



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2026

Stephen Forkpah
Kingdom Rest Center, LLC
7174 Martin Avenue SE
Grand Rapids, MI 49548

RE: License #: AS410417965
Investigation #: 2026A0469004
Kingdom Rest Center

Dear Mr. 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in blue ink that reads "Natasha Grew". The signature is written in a cursive style with a large initial 'N'.

Natasha Grew, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410417965
Investigation #:	2026A0469004
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/23/2026
Report Due Date:	05/22/2026
Licensee Name:	Kingdom Rest Center, LLC
Licensee Address:	7174 Martin Avenue SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 323-4379
Administrator:	Stephen Forkpah
Licensee Designee:	Stephen Forkpah
Name of Facility:	Kingdom Rest Center
Facility Address:	5252 Kimball Avenue SE Kentwood, MI 49508
Facility Telephone #:	(616) 323-4379
Original Issuance Date:	02/12/2024
License Status:	REGULAR
Effective Date:	08/12/2024
Expiration Date:	08/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED, AGED

II. ALLEGATION(S)

	Violation Established?
There were no staff at the facility on 03/22/2026 when residents were present.	No
Additional Findings	Yes

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A0469004
03/23/2026	Special Investigation Initiated - Telephone Ariel Simaz, Network 180 Case Manager
03/26/2026	Inspection Completed On-site
03/27/2026	APS Referral APS referral made
03/30/2026	Contact - Telephone call made Staff- Rebecca Sulonteh
04/02/2026	Exit Conference Licensee- Stephen Forkpah

ALLEGATION: There were no staff at the facility on 03/22/2026 when residents were present.

INVESTIGATION: On 03/23/2026, I received a complaint from the BCHC online complaint system. The complaint alleged that on 03/22/2026 around noon, Resident A had another person at the facility with him, and there were no staff present. An incident was reported that Resident A raped this other person, and after the incident the other person reported it to staff at the facility, law enforcement, and Adult Protective Services (APS).

On 03/23/2026, I interviewed Ariel Simaz who is a case manager at Network 180. Ms. Simaz stated her client reported to her that on 03/22/2026 her client went to Resident A's AFC home, and there were no staff present upon arriving to the home. I asked Ms. Simaz if her client is a resident at this facility. Ms. Simaz stated her client is not a resident at this facility. Ms. Simaz stated her client reported being raped by Resident A on 03/22/2026. Ms. Simaz stated her client reported on that same day following the incident and while still at the facility, her client did find staff there and reported the incident to them prior to her leaving the facility. Ms. Simaz stated that

her client has filed a report with law enforcement and APS regarding the incident.

On 03/26/2026, an onsite inspection was completed with Licensing Consultant Cassandra Duursma. I completed interviews with staff Abraham Sulonteh, Resident A, and Resident B.

I asked Mr. Sulonteh if he was working on 03/22/2026. Mr. Sulonteh reported he worked from 10pm on 03/21/2026 to 3pm on 03/22/2026. I asked who worked after he ended his shift at 3pm. Mr. Sulonteh stated that staff Rebecca Sulonteh worked after he did from 3pm to 7pm. I asked Mr. Sulonteh when he is usually scheduled to work. Mr. Sulonteh stated he usually works third shift from 10pm to 10am, and then Stephen Forkpah comes in after him to cover the day 10am to 10pm. Mr. Sulonteh stated that Ms. Sulonteh has been covering some of his shifts when he has to work at his other job. I asked Mr. Sulonteh if he was at the facility for his entire shift from 03/21/2026 to 03/22/2026, or if he had left at any point. Mr. Sulonteh stated he was present at the facility for the duration of his shift 03/21/2026 to 03/22/2026 and did not leave the facility for any outings. I asked Mr. Sulonteh if Resident A was at the facility all day on 03/22/2026. Mr. Sulonteh stated Resident A left the facility in the morning and returned to the facility in the afternoon with some friends. Mr. Sulonteh stated that prior to him leaving work for the day and Ms. Sulonteh arriving, Resident A's friends had left the facility.

I interviewed Resident A and asked if he was at the facility on 03/22/2026. Resident A stated he was at the facility on 03/22/2026. Resident A continued to state that he has already talked with the police about the alleged incident and he did not do anything wrong. I asked Resident A if staff were present when he was at the home on 03/22/2026. Resident A stated that staff were present when he woke up that morning, and after he left and came back to the home with "some people" staff were still present. He stated that staff were present the entire time he was at the home. Resident A stated that staff did not leave the home until they changed shifts when there were still staff present for the next shift. I asked Resident A which staff member was working on 03/22/2026. He stated Mr. Sulonteh was at first, then Ms. Sulonteh, and then Mr. Forkpah. Resident A did not want to engage in conversation after that and the interview ended.

I interviewed Resident B in his bedroom. I asked Resident B if there has been any time when staff have not been present when he was at the home. Resident B stated that staff have been present regularly. I asked if Resident B had any concerns with staff not being at the home. Resident B stated he did not have any concerns regarding staffing at the home. I asked Resident B if he knew all of the staff who worked at the home. Resident B stated Mr. Sulonteh, Ms. Sulonteh, and Mr. Forkpah are the staff that work in the home. I asked Resident B if he knew who worked on 03/22/2026. Resident B stated that Mr. Sulonteh worked in the morning until the afternoon, then Ms. Sulonteh worked after that "for a while" until Mr. Forkpah got there.

On 03/27/2026, a referral was made to Adult Protective Services (APS).

On 03/30/2026, I interviewed Ms. Sulonteh via telephone. I asked Ms. Sulonteh if she worked on 03/22/2026. Ms. Sulonteh stated she worked on 03/22/2026 from 3pm to 7pm or 8pm. I asked Ms. Sulonteh if she was present for her entire shift at the home, or if she left for any reason. Ms. Sulonteh stated she was present at the home for the duration of her shift and did not leave until her shift ended. Ms. Sulonteh stated Mr. Forkpah worked after her on 03/22/2026.

On 04/02/2026, I completed an exit conference via telephone with licensee Stephen Forkpah. He stated that he agreed with the special investigation finding.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (b) 12 residents for small group and family homes.
ANALYSIS:	<p>It was alleged that staff were not present at the facility on 03/22/2026 when residents were present.</p> <p>Ms. Simez stated her client told her there were initially no staff present when her client was at the facility with Resident A on 03/22/2026. However, Ms. Simez stated that her client did find staff at the facility prior to her leaving the facility on 03/22/2026.</p> <p>During interviews with Mr. Sulonteh, Ms. Sulonteh, Resident A, and Resident B it was reported that staff were present in the home the entire day on 03/22/2026.</p> <p>There is no evidence for this rule violation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The facility's staffing schedule is incorrect and does not reflect staff schedule changes.

INVESTIGATION: While onsite on 03/26/2026, I reviewed the staff schedule for March 2026. The schedule listed the same staff schedule every day, which was Mr.

Sulonteh from 10pm-10am and Mr. Forkpah from 10am-10pm. Ms. Sulonteh was not listed on any day for this staff schedule. There were no changes written on the staff schedule to show where any shifts were adjusted.

The staff schedule noted that on 03/22/2026, Mr. Sulonteh was scheduled from 10pm-10am and Mr. Forkpah was scheduled from 10am-10pm.

The staffing scheduled noted that on 03/26/2026, Mr. Sulonteh was scheduled from 10pm-10am and Mr. Forkpah was scheduled from 10am-10pm. I completed the onsite inspection on 03/26/2026 around 12:30pm. Mr. Sulonteh was the staff present during the onsite visit.

During the onsite inspection on 03/26/2026, I asked Mr. Sulonteh if there were any other copies of the staff schedule. Mr. Sulonteh stated that the copy at the facility that was reviewed is the copy they use. I asked Mr. Sulonteh if staffing changes were documented anywhere. Mr. Sulonteh stated "no".

When I interviewed Ms. Sulonteh via telephone on 03/30/2026, I asked Ms. Sulonteh when she started working at this home. Ms. Sulonteh stated she has been working at this home for about two months. Ms. Sulonteh stated she works every Monday and every other weekend. Ms. Sulonteh stated she starts at 2:30pm or 3pm and ends at 7pm, 8pm, or 9pm. Ms. Sulonteh continued to state her start and end times change depending on what is agreed upon with Mr. Forkpah. Ms. Sulonteh stated she has another job as an aid at a nursing home and has to schedule around that. Ms. Sulonteh stated Mr. Sulonteh works every day from 10pm to 10am, or when she gets there at 2:30pm or 3pm. Mr. Forkpah typically comes in after Ms. Sulonteh. I asked Ms. Sulonteh if there is a schedule that is written down. Ms. Sulonteh stated there is no schedule written down, she plans to work based on what is agreed upon.

On 04/02/2026, I completed an exit conference via telephone with licensee Stephen Forkpah. I informed him of the investigative findings and discussed the corrective action plan (CAP), which is due within 15 days of receipt of this report. Mr. Forkpah stated he understood the special investigation findings and agreed to submit an acceptable CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.639	Staff records.
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: (a) Names of staff on duty. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Scheduling changes when made.

<p>ANALYSIS:</p>	<p>During the onsite inspection on 03/26/2026 the staff schedule was reviewed for March 2026. This staff schedule lacks documentation of all staff, job titles, and scheduling changes.</p> <p>The staff scheduled noted that on 03/22/2026, Mr. Sulonteh was scheduled from 10pm-10am and Mr. Forkpah was scheduled from 10pm-10am. However, what was reported through interviews with staff and residents is that Mr. Sulonteh worked 03/21/2026 from 10pm to 03/22/2026 to 3pm, Ms. Sulonteh worked on 03/22/2026 from 3pm-7pm or 8pm, and then Mr. Forkpah worked following that.</p> <p>The staffing schedule noted that on 03/26/2026, Mr. Sulonteh was scheduled from 10pm-10am and Mr. Forkpah was scheduled from 10am-10pm. However, when the onsite inspection was completed on 03/26/2026 around 12:30pm, Mr. Sulonteh was the staff present. According to the schedule, Mr. Forkpah had been scheduled to work that day starting at 10am.</p> <p>During my interview with Ms. Sulonteh, she stated she works every Monday and every other weekend from 2:30pm or 3p to 7pm, 8pm, or 9pm. Ms. Solunteh stated she has been employed for approximately two months at this facility helping cover shifts. Ms. Sulonteh was not on the staff schedule for the month of March 2026. The staff schedule did not list job titles and did not document staffing changes. Therefore, there is evidence to support this rule violation.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

ADDITIONAL FINDINGS: Resident B’s bedroom door has holes and is in poor condition.

INVESTIGATION: While onsite on 03/26/2026, I observed Resident B’s bedroom door with holes in it as I was walking through the facility to interview Resident A. I observed Resident B’s bedroom door to be closed as I walked past it. When the door was closed, I observed two holes in the bedroom door. One of the holes was toward the top right. The other hole was larger in size and on the bottom portion of the bedroom door. While the bedroom door was closed, I could see through it and into Resident B’s bedroom.

On 04/02/2026, I completed an exit conference via telephone with licensee Stephen Forkpah. I informed him of the investigative findings and discussed the corrective action plan (CAP), which is due within 15 days of receipt of this report. Mr. Forkpah

stated he understood the special investigation findings and agreed to submit an acceptable CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	<p>During the onsite inspection on 03/26/2026, Resident B's bedroom door was observed to have two holes through it. One hole was observed toward the top right of the door. The second hole was observed on the bottom portion of the door and was large in size. The inside of the room could be seen through the hole when the door was closed.</p> <p>This bedroom door did not appear to be in good condition during the onsite visit and therefore this is a rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



04/02/2026

Natasha Grew
Licensing Consultant

Date

Approved By:



04/02/2026

Jerry Hendrick
Area Manager

Date