with Sparrow Hospital regarding the heart monitoring.

I interviewed direct care staff member (DCSM) Teria Young at the facility on 04/09/2024. Ms. Young said DCSM Ashanti Wright who functions as the regional manager recently purchased a new house phone. Ms. Young explained a resident had broken the previous one. She stated DCSM Falisha VanHorn who is the home manager has not been able to get the house phone to work yet.

I interviewed DCSM Falisha VanHorn via phone on 04/09/2024. Ms. VanHorn said she has yet to figure out how to get the house phone to work but she and the other DCSMs allow the residents to use their cell phones to make and receive phone calls as needed. She stated she gives her cell phone number to all the residents, the residents' designated representatives, case managers, and providers so residents can make and receive calls as needed. Ms. VanHorn said she will ensure the house phone is working as soon as possible.

Ms. VanHorn stated Resident B received his monthly injection for his mental illness last Monday 04/01/2024. She said Resident B has been able to contact the AETNA Care Management Team.

Ms. VanHorn said Resident B has been experiencing low blood pressure and has blood clots in his legs. She said Resident B was supposed to get a 14-day heart monitor since he was discharged from Sparrow Hospital weeks ago, but she has not been able to schedule it because they did not have access to a company car for a period. Ms. VanHorn stated she will get an appointment scheduled with Sparrow Hospital tomorrow to get the 14-day heart monitor for Resident B. Ms. VanHorn said she will give Guardian B1 her cell phone number so Guardian B1 can reach Resident B.

I interviewed Resident B on 04/10/2024. Resident B said things have been going well at the facility. Resident B stated he has been getting to his medical appointments and received his monthly injection for his mental illness last week. Resident B stated he spoke to Guardian B1 yesterday. Resident B stated he can contact anyone he needs or wants to at any time via phone. He said DCSMs are always willing to let him use their cell phones when he needs to call someone.

I spoke with DCSM Ms. VanHorn via phone on 04/11/2024. Ms. VanHorn said Resident B has been scheduled to receive a 14-day heart monitor on 05/01/2024 at 3:30 p.m. She stated a follow up visit has been scheduled on 06/24/2024 for Resident B to discuss the results of the data received from the 14-day hear monitor.

I reviewed Resident B's *Resident Records* and found no physician's orders stating when the 14-day heart monitor was supposed to begin or when Resident B's monthly mental health injection was supposed to be completed.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Guardian B1, DCSMs Ms. Wright, Ms. Young, Ms. VanHorn, and Resident B there was insufficient evidence found indicating Resident B does not have reasonable access to a telephone for private communications. The facility had a house phone until a resident recently broke it. The house phone has subsequently been replaced and DCSMs are attempting to figure out how to get it to work. Resident B has been able to contact Guardian B1 and the providers mentioned in this special investigation. He said he can contact anyone he needs or wants to at any time via phone.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is no company vehicle available to transport residents to medical or other appointments and activities.

INVESTIGATION:

The Bureau of Community and Health Systems Online Complaint stated there is no company vehicle available to transport residents to medical and other appointments and activities.

Guardian B1 said there is currently no company vehicle available to transport residents to medical or other appointments and activities.

Ms. Wright said the company vehicle used to transport residents at the facility has had some mechanical failures recently and is currently at a garage being fixed by a licensed mechanic. Ms. Wright stated historically residents at the facility have had a company vehicle available to transport them to medical and other appointments and on outings. She said the vehicle used to transport the residents has only been undrivable for approximately one week.

Ms. Young said DCSMs have access to a company vehicle to use for transporting residents to doctor's appointments, other appointments, and on outings.

Ms. VanHorn said DCSMs have access to a company vehicle to use for transporting residents to doctor's appointments, medical and other appointments, and on outings.

Resident B said he and the other residents go on outings. Resident B stated they sometimes just drive around. He said he likes getting out and just driving around.

I reviewed Resident A's *Resident Care Agreement* which stated the following regarding transportation provided: "Transportation within the county. Transportation will only be provided based on staffing and home availability. We will not transport outside the county of residence."

I reviewed Resident B's *Resident Care Agreement* which stated the following regarding transportation provided: "Basic transportation will be provided inside the county of residence. Any transportation outside the county will be limited to medical necessity and/or doctor's appointments."

I conducted an exit conference with licensee designee Kehinde Ogundipe. I informed Mr. Ogundipe there were rule violations established because of this special investigation and a Corrective Action Plan (CAP) is requested within the required timeframe.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.

ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Guardian B1, DCSMs Ms. Wright, Ms. Young, Ms. VanHorn, and Resident B, per Resident A and Resident B's *Resident Care Agreements* transportation within the county of residence and to medical appointments was to be provided by the licensee. At the time of the investigation, the transportation vehicle was not available to transport residents and there was no other plan in place to assure residents had available transportation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/11/2024

_____

Rodney Gill Date
Licensing Consultant

Approved By:

04/17/2024

_____

Dawn N. Timm Date
Area Manager