GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Yewande Okubanjo
P.O. Box 4625
East Lansing, MI 48826

RE: License #: AS330413499
Investigation #: 2025A0581044
ZION ADULT FOSTER CARE HOME

Dear Yewande Okubanjo:

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 #:	AS330413499
Investigation #:	2025A0581044
Complaint Receipt Date:	08/13/2025
Investigation Initiation Date:	08/15/2025
Report Due Date:	10/12/2025
Licensee Name:	Yewande Okubanjo
Licensee Address:	5946 N HAGADORN RD EAST LANSING, MI 48823
Licensee Telephone #:	(404) 992-2222
Administrator:	Yewande Okubanjo
Licensee Designee:	N/A
Name of Facility:	ZION ADULT FOSTER CARE HOME
Facility Address:	3800 Stillwell Avenue Lansing, MI 48911
Facility Telephone #:	(517) 515-7152
Original Issuance Date:	02/27/2023
License Status:	REGULAR
Effective Date:	08/27/2023
Expiration Date:	08/26/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
The licensee does not provide balanced meals.	Yes
The licensee does not include protein with meals.	Yes
The facility has bed bugs that are not treated.	No
The facility's basement has black mold.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/13/2025	Special Investigation Intake - 2025A0581044
08/15/2025	Contact - Telephone call made - Left voicemail with Nichole Taylor, CEI CMH case manager.
08/15/2025	Contact - Document Sent - Email to Nichole Taylor
08/15/2025	APS Referral - made referral online
08/15/2025	Special Investigation Initiated – Letter - with APS
08/19/2025	Contact - Document Received - Email with APS
08/22/2025	Contact - Document Received - Additional allegations.
08/22/2025	Contact - Telephone call made - Left voicemail with Ariana Bott
08/22/2025	Inspection Completed-BCAL Sub. Compliance - Interview with licensee and residents.
08/22/2025	Contact - Document Received - Email from licensee, Yewende Okubanjo.
09/11/2025	Contact - Telephone call made - Interview with Resident A.
09/11/2025	Contact – Document Received – Email from licensee.
09/19/2025	Contact – Document Sent – Email to licensee.
09/22/2025	Contact – Document Received – Email from licensee.
09/23/2025	Exit conference with the licensee, Yewende Okubanjo.

ALLEGATION:

- **The licensee does not provide balanced meals.**

- **The licensee does not include protein with meals.**

INVESTIGATION: On 08/15/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The compliant alleged the facility provides “unbalanced meals” such as ramen or mashed potatoes. The complaint alleged meals do not contain protein. Additionally, the complaint alleged residents are only served sandwiches.

On 08/19/2025, I received an email from Ingham County Adult Protective Services (APS) specialist, Shonna Simms-Rosa, who documented both she and an on-call APS specialist recently interviewed Resident A at the facility. She documented he provided the same information to both her and the on-call APS specialist. Shonna Simms-Rosa documented Resident A reported to her he purchases all his own food. She documented that she was unable to provide direct information regarding the meals provided and served by the licensee and the facility’s staff because she did not go into the facility. Shonna Simms-Rosa had no additional information concerning the meals provided to residents in the facility.

On 08/22/2025, I conducted an unannounced inspection at the facility. I interviewed Residents B, C, D, and E. Resident B stated he was being “starved to death”. Resident B stated he did not eat breakfast in the facility despite the licensee providing it because he purchases his own; however, he stated cereal was offered as a breakfast food. Resident B identified food served for lunches and dinner as rice, ramen, pizza, chicken nuggets, French fries, and meatballs. He stated occasionally the licensee provided chicken as a source of protein. Resident B stated vegetables may be added to the rice and sometimes fruit like watermelon is served. Resident B stated he does not often eat chicken when it is prepared by the licensee because chewing the chicken is difficult for him to chew due to issues with his teeth. Resident B stated sandwiches and snacks were not available for consumption.

Resident C’s statement about not eating breakfast was consistent with Resident B’s statement. Resident C stated lunches and dinners consist of hot pockets and pot pies. He stated fruit and vegetables were available. He stated the licensee occasionally provides protein in meals like ground beef in tacos; however, he stated protein is “not really available”.

Resident D’s statement was consistent with the other residents’ statements. He also identified hot dogs as a meal that is often served to the residents.

I reviewed the facility’s menus for 08/17 through 08/23 and 08/24 through 08/30. Based on my review of these menus, I determined the following items were identified as being served for breakfast, lunch and dinner:

- Breakfast: waffles, syrup, cereal, pancakes, oatmeal, boiled eggs, milk, coffee, and fruit.

- Lunch: peanut butter sandwich, ham and turkey sandwich, hot dogs, potato salad, sloppy joes, snacks and juice.

- Dinner: chicken nuggets, fries, pizza, ramen and mixed vegetables, mac and cheese, mashed potatoes and gravy, spaghetti and meat malls, snacks, and juice.

- Available snacks: popcorn, pretzels, cookies, apple slices and crackers.

The facility's refrigerator had items such as potato salad, eggs, bread, watermelon, and lunch meat. I also observed canned vegetables in the kitchen such as beans, sweet peas, and green beans.

I interviewed the licensee, Yewande Okubanjo, during the inspection. She stated residents are given options on what to eat for meals and residents contribute ideas to the menu. She stated residents receive balanced meals for breakfast, lunch, and dinner.

On 09/11/2025, I interviewed Resident A whose statement was consistent with the other residents' statements to me. Resident A stated he does not eat in the facility because he does not like what is served to him. Resident A stated, "too much starch is served" and he does not like the way food is cooked as food is often boiled, like hot dogs and pasta. Resident A stated residents are served meals like mac and cheese, sloppy joes, and rice for dinner. He stated items like hot pockets and sandwiches are served for lunch. Resident A stated bananas were occasionally available for breakfast, but he was unable to identify any additional fruits and vegetables.

On 09/23/2025, I reviewed Resident A's, B's, C's, D's, and E's *Assessment Plans for AFC Residents*, which did not document any special dietary requirements or specifications regarding meal planning for any of the residents.

I also reviewed monthly weight records for Resident A, C, D, and E, which were forwarded to me by the licensee. Based on my review of the documentation, I determined from August 2025 to September 2025 Resident A lost 13 pounds, Resident C gained 6.2 pounds, Resident D lost 0.6 pounds, and Resident E lost 1.6 pounds.

On 09/23/2025, I conducted a follow-up interview with the licensee, Yewende Okubanjo. She confirmed she wrote the menu provided during the 08/22 inspection; however, she clarified the meals documented on the menu were not what was served to residents. She stated residents were given options for their meals, which

included protein and other nutritious foods to create a balanced meal. I informed Yewende Okubanjo that the facility's menu needed to be updated to reflect what was actually served to residents.

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:	Based on my review of the facility's menu, interviews with Resident A, B, C, D and E and my own observations, the licensee does not provide three nutritious meals per day, as required. The meals identified on the menu and reported by residents as being served consist of heavily processed foods like chicken nuggets, hot pockets, and hot dogs, which can be high in sodium and low in nutrients. The facility's menu identifies minimal servings of vegetables and fruits, which are vital for receiving proper vitamins, minerals and fiber. Additionally, the menu appears to lack whole grains and sufficient protein while having refined carbohydrates and sugary options as readily available. Consequently, though the facility's menu identifies meals sufficient in calories it does not offer balanced and nutritious meal options.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility has bed bugs that are not treated.

INVESTIGATION: The complaint alleged the facility has bed bugs, which have only been treated once. The complaint also alleged residents have bed bug bites.

Shonna Simms-Rosa documented in her email Resident A reported to her the facility had bed bugs; however, she provided no additional information regarding the treatment of them.

Yewende Okubanjo denied the facility currently having a bed bug infestation. She stated Resident B reported to her seeing bed bugs in his room; however, she stated she treated them by spraying them with a bed bug specific chemical spray.

Resident B, who resided on the facility's main level, stated he had bed bugs in his room; however, he stated the licensee, Yewende Okubanjo, treated them by spraying them with a chemical, which he stated was approximately one week ago. He stated she also used a "steam" treatment. Resident B stated despite Yewende Okubanjo treating the bed bugs they end up coming back.

Resident C's statement was consistent with Resident B's statement. Resident C stated he had bumps on his arms; however, he was unable to report if the bumps were from being bitten by bed bugs.

Resident D stated he did not have any concerns with bed bugs.

Resident E stated bed bugs had been present in Resident B's and Resident C's bedrooms; however, he stated they were treated by the licensee, but he could not recall when the treatment took place. Resident E stated since the bed bugs were treated by the licensee he had not observed any in the facility.

I checked each resident's bed and bedroom for bed bugs; however, I did not observe any signs of them and therefore, I was unable to establish if the facility had a current infestation of bed bugs.

I interviewed Resident A at a later date; however, his statement was consistent with Resident B's and Resident C's statement to me.

On 09/22/2025, the licensee provided pictures of the chemicals used to treat the facility's bed bugs and explained the steps for treatment. The licensee documented Hot Shot Bed Bug Killer Dust with Diatomaceous Earth and Hot Shot Bed Bug Killer with Egg Kill Treatment is used to treat bed bugs in the facility. The licensee documented the treatment steps as bagging resident clothing and items to prepare for laundry, rooms and beds are then vacuumed thoroughly, the Hot Shot bed bug killer is then applied to the room, bed frames, and mattresses using the sprayer and left for approximately six hours, the rooms are then vacuumed a second time, then the room, bed frames, and mattresses are steamed using the steamer before the rooms are vacuumed again and mopped. The licensee documented the last step as reapplying the Hot Shot with Diatomaceous Earth to the bed frames and floor corners. The licensee documented this process is redone every 4-6 weeks until it is established that the issue is resolved.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.

ANALYSIS:	Based on my interviews with the licensee and residents, the facility did have bed bugs; however, the licensee treated them using chemicals that specifically target bed bugs. During my inspection on 08/22/2025, I did not observe any current signs of bed bugs in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility's basement has black mold.

INVESTIGATION: The complaint alleged bedrooms in the facility's basement have black mold and the licensee instructed the residents to clean it off the walls.

Residents A, B, D, and E all reported the facility's basement had mold in it; however, they all reported the licensee, with the assistance of the residents, cleaned the mold off the bedroom walls. The residents stated they could not recall what was used to clean the walls, but stated the mold was no longer present. The residents were unable to recall when the mold was removed from the walls, but Resident A stated he believed it to be approximately one month ago.

In my observation of the basement, I did not observe the presence of mold in either of the two resident bedrooms; however, a black substance was observed on a window curtain in the basement bathroom indicating either mold or mildew.

Yewende Okubanjo stated she was informed by staff and residents in approximately March 2025 that the facility's basement had either mold or mildew on the walls after a heavy rainfall. She stated she and staff then cleaned the walls off. She stated Resident A then left his window open several days prior to my 08/22 inspection and water got on his floor. She stated his bedroom walls also had mold or mildew on them; however, after cleaning the walls it was removed. Yewende Okubanjo stated she was not aware of the condition of the bathroom curtain at the time of my inspection; however, she stated the curtain has since been replaced. I discussed with Yewende Okubanjo using a dehumidifier to help reduce moisture in the basement and provided consultation on obtaining an inspection to determine if the black substance observed on 08/22 was mold or mildew and to receive instruction on how to prevent future issues.

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:	Based on my investigation, mold or mildew is present in the facility's basement, especially in the bathroom as evidenced by a black substance on the bathroom window curtain.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While interviewing Resident C in his bedroom, I observed multiple medications on a small table just within the room that were out in the open. The medications I observed included Ibuprofen 800 mg (in a pharmacy labeled bottle for Resident C), over the counter (OTC) Vitamin E, OTC eye drops, and OTC nasal spray. Resident C stated he purchased the medications when he was out in the community.

The licensee, Yewande Okubanjo**,** stated she was not aware of the medications being in Resident C's bedroom. She stated Resident C often goes into the community and must have purchased them while he was out.

I reviewed Resident C's *Assessment Plan for AFC Residents*, dated 12/20/2024, which documented Resident C requires assistance with taking his medications.

In a follow-up interview, Yewende Okubanjo stated Resident C has continued purchasing OTC medications and bringing them back to the facility and hiding them in his bedroom. She stated she has reported this to Resident C's Community Mental Health (CMH) case worker. She stated she continues to remove the medications from Resident C's bedroom and locks them up. She stated Resident C reports he is able to purchase these medications; therefore, he should be able to keep them in his room. Yewende Okubanjo stated Resident C does not have a physician's order to self-administer any of his medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Resident C had multiple medications in his bedroom that were not being kept in a locked cabinet or drawer, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While interviewing Resident C in his bedroom, I observed multiple bottles and containers of cleaners throughout his bedroom, including LA's Totally Awesome all purpose concentrated cleaner and degreaser spot remover, multiple bottles of Oxdol lavender floor cleaner, True Living cleaner with bleach, multiple bottles of Oxdol fabric softener, and the Works toilet bowl cleaner. All of these items were readily accessible to Resident C. Resident C stated he purchased the items while out in the community and uses them to keep his room and laundry clean.

The licensee, Yewende Okubanjo, was not aware of these cleaners being in Resident C's bedroom.

The basement bathroom also had Lime Away toilet bowl cleaner on a shelf accessible to residents.

In a follow-up interview with Yewende Okubanjo, she stated all the chemicals accessible to Resident C and the remaining residents were locked away after the 08/22 inspection.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	The licensee was not safeguarding poisonous and dangerous cleaning products from the residents in the facility, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: During my unannounced inspection, I observed the basement bathroom, living area, and laundry spaces unclean and in need of maintenance attention. The toilet, tub and sink were observable dirty. The closet door in the bathroom was also broken and not in place. The concrete floors throughout the basement were dirty, discolored, stained, and missing paint in areas creating an uncomfortable and disorderly appearance.

The single resident bedroom in the basement had a rug that was discolored and stained.

Yewende Okubanjo stated she and other staff clean the facility every Tuesday and Thursday. She stated the basement is cleaned on these days.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	The facility's basement bathroom and living spaces were observably dirty and in disrepair.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: During my inspection of the facility's basement area, I observed multiple ceiling tiles missing in the dining/living area revealing ceiling joists. An approximate 1.5 foot wide section of wood paneling beneath the missing ceiling tiles was also not attached to the wall.

The basement bathroom walls had what appeared to be peeling paint in a corner near the closet and on the baseboards near the toilet. The bathroom walls were discolored, covered in grime and dirt.

The concrete floors throughout the bathroom, living, dining, and laundry room areas appeared dirty, discolored, and stained. In particular, the laundry room floors were heavily stained and/or covered in a substance near the washer and dryer.

In a follow-up interview, Yewende Okubanjo stated the ceiling tiles were replaced after the 08/22 inspection.

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:	Ceiling tiles were missing in the dining and living room area of the basement The floors and walls throughout the basement were unclean and in disrepair.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: During my unannounced inspection, I observed a twin bed in the facility's dining room on the main floor. The licensee, Yewende Okubanjo, stated she sleeps in this space and had been for approximately one year.

All the residents stated Yewende Okubanjo slept in the dining room and stated this was her personal space. All the residents stated they ate their meals in the dining room located in the basement. Upon entering the basement, I observed a dining room to the left of the living area.

I reviewed the facility's layout that was submitted at time of licensure. According to my review of this layout, the dining room was on the main level off the kitchen and there was no dining room identified in the basement. Additionally, the original licensing study report documents staff will be awake during the overnight hours.

In a follow-up interview with Yewende Okubanjo, she clarified working in the facility by herself throughout the week. She stated she had paid someone to work the overnight; however, it was not cost effective to pay an employee to sleep. She stated as a result, she works during the day and then sleeps in the facility at night. She stated the staff who work in the facility on the weekends also sleep at night.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	The licensee, Yewende Okubanjo, placed a bed in the facility's identified dining room and sleeps in this area. A dining room is not to be utilized for sleeping purposes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	The licensee changed the layout of the facility without notifying Licensing, as required. Additionally, the licensee and staff are sleeping during the overnight, which was not documented in the original licensing study report.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/23/2025, I conducted my exit conference with the licensee, Yewende Okubanjo whereas I explained my findings and provided her with an opportunity to ask questions and comment on the investigation.

IV. RECOMMENDATION

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

09/23/2025

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

09/24/2025

_____

Dawn N. Timm Date
Area Manager