GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

Roland Awolope
3916 Oakland Dr.
Kalamazoo, MI 49008

RE: License #: AS390402971
Investigation #: 2025A0581022
Greater Heights Adult Foster Care

Dear Roland Awolope:

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) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390402971
Investigation #:	2025A0581022
Complaint Receipt Date:	03/19/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	05/18/2025
Licensee Name:	Roland Awolope
Licensee Address:	3916 Oakland Dr. Kalamazoo, MI 49008
Licensee Telephone #:	(269) 873-4532
Administrator:	Roland Awolope
Licensee Designee:	N/A
Name of Facility:	Greater Heights Adult Foster Care
Facility Address:	3916 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 873-4532
Original Issuance Date:	07/10/2020
License Status:	REGULAR
Effective Date:	01/10/2025
Expiration Date:	01/09/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS

	Violation Established?
The facility's direct care staff are retaliating against Resident A.	No
Direct care staff do not document when medication is administered to residents.	Yes
Direct care staff do not give residents breakfast when they ask for it.	No
The facility's bathroom and a window are broken.	No
Additional findings.	Yes

III. METHODOLOGY

03/19/2025	Special Investigation Intake - 2025A0581022
03/19/2025	Special Investigation Initiated – Telephone - Interview with Complainant.
03/19/2025	APS Referral - Upon interviewing Complainant, there are no allegations of abuse/neglect.
03/19/2025	Contact – Telephone call made – Interview with Resident A.
03/24/2025	Inspection Completed On-site - Interviewed staff and residents.
03/24/2025	Contact - Telephone call made - Interview with licensee, Roland Awolope.
03/24/2025	Contact – Document Received – Email from Roland Awolope.
04/30/2025	Inspection Completed-BCAL Sub. Compliance
05/09/2025	Exit conference with the licensee, Roland Awolope.

ALLEGATION: The facility's direct care staff are retaliating against Resident A.

INVESTIGATION: On 03/19/2025, this complaint was received through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged the facility's direct care staff were retaliating against Resident A for calling in complaints. The complaint provided no additional information.

On 03/19/2025, I interviewed Complainant whose statement was consistent with the allegations. Complainant provided Resident A's contact information.

On 03/19/2025, I interviewed Resident A via telephone whose statement was consistent with the allegations. Resident A stated the facility's staff have been "real weird" with him and make him "look bad" in front of other agencies; however, he was unable to identify specific ways in which staff were retaliating against him. He stated neither the licensee nor any of the facility's direct care staff told him he had to leave the facility. He also stated he had not received a discharge notice.

On 03/25/2025, I conducted an unannounced inspection and interviewed direct care staff, Denyse Murekatete and London Lockett, who both denied retaliating against Resident A. Additionally, both staff stated they had not observed or heard of the licensee or any other staff retaliating against Resident A or treating him differently than the other residents. I observed both staff and Resident A interacting appropriately with one another during my inspection.

I interviewed Resident B, C, D and E; however, none of them could identify any way the licensee or direct care staff were retaliating against Resident A or treating him differently than the other residents.

On 05/09/2025, the licensee, Roland Awolope, denied the allegations. He stated Resident A was unhappy living in the facility and he was working with Resident A's case manager on moving him to a facility closer to his family.

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: **(f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on my interviews with direct care staff, Resident A, B, C, D, and E, the licensee, Roland Awolope, and my observations, there is no supporting evidence that the licensee or direct care staff are retaliating against Resident A or treating him differently for voicing his complaints.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff do not document when medication is administered to residents.

INVESTIGATION: The complaint alleged direct care staff do not document on the paper Medication Administration Records (MAR) when medications are administered to residents.

Resident A stated he has received his medication as required; however, he stated on or around 03/17 a direct care staff forgot to write down he took his medications after staff administered them.

Neither Resident B, C, D, nor E identified any issues or concerns with receiving their medications. They all stated they receive their medications, as prescribed.

Direct care staff, Denyse Murekatete, did not identify any issues with medications in the facility. She stated resident MARs are initialed by staff after medications are administered to residents.

I reviewed Resident A's March MAR during the inspection, which documented medication was not administered for the following dates and times as staff did not initial it was administered:

- Lamotrigine tab 25 mg, with the instruction of take 1 tablet by mouth every morning. This medication was not administered on 03/16.

- Benztropine tab 2 mg, with the instruction of take 1 tablet by mouth twice daily. This medication was not administered at 8 pm on 03/01, 8 pm on 03/02, 8 am on 03/05, 8 am on 03/15, 8 am on 03/16, and 8 pm on 03/16.

- Levetiracetam tab 100 mg, with the instruction of take 2 tablets by mouth twice daily. This medication was not administered at 8 pm on 03/01, 8 pm on 03/02, 8 am on 03/05, 8 am on 03/15, 8 am on 03/16, and 8 pm on 03/16.

- Melatonin tab 5 mg, with the instruction of take 1 tablet by mouth every night at bedtime. This medication was not administered at 8 pm on 03/01 or 8 pm on 03/16.

- Olanzapine tab 10 mg, with the instruction of take 1 tablet by mouth every night at bedtime. This medication was not administered at 8 pm on 03/16.

Direct care staff, London Lockett, stated she spoke to the staff who did not initial Resident A's MAR for the identified dates and times. London Lockett stated the staff accidentally put her initials on a copy of Resident A's original March MAR. She stated there were not any concerns Resident A did not receive his medications.

The licensee, Roland Awolope's, statement was consistent with London Lockett's statement. Roland Awolope stated staff copied Resident A's March 2025 MAR for Resident A to take to a medical appointment. Roland Awolope stated Resident A returned to the facility with the copied MAR, which is the MAR staff initialed rather than the MAR I reviewed during the inspection.

Roland Awolope provided a copy of Resident A's duplicate March 2025 MAR via email. When I compared the duplicate March MAR with the original March 2025 MAR, I determined the following medication was not administered for the following date and time as staff did not initial it was administered:

- Levetiracetam tab 100 mg, with the instruction of take 2 tablets by mouth twice daily. This medication was not administered at 8 pm on 03/16.

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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Upon reviewing Resident A's original and duplicate March Medication Administration Records, I determined direct care staff did not initial either MAR after Resident A received his Levetiracetam tab 100 mg at 8 pm on 03/16. Consequently, staff did not complete Resident A's individual medication log, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff do not give residents breakfast when they ask for it.

INVESTIGATION: The complaint did not contain any additional information other than what was identified in the complaint.

Resident A stated staff make breakfast every morning in the facility at approximately 8 am. He stated that despite being able to make his own plate of food and serve himself the staff were not asking him if he wanted to eat. Resident A stated he was upset when staff asked other residents if they were hungry and wanted to eat, but not him. Resident A expressed he did not feel he needed to ask staff if it was time to eat.

Both direct care staff, Denyse Murekatete and London Lockett, stated residents are made three meals a day and offered to eat; however, they both stated Resident A often declines to eat breakfast.

Resident B, C, D, and E stated staff treat all the residents equally by making and offering three meals a day for all the residents. None of the residents stated Resident A was being treated differently by staff for not allowing him to eat or not offering him meals after they were prepared.

The licensee, Roland Awolope, denied the allegations. He stated he recently worked in the facility making meals and witnessed Resident A decline lunch; despite offering him a substitute meal.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	There is no supporting evidence that the licensee or the facility's direct care staff are not offering Resident A a meal for any meal times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility's bathroom and a window are broken.

INVESTIGATION: The complaint alleged the facility's bathroom was broken and neither the licensee nor the direct care staff have fixed it. The complaint alleged a window in the back of the facility was also broken and not boarded up or fixed; therefore, making the facility easily accessible and unsafe.

Resident A stated on 03/14/2025 around 12 am, while he was in his bedroom, he thought he heard someone breaking into the facility; however, he discovered it was Resident B causing significant destruction throughout the facility. He stated Resident B damaged the facility's bathroom by ripping the sink off the wall and breaking the mirror. He stated Resident B also broke a window in Resident B's bedroom.

Resident A stated the bathroom mirror was replaced and the sink was back against the wall; however, Resident A did not think the sink was adequately sealed. Resident A stated the licensee was supposed to fix the window a couple days ago, but he stated it was still broken and had plastic wrap over it.

During my unannounced inspection, I did not observe any broken windows in the facility, including Resident B's bedroom. I also did not observe any significant damage to the facility's bathroom. I observed the bathroom mirror intact, and the sink was against the wall with no apparent signs of water damage around the sink, wall, or floor.

Direct care staff, London Lockett, confirmed Resident B caused damage to the facility's bathroom and the window in Resident B's room on or around 03/14; however, she stated the bathroom's damage was repaired the same day while the window was repaired on 03/17.

Resident B's, C's, D's, and E's statements were all consistent with Resident A's and London Lockett's statements to me.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	The facility's bathroom was functioning and in good working condition at the time of my 03/25/2025 unannounced inspection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	The window in Resident B's bedroom was in sound condition and good repair at the time of my 03/25/2025 unannounced inspection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

While reviewing resident March MARs, I discovered Resident C's Januvia tab 50 mg medication, with the instruction of take 1 tablet by mouth once daily, had not been administered to him at 8 am on 03/21, 03/22, 03/23, or 03/24. Additionally, direct care staff, Denyse Murekatete, was unable to locate the medication during my inspection.

Roland Awolope stated direct care staff contacted the pharmacy and requested a refill on Resident C's Januvia medication; however, the pharmacy reported they could not refill it because Resident C needed a new prescription. Roland Awolope stated staff contacted Resident C's physician, but Resident C could not get in for an appointment with his physician until the morning of 03/24/2025, which is when a refill for the medication was provided.

On 03/24/2025, Roland Awolope emailed me documenting direct care staff could not provide any documentation confirming they contacted or attempted contact with Resident C's physician's office or pharmacy requesting a refill on Resident C's Januvia medication. Roland Awolope attached Resident C's after visit summary, dated 03/24/2025, from his physician's appointment confirming Resident C's Januvia medication was sent to the pharmacy for a refill.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Upon reviewing Resident C's March Medication Administration Record, I determined direct care staff did not administer Resident C's Januvia tab 50 mg medication from 03/21-03/24 because it was not in the facility, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

Resident A stated his bedroom wall was damaged when Resident B damaged the facility's bathroom on or around 03/14/2025. He stated it had been patched but not painted. During my inspection, I observed an approximate 1.5 ft x 3 ft section of wall patched, but not painted in Resident A's bedroom.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	A wall in Resident A's bedroom walls sustained damage on or around 03/14/2025 when Resident B caused damage to the facility's bathroom. Though the licensee patched the wall, it had not been painted. A patched but not painted wall will generally not be easily cleanable compared to a painted wall.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/09/2025, I conducted my exit conference with the licensee, Roland Awolope, via telephone explaining my findings. Roland Awolope stated he has addressed the medication errors by implementing changes that would be documented on the corrective action plan.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/09/2025

Cathy Cushman Date
Licensing Consultant

Approved By:

05/13/2025

Dawn N. Timm Date
Area Manager