GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 4, 2024

Kehinde Ogundipe
Eden Prairie Residential Care, LLC
325
405 W Greenlawn
Lansing, MI 48910

RE: License #: AS250402729
Investigation #: 2024A0779052
Welch Home I

Dear Ken Ogundipe:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 A. Holvey

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 #:	2024A0779052
Complaint Receipt Date:	08/19/2024
Investigation Initiation Date:	08/19/2024
Report Due Date:	10/18/2024
Licensee Name:	Eden Prairie Residential Care, LLC
Licensee Address:	325 405 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:	02/24/2024
Expiration Date:	02/23/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
This home had the water shut off on Wednesday, 8/14/24 and is still without running water.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2024	Special Investigation Intake 2024A0779052
08/19/2024	APS Referral Complaint was received from APS.
08/19/2024	Special Investigation Initiated - Telephone Spoke to APS worker.
08/19/2024	Contact - Telephone call made Interview conducted with home manager, Jessica Ortiz.
08/19/2024	Contact - Telephone call made Spoke with licensee designee, Kehinde Ogundipe.
08/20/2024	Contact - Telephone call made Spoke to recipient rights investigator.
08/20/2024	Contact - Telephone call received Spoke to APS worker.
08/20/2024	Contact - Telephone call made Spoke to staff person, Damise Young.
08/21/2024	Contact - Telephone call received Spoke to APS worker.
08/21/2024	Contact - Document Sent Email sent to City of Flint Water Dept.
08/21/2024	Contact – Telephone call made Called Flint City Water Dept. but no voicemail was set up.
08/22/2024	Contact – Telephone call made Called Flint City Water Dept. but no voicemail was set up.

08/22/2024	Inspection Completed On-site
08/23/2024	Contact – Telephone call made Called Flint City Water Dept. but no voicemail was set up.
08/23/2024	Contact - Telephone call made Spoke with home manager, Jessica Ortiz.
08/23/2024	Contact - Telephone call made Spoke to recipient rights investigator.
08/23/2024	Contact - Telephone call made Phone interview conducted with staff person, Devante Johnson.
08/23/2024	Contact – Telephone call made Two attempts to reach staff person, Richard Parker. Could not be completed as dialed.
08/26/2024	Contact - Telephone call received Spoke to APS worker.
08/27/2024	Contact - Telephone call made Spoke to recipient rights investigator.
08/28/2024	Contact - Document Sent Email sent to City of Flint of Water Dept.
08/28/2024	Contact - Telephone call made Spoke to home manager, Jessica Ortiz.
09/24/2024	Contact - Telephone call made Spoke to APS worker.
09/26/2024	Contact – Telephone call made Spoke to resident's legal guardian.
09/30/2024	Exit conference Held with licensee designee, Kehinde Ogundipe

ALLEGATION:

This home had the water shut off on Wednesday, August 14, 2024, and is still without running water.

INVESTIGATION:

On August 19, 2024, a phone conversation took place with APS (Adult Protective Services) worker, Kyle Whitman, who confirmed that he was investigating the same allegations. APS Whitman stated that he was at this home on August 16, 2024, and confirmed that the water to the home was shut off. APS Whitman stated that the home manager, Jessica Ortiz, and the residents said that the water was shut off on August 14, 2024. APS Whitman reported that the residents told him that they had not showered in two days, but he had observed that the home had jugs of water and water bottles to drink. APS Whitman stated that Manager Ortiz told him that she had no idea how much the home's water bill is and that the plan was to take the residents to a hotel for the weekend. APS Whitman stated that he called and spoke to the licensee designee (LD), Kenhinde Ogundipe, and said LD Ogundipe had no idea that was happening. APS Whitman reported that he called the Flint City Water Dept., but that their computer system was recently hacked and they could not say when this home's water got shut off or how much their water bill is.

On August 19, 2024, a phone interview was conducted with home manager, Jessica Ortiz, who confirmed that the water to the home was shut off on August 14, 2024, that it was a surprise to her and that she had no idea why it was turned off. Manager Ortiz stated that she went to the City of Flint on August 14, 2024, and again on August 15, 2024, to check on the reason for the shut off, but their offices were closed. Manager Ortiz reported that she has not seen a water bill for this home since she started as the home manager in July 2024 and that she does not know how much is owed. Manager Ortiz stated that the water may have been shut off because a resident kicked the outside spicket off the house and water was running everywhere, but that she was the present when that happened. Manager Ortiz stated that she left for a vacation on August 15, 2024, but had taken several jugs of water and water bottles to the home before she left for the weekend. Manager Ortiz stated that a plumber is at the home today fixing the spicket.

On August 19, 2024, a second phone conversation took place with APS Whitman, who stated that he went back to the home today and that two of the residents were there. APS Whitman stated that one of the residents told him that not all the residents went to the hotel and some of them stayed at the home over the weekend.

On August 19, 2024, a phone interview was conducted with licensee designee (LD), Kehinde Ogundipe, who stated that he was told the water was shut off because a resident broke the outside water spicket, that the spicket was being repaired today, and that he would be going to the City of Flint and try and resolve this issue. LD Ogundipe stated that he authorized for payment of three hotel rooms and was told that all six residents went to a hotel for the weekend. When questioned further on how many of the residents actually went to the hotel, LD Ogundipe changed his story to say that three of the residents had eloped and did not go to the hotel. LD Ogundipe did not appear to have any further detailed information as to what took place with the water or

with the residents over that weekend. LD Ogundipe stated that he would do everything he could to get the water turned back on that day.

On August 20, 2024, a phone conversation took place with recipient rights investigator, Michele McCormick, who stated that all six residents at this home are provided services through Oakland County Health Network (OCHN) and that she was investigating the same allegations. Investigator McCormick stated that she had spoken to an employee of this company, Eden Prairie Residential Care Inc., Damise Young, who told her that she was a home manager for another home that Eden Prairie owns and that she helped out at this home over weekend. Investigator McCormick reported that Staff Young told her that she walked into this situation at this home on August 16, 2024, that she had called LD Ogundipe, and that LD Ogundipe asked her to get hotel rooms for the residents for the weekend. Investigator McCormick stated that Staff Young claimed that she cleaned the home, cooked food for the residents and took it to them at the hotel, took residents clothes to a laundry mat, and made sure staff were scheduled to provide care at the hotel. Investigator McCormick stated that OCHN had no idea any of this was happening until AFC licensing reported it to them on August 19, 2024.

On August 20, 2024, a phone interview was conducted with staff person, Damise Young, who stated that she does not work at this home or know any of the residents, but she does work for Eden Prairie and that she walked into the situation with this home not having any water on August 16, 2024. Staff Young stated that she contacted LD Ogundipe several times that day about this situation and was told to get three hotel rooms, with two beds each, for the residents for the weekend. When asked if all the residents went to the hotel, Staff Young stated that only four residents went to the hotel on the morning of August 17, 2024, because when she called the hotel on August 16, 2024, the hotel did not have enough rooms available. Staff Young reported that Resident D refused to go to the hotel, so she arranged staff to stay at the home with Resident D for the weekend. Staff Young stated that Resident B eloped from the home the morning of August 17, 2024, before going to the hotel, and did not return to the home until August 19, 2024. Staff Young reported that Resident E initially went to the hotel, but then eloped from the hotel sometime on August 17, 2024. Staff Young did not have any further detailed information regarding Resident B and Resident E's elopements. Staff Young stated that, other than the elopements, the other residents were well cared for over the weekend.

On August 21, 2024, APS Whitman called to report that he had spoken to the Flint City Water Manager and was informed that the water to the home was shut off due to non-payment of the water bill. APS Whitman stated that the water manager told him that the shut off notice for this home was generated on the night of August 13, 2024, and they went and shut the water off to this home on August 14, 2024. APS Whitman reported that the water manager told him that someone went to the city and made a payment on August 19, 2024, and that they turned the water back on to this home later that same day. The water manager also told APS Whitman that the water dept. never received any call from this home regarding a broken spicket at this home's address.

Two separate emails were sent to the Flint City Water Manager, one on August 21, 2024, and a second on August 28, 2024. No response has been received. Several phone calls were also made to the Flint City Water Dept., but the phone just ran continuously with no way to leave a voicemail message.

On August 22, 2024, an onsite inspection was conducted and five residents were observed to be doing okay. Resident G stated that he stayed the weekend at the hotel and that staff were there with him the entire time. Resident D stated that he did not want to go to the hotel, so they let him stay back at the home. Resident A stated that one staff was with him at all times at the home over the weekend.

On August 22, 2024, staff person, T'omel Bridges, stated that he worked shifts at the home on August 17, 2024, and August 18, 2024. Staff Bridges stated that during his shifts, he was responsible for supervising Resident D, who was the only resident in the home on those days.

On August 22, 2024, staff person, Masen Ford, stated that he was one of the staff who worked at the hotel on August 17, 2024, and August 18, 2024. Staff Ford stated that he was assigned to supervise Resident F and that there was one staff assigned to each of the three hotel rooms for the entire weekend.

On August 23, 2024, a phone call was made to Manager Ortiz to get clarifying information about the water being turned back on August 19, 2024. Manager Ortiz stated that she took a water bill to the City of Flint and made a payment. Manager Ortiz reported that the city's computer system was still down and they could not see how much was owed, so they suggested making a $300.00 payment. Manager Ortiz stated that LD Ogundipe authorized her making the $300.00 payment and the water was turned back on later that day. Manager Ortiz did confirm that the water bill she took to the city on August 19, 2024, showed that the home owed $1994.87.

On August 23, 2024, an email was received from Manager Ortiz that contained two separate water bills for this home's address, 913 Welch Blvd, Flint, MI. 48504. The water bill with a due date of 7/30/24, indicated that the amount owed was $1994.87. The water bill with a due date of August 30, 2024, indicated that the amount owed was $2,134.82.

Special investigation #2024A0779005 dated December 7, 2023, cited a violation of R 400.14201 (2) when it was found that direct care staff at this home were being treated as salary and not hourly and not being paid for overtime hours earned. An investigation done by the Dept. of Labor found that the licensee, Eden Prairie Residential Care Inc., had to pay employee's $1.8 million in back pay. On December 19, 2023, a corrective action plan (CAP) was submitted and signed by licensee designee, Kehinde Ogundipe, stating that Eden Prairie Residential Care Inc. had reached an agreement with the Dept. of Labor to pay employees back over a 3-year period.

Special investigation #2023A0872007 dated December 15, 2022, cited a violation of R 400.14305 (3) when it was found that staff were being inappropriate with residents by taking videos of themselves teasing and making residents feel uncomfortable. On December 17, 2022, a CAP was submitted and signed by licensee designee, Kehinde Ogundipe, stating that one staff person was terminated and all staff were provided Gentle Teaching and HIPPA Privacy training.

On September 30, 2024, an exit conference was held with licensee designee (LD), Kehinde Ogundipe. LD Ogundipe initially stated that the residents only stayed in the home for one day while the water was shut off and then had no response when confronted with the fact there was proof that the residents remained in the home for several days with no running water. When told that evidence was found to prove that the water was shut off due to nonpayment, LD Ogundipe's only response was to say "Okay".

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:	It was confirmed that the City of Flint Water Dept. turned the water off to this home, address of 913 Welch Blvd, Flint, MI. 48504, on Wednesday August 14, 2024, due to non-payment. A water bill shows that as of August 14, 2024, this home/address owed a total of $1994.87. A water bill with a due date of August 30, 2024, shows that the home owed a total of $2,134.82. Sufficient evidence was found to warrant the citing of this rule indicating that licensee, Eden Prairie Residential Care Inc., does not have the financial and administrative capability to operate this home to provide an adequate level of care to the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2024A0779005 Dated December 17, 2024.**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was confirmed that the water to this home was turned off on Wednesday August 14, 2024, and was not turned back on until Monday August 19, 2024. All six residents of this home were allowed to stay in this home several days without any running water, until the morning of Saturday August 17, 2024. Resident A was allowed to stay in this home during the entire five-day period that this home was without water. The residents of this home were not treated with dignity or provided adequate protection and safety when being made to stay in a home for several days without any running water.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0872007 dated December 15, 2022.**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	The licensee allowed residents to stay in this home without running water for a five-day period, August 14, 2024, to August 19, 2024. The licensee not providing residents hot and cold running water that is under pressure warrants citation of this licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On August 20, 2024, staff person Damise Young stated that Resident B eloped from the home the morning of August 17, 2024, and did not return to the home until August 19, 2024. Staff Young reported that Resident E initially went to the hotel, but then eloped from the hotel sometime on August 17, 2024. Staff Young did not have any further detailed information regarding Resident B and Resident E's elopements.

On August 21, 2024, APS worker, Kyle Whitman, stated that he was at this home on August 16, 2024, and observed Resident B to be sleeping in his room and that there was only one staff in the room with Resident B. APS Whitman stated that he was also at this home on August 19, 2024, and he again observed only one staff present supervising Resident B.

On August 22, 2024, Manager Ortiz, stated that they have not been providing 1:1 staffing for Resident D or Resident E, even though their Individual Plan of Service (IPOS) state they require it. Manager Ortiz stated that they are not getting paid to provide 1:1 staffing for those two residents so she was told by management not to schedule it. When asked specifically about Resident E, Manager Ortiz stated that Resident E has a drug addiction and will frequently leave the home in search of drugs. Manager Ortiz reported that staff will attempt to follow Resident E but they give up when Resident E gets verbally aggressive and/or goes into dangerous areas searching for drugs.

Resident A and Resident E's *Assessment Plan for AFC Residents* indicate that they are not able to move independently in the community. Resident E's IPOS was observed to require Resident E to receive 1:1 staffing, but the IPOS does not get more specific or describe what 1:1 staffing should entail.

Resident B's IPOS was observed to indicate that he requires 2:1 staffing, 24 hours a day. It states that staff providing the 2:1 should both keep Resident B within arm's length/eyesight.

The home provided a copy of *An AFC Licensing Division Incident/Accident Report* dated August 17, 2024, regarding Resident E eloping from the hotel room. The IR stated that Resident E eloped from the hotel room countless times. It stated that Resident E would leave for several hours and then come back and then leave again. The IR states that staff tried to redirect and encourage Resident E to stay in the hotel room, but Resident E would refuse. The corrective measures listed was for staff to continue to provide enhanced support, continue to encourage Resident E not to elope and try to get Resident E to consider going to rehab. The IR does not mention anywhere that staff attempted to contact law enforcement.

The home provided a copy of an IR regarding Resident B eloping from the home on August 17, 2024. The IR stated that staff were cleaning up a mess that Resident B had made in his room and Resident B snuck out of the home. It states that staff immediately searched the surrounding area but could not find Resident B, so they contacted 911 to report Resident B missing. The IR indicates that staff found Resident B walking down the street at 12:20am on August 19, 2024. The corrective measures listed were for staff to continue to provide enhanced support and to follow Resident B's IPOS.

On August 23, 2024, a phone conversation took place with recipient rights investigator from OCHN, Michele McCormick, who confirmed that as of July 2024, OCHN is not paying this home for 1:1 staffing for Resident D or Resident E, although both their

IPOS's state they still require it. Investigator McCormick stated that it appears that the case managers did not submit the proper request to continue enhanced staffing funds for these residents.

On August 23, 2024, a phone interview was conducted with staff person, Devante Johnson, who stated that he was one of the staff assigned to provide 2:1 staffing for Resident B during 3rd shift starting the night of August 16, 2024, going into the morning of August 17, 2024. Staff Johnson stated that everyone was cleaning the house and that he was in the living room with Resident B. Staff Johnson stated that he briefly left Resident B in the living room when he went into another room to get cleaning supplies. Staff Johnson reported that when he got back to the living room, Resident B was gone. When asked where the second staff was at that time, Staff Johnson claimed that he had no idea where that staff was and stated that he can't remember who that staff even was working with him that night. Staff Johnson confirmed that Resident B eloped at approximately 6:00am on August 17, 2024. Staff Johnson claimed that they went searching the neighborhood but couldn't find Resident B, so they called 911 to report Resident B as missing.

On August 23, 2024, two attempts to reach staff person, Richard Parker, by phone were unsuccessful. Staff Parker was the second staff assigned to provide 2:1 staffing for Resident B on August 17, 2024. When calling the phone number provided for Staff Parker, it states that the number cannot be completed as dialed. Manager Ortiz stated that is the only phone number the home has for him.

On August 26, 2024, a call was received from APS Whitman, who reported that he was notified that Resident E had eloped from the home on August 25, 2024. APS Whitman stated that police found Resident E walking down interstate I-75 in Oakland County, about 25-miles from the AFC home. APS Whitman reported that the police took Resident E to the hospital, but that Resident E left the hospital a short while after and is nowhere to be found. APS Whitman stated that the home waited to call the police and report Resident E as missing until today, August 26, 2024.

On August 27, 2024, a call was made to Investigator McCormick, who stated that she was aware of Resident E's elopement and had already spoken to a staff person, Masen Ford, about the incident. Investigator McCormick stated that Staff Ford claimed that he asked Resident E not to leave and attempted to follow Resident E but stopped when Resident E started screaming and cussing at him. Staff Ford told Investigator McCormick that he went back to the home and reported the situation to the Manager Ortiz.

On August 28, 2024, Manager Otiz confirmed that Resident E eloped from the home at approximately 11:30am on August 25, 2024. Manager Ortiz claims that the Flint police dept. will not take missing person reports until after 24-hours missing. Manager Ortiz stated that her first call to law enforcement regarding this elopement was to Flint Police on August 26, 2024, but they wouldn't take the report because Resident E was then in Oakland County, so she called Oakland County police, but they wouldn't take a report

either. Manager Ortiz claimed that Genesee County 911 finally gave her a phone number for a Flint City Sergeant, but that she was not able to ever get in touch with anyone. Manager Ortiz reported that she then received a call from a hospital in Royal Oak stating the Resident E had been there since 5:50pm on August 25, 2024.
On September 24,2024, APS Whitman stated that OCHN has moved all six residents of this home into other AFC homes. APS Whitman reported that Resident E went from the hospital to his new AFC home. APS Whitman stated that he has visited all six residents at their new homes and they appear to be doing fine.

On September 26, 2024, a phone conversation took place with Resident E's legal guardian, Guardian E1, who confirmed that Resident E went from the hospital to a new AFC home placement. Guardian E1 stated that Resident E was supposed to be receiving 1:1 staffing according to his IPOS and that she thought Welch Home I was providing that. Guardian E1 stated that Resident E was very clever with ways to elope from the home and would do it quite often. Guardian E1 reported that this home became very inconsistent with notifying her when Resident E would elope and would often not contact the police to report Resident E as missing. Guardian E1 stated that when Resident E eloped on August 25, 2024, it was Oakland County police who called her to tell her that they had taken him to a hospital and that this home did not contact her until the next day. When asked if she was aware of the water and hotel situation, Guardian E1 stated that it was her understanding that Resident E refused to go to the hotel and stated that she was not aware of Resident E's multiple elopements from the hotel.

The home provided a copy of an IR regarding Resident E's elopement from the home on August 25, 2024. The IR stated that Staff Ford tried to redirect Resident E not to leave and then tried to follow Resident E, but stopped following him when Resident E became hostile. The corrective measure listed was for staff to continue to encourage Resident E not to elope and encourage Resident E to seek rehab services. There was no mention on the IR that staff had contacted law enforcement.

Special investigation #2023A0779028 dated April 10, 2023, cited a violation of R 400.14303 (2) when it was found that Resident B was not being provided with his required 2:1 staffing per his CMH IPOS. On April 17, 2023, a CAP was submitted and signed by licensee designee, Kehinde Ogundipe, stating that the employment of the two staff persons involved was terminated.

Special investigation #2023A0872007 dated December 15, 2022, cited a violation of R 400.14303 (2). A resident missed his school bus and was allowed to walk several miles to school unsupervised. The resident was provided the required line-of-sight supervision in the community per his written assessment plan. On June 28, 2023, a CAP was submitted and signed by licensee designee, Kehinde Ogundipe, stating that staff were retrained on the resident's IPOS and that the resident would be provided line-of-sight supervision moving forward.

Special investigation #2023A0779065 dated October 27, 2023, cited a violation of R 400.14303 (2) when it was found that staff were not completing required documentation regarding personal care that was being provided to a resident per his IPOS (Individual Plan of Service) and Occupational Treatment Plan. On November 1, 2023, a CAP was submitted and signed by licensee designee, Kehinde Ogundipe, stating that the home manager of the home was given a written reprimand and that all the staff were retrained on the resident's IPOS and OT plan. The CAP also stated that required paperwork would be reviewed by management on a regular basis to ensure plans are being executed properly.

Special investigation #2024A0779011 dated January 17, 2024, cited a violation of R 400.14303 (2) when Resident B was found to not being provided his 2:1 staffing required per his CMH IPOS. This home did not have alarms placed on bedroom doors and bedroom windows as required by the resident's CMH IPOS. On January 29, 2024, a CAP was submitted and signed by licensee designee, Kehinde Ogundipe, stating that the employment of the home manager was terminated, that the administrator would monitor staffing to ensure IPOS requirements are met and that alarms would be installed in required areas.

On September 30, 2024, an exit conference was held with licensee designee, Kehinde Ogundipe. LD Ogundipe was informed of this investigation resulting in multiple licensing rule violations, many being repeat violations, and with the reasoning for each individual citation. LD Ogundipe's response to each violation was to say "Okay" and he did not provide anything further. LD Ogundipe was informed that due to the severity of the violations, disciplinary action against this license is being recommended. LD Ogundipe stated that there have not been any residents residing in this home for about two weeks and that he will be closing this home/license.

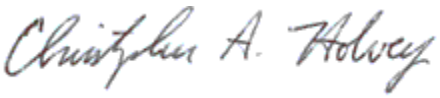
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Home manager, Jessica Ortiz, stated that the home has not provided 1:1 staffing for Resident D or Resident C since she started there in July 2024, even though their IPOS's state they require it. It was made clear that when Resident C elopes from the home, staff only make minimal effort to follow him. When Resident B eloped from the home on August 17, 2024, he was not being provided his 2:1 staffing that is required per his IPOS. Staff person, Devante Johnson, admits that he left the

	living room in which he was supervising Resident B and that when he returned to the living room, Resident B was gone.
	Staff Johnson stated that he had no idea where the second staff who was supposed to be assisting with providing the 2:1 staffing was at the time. There was a preponderance of evidence found to prove that this home was not providing residents with the supervision, protection and personal care as specified in their assessment plans and IPOS's.
CONCLUSION:	**REPEAT VIOLATIONS ESTABLISHED** **SIR #2023A0779028 dated April 10,2023.** **SIR #2023A0779043 dated June 21, 2023.** **SIR #2023A0779065 dated October 27, 2023.** **SIR #2024A0779011 dated January 17, 2024.**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.
ANALYSIS:	It was confirmed that Resident C eloped from this home at approximately 11:30am on August 25, 2024. Home manager Jessica Ortiz stated that her first call to law enforcement regarding Resident C's elopement was on August 26, 2024. Resident C's legal guardian, Guardian C1, reported that this home became very inconsistent with notifying her when Resident C would elope and would often not contact the police to report Resident C as missing. There was a preponderance of evidence found to prove that staff failed to report the elopement of Resident C within 30 minutes after the elopement occurred on August 25, 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

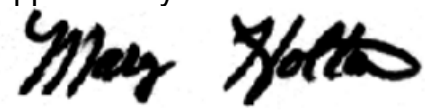
Due to the multiple repeat violations regarding resident protection and safety and lack of financial and administrative capabilities, revocation of this license is recommended.



9/30/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



10/04/2024

Mary E. Holton Date
Area Manager