GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 4, 2026

Roland Awolope
6425 Trotwood Street
Portage, MI 49024

RE: License #: AS390418731
Investigation #: 2026A0581013
Radiant Adult Foster Care

Dear Roland Awolope:

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 #:	AS390418731
Investigation #:	2026A0581013
Complaint Receipt Date:	01/13/2026
Investigation Initiation Date:	01/13/2026
Report Due Date:	03/14/2026
Licensee Name:	Roland Awolope
Licensee Address:	6425 Trotwood Street Portage, MI 49024
Licensee Telephone #:	(269) 873-4532
Administrator:	Roland Awolope
Licensee Designee:	N/A
Name of Facility:	Radiant Adult Foster Care
Facility Address:	Kalamazoo 5204 Beech Ave Kalamazoo, MI 49006
Facility Telephone #:	(269) 873-4532
Original Issuance Date:	10/30/2024
License Status:	REGULAR
Effective Date:	04/30/2025
Expiration Date:	04/29/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS

	Violation Established?
Resident A's bedroom contains cockroaches.	No
Resident A's bedroom is not maintained in a clean and sanitary condition due to the presence of garbage.	Yes
Resident A sexually assaulted Resident B and staff did not take appropriate action.	No

III. METHODOLOGY

01/13/2026	Special Investigation Intake - 2026A0581013
01/13/2026	Special Investigation Initiated – Telephone – Interview with Complainant.
01/22/2026	Inspection Completed On-site - Interview with staff and residents
01/22/2026	Contact - Telephone call made - Interview with licensee, Roland Awolope.
01/22/2026	Contact - Telephone call received - Voicemail from Amber Price Johnson, APS specialist.
01/23/2026	APS Referral - No referral necessary; APS received allegations and investigated.
01/23/2026	Contact - Telephone call made - Interview with Amber Price - Johnson
01/23/2026	Contact - Document Sent - Requested Kalamazoo Sheriff's Department police report
01/26/2026	Contact - Document Received - Email from Roland Awolope.
02/11/2026	Contact – Document Received – Email from Roland Awolope.
02/12/2026	Contact – Document Received – Email from Roland Awlope.
03/02/2026	Contact - Document Sent - Emails to Resident A's and Resident B's case managers.
03/02/2026	Contact - Telephone call made - Left voicemail with direct care staff, Honorine Gaju.

03/03/2026	Contact – Document Sent – Requested Kalamazoo Department of Public Safety police report.
03/03/2026	Contact – Telephone call made – Interview with Honorine Gaju.
03/04/2026	Contact – Document Received – Kalamazoo Sheriff's Department police report # 2026-00000792
03/04/2026	Exit conference with the licensee, Roland Awolope.

ALLEGATION:

- **Resident A's bedroom contains cockroaches.**

- **Resident A's bedroom is not maintained in a clean and sanitary condition due to the presence of garbage.**

INVESTIGATION: On 01/13/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. Although the written complaint did not specifically identify these concerns, Complainant alleged the concerns during an interview conducted by Adult Foster Care Consultant, Eli Deleon, on 01/13/2026.

On 01/22/2026, I conducted an unannounced inspection at the facility. I interviewed direct care staff, Sandrine Uwera. She acknowledged Resident A's bedroom being messy; however, she stated Resident A does not allow staff to clean or organize his belongings. She stated Resident A can become aggressive if staff try to clean his room. She stated she had not seen any bugs, including cockroaches, in either Resident A's bedroom or within the facility.

During my inspection, I observed Resident A's bedroom. Resident A's bedroom floor was observed with a significant amount of clutter and debris throughout the room, including clothing, paper items, boxes, and miscellaneous personal belongings scattered across the floor. Multiple items were piled along the walls and in front of furniture, limiting clear walking paths within the room. Open containers, loose items, and personal effects were observed on the floor near the bed area and storage furniture. The overall condition of the bedroom presented as cluttered and disorganized, with items not properly stored or contained. No pests, bugs, or signs of cockroaches were observed in Resident A's bedroom.

I interviewed Resident A who stated he did not want staff cleaning his room and stated he threatens staff when they attempt to do so. He stated he knows where all his belongings are located and reported no concerns with the current condition of his

room. Resident A denied the presence of any pests, bugs, or cockroaches in his bedroom.

Resident C stated she has observed staff attempting to assist Resident A in cleaning his room, but that he does not want assistance. She stated Resident A is “autistic” and prefers a messy room. Resident C stated staff assist her with keeping her room clean and that staff regularly clean the facility. Resident C stated she is familiar with what a cockroach looks like and would immediately report concerns to staff or the licensee, Roland Awolope, if observed. She denied seeing any kind of pests in the facility, including cockroaches.

Resident D and Resident E were interviewed; however, both residents had difficulty remaining focused and responding to questions. They denied observing any presence of bugs in the facility. I was unable to obtain information from either resident regarding staff cleaning or addressing the condition of Resident A’s bedroom.

I did not observe any signs of pests, bugs or cockroaches throughout the facility.

On 01/22/2026, I interviewed licensee Roland Awolope who stated he had been in the facility on or around 01/20 and was aware of the condition of Resident A’s bedroom. He stated Resident A threatens staff when they attempt to clean his room, which was consistent with information obtained during interviews with staff and residents. He stated Resident A can become verbally and physically assaultive and instructs staff not to clean his room or touch his belongings.

Roland Awolope stated staff are willing to clean Resident A’s room, but are unable to do so due to Resident A refusing assistance. He stated Resident A’s case manager has been able to encourage Resident A to clean his room by offering him incentives. Roland Awolope denied any concerns related to bugs, pests, or cockroaches in Resident A’s bedroom or elsewhere in the facility.

On 02/12/2026, I received an email from Roland Awolope containing a 30 day discharge notice for Resident A. The notice documented the reason for the discharge as “aggressive behavior”, which included breaking items in the house and using derogatory names towards staff and neighbors. Roland Awolope further documented in his email that the facility staff implemented a reward system when Resident A allowed staff to clean his room without verbal threats. Roland Awolope stated this effort, along with licensing’s expressed concern for the condition of his bedroom, had positively impacted the condition of Resident A’s bedroom.

Additionally, Roland Awolope provided photographs of Resident A’s bedroom. Based on my review of the photographs, the bedroom appeared clean, organized, and free of clutter and debris. Clear walking paths were observed, and the room appeared to be maintained in an acceptable condition.

On 03/03/2026, I interviewed direct care staff, Honorine Gaju. She stated Resident A's bedroom frequently becomes cluttered. She stated staff clean and mop the room during their shifts, but Resident A removes items from boxes and returns them to the floor. She denied Resident A being verbally or physically aggressive toward her during cleaning. She stated she has not observed or seen evidence of insects, pests, or cockroaches in the facility or in Resident A's bedroom.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on my onsite observations, interviews with residents, staff, and the licensee, Roland Awolope, there were no observed insects, rodents, pests, or sign of cockroaches in Resident A's bedroom or elsewhere in the facility. Therefore, there is no evidence supporting the failure to maintain an insect, rodent, or pest control program.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 01/22/2026, I observed Resident A's bedroom with excessive clutter and debris that limited clear walking paths and presented a potential safety hazard. Although photographs submitted by the licensee, Roland Awolope, on 02/12/2026 showed the bedroom had been cleaned and brought into an acceptable condition, the condition observed at the time of my inspection demonstrated that the premises were not adequately maintained to ensure resident health and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A sexually assaulted Resident B and staff did not take appropriate action.

INVESTIGATION: No additional information was provided in the complaint other than staff have limited English proficiency.

On 01/13/2026, Adult Foster Care consultant, Eli Deleon, interviewed Complainant. Complainant stated on 01/07/2026, Resident A sexually assaulted Resident B multiple times. Complainant stated the first incident occurred at approximately 8 pm, when Resident A exposed his penis and rubbed it against Resident B while Resident was fully clothes. Complainant further stated that Resident A told Resident B if he told anyone he would kill him. According to Complainant, Resident B went upstairs to report the incident to staff, but staff instructed him to return downstairs and go to bed.

Complainant stated the second sexual incident occurred when Resident A exposed his buttocks and passed gas into a fan that blew toward Resident B's face. Complainant did not provide a specific time for this incident.

Complainant stated the third incident occurred while Resident B was on the phone with Relative B1. Complainant stated Resident A told Resident B he had a "boner" and Resident B could see Resident A's erect penis through his pants. Complainant stated there was no physical contact between Resident A and Resident B during this incident and again did not provide a specific time for when it occurred.

Complainant stated law enforcement was notified of the incidences, but Complainant did not provide the name of the agency or a report number. Complainant stated Resident B was transported by law enforcement to the hospital for a psychological evaluation due to being upset about the alleged incidents and remained overnight. Complainant stated that after Resident A was released from the hospital, he returned to the facility to retrieve his belongings but left to reside with Relative B1.

Complainant also stated Resident A is a known sex offender. Complainant stated Resident B does not have supervision requirements such as line of sight or one on one staffing and has independent community access.

On 01/13/2026, a Public Sex Offender Registry search was completed for the facility's address. No registered sex offenders were identified as residing at the address.

Direct care staff Sandrine Uwera, stated she was not working on 01/07/2026; however, she stated it was her understanding Resident B reported he had been touched inappropriately by Resident A. Sandrine Uwera stated Resident A reported to her that he told Resident B he was going to touch him, but did not actually touch him.

Sandrine Uwera further stated Resident A tends to talks about what he will do rather than actually doing what he says. She stated Resident A and Resident B do not share a bedroom and that neither resident requires increased or enhanced

supervision while in the facility. Sandrine Uwera stated Resident B is generally able to communicate effectively and is outspoken. She denied being aware of any sexual assault occurring in the facility between Resident A and Resident B, as alleged.

Resident A initially stated he did not recall any incident consistent with the allegations. He later denied engaging in any wrongdoing or sexually assaulting Resident A declined to provide additional information.

Resident C stated she was not present in the facility when the alleged assault between Resident A and Resident B occurred. Resident C stated that Resident A has autism and ADHD and will sometimes “pick on” other by making gestures such as “bunny ears” or engaging in verbal teasing. She stated Resident A may make inappropriate comments, including sexual remarks, but she did not believe he would engage in sexually inappropriate physical behavior toward anyone, including Resident B. She further stated she would report any concerning behavior to staff and believes staff, including the licensee, Roland Awolope, would intervene if necessary.

Resident D and Resident E were interviewed; however, both residents had difficulty remaining focused and responding to questions. Resident D was unable to provide any information regarding the allegations and Resident E stated he moved into the facility after the alleged incident occurred. Resident F declined to be interviewed. Resident B was no longer residing in the facility at the time of inspection and therefore, I was unable to interview him regarding the allegations.

Licensee Roland Awolope stated on 01/07/2026 at approximately 10 pm, Resident B contacted him and reported that Resident A touched him in Resident B’s bedroom. Roland Awolope stated he asked Resident B how he wanted to proceed, including whether he wanted him to contact law enforcement. Roland Awolope stated Resident B reported he wanted to go to the Emergency Room (ER). Roland Awolope stated he also discussed the option of Resident B going to Relative B1’s residence.

Roland Awolope stated Resident B reported to him that Resident A touched his nipples; however, according to Roland Awolope, Resident B did not report the incident to staff and contacted him before notifying staff. Roland Awolope further stated Resident B contacted Relative B1 and reported the incident. Roland Awolope stated Resident B was transported to the hospital that evening due to expressing suicidal ideation, but returned the following day with Relative B1. He stated that while Relative B1 was present in the facility, he repeatedly asked Resident B whether Resident A touched him, but Resident B did not respond. Roland Awolope stated he also asked Resident B whether any penetration occurred, and Resident B responded “no”. Roland Awolope stated Resident A struggles with personal boundaries and may touch others; however, he indicated he did not believe such behavior was intended to be sexually inappropriate.

On 01/232026, I interviewed Adult Protective Services specialist, Amber Price-Johnson. She stated Resident A denied the allegations to her; however, she stated that Resident A admitted to the allegations when speaking with staff and law enforcement. She stated Resident A was issued a 30 day discharge notice due to behavior concerns. Amber Price-Johnson stated her investigation was not yet complete, but that she was leaning toward substantiating emotional abuse, as the reported incidents resulted in Resident B experiencing suicidal ideation and hospitalization.

On 01/26/2026, I reviewed the licensee's Incident Report (IR), dated 01/07/2026, completed by Roland Awolope. According to the IR, Roland Awolope received a phone call from Resident B reporting he was feeling suicidal due to an alleged sexual assault by Resident A. The IR documented that upon Roland Awolope arriving to the facility, Resident A admitted to him that he had sexually harassed Resident B. The IR further documented that law enforcement responded and would be contacting the prosecutor's office to determine whether charges would be pursued. The IR documented staff were instructed to continue monitoring the residents and that Resident A would be given a 30 day discharge notice.

I reviewed Resident A's *Pines Behavioral Health Annual Assessment* plan, dated 08/29/2025, and his *Assessment Plan for AFC Residents*, dated 12/26/2025. According to these assessment plans, Resident A has a diagnosis of autism, attention-deficit/hyperactivity disorder, generalized anxiety disorder, and disruptive mood dysregulation disorder. The assessment plan documented Resident A does not have any enhanced or increased supervision requirements; however, he lacks appropriate boundaries in relationships, frequently lies, experiences behavioral issues, and has inappropriate or extreme sexual behavior.

I also reviewed Resident B's Assessment Plan for AFC Residents, dated 12/25/2025. According to my review of this assessment plan, Resident B also does not have any enhanced or increased supervision requirements. The plan further documents he is capable of communicating his needs, but requires assistance with managing aggressive behaviors.

On 03/03/2026, I interviewed direct care staff, Honorine Gaju. She stated she began her shift at 4 pm on the date of the incident, which she believed to be 01/07/2026. She stated that the facility was calm that evening and the residents were getting along without any issues.

Honorine Gaju stated that approximately 9 pm, Resident B came upstairs while speaking on speakerphone with Relative B1. She stated Resident B told Relative B1 that Resident A touched him; however, she stated Resident B did not report this directly to her. She stated she recognized Relative B1's voice and stated Relative B1 was instructing Resident B to contact law enforcement. She reported that Resident B stated Resident A had touched him but did not specify where. She further stated Resident B indicated Resident A had threatened to beat him up if he told anyone.

Honorine Gaju stated she only became aware of the allegations while Resident B was on the phone with Relative B1. She stated that between approximately 8 pm and 9 pm, all the residents had gone to their bedrooms around 8 pm after medications were administered. She stated she did not hear any disturbances and was surprised by the allegations, noting that Resident A is typically loud and she would have expected to hear something if an altercation had occurred.

Honorine Gaju stated Resident B contacted law enforcement and spoke with officers privately outside. She stated that the officers attempted to speak to Resident A, but he did not respond, and she believed he may have been sleeping. She stated law enforcement transported Resident B from the facility. She stated that the officers spoke with the licensee, Roland Awolope, and that he then managed the situation.

Honorine Gaju stated she did not speak with Resident A about the allegations that evening or afterward.

On 03/04/2026, I reviewed Kalamazoo County Sheriff's Department police report # 2026-00000792. The report documented law enforcement responded to the facility on 01/07/2026 at approximately 10:25 pm for a "suicidal subject." Resident B reported he was feeling suicidal due to ongoing issues with Resident A entering his room without permission and asking him to touch his genitals and grabbing his nipples. Resident B reported to officers that he asked Resident A to stop and reported Resident A threatened to beat him up if he told staff. Resident A denied the allegations and was described by officers as mostly uncooperative. Officers also interviewed direct care staff, Honorine Gaju, whose statement was consistent with her statement to me.

The report further documented that Resident B was petitioned for evaluation at a local hospital due to suicidal ideation. Officers observed no injuries at the time Resident B was transported and the report indicated law enforcement was pursuing charges against Resident A.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Based on my investigation, which included interviews with staff, the facility's licensee, Roland Awolope, review of available pertinent documentation, including Kalamazoo County Sheriff's Department police report # 2026-00000792, there is insufficient evidence to establish that a sexual assault occurred between Resident A and Resident B on or around 01/07/2026 and that staff failed to provide appropriate action after becoming aware of the allegations. Direct care staff, Honorine Gaju who worked the night of the alleged incident stated she became aware of the allegations only after overhearing Resident B reporting the incident to Relative B1 on speakerphone. Documentation reflects that upon being notified that evening, the licensee, Roland Awolope, initiated law enforcement involvement and facilitated a medical evaluation for Resident B. Although it could not be determined whether Resident B or Roland Awolope first contacted law enforcement, police responded to the facility that evening to address the allegations. Accordingly, the information obtained throughout the investigation does not support the licensee or the facility's staff failed to protect Resident B on or around 01/07/2026 or failed to provide appropriate action upon learning the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/04/2026, I conducted my exit conference with licensee Roland Awolope informing him of my findings.

IV. RECOMMENDATION

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

03/04/2026

Cathy Cushman Date
Licensing Consultant

Approved By:

03/04/2026

Dawn N. Timm Date
Area Manager