



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 12, 2025

Stephen Forkpah
5896 Sable Ridge Drive SE
Kentwood, MI 49508

RE: License #: AS410415177
Investigation #: 2025A0579016
Kingdom Rest Center

Dear Stephen Forkpah:

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 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 (616) 356-0183.

Sincerely,

A handwritten signature in black ink that reads "Cassandra Duursma". The script is cursive and fluid.

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410415177
Investigation #:	2025A0579016
Complaint Receipt Date:	01/17/2025
Investigation Initiation:	01/17/2025
Report Due Date:	03/18/2025
Licensee Name:	Stephen Forkpah
Licensee Address:	5896 Sable Ridge Drive SE Kentwood, MI 49508
Licensee Telephone #:	(616) 323-4379
Administrator:	Gayflor Cooper
Licensee Designee:	Stephen Forkpah
Name of Facility:	Kingdom Rest Center
Facility Address:	7174 Martin Avenue SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 323-4379
Original Issuance Date:	12/22/2022
License Status:	REGULAR
Effective Date:	06/22/2023
Expiration Date:	06/21/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/AGED/ TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Guardian A was not properly notified when Resident A left the home and did not return.	Yes

III. METHODOLOGY

01/17/2025	Special Investigation Intake 2025A0579016
01/17/2025	Special Investigation Initiated - Letter Complainant
01/17/2025	APS Referral
01/30/2025	Contact- Document Received Additional Information
02/10/2025	Contact- Face to Face Judith Jackson, Direct Care Worker
02/10/2025	Contact- Telephone Call Received Stephen Forkpah, Licensee Designee
02/18/2025	Contact- Document Received Stephen Forkpah, Licensee Designee
03/10/2025	Contact- Document Sent Stephen Forkpah, Licensee Designee
03/11/2025	Exit Conference Stephen Forkpah, Licensee Designee

ALLEGATION: Guardian A was not properly notified when Resident A left the home and did not return.

INVESTIGATION: On 1/17/25, I received this referral which alleged Resident A left the home on 1/11/25 and had not returned by 1/15/25. Guardian A and Resident A's case management program were not made aware of this. Licensee Designee Stephen Forkpah reported on 1/15/25, he did not know that Resident A had not returned to the home, and he would try to contact Resident A to see when he was returning. Resident A misses work and his medications when not in the home.

On 1/17/25, I contacted the complainant to confirm receipt of the allegation.

On 1/30/25, I received an additional referral. It was reported Resident A was not reported as leaving the home for multiple days at a time and Resident A's support staff were not notified of this, and law enforcement was not contacted to confirm Resident A's whereabouts. Direct care workers (DCWs) and Mr. Forkpah did not make effort to contact Resident A to locate him or ensure his safety. Resident A has left for multiple days at a time on two occasions recently. He has missed work, a medication appointment, may be using substances, and is staying with an unsafe person when not in the home.

On 2/10/25, I completed an unannounced on-site investigation at the home. An in-person interview was completed with DCW Judith Jackson. Ms. Jackson called Mr. Forkpah while I was at the home, and he was interviewed via telephone. Ms. Jackson reported Resident A was at work today and not available for interviewing.

Ms. Jackson stated Resident A can move independently in the community and he independently goes to work. She stated his work schedule often changes so the days he is gone varies. She stated there is a home sign-in/sign-out sheet, but Resident A often does not use it and since he often works, DCWs do not enforce the use of it on days he goes to work, it is mostly used when he has visitors pick him up or he is going somewhere he does not usually go. She stated Resident A will also leave for work and then go elsewhere after work instead of returning to the home, which he often does on Thursdays, so he does not sign in or out.

Ms. Jackson stated recently (date unknown) Resident A left for work on Thursday and did not return by the time her shift ended at 7:00 p.m. that day. She stated she arrived to work on Friday and after not seeing Resident A all day Friday, she called Mr. Forkpah to report Resident A had not returned to the home. She stated Mr. Forkpah called Resident A. She stated Mr. Forkpah also called Resident A's guardian (Guardian A) and left a voicemail message but they did not receive a response. She stated Resident A was gone approximately four days. She stated they did not call law enforcement because it is a known behavior for Resident A to leave for days at a time and she knew he would return.

Ms. Jackson stated Resident A sometimes returns to the home to take his medications, since he only has morning medications, but he will not remain at the home. She stated Resident A has recently been staying with his girlfriend who lives near this home. She stated Resident A requested his medications one time when he planned to be gone for several days, and he had a medication appointment during that time. She stated Resident A has a cell phone and will occasionally communicate with DCWs, so they know his whereabouts.

Ms. Jackson stated when someone is missing from the home the appropriate protocol is to inform Mr. Forkpah, inform the resident's guardian, case manager, supports coordinator, and call law enforcement. She stated since it was known that Resident A leaves the home for days at a time, she did not feel Resident A was

missing, was not concerned for his safety, and did not feel measures aside from notifying his guardian were needed.

Mr. Forkpah confirmed Resident A moves independently in the community and has a known behavior for leaving for multiple days at a time. He agreed to provide Resident A's assessment plan.

On 2/12/25, I received an e-mail from Jeannie Haff at the Office of Recipient Rights. She reported she tried but was not able to contact Resident A during her investigation. She stated she substantiated the allegation as they were also reported to her.

On 2/18/25, I received Resident A's Assessment Plan for AFC Residents dated 2/18/25. It was signed by Guardian A. It was noted Resident A moves independently in the community.

On 3/10/25, I communicated with Mr. Forkpah. He stated he did not send an Incident/Accident Report to Guardian A or Resident A's case management team because he did not feel that Resident A was missing because it is a known behavior for him to leave the home for days at a time and he knows where Resident A is. He stated Guardian A has been aware of this behavior since 2023 and provided screenshots of text messages from June 2023 that included Guardian A and Resident A's former case manager. These messages discussed Resident A leaving the home without notification multiple times in June 2023. He stated during the incident Ms. Jackson discussed, he called Resident A to come home, and Resident A returned to the home that evening. He stated most recently, Resident A has not been returning to the home and chooses to stay with his girlfriend who lives near the home, so he knows where Resident A is when he is not at the home.

APPLICABLE RULE	
R 400.14311	Investigation and reporting of incidents, accidents, illnesses, absences, and death.
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	Ms. Jackson and Mr. Forkpah acknowledged incident reports are not sent to Guardian A or Resident A's case managers when Resident A fails to return to the home or leaves without notice. Ms. Jackson and Mr. Forkpah report it is a known behavior for Resident A to leave the home and most recently he has been staying with his girlfriend who lives near the home, whenever he is not in the home.

	Based on the interviews completed, there is sufficient evidence that a written report was not sent to Guardian A or Resident A's case manager when he was absent without notice.
CONCLUSION:	VIOLATION ESTABLISHED

On 3/11/25, I completed an exit conference with Mr. Forkpah who expressed it would be challenging to address these concerns because Resident A has not complied with requests to sign in and sign out and has been leaving the home without notice the entire time he has lived in the home. The importance of providing appropriate supervision in a licensed AFC home was discussed with Mr. Forkpah. Options for addressing his concern with Resident A and Guardian A and coming into to compliance with licensing rules were discussed.

IV. RECOMMENDATION

Contingent upon receipt of acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma

03/12/2025

Cassandra Duursma
Licensing Consultant

Date

Approved By:

Jerry Hendrick

03/12/2025

Jerry Hendrick
Area Manager

Date