GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 21, 2026

Osaretin Uwaifo
Amen's Care, Inc.
9014 Rockland
Redford, MI 48239

RE: License #: AS820294357
Investigation #: 2026A0901021
Olympia Home

Dear Osaretin Uwaifo:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820294357
Investigation #:	2026A0901021
Complaint Receipt Date:	02/17/2026
Investigation Initiation Date:	02/18/2026
Report Due Date:	04/18/2026
Licensee Name:	Amen's Care, Inc.
Licensee Address:	9014 Rockland Redford, MI 48239
Licensee Telephone #:	(313) 935-0345
Administrator:	Osaretin Uwaifo
Licensee Designee:	Osaretin Uwaifo
Name of Facility:	Olympia Home
Facility Address:	17471 Olympia St. Redford, MI 48240
Facility Telephone #:	(313) 740-7231
Original Issuance Date:	03/10/2008
License Status:	REGULAR
Effective Date:	09/23/2024
Expiration Date:	09/22/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has dysphagia and choked while eating, after being left unattended. He was hospitalized with severe brain damage from the incident.	Yes

III. METHODOLOGY

02/17/2026	Special Investigation Intake 2026A0901021
02/17/2026	Referral - Recipient Rights (ORR)
02/17/2026	Adult Protective Services Referral (APS)
02/18/2026	Special Investigation Initiated - On Site
02/18/2026	Contact - Telephone call made Carolyn Mosby
02/23/2026	Contact - Face to Face Resident A
02/27/2026	Contact - Telephone call made Staff, Carolyn Mosby
03/03/2026	Contact - Telephone call made Staff, Carolyn Mosby
03/03/2026	Contact - Telephone call made Licensee designee, Osaretin Uwaifo
03/03/2026	Contact - Telephone call made Resident B
03/03/2026	Contact - Telephone call made Resident C
03/04/2026	Contact - Telephone call made Supports coordinator, Tamara Walton
03/17/2026	Contact - Document Received

	Email, updated information from APS
03/17/2026	Inspection Completed-BCAL Sub. Non-Compliance
04/14/2026	Exit Conference Licensee designee, Osaretin Uwaifo
04/16/2026	Contact - Telephone call made ORR, Nia Creighton
04/17/2026	Contact - Telephone call made Supports coordinator, Pamela Morgan

ALLEGATION:

Resident A has dysphagia and choked while eating, after being left unattended. He was hospitalized with severe brain damage from the incident.

INVESTIGATION:

On 02/18/2026, I conducted an onsite inspection at the facility. The home manager, Renita McClendon was present and was interviewed. She confirmed the allegations were true. She said she was not working at the time, but staff, Carolyn Mosby, was on duty. Renita explained that due to Resident A having dysphagia, he is at risk of choking, therefore, he must be monitored while eating. His food is required to be cut into small pieces, he has to take sips of water in between eating, and he has to be encouraged to eat slowly. Taking sips of water and being encouraged to eat slowly were internal practices done at the facility and were not specified in the Individual Plan of Service (IPOS). Renita said the incident happened on 02/07/2026 and based on her internal investigation, the residents were in the kitchen eating dinner. Carolyn left out of the kitchen to answer the phone. Although she was not gone long, when she returned, Resident A was choking. She performed the Heimlich maneuver and called for the EMS. When they arrived, they had to cut his throat so he could breathe. Renita indicated Resident A was heavily sedated and suffered severe brain damage from the choking incident. He remains hospitalized at Corwell Health Farmington.

During the onsite investigation on 02/18/2026, Renita gave me a copy of the incident reports and Resident A's Individual Plan of Service (IPOS). The incident report was dated 02/07/2026 at 5:15 pm. It was written by Carolyn and indicated "Resident A was eating. I Carolyn Mosby went to answer the phone, returned to the kitchen Resident A was leaning to the left choking." It further stated, she called his name and lifted him. She performed the Heimlich maneuver while he was in the chair.

She called 911 and they arrived and took over and admitted Resident A to the hospital. There was another incident report dated 02/07/2026 at 5:30 p.m. and was written by Renita. It indicated that "management was notified of Resident A choking and EMS transported Resident A to the hospital emergency. Emergency room doctor spoke with staff concerning Resident A's condition, stating he had to be intubated and Resident A coded once but they were able to revive him. Management was also told that Resident A had to be sedated and after testing was completed, Resident A showed signs of severe brain damage and that his next of kin should be notified." Resident A's IPOS was from All Well-Being Services and was dated 05/01/2025-04/30/2026. It specified that Resident A had "documented restrictions in place and that his food had to be cut into bite sized pieces during mealtime. Staff have to monitor him during mealtimes to ensure he did not aspirate while eating."

On 02/18/2026 and 02/23/2026 I made telephone calls to Carolyn but there was no answer and her mailbox was full. I attempted again on 03/03/2026 and spoke with her. She explained that she had just served the residents' dinner. While they were eating, Resident A began coughing. He seemed to be choking so she called 911 and did the Heimlich maneuver until they came. He was eating a cut-up fish sandwich and had a beverage. Carolyn denied leaving out the kitchen. She stated she was present the whole time and that the phone was in the kitchen with her. When I pointed out the discrepancy with what she reported in the incident report, she kept insisting she never left the kitchen. She further indicated that Residents B and C were present at the table during the incident.

On 02/23/2026, I made face to face contact with Resident A at Corewell Health hospital. He was in the critical care unit and was not conscious.

On 03/03/2026, I made a telephone call to the licensee designee, Osaretin Uwaifo. She stated that due to Resident A being a choking risk, staff normally sit with him at mealtimes to monitor him closely. Osaretin reported that when she spoke with Carolyn about the incident, she stated the phone rang in the living room and she briefly left the kitchen to answer it. She immediately went back and Resident A was choking. She performed the Heimlich maneuver and called 911.

On 03/03/2026, I made a telephone call to the facility and interviewed Resident B. Resident C was not present during this call. Resident B stated they were at the table eating and Resident A started choking. When asked who was in the kitchen at the time, he stated just him, Resident A and Resident C. He said Carolyn was at the desk in the living room. When she came back into the kitchen, she started calling Resident A's name and shaking him and yelling for someone to call 911. What Resident B reported contradicts what Carolyn reported during my interview with her

and confirms what she wrote in the incident report that she left the kitchen and returned to find Resident A choking.

On 03/03/2026, I made another telephone call to the facility and interviewed Resident C. He stated him and the other two residents, A and B, were at the kitchen table eating dinner when Resident A started gaging. The food would not come out, and he was choking and fell out at the table. Resident C said Resident A was eating too fast at the time, which implies no one was present to slow him down, and he believed that is why he choked. This reiterates what was previously reported by Renita, that Resident A had to be encouraged to eat slowly. When asked where Carolyn was when the choking started, he stated she was in the living room sitting at the desk. The information Resident C reported was the same as what Resident B reported. Both indicated Carolyn was not in the kitchen at the time of the choking incident, which is contradictory to what she reported to me.

On 03/04/2026, I made a telephone call to Resident A's supports coordinator, Tamara Walton, from All Well-Being Services. She stated she had not had the opportunity to talk to Carolyn but did speak with Renita. She said she was given the same information I was given, which was that Carolyn left the kitchen to answer the phone and when she returned Resident A was choking. Tamara stated the last update she was given from the hospital was that Resident A had severe brain damage and the hospital was filling a request for emergency guardianship. She further said there were no restrictions regarding what Resident A ate but his food needed to be cut into small bite size pieces, and he needed to be monitored closely while eating.

On 03/17/2026, I received an email from APS informing me that Resident A died 03/10/2026.

On 04/14/2026, I made a telephone call to Osaretin for an exit conference. She stated Carolyn was still employed with them and no reprimand was given because she felt Carolyn did everything she should have to save Resident A. I explained to Osaretin my investigative findings. She stated Carolyn was with the residents while they were eating due to the close proximity of the living room from the kitchen. I explained to her that the violation was due to her not monitoring him while eating because based on the incident report she wrote, she left the kitchen and did not observe him choking until she returned. I also informed her that Residents B and C corroborated that she was not in the kitchen with them when the choking started.

On 04/16/2026, I made a telephone call to Nia Creighton, from ORR. She stated her complaint was not substantiated. She was unable to give me a copy of her report. but was able to share the details of it. She said she could not confirm that Carolyn left the kitchen. She reported interviewing Renita who said Carolyn indicated she left the kitchen to answer the phone and when she returned Resident A was choking but when she interviewed Carolyn on 02/11/2026, she stated she never left the kitchen and that the phone was in the kitchen with her. Nia was aware that this

contradicted what Carolyn wrote in the incident report dated 02/07/2026, but said according to Carolyn, Resident C was the only witness. When she interviewed him on 03/12/2026, which was after I interviewed him, he reported Carolyn never left the kitchen. Nia was not aware that Resident B was also present during the incident, so he was not interviewed.

On 04/17/2026, I left a voice message for Pamela Morgan, Residents' B and C supports coordinator, from Lincoln Behavior Services. She returned the call on 04/20/206. I inquired about the residents' cognitive awareness such as their ability to be interviewed, comprehend and give accurate information. Pamela stated Resident B was more cognitively sound than C and could be interviewed and give more accurate information depending on the mood he was in at the time. She indicated that Resident C was not always credible and that he tends to be "all over the place" with his thoughts at times. She stated she would not take what he says as fully valid.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based on the information obtained during this investigation, Resident A was not provided with the supervision required based on his IPOS and the internal practices of the facility to ensure his safety and wellbeing. His IPOS from All Well-Being specified that staff must monitor him during mealtimes to ensure he did not aspirate while eating. His supports coordinator, Tamara Walton, indicated he had to be closely monitored while eating. Although not a part of his IPOS, as indicated by the licensee designee, Osaretin Uwaifo, and the home manager, Renita McClendon, there were internal practices put in place at the facility to prevent Resident A from choking, such as staff sitting with him during mealtimes, having him take sips of water in between eating, and encouraging him to slow down while eating. Carolyn was the only staff person on duty at the time of the incident and admitted in the incident report she wrote that she went to answer the phone and when she returned to the kitchen, Resident A was choking. This implies that she left the kitchen and did not physically see him until she returned. Residents B and C, who were also present in the kitchen at the time of the incident, also reported that Carolyn was not in the kitchen with the three residents, but was at the desk in the living room. Furthermore, there were inconsistencies in what Carolyn reported in the incident report on 02/07/2026 and what was reported to ORR on 02/11/2026 and to me on 03/03/2026. Due to a preponderance of the evidence, it is more likely than not that Carolyn did not monitor Resident A while eating, according to the IPOS and the internal procedures of the facility, to prevent him from aspirating while choking.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.

_____ 04/21/2026

Regina Buchanan — Date
Licensing Consultant

Approved By:

04/21/2026

_____

Ardra Hunter — Date
Area Manager