GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2025

Bose Ogbeifun
Trustcare Group Home Inc
Suite 330
16250 Northland Drive
Southfield, MI 48075

RE: License #: AS820293763
Investigation #: 2025A0992021
Wyandotte AFC Home 2

Dear Bose Ogbeifun:

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,

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 #:	AS820293763
Investigation #:	2025A0992021
Complaint Receipt Date:	03/26/2025
Investigation Initiation Date:	03/27/2025
Report Due Date:	05/25/2025
Licensee Name:	Trustcare Group Home Inc
Licensee Address:	Suite 330 16250 Northland Drive Southfield, MI 48075
Licensee Telephone #:	(313) 213-6723
Administrator:	Bose Ogbeifun
Licensee Designee:	Bose Ogbeifun
Name of Facility:	Wyandotte AFC Home 2
Facility Address:	395 Kings Hwy. Wyandotte, MI 48192
Facility Telephone #:	(734) 282-5530
Original Issuance Date:	03/17/2008
License Status:	REGULAR
Effective Date:	10/27/2024
Expiration Date:	10/26/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Chinyeaka left the keys to the medicine cabinet in the door, and Resident A took a lot of medication and overdosed.	Yes
Direct care staff, Rosemary was yelling and asking why Resident A was recording her and she asked if he was “mental” and did he have a problem.	Yes

III. METHODOLOGY

03/26/2025	Special Investigation Intake 2025A0992021
03/27/2025	Special Investigation Initiated - On Site Home manager, Lashonda Wilson and Resident A
04/10/2025	Contact - Telephone call made Direct care staff, Chinyeaka "Chi-Chi" Gerald
04/10/2025	Contact - Telephone call made Licensee designee, Bose Ogbeifun.
04/10/2025	Contact - Telephone call made Office of Recipient Rights, Ann Alexander.
05/09/2025	Contact - Telephone call made Direct care staff, Emuobonuvie “Queen” Odjugo
05/09/2025	Contact - Telephone call made Direct care staff, Rosemary Okpo.
05/09/2025	Contact - Telephone call made Ms. Ogbeifun.

ALLEGATION: Direct care staff, Chinyeaka left the keys to the medicine cabinet in the door, and Resident A took a lot of medication and overdosed.

INVESTIGATION: On 03/27/2025**,** I completed an unannounced onsite inspection and interviewed the home manager, Lashonda Wilson and Resident A regarding the allegation. Lashonda stated she was not on shift when the incident occurred. She stated she received a telephone call from Resident A around 4:00 a.m. and he stated he will be gone, unalive by the time she arrives for shift. Lashonda stated Resident A told her the keys to the medication cabinet were left in the door and he had taken several of his medications at once. Lashonda stated she immediately called the staff on shift which was Chinyeaka "Chi-Chi" Gerald and Emuobonuvie “Queen” Odjugo and told them to check on Resident A and call 911. Lashonda stated she contacted patient care coordinator, Quiana Jackson, and proceeded to the home. She stated Quiana notified the licensee designee, Bose Ogbeifun. She stated when she arrived, law enforcement and the emergency medical services (EMS) were there. She stated Resident A was giving them a hard time and he refused to go the hospital. However, the incident was identified as a suicide attempt, and Resident A was forced to go to the hospital by law enforcement. Lashonda stated Resident A was examined by Wyandotte Henry Ford Hospital and released the same day. As far as the medications being left unlocked, Lashonda explained that all staff are equally responsible for making sure the medications are always locked. Lashonda stated she conducted an internal investigation and Chi-Chi admitted to leaving the keys in the door. Lashonda stated the medications are stored in the hallway closet near the resident bathroom. Lashonda stated Chi-Chi is suspended pending investigation. Lashonda provided me with copies of the incident reports that were completed and Resident A’s hospital discharge documents.

I interviewed Resident A; he requested that Lashonda remain present. Resident A stated it was approximately 3:00 a.m. and he noticed the keys were left in the door. He stated he cracked the door just enough to get a handful of medication. He stated he wanted to take enough medication to suppress his breathing. He stated the staff were asleep on the couch in the living room. Resident A showed me a picture of two females he identified as staff sleeping on the couch. He stated he started writing a letter to Lashonda but decided to call her instead. He stated he called her to thank her for everything she had done for him, and he let her know he had taken a handful of medication. Resident A stated he does not remember much after that other than struggling with the police because he did not want to go to the hospital. He stated at times he still wants to die.

On 04/10/2025, I contacted direct care staff, Chi-Chi regarding the allegation. Chi-Chi confirmed she was on midnight shift with Queen on the day in question. She stated it was time to clean the home, and the cleaning supplies are in the hallway closet with the medications. She stated after she finished mopping, she mistakenly left the keys in the door. She stated after she finished cleaning, she was sitting in the chair in the living room, she denied being asleep. She stated Lashonda called and made her aware that the keys were left in the door, and Resident A had taken some medication. She stated they checked on the residents and called 911. Chi-Chi stated EMS arrived and Resident A was transported to the hospital. Chi-Chi stated it was a mistake. She stated she was suspended and just returned this week.

On 04/10/2025, I contacted licensee designee, Bose Ogbeifun regarding the allegation, which she confirmed. She stated Chi-Chi was suspended and will receive in-service training. Bose stated she has been having issues with staff sleeping on shifts, which is a concern. She stated she has held staff meetings to address this issue, and she intends to have the Office of Recipient Rights come out and train the staff.

On 04/10/2025, I contacted the Office of Recipient Rights Investigator (ORR), Ann Alexander. Alexander confirmed the allegation. She stated Resident A showed her a video of staff sleeping. She stated the allegation is substantiated.

On 05/09/2025, I contacted direct care staff, Emuobonuvie “Queen” Odjugo regarding the allegation. Queen confirmed she was on shift when the incident occurred. She stated both staff are responsible for cleaning the home; one staff does the main level and the other does the second level. She stated after the residents went to bed, she completed her chores downstairs. She stated when she finished, she put the cleaning supplies away, locked the door and put the key in her bag. She stated the cleaning supplies and medications are in the same closet. She stated later that night, Chi-Chi asked for the key to get the cleaning supplies to do her chores upstairs. Queen stated she was sitting in the chair, and she saw Resident A in the hallway and assumed he was going to the bathroom. She stated around 3:00 a.m. or so, the telephone rang and it was Lashonda. Queen stated Lashonda was speaking very fast and she could not understand her. She stated Chi-Chi grabbed the phone and Lashonda told her to the keys were left in the door, and Resident A had taken a handful of medication. Queen stated she checked on all the residents and they were sleeping except for Resident A. She stated Resident A was sitting up. She stated Resident A told them there was no need to call 911 because he wants to kill himself. Queen stated Chi-Chi called 911.

On 05/09/2025, I conducted an exit conference with Bose. I made her aware that based on the investigative findings, there is sufficient evidence that the medications were not locked. Resident A was able to access the medications and consumed a handful. The allegation is substantiated. Ms. Bose denied having any questions. She stated she would review the report and respond accordingly.

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:	During this investigation, I interviewed licensee designee, Bose Ogbeifun; home manager, Lashonda Wilson; direct care staff, Chinyeaka "Chi-Chi" Gerald and Emuobonuvie “Queen” Odjugo; ORR, Ann Alexander; Resident A regarding the allegation. All confirmed the allegation. Based on the investigative findings, there is sufficient evidence that the medications were not locked. Resident A was able to access the medications and consumed a handful and required medical attention. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During this investigation, I interviewed licensee designee, Bose Ogbeifun; home manager, Lashonda Wilson; direct care staff, Chinyeaka "Chi-Chi" Gerald and Emuobonuvie “Queen” Odjugo; ORR, Ann Alexander; Resident A regarding the allegations. I observed pictures of two females staff sleeping on the couch Direct care workers Chinyeaka "Chi-Chi" Gerald and Emuobonuvie “Queen” Odjugo did not provide Resident A with supervision and protection. Resident A accessed the medications and consumed a handful of medications while staff were asleep on the couch. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Rosemary was yelling and asking why Resident A was recording her and she asked if he was "mental" and did he have a problem.

INVESTIGATION: On 03/27/2025, I completed an unannounced onsite inspection and interviewed the home manager, Lashonda Wilson and Resident A regarding the allegation. Lashonda stated she has never witnessed Rosemary yelling at Resident A, but stated Resident A showed her recordings of Rosemary yelling at him.

I interviewed Resident A; he requested that Lashonda remain present. Resident A stated the home is hectic because the staff, specifically Rosemary, does not do her job and she is confrontational. Resident A played a recording that he recorded on 3/21/2025, of a female voice going back and forth with him. The female asked him if he was "mental" and did he "have a problem." Resident A stated he feels he is being targeted because he told Lashonda and Bose that the staff sleep on shift. Resident A stated Rosemary makes it difficult for him to be at peace when she is on shift. Resident A had several different recordings of staff yelling and being argumentative.

On 04/10/2025, I contacted licensee designee, Bose Ogbeifun regarding the allegation. Bose stated Resident A has expressed his concerns regarding the staff. She stated she conducted an internal investigation and determined this issue is only with Resident A. Bose went on to say that Resident A constantly records the staff and makes it difficult for the staff to do their work. She stated staff does not want to work in that home because Resident A tends to be intrusive. Bose stated she has held staff training, and she intends to have the Office of Recipient Rights come out and train the staff.

On 04/10/2025, I contacted the Office of Recipient Rights Investigator (ORR), Alexander. Alexander confirmed she investigated the allegation. She stated the allegation is substantiated. She stated Resident A showed her a video recording and she overheard the staff calling Resident A "mental."

On 05/09/2025, I contacted direct care staff, Emuobonuvie "Queen" Odjugo and interviewed her regarding the allegation. Queen denied she has ever witnessed Rosemary or any of the other staff argue with Resident A, call him names or speak to him in a demeaning manner. She stated Resident A can be very dramatic and intrusive. She stated he walks up to the staff and just starts recording. Queen stated you have to have self-control because it is upsetting when you are constantly being recorded.

On 05/09/2025, I contacted direct care staff, Rosemary Okpo and interviewed her regarding the allegation. Rosemary denied the allegation. Rosemary stated one day Resident A was acting strange. She stated he was stalking the staff, she stated she was assigned as Resident B's 1:1 staffing but Resident A was recording her. She stated he was swearing and taking pictures of her, and she asked him, why was he behaving like that. She stated she was removed from the schedule and suspended

because of her interaction with Resident A. Rosemary stated she also received in-service training.

On 05/09/2025, I conducted an exit conference with Bose. I made her aware that based on the investigative findings, there is sufficient evidence that Rosemary made derogatory remarks about Resident A. The allegation is substantiated. Ms. Bose denied having any questions. She stated she would review the report and respond accordingly.

APPLICABLE RULE	
R 400.14308	**Resident protection.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R400.14102(1)(m).** **(i) Any electrical shock device.**

ANALYSIS:	During this investigation, I interviewed licensee designee, Bose Ogbeifun; home manager, Lashonda Wilson; direct care staff, Emuobonuvie “Queen” Odjugo and Rosemary Okpo; ORR, Ann Alexander; and Resident A regarding the allegations. I reviewed a recording recorded on 3/21/2025 by Resident A, of a female voice going back and forth with him. The female asked him if he was “mental” and did he “have a problem.” It has been established that direct care worker Rosemary Okpo made derogatory remarks about Resident A. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

5/13/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

5/14/2025

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Ardra Hunter Date
Area Manager