GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 11, 2025

Oluwaseun Olawunmi
Greater Grace Health System,Inc
7826 Terri Dr.
Westland, MI 48185

RE: License #: AS820416532
Investigation #: 2025A0778033
Garfield Group Home

Dear Mr. Olawunmi:

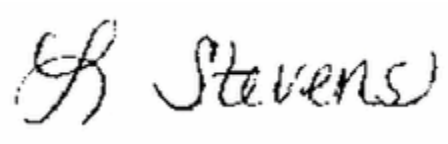
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0439.

Sincerely,



LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
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Detroit, MI 48202
(313) 949-3055

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT HAS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820416532
Investigation #:	2025A0778033
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/11/2025
Report Due Date:	08/08/2025
Licensee Name:	Greater Grace Health System, Inc
Licensee Address:	7826 Terri Dr. Westland, MI 48185
Licensee Telephone #:	(734) 334-3451
Administrator:	Oluwaseun Olawunmi
Licensee Designee:	Oluwaseun Olawunmi
Name of Facility:	Garfield Group Home
Facility Address:	19272 Garfield Redford, MI 48240
Facility Telephone #:	(313) 740-7024
Original Issuance Date:	02/15/2024
License Status:	REGULAR
Effective Date:	02/15/2025
Expiration Date:	02/14/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident, upset by disrupted routine and medication changes. The resident used racial slurs and threw water at staff member Chima, who then grabbed her by the arm and dragged her to the bedroom.	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A0778033
06/11/2025	Special Investigation Initiated - Telephone Telephone call made to APS, Mia Alston
06/11/2025	Referral - Recipient Rights Referral generated
06/18/2025	Inspection Completed On-site Face to face with staff Anita Aniamal and Hannah Olawunmi, Observation of Resident B
06/18/2025	Contact - Telephone call made I made a telephone call to the case manager, Tina Austin. I left a message requesting a return call.
07/08/2025	Contact - Telephone call made I made a telephone call to the case manager, Tina Austin. I left a message requesting a return call.
07/10/2025	Contact - Telephone call made I made a telephone call to case manager, Tina Austin. I left a message requesting a return call.

07/10/2025	Contact - Telephone call made Telephone call made to Resident B. She was asleep
07/10/2025	Contact - Telephone call made I completed a telephone call made to Resident A's husband.
07/10/2025	Exit Conference Telephone exit conference with licensee designee, Oluwaseun Olawunmi

ALLEGATION: Resident, upset by disrupted routine and medication changes. The resident used racial slurs and threw water at staff member Chima, who then grabbed her by the arm and dragged her to the bedroom.

INVESTIGATION: On 06/11/2025, I completed a telephone interview with Adult Protective Services Worker, Mia Alston. Ms. Alston stated Resident A is a geriatric resident and suffers from Dementia. According to Ms. Alston, there was a change in Resident A's schedule, and she became upset. Ms. Alston stated Resident A called staff Chime a "nigger," but he did not drag her. Ms. Alston indicated Resident B stated Resident A called staff a "nigger," and denied witnessing staff Chime drag Resident A.

On 06/18/2025, I completed an unannounced onsite inspection. I attempted to interview Resident B, but she was asleep and would not respond. Staff Hannah Olawunmi indicated Resident A went to the hospital the day of this incident and did not return to the facility. Ms. Olawunmi stated Resident A was placed in a rehabilitation center. Ms. Olawunmi provided me with Resident A's case manager's information. In addition, she informed me Resident A is her own guardian. However, she has an involved husband and provided me with his contact information.

I've made several telephone calls to Tina Austin, Resident A's case manager. To date, she has not returned a call.

I attempted to interview Resident B on two separate occasions. Each time she was asleep and would not respond. Staff, Hannah Olawunmi indicated Resident B recently had a change of medication and it causes her to sleep a lot.

On 07/08/2025, I completed a telephone interview with staff, Chime Okemiri. He stated Resident A poured a glass of water on him because she was upset. He stated she called him names. He denied grabbing her arm and dragging her. He stated he

called the police due to her level of aggression. He stated the police/paramedics transported Resident A to the hospital.

On 07/10/2025, I completed a telephone interview with the husband of Resident A. He stated he arrived at the facility during the conclusion of this incident. He stated he was there before the paramedics arrived. He indicated Resident A was not dragged by staff. He stated she had no marks or bruise on her. He further stated Resident A threw water on staff, but he did not hurt her in any way. He indicated the facility provided excellent care for his wife and he had no complaints.

I completed a telephone exit conference with licensee designee, Oluwaseun Olawunmi. He denied staff Chime dragged Resident A. He stated Resident A suffers from dementia and is becoming aggressive. He stated she has been in-out of the hospital and the doctors are attempting to find a balance of medication.

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:	There is no evidence that staff did not treat Resident A with dignity and respect. Adult Protective Services Worker, Mia Alston, indicated she is not substantiating her complaint. She stated Resident A is a geriatric resident with dementia. She indicated Resident B denied witnessing staff drag Resident A. Resident A's husband denied staff Chime dragged Resident A. He stated Resident A threw water on staff Chime, but he did not harm her. He indicated Resident A had no marks or bruise. Staff, Chime, denied grabbing Resident A by the arm and dragging her. He stated she was aggressive and that resulted in him calling the police. Licensee Designee, Oluwaseun Olawunmi stated Resident A has become aggressive. He denied that staff Chime dragged Resident A. He stated Resident A has been in and out of the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

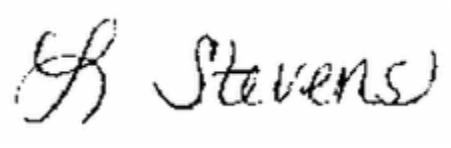
INVESTIGATION: During my unannounced onsite inspection, I arrived at the facility and staff, Hannah Olawunmi, pulled in behind me. Inside the facility was Anita Aniamal. Ms. Aniamal stated she did not know how to identify herself. She stated she was unsure of her role. Staff, Hannah Olawunmi, stated Ms. Aniamal was "shadowing" as a potential new hire. Resident B was asleep in her room while Ms. Olawunmi was away from the facility. Ms. Olawunmi stated she had been gone approximately fifteen minutes. I asked for the staff file for Ms. Aniamal. I was informed she did not have a file because she was a potential new hire and only shadowing. I informed Ms. Olawunmi, Ms. Aniamal was no longer shadowing when she was left alone with Resident B.

I completed a telephone exit conference with licensee designee, Oluwaseun Olawunmi. I informed him I am substantiating for insufficient staffing. Mr. Olawunmi stated he was at the facility and left. He further stated staff Ms. Olawunmi was only gone a few minutes. I informed him Resident B was left at the facility without direct care staff. Therefore, I am substantiating for not having sufficient direct care staff on duty at all times.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The licensee did not have sufficient staff on duty for the supervision, personal care and protection of Resident B. Resident B was left in the facility without sufficient staff. Staff Hannah Olawunmi arrived at the facility after my arrival.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective plan I recommend the status of the license remain unchanged.



08/04/2025

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LaKeitha Stevens Date
Licensing Consultant

Approved By:

08/11/2025

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Ardra Hunter Date
Area Manager