GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 20, 2026

Michael Ojomolade
Glamike Cares Inc
31451 Grandview Ave.
Westland, MI 48186

RE: License #: AS820386017
Investigation #: 2026A0992008
Clair Home

Dear Michal Ojomolade:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820386017
Investigation #:	2026A0992008
Complaint Receipt Date:	12/01/2025
Investigation Initiation Date:	12/04/2025
Report Due Date:	01/30/2026
Licensee Name:	Glamike Cares Inc
Licensee Address:	31451 Grandview Ave. Westland, MI 48186
Licensee Telephone #:	(734) 664-5877
Administrator:	Natashia Coleman
Licensee Designee:	Michael Ojomolade
Name of Facility:	Clair Home
Facility Address:	710 Clair Street Inkster, MI 48141
Facility Telephone #:	(734) 895-7373
Original Issuance Date:	10/30/2017
License Status:	REGULAR
Effective Date:	01/01/2024
Expiration Date:	12/31/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has been repeatedly observed screaming and appearing distressed, with another male resident yelling at him, trying to pull him into a vehicle, and attempting to force him back inside, causing the man to appear fearful. No known staff was present was present. There are concerns regarding adequate supervision. There is no healthy food in the home just frozen hot dogs and bologna.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/01/2025	Special Investigation Intake 2026A0992008
12/04/2025	Special Investigation Initiated - Telephone Adult protective services, Megan Kinder.
12/05/2025	Contact - Face to Face Resident B
12/05/2025	Contact - Telephone call made Licensee designee, Michael Ojomolade.
12/05/2025	Direct care staff, Emmanul, Residents A and B.
12/05/2025	Contact - Telephone call made Resident A
12/10/2025	Inspection Completed On-site Mr. Ojomolade and Resident B
01/22/2026	Contact - Telephone call made Resident A's supports coordinator, Tanielle Brown with Adult Wellbeing Services, was not available. Message left.
01/29/2026	Contact - Telephone call made Ms. Brown
01/29/2026	Inspection Completed On-site Resident A, and Relative A

01/29/2026	Exit Conference Mr. Ojomolade
01/30/2026	Contact - Telephone call made Administrator, Natashia Coleman

ALLEGATION: Resident A has been repeatedly observed screaming and appearing distressed, with another male resident yelling at him, trying to pull him into a vehicle, and attempting to force him back inside, causing the man to appear fearful. No known staff was present was present. There are concerns regarding adequate supervision.

INVESTIGATION: On 12/04/2025, I contacted adult protective services (APS), Megan Kinder regarding the allegation. Prior to addressing the allegation, Ms. Kinder stated Resident A is verbal and high functioning. She stated there are concerns regarding Resident A receiving nutritious meals and the lack of staffing. She stated Resident A disclosed meals are not being provided on a regular basis and when he is given a meal, it is typically hot dogs or bologna sandwiches. She stated Resident A also stated license designee, Michael Ojomolade is very mean to him. Ms. Kinder stated Resident A's father, Relative A, resides in the facility and assists with Resident A's care. She stated Relative A does not require adult foster care but resides in the home. Ms. Kinder stated she substantiated.

On 12/05/2025, I conducted an unannounced onsite inspection. Upon my arrival, Resident B answered the door. He stated there was no direct care staff (DCS) onsite, and he was not sure when DCS was going to arrive. I immediately contacted licensee designee, Michael Ojomolade and made him aware that allegations were received against the facility. I made Mr. Ojomolade aware that I was currently at the facility and there is no DCS onsite. Mr. Ojomolade stated he was at the grocery store and would return shortly. I explained that the residents cannot be left unsupervised and that adult foster care requires 24-hr supervision. Mr. Ojomolade explained that Residents A and B are private pay and they do not require 24-hr supervision; he stated they can be left unsupervised. I asked Mr. Ojomolade how soon he could return to the facility. He stated he needed to complete an assessment and would return thereafter. I insisted he return or contact a DCS to come onsite. Mr. Ojomolade stated he cannot afford to hire staff to provide 24-hr supervision and he reiterated the residents do not require 24-hr supervision. Mr. Ojomolade stated he has attempted to obtain a contract through Detroit Wayne Integrated Health Network (DWIHN) so that he would receive additional contract dollars to hire additional staff, but he has not secured a contract. Mr. Ojomolade stated he has invested a lot of money in the facility and cannot afford to pay staff. I insisted he return to the facility or contact a DCS to come onsite. Mr. Ojomolade stated he would have DCS come onsite momentarily.

Ten minutes later DCS, Emmanul Ojomolade arrived. I explained to him that there must be staff on shift at all times, unless the residents are not in the facility, he stated he understood. I confirmed Resident A and B's wellbeing and obtained a contact number for Residents A; he agreed to be interviewed by telephone for privacy. Resident B denied having any concerns.

On 12/05/2025, I contacted Resident A and interviewed him regarding the allegation. Resident A stated after I visited the facility, he left with Relative A and the staff left as well; he stated Resident B remained at the facility. He stated there is no DCS onsite 24-hrs a day, and most of the time the residents are there alone. He stated Relative A buys his food and prepares his meals. He stated if DCS prepare a meal, it is either hot dogs or a bologna sandwich. He stated Mr. Ojomolade has his bridge card and he only buys hot dogs and bologna. He stated he and Relative A buy their own breakfast. He stated Relative A also helps with his medications and provides transportation as needed. He stated DCS administers his medication when they are onsite, but that it is not on a regular basis.

On 12/10/2025, I completed an unannounced onsite inspection, Mr. Ojomolade was present, and I addressed the allegation with him. Mr. Ojomolade stated he cannot afford DCS. He stated he has exhausted his funds trying to maintain the facility and cannot afford additional staffing. Mr. Ojomolade stated he has assessed Residents A and B, and they do not require 24-hr supervision. He stated Residents A and B can be left alone and they are private pay. I explained that Residents being private pay does not determine if they require 24-hr supervision and if living in a licensed adult foster care 24-hr supervision is not optional. I requested Resident A and B's resident files to review their assessment plans. Mr. Ojomolade looked for the resident files, around the facility, and, in his car, he was unable to provide Resident A and B's assessment plans. I reviewed Resident A and B's resident files. Resident A's resident file did not contain an assessment plan, resident care agreement or health care appraisal for 2024 or 2025. Resident B's resident file contained an assessment plan, resident care agreement, and health care appraisal but neither document was thoroughly completed. Mr. Ojomolade stated he needed to get the files together. I explained to Mr. Ojomolade, Resident A's documentation has not been updated in the last two years. As for Resident B's resident file, the documentation is incomplete. Mr. Ojomolade stated he has been having some difficulty maintaining the files. I requested Resident A and B's medication records. Mr. Ojomolade was unable to provide 2024 or 2025 medication administration records (MARs) for Resident A, although he stated he does administer Resident A's medications as prescribed. The last MARs completed for Resident A was dated 11/30/2023. He stated Resident B is not prescribed medication. I requested the facility emergency evacuation records, which Mr. Ojomolade was unable to provide.

I requested to review the menu, which Mr. Ojomolade was unable to provide. I observed minimal food in the refrigerator milk, eggs, bologna and hot dogs. The freezer contained multiple packs of frozen hot dogs and bologna. The deep freezer

contained multiple bags of groceries that Mr. Ojomolade stated were for his family, not the residents. I observed four frozen dinners (two baked chicken and two mac-n-cheese dinners), two loaves of bread and a bag of frozen french fries. The pantry contained several non-perishable items including cans of diced tomatoes, chili, sloppy joe, vegetables, wild rice, two boxes of cereal, sugar and peanut butter. Mr. Ojomolade stated the residents eat cereal for breakfast and deli sandwiches for lunch. The only deli meat observed was bologna. He stated Resident A and Relative A go out for dinner daily and Resident B's aunt brings him dinner daily. Mr. Ojomolade confirmed he is in possession of Resident A's bridge card and he buys what they request.

I explained to Mr. Ojomolade that it appears he has not demonstrated compliance with the Act and administrative rules within the past two years. Mr. Ojomolade reiterated that he has tried to secure a contract to receive additional funds to operate the facility. He stated he has exhausted his funds and cannot afford to hire additional staff to assist him. Mr. Ojomolade was unable to provide an explanation why he has not maintained the resident and facility records.

I interviewed Resident B regarding the allegation. Resident B stated DCS come onsite daily, but they do not remain onsite throughout the day. He stated the DCS are there for maybe four hours a day. He stated he doesn't really eat breakfast and if he does, he eats cereal. He stated his aunt brings him dinner daily. Resident B stated he is not prescribed medication. Resident B denied having any concerns.

On 01/29/2026, I contacted Resident A's supports coordinator, Tanielle Brown with Adult Wellbeing Services. Ms. Brown stated she inherited the case in late October 2025. She stated she was not aware the facility was licensed. She stated she visited with Resident A on 1/27/2026 and at that time there was no DCS onsite. She stated the facility does not really have staffing. She stated on 01/10/2026, Resident A fell in the home and he is currently wearing a cast; Ms. Brown was uncertain if DCS was onsite at the time Resident A fell. She stated she has not received an incident report regarding Resident A falling. Ms. Brown stated Resident A does not have a guardian and makes his own decision with the help of Relative A. She confirmed Relative A resides in the facility. She stated she is in the process of trying to establish a guardian for Resident A and she does not feel Relative A is capable of being his guardian. Ms. Brown stated Resident A requires regular medical visits and Relative A sometimes interferes with appointments. She stated at this time she is exploring other relatives.

On 01/29/2026, I completed an unannounced inspection and interviewed Resident A, and Relative A. I observed a cast on Resident A's right arm. When I asked what happened, he stated he fell in his bedroom. I asked what DCS was onsite when he fell, he stated he wasn't sure. He stated the DCS is rarely onsite. He stated Relative A took him to urgent care and the cast was placed on his arm because he injured his wrist.

I interviewed Relative A, he stated Resident A's feet were tangled in his cover and he fell on the floor. He stated he immediately took him to urgent care for medical treatment. Relative A stated there was no DCS onsite when the incident occurred.

On 01/29/2026, I conducted an exit conference with Mr. Ojomolade; he did not dispute the findings. I provided Mr. Ojomolade an opportunity to explain the deficiencies. He stated that he exhausted his funds trying to maintain the facility and could not afford to hire staff to assist him with the operations. He did not provide an explanation for the quality-of-care violations. I explained that due to multiple violations and the level of substantial non-compliance that jeopardizes the health and safety of the residents, disciplinary action against the license is recommended. I informed him he will be notified in writing of the department's action and his options for resolution of this matter.

On 01/30/3036, I contacted Administrator, Natashia Coleman regarding the allegation. Ms. Coleman stated she has been on medical leave for a couple months and denied having any knowledge of the daily operations of the facility.

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: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**

ANALYSIS:	During this investigation, I interviewed licensee designee, Michael Ojomolade; Administrator, Natashia Coleman; APS, Megan Kinder; Resident A's supports coordinator, Tanielle Brown with Adult Wellbeing Services; Relative A and Resident A and B regarding the allegation. All confirmed residents are regularly left home alone. Licensee designee, Michael Ojomolade stated he cannot afford the staffing to provide 24-hr supervision and assist with the operation of the facility. On 12/05/2025, I completed an unannounced onsite inspection, and there was no DCS onsite. Based on the findings, there is sufficient evidence to support the allegation that licensee designee, Michael Ojomolade did not provide sufficient direct care staff for the supervision, personal care, and protection of residents which jeopardizes the licensee's guidance of residents in the activities of daily living and the continual responsibility of the licensee to take reasonable action to insure the health, safety, and well-being of a resident. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.

ANALYSIS:	During this investigation, I interviewed licensee designee, Michael Ojomolade; APS, Megan Kinder; Resident A and B regarding the allegation. Resident A confirmed the allegation and stated when a meal is prepared it is primarily hot dogs and bologna. On 12/10/2025, I completed an unannounced onsite inspection. I observed minimal food in the refrigerator. I observed milk, eggs, bologna and hot dogs. The freezer contained multiple packs of frozen hot dogs and bologna, which supports statements made by Resident A. Based on the findings there is sufficient evidence to support the allegation licensee designee, Michael Ojomolade. Mr. Ojomolade stated the residents eat cereal for breakfast and deli sandwiches for lunch. The only deli meat observed was bologna. He stated Resident A and Relative A go out for dinner daily and Resident B's aunt brings him dinner daily. Mr. Ojomolade, did not provide daily a minimum of 3 nutritious meals to residents, which jeopardizes resident health and care by not providing the opportunity for improved physical condition based on the benefits of nutritious meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/10/2025, I reviewed Resident A and B's resident files. Resident A's resident file did not contain an assessment plan, resident care agreement or health care appraisal for 2024 or 2025. Resident B's resident file contained an assessment plan, resident care agreement, and health care appraisal form but the documents were not completed. Mr. Ojomolade stated he needed to get the files together. I explained to Mr. Ojomolade Resident A's documentation has not been updated in the last two years. As for Resident B's resident file, the documentation is not completed. Mr. Ojomolade stated he has been having some difficulty maintaining the files. I reviewed Resident A and B's medication records. Mr. Ojomolade was unable to provide 2024 or 2025 medication administration records (MARs) for Resident A, although he stated he does administer Resident A's medications as prescribed. The last MARs completed for Resident A was dated 11/30/2023. He stated Resident B is not prescribed medication. I reviewed Resident A and B's weight record. The last weight recorded for Resident A was dated 12/05/2023. Resident B's weight was last

recorded 09/2025. I requested the facility emergency evacuation records, which Mr. Ojomolade was unable to provide. I requested to review the menu, which Mr. Ojomolade was unable to provide. I observed minimal food in the refrigerator. I observed milk, eggs, bologna and hot dogs. The freezer contained multiple packs of frozen hot dogs, and I explained to Mr. Ojomolade that it appears he has not demonstrated compliance with the Act and administrative rules within the past two years. Mr. Ojomolade reiterated that he has tried to secure a contract to receive additional funds to operate the facility. He stated he has exhausted his funds and cannot afford to hire additional staffing. Mr. Ojomolade was unable to provide an explanation why he has not maintained the resident and facility records

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.
ANALYSIS:	On 12/10/2025, I requested to review the facility emergency evacuation records. Mr. Ojomolade was unable to provide emergency evacuation records within the last 2 years, which jeopardizes resident safety and the continual responsibility of the licensee to take reasonable action to ensure the safety and well-being of a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	On 12/10/2025, Mr. Ojomolade was unable to provide 2024 or 2025 medication administration records (MARs) for Resident A, although he stated he does administer Resident A's medications as prescribed. The last MARs completed for Resident A was dated 11/30/2023. Not completing a resident individual MAR jeopardizes resident health, treatment and care because the licensee is unable to demonstrate that medications have been administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.

ANALYSIS:	On 12/10/2025, Resident A's resident file did not contain a 2024 or 2025 health care appraisal. Resident B's resident file did not contain health care appraisal completed at the time of admission. Mr. Ojomolade was unable to provide current health care appraisals for Residents A and B. **REPEAT VIOLATION** **Rule 400.685 (10) is the updated rule for R 400. 14301 (10) as promulgated 11/03/2025. Licensing Study Report dated 12/21/2023, CAP dated 12/19/2023. The licensee submitted an approved plan of correction, but based on these findings, Mr. Ojomolade has yet to implement the plan successfully.**
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	On 12/10/2025, Resident A's resident file did not contain a completed 2024 or 2025 assessment plan. Resident B's resident file did not contain a complete assessment plan at the time of admission. Mr. Ojomolade was unable to provide a current assessment plan for Residents A and B. **REPEAT VIOLATION** **Rule 400.685 (4) is the updated rule for R 400. 14301 (4) as promulgated 11/03/2025. Licensing Study Report dated 12/21/2023, CAP dated 12/19/2023. The licensee submitted an approved plan of correction, but based on these findings, Mr. Ojomolade has yet to implement the plan successfully.**
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	On 12/10/2025, Resident A's resident file did not contain a complete 2024 or 2025 resident care agreement. Resident B's resident file did not contain a complete resident care agreement at the time of admission. Mr. Ojomolade was unable to provide a current resident care agreement for Residents A and B. Not completing a resident care agreement jeopardizes resident care and protection because it provides an agreement for care and cost and protects them from financial exploitation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(g) Admission and monthly weight record.**

ANALYSIS:	On 12/10/2025, I reviewed Resident A and B's weight record. Resident A's weight was last recorded on 12/05/2023. Resident B's weight was last recorded 09/2025. Mr. Ojomolade was unable to provide current weight records for Residents A and B. Not completing a resident's weight record jeopardizing resident health and care because weights are essential for accurate medication dosage, evaluating the effectiveness of health plans, and monitoring significant changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Michael Ojomolade has not demonstrated compliance with the Act and administrative rules. On 11/19/2025, the department received an on-line application from Michael Ojomolade. When a licensee and or applicant submit an application, they attest to the following:

> I have read 1979 PA 218 and the Administrative Rules Regulating the operation of Adult Foster Care Facilities.
> If granted a license I will comply with the Act and these Rules.

Even though Michael Ojomolade agreed to comply with the rules he willfully and substantially violated them with repeat violations. I recommend revocation of the license.

2/5/2026

_____

Denasha Walker Date
Licensing Consultant

Approved By:

2/5/2026

_____

Ardra Hunter Date
Area Manager