GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 29, 2022

Yewande Okubanjo
PO Box 4625
East Lansing, MI 48826

RE: License #: AS330387746
Investigation #: 2023A1033014
Shalom Adult Foster Care

Dear Ms. 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) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330387746
Investigation #:	2023A1033014
Complaint Receipt Date:	12/08/2022
Investigation Initiation Date:	12/13/2022
Report Due Date:	02/06/2023
Licensee Name:	Yewande Okubanjo
Licensee Address:	507 West Barnes Avenue Lansing, MI 48910
Licensee Telephone #:	(404) 992-2222
Administrator:	Olufemi Okubanjo
Licensee Designee:	N/A
Name of Facility:	Shalom Adult Foster Care
Facility Address:	507 West Barnes Avenue Lansing, MI 48910
Facility Telephone #:	(517) 721-1916
Original Issuance Date:	09/27/2017
License **Status:**	REGULAR
Effective Date:	03/27/2022
Expiration Date:	03/26/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
There are bedbugs in the facility.	Yes
There is a curfew and if residents are not home by a certain time, they will be locked out.	No

III. METHODOLOGY

12/08/2022	Special Investigation Intake 2023A1033014
12/08/2022	Contact - Telephone call made Attempt to interview Resident A. Message left, awaiting call back.
12/13/2022	Special Investigation Initiated - On Site Interview with Administrator, Olufemi Okubanjo, Resident B & Resident C. Walk through of facility completed.
12/13/2022	Exit Conference in person with Administrator Olufemi Okubanjo. Via email with Licensee Yewande Okubanjo.
12/13/2022	Inspection Completed-BCAL Sub. Compliance
12/14/2022	APS Referral- No referral required at this time. There is no current suspicion of abuse or neglect.

ALLEGATION:

There are bedbugs in the facility.

INVESTIGATION:

On 12/8/22 I received an online complaint regarding the Shalom Adult Foster Care (the facility). The complaint alleged that there has been a bedbug infestation in the facility since 9/1/22. On 12/13/22 I completed an on-site investigation at the facility and I interviewed facility Administrator, Olufemi Okubanjo. Mr. Okubanjo reported he was first made aware of the issue with bedbugs about five weeks prior to this investigation. Mr. Okubanjo reported that the facility does not currently have a bedbug infestation as he took the proper precautions to treat the issue. He reported the adjoining facility currently has an issue with bedbugs that they are working to resolve. Mr. Okubanjo reported that he has spoken with a representative from the

Orkin Pest Control company and has been using sprays and powder to eliminate the issue with the bedbugs. He reported they launder all the linens weekly and residents shower on a frequent basis to help control the issue. Mr. Okubanjo reported that the issue with the bedbugs was first reported to him by Resident A.

During the on-site investigation on 12/13/22, I walked through the facility with Mr. Okubanjo and observed the furniture in the living room and the furniture in all three resident bedrooms. The living room did not have active evidence of bedbugs however all three resident bedrooms contained evidence of living bedbugs on the mattresses of all four residents. There was evidence of young and mature bedbugs, on mattresses and pillows, as well as stains on the mattresses and mattress covers from the infestation.

During on-site investigation on 12/13/22, I interviewed Resident B who reported he "loves it here" when talking about the facility. He reported that there have been issues with the bedbug infestation that has not been resolved. Resident B reported that he has been "squishing" the bedbugs when he sees them, and he did report bites on his arms from the bedbugs.

During on-site investigation on 12/13/22, I interviewed Resident C who reported the facility has been having issues with bedbugs. Resident C reported he tries to kill the bedbugs when he sees them, but it has not been doing much good in the effort to remedy the problem.

During on-site investigation I, again, spoke with Mr. Okubanjo about the visible bedbugs in the facility. Mr. Okubanjo reported that the residents had not come to him, after the initial bedbug treatment, to tell him that there was a continued issue.

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 upon interviews with Mr. Okubanjo, Resident B, and Resident C, as well as observations during the on-site investigation on 12/13/2022, this facility does have an active issue with a bedbug infestation. Although Mr. Okubanjo noted he had been aware of the issue and completed preliminary treatments and modified the laundry schedule as well as resident shower schedules, the evidence of bedbug activity in the resident rooms was highly noticeable. Mr. Okubanjo further reported that the residents did not come to him to update him to the continued infestation, however, the evidence of bedbug activity was visible upon simple visual inspection and required further treatment that was not being provided at the time of the on-site investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a curfew and if residents are not home by a certain time, they will be locked out.

INVESTIGATION:

On 12/8/22 I received an online complaint which alleged direct care staff at the facility are expecting residents to abide by a 7:30pm curfew and if residents do not make it back in time for curfew, the residents are being told that they will be locked out of the facility. On 12/13/22 I completed an on-site investigation at the facility and interviewed Mr. Okubanjo. Mr. Okubanjo reported the facility does enforce a 7:30pm curfew but they do not threaten residents that they will be locked out of the facility if they are not home by 7:30pm. Mr. Okubanjo reported he has never told a resident that they will be locked out of the facility for the night if they miss the curfew time. Mr. Okubanjo reported that there was a recent incident where Resident A was late for curfew as he was watching television with a resident at the adjoining facility and was told to lock the door behind him when he came back to the facility. Mr. Okubanjo reported Resident A became upset with the request for him to lock the door and they had a disagreement about why Mr. Okubanjo wanted the door to the facility locked. Mr. Okubanjo reported that locking the door at night is for the safety of the residents and he did explain this to Resident A. Mr. Okubanjo reported that when residents move into the facility, they are told about the 7:30pm curfew, verbally. Mr. Okubanjo reported that the facility does have a list of house rules provided to each resident upon admission to the facility but the rule about curfew has not been added to this list. Mr. Okubanjo reported that if a resident has an activity that is known to extend beyond the curfew, they make accommodations with the resident for this activity.

During on-site investigation on 12/13/22 I interviewed Resident B. Resident B reported that he cannot recall how long he has lived at the facility but, “I love it here!” Resident B reported that he is familiar with the curfew policy at the facility and has no difficulty with this policy. Resident B reported direct care staff lock the door at 7:30pm but if someone comes home late for curfew they are always let in the facility. Resident B reported he has never been told that he is not allowed in the facility past curfew, and he has never heard this stated to any of the four residents of the facility.

During on-site investigation on 12/13/22 I interviewed Resident C who reported he has lived at the facility for about four years. Resident C reported he is familiar with the curfew policy of the facility and that he has no issues following this policy. Resident C reported the facility doors are locked at 7:30pm but if a resident comes home late, they will unlock the doors and let the resident in the building. Resident C reported that at one time he was out smoking on the porch, past curfew, and the doors were locked but he knocked and was granted access to the facility. Resident C reported he has never experienced any resident being told they would not be allowed in the facility if they were late for curfew.

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:	Based upon interviews with Mr. Okubanjo, Resident B, and Resident C, the facility does enforce a 7:30pm curfew but they are not locking residents out and denying them access to the facility if they are late for this curfew time. Mr. Okubanjo reported that the curfew is established for resident safety and accountability to ensure direct care staff know where all residents are at the end of the day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, no change to the current status of the license is recommended at this time.

12/14/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

12/29/2022

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Dawn N. Timm Date
Area Manager