GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2025

Roland Awolope
3916 Oakland Drive
Kalamazoo, MI 49008

RE: License #: AS390417369
Investigation #: 2025A0578049
Care From The Heart AFC

Dear Roland Awolope:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390417369
Investigation #:	2025A0578049
Complaint Receipt Date:	08/27/2025
Investigation Initiation Date:	08/28/2025
Report Due Date:	10/26/2025
Licensee Name:	Roland Awolope
LicenseeAddress:	3916 Oakland Drive Kalamazoo, MI 49008
Licensee Telephone #:	(269) 873-4532
Administrator:	Roland Awolope
Licensee Designee:	Roland Awolope
Name of Facility:	Care From The Heart AFC
Facility Address:	2209 Romence Rd Portage, MI 49024
Facility Telephone #:	(269) 873-4532
Original Issuance Date:	10/26/2023
License Status:	REGULAR
Effective Date:	04/26/2024
Expiration Date:	04/25/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had to call for emergency services after direct care staff ignored her ongoing health complaints.	No
Direct care staff were sleeping when emergency services arrived.	No

III. METHODOLOGY

08/27/2025	Special Investigation Intake 2025A0578049
08/27/2025	APS Referral
08/28/2025	Special Investigation Initiated - On Site
08/28/2025	Special Investigation Completed On-site -Interview with Resident A. Interview with Resident B. Interview with direct care staff Dolpart Mihna.
08/28/2025	Contact-Documentation Reviewed -*AFC Health Care Appraisal* for Resident A, dated 07/24/2025.
08/28/2025	Contact-Documentation Reviewed -*After Visit Summary* for Resident A provided by Bronson Methodist Hospital, dated 08/25/2025.
08/28/2025	Contact-Documentation Reviewed -*Functional Behavior Assessment and Behavior Treatment Plan* for Resident A, dated 01/03/2025.
09/30/2025	Contact-Documentation Reviewed -Portage Police Department *Incident: 2025-26614*, dated 08/03/2025.
10/07/2025	Contact-Documentation Reviewed. -*Incident Report* dated 08/03/2025.
10/07/2025	Exit Conference -With licensee designee Roland Awolope.
10/14/2025	Contact-Telephone -Interview with direct care staff Naza Ruben, unsuccessful.
10/15/2025	Contact-Telephone -Interview with direct care staff Naza Ruben.

ALLEGATION: Resident A had to call for emergency services after direct care staff ignored her ongoing health complaints.

INVESTIGATION:

On 08/27/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A is developmentally and intellectually disabled and resides at this facility. Complainant reported Resident A called emergency services due to arm pain and spitting up yellow sputum. Complainant alleged Resident A reported her condition to direct care staff and direct care staff did nothing. Complainant reported Resident A has been complaining about her arm bothering her for a while but direct care staff report nothing is wrong with Resident A.

On 08/28/2025, I completed an unannounced investigation on-site and interviewed Resident A regarding the allegations. Resident A acknowledged that emergency services had responded to this facility but clarified it was because she was having trouble breathing. Resident A clarified that she was taken to the hospital regarding pain she had reported in her arm. Resident A reported she was treated for a broken arm, and this arm was x-rayed and broken in three different places. Resident A could not recall when or how she had broken her arm. Resident A demonstrated the arm she reported as broken. I observed this arm with no cast and no evidence of marks or bruising. I observed Resident A with no other evidence of marks or bruising. Resident A denied having any additional concerns.

While at the facility, I interviewed direct care staff Dolpart Mihna regarding the allegations. Dolpart Mihna reported working at this facility for over two years and serving as the assistant home manager. Dolpart Mihna reported Resident A will frequently make delusional comments as a part of her diagnosis, such as having a broken arm, being pregnant with twins, and talking to people that are not present. Dolpart Mihna denied being informed of any concerns for Resident A's arm before this incident.

On 08/28/2025, I reviewed the *AFC Health Care Appraisal* for Resident A, dated 07/24/2025. The *AFC Health Care Appraisal* for Resident A documented that Resident A is diagnosed with schizophrenia, emotional dysregulation, hearing loss and diabetes type 2.

On 08/28/2025, I reviewed the *After Visit Summary* for Resident A provided by Bronson Methodist Hospital and dated 08/25/2025. The *After Visit Summary* for Resident A documented Resident A's visit was related to Resident A's "arm pain". The *After Visit Summary* for Resident A documented that Resident A was diagnosed with pain of the upper right extremity. The *After Visit Summary* for Resident A documented no changes in medications for Resident A. The *After Visit Summary* for

Resident A documented that Resident A is to rest the injured area by limiting use and elevating and applying ice. No fractures were noted on the *After Visit Summary*.

On 09/30/2025, I reviewed *Incident: 2025-26614* provided by the Portage Police Department and dated 08/03/2025. *Incident: 2025-26614* documented that Resident A called to report having issues with her hearing aids and that her arm hurt and was stiff from twisting her arm overnight while she slept. *Incident: 2025-26614* documented that Resident A would not provide the phone to direct care staff. *Incident: 2025-26614* documented that Resident A was reporting her arm began hurting a week and a half ago. *Incident: 2025-26614* documented that law enforcement was unsure what Resident A had called emergency services for. *Incident: 2025-26614* did not include any additional information regarding Resident A's reported injury or document any additional concerns.

On 10/07/2025, I reviewed an *Incident Report* dated 08/03/2025 and completed by direct care staff Naza Rueben. The *Incident Report* documented that Resident A took a phone to her bedroom and began making phone calls, including emergency services, and reporting that she was pregnant and wanted to move. The *Incident Report* documented that when law enforcement arrived, direct care staff facilitated Resident A's transport to the local hospital for additional screening, as law enforcement was unsure if Resident A's reporting was accurate.

On 10/15/2025, I interviewed direct care staff Naza Ruben regarding the allegations. Naza Ruben acknowledged working the day of the incident, and reported Resident A was fine and sitting on the couch prior to calling emergency services. Naza Ruben reported Resident A had commented that she needed to go to bed and had made several comments about being pregnant and having "twins in her stomach." Naza Ruben reported these comments are common for Resident A, and that Resident A is not pregnant. Naza Ruben reported that another resident had provided Resident A with a cell phone and Resident A had called for ambulance services. Naza Ruben reported Resident A was taken to the hospital and returned to the facility with no medical concerns. Naza Ruben denied that Resident A had made any comments about her arm being injured in any way prior to calling emergency services.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, direct care staff Naza Ruben, and direct care staff Dolpart Mihna, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, there was not

	enough evidence to substantiate the allegation that Resident A was not provided with needed care immediately when reporting any adverse change in her physical condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff were sleeping when emergency services arrived.

INVESTIGATION:

On 08/27/2025, Complainant alleged that “firefighters” had to physically wake up the direct care staff when they arrived at the facility. Complainant added there is significant concern for supervision at this facility.

On 08/27/2025, I interviewed Resident A regarding the allegations. Resident A acknowledged that direct care staff “Tee-tee” (Naza Ruben) was present and greeted emergency services but clarified that she thought direct care staff was “half-asleep”. Resident A could not clarify why she thought direct care staff would be half asleep. Resident A reported Naza Rueben had prevented her from calling for emergency services but reported Naza Rueben was asleep when emergency services arrived. Resident A reported Naza Rueben was asleep ten or fifteen minutes before emergency services arrived.

On 08/27/2025, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for over five months. Resident B reported he was not awake when emergency services responded to the facility. Resident B reported always receiving assistance from direct care staff when he needs assistance during the night and clarified that direct care staff will help him reposition in his bed at night. Resident B reported he simply calls for assistance from his bedroom during the night and direct care staff will respond and provide assistance. Resident B denied having any additional concerns.

On 08/28/2025, I interviewed direct care staff Dolpart Mihna regarding the allegations. Dolpart Mihna reported direct care staff Naza Rueben had called her on the night of the allegations and informed her that Resident A had called for emergency services. Dolpart Mihna clarified Naza Rueben had informed her she did not know why Resident A had called emergency services, but she was informed by Naza Rueben a short time later that Resident A was reporting she had a broken arm and wanted to go to the hospital. When asked if Naza Rueben was asleep at any time during this incident, Dolpart Mihna denied this allegation and reported that two residents were outside smoking at the time of the incident and were being observed by direct care staff. Dolpart denied that any direct care staff sleeps at night and denied receiving any reports regarding any direct care staff sleeping at night. Dolpart Mihna clarified that three residents at this facility smoke cigarettes throughout the

night. Dolpart Mihna reported these three residents will step outside to smoke during all hours of the night and staff assist and supervise these residents while they smoke outside.

On 08/28/2025, I reviewed the *Functional Behavior Assessment and Behavior Treatment Plan* for Resident A, dated 01/03/2025. The *Functional Behavior Assessment and Behavior Treatment Plan* for Resident A documented that Resident A has a history of engaging in verbal aggression, sexually inappropriate behavior and using delusional speech and making false allegations against staff. The *Functional Behavior Assessment and Behavior Treatment Plan* for Resident A documented that Resident A's false allegations may be symptoms of her schizophrenia but can also be reinforced or exacerbated by attention from others. The *Functional Behavior Assessment and Behavior Treatment Plan* for Resident A documented that phone calls may serve Resident A in gaining attention as well. The *Functional Behavior Assessment and Behavior Treatment Plan* for Resident A documented that appropriate response strategies for Resident A's false allegations is for direct care staff to remain diligent in reporting any allegations while maintaining an objective and neutral approach.

On 10/15/2025, I interviewed direct care staff Naza Ruben regarding the allegations. Naza Ruben denied being asleep when emergency services arrived and clarified that no "firefighter" or fire services personnel had been to the facility on the night of the allegations and clarified that it was only ambulance personnel. Naza Ruben reported emergency services arrived at this facility between 11PM and 12AM. Naza Ruben clarified that she turns off the living room light at night to prompt residents to go to bed during sleeping hours. Naza Ruben reported that even with the lights out in the living room, she does not sleep during the overnight hours.

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:	Based upon my investigation, which consisted of interviews with Resident A, Resident B, direct care staff Naza Ruben, and direct care staff Dolpart Mihna as well as a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that sufficient direct care staff were not on duty at all times to provide supervision, personal care or protection to residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

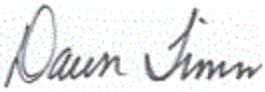
IV. RECOMMENDATION

I recommend that the current license status continue.

10/15/2025

Eli DeLeon Date
Licensing Consultant

Approved By:



10/15/2025

Dawn N. Timm Date
Area Manager