GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 26, 2026

Yewande Okubanjo
PO Box 4625
East Lansing, MI 48826

RE: License #: AS330393478
Investigation #: 2026A0577038
His Able Hands

Dear Ms. Okubanjo:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care and physical plant 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.

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.

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,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AS330393478
Investigation #:	2026A0577038
Complaint Receipt Date:	04/24/2026
Investigation Initiation Date:	04/27/2026
Report Due Date:	06/23/2026
Licensee Name:	Yewande Okubanjo
Licensee Address:	507 West Barnes Avenue Lansing, MI 48910
Licensee Telephone #:	(404) 992-2222
Administrator:	Olufemi Okubanjo
Name of Facility:	His Able Hands
Facility Address:	509 West Barnes Avenue Lansing, MI 48910
Facility Telephone #:	(404) 992-2222
Original Issuance Date:	12/20/2018
License Status:	REGULAR
Effective Date:	07/17/2024
Expiration Date:	07/16/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are being left unsupervised in the facility.	Yes
Breakers in the bedrooms are tripping.	Yes
Resident A is not being served a soft diet as prescribed.	No
Resident are administering their own medications and not being supervised.	Yes
Resident A slept in a homeless shelter due to fear of retaliation due to breaking the house curfew.	No
Resident A is made to do chores, even though Resident A is legally blind.	No
Additional Findings	Yes

III. METHODOLOGY

04/24/2026	Special Investigation Intake, 2026A0577038
04/27/2026	Special Investigation Initiated - Telephone Interview with Complainant.
04/28/2026	Contact - Document Received Via email, pictures from Complainant.
05/07/2026	Inspection Completed On-site
05/07/2026	Inspection Completed-BCAL Sub. Compliance
05/11/2026	Contact-Document Received Complainant via email send Resident A's MAR and current physician orders for medications.
05/14/2026	Contact - Telephone call made, Resident A.
05/15/2026	APS Referral
05/18/2026	Contact-Telephone call made, Concerned Citizen 1
5/27/2026	Exit Conference, Yewande Okubanjo, Licensee.

ALLEGATION: Residents are being left unsupervised in the facility.

INVESTIGATION:

On April 24, 2026, a complaint was received alleging that residents were being left unsupervised at the facility.

On April 27, 2026, I interviewed Complainant, who reported that on February 27, 2026, they visited the facility to see Resident A. Complainant stated being greeted at the door by a resident and, upon entering, did not observe any direct care staff present. Approximately ten minutes after Complainant's arrival, administrator Olufemi Okubanjo entered the home, apologized, and stated he had been next door. Complainant further reported that during a subsequent visit on April 22, 2026, no direct care staff were present until Mr. Okubanjo arrived approximately 45 minutes after Complainant had entered the facility. Complainant was unsure how long the facility had been without staff prior to their arrival.

On May 7, 2026, I conducted an unannounced onsite investigation. I observed that the facility is a duplex consisting of two separately licensed homes that share a front porch, with each license having its own entrance. I informed Mr. Okubanjo that, while I was parked outside, I observed licensee Yewande Okubanjo arrive, enter 509 W Barnes Ave, exit, and then enter 507 W Barnes Ave. Shortly thereafter, I observed Mr. Okubanjo standing in the doorway of 507 W Barnes Ave. Mr. Okubanjo stated he had been inside 509 W Barnes Ave when Ms. Okubanjo first entered and that he then accompanied her into 507 W Barnes Ave. He denied being inside 507 W Barnes Ave at the time of my arrival. Mr. Okubanjo acknowledged he had previously been cited for leaving residents unsupervised but stated he had not repeated this behavior since that citation.

During the onsite investigation on May 7, 2026, I interviewed Resident B, Resident C and Resident D. Resident B and Resident D both reported that residents are occasionally left unsupervised, though not frequently. Resident C reported he was not aware of being left unsupervised. Residents B, C, and D stated that Mr. Okubanjo does go to the adjacent facility and that residents sometimes accompany him, though at times they choose to remain in their own home unsupervised. Residents B and D were unable to provide specific dates when they were left unsupervised, stating that it "does not happen that often, but does happen once in a while." Resident B added, "it is fine, I can be by myself."

On May 14, 2026, I interviewed Resident A, who confirmed that on two occasions when Complainant visited, no direct care staff were present in the facility. Resident A could not recall the specific dates of these visits. Resident A reported that Mr. Okubanjo frequently goes to the facility next door, leaving residents unsupervised, and stated, "we just go next door if we need anything." Resident A also reported that Mr. Okubanjo

occasionally leaves to go to the store or run errands, during which time residents remain alone, adding, “but there is a staff person at the facility next door if they need anything.”

On May 18, 2026, I interviewed Concerned Citizen 1, who reported that since Resident A was admitted in January 2026, there was one visit when Concerned Citizen 1 observed no direct care staff in the home. Concerned Citizen 1 reported they are not sure of the specific date when this occurred.

Special Investigation Report (SIR) 2024A0466009, dated December 27, 2023, cited Rules 400.14206 (1) (2) after conducting an unannounced onsite investigation on November 13, 2023, and finding no direct care worker on duty at the facility. Consequently the staff to resident ratio was not met nor was there sufficient staff on duty to meet the needs of the residents.

**Please note on November 3, 2025, new AFC rules were promulgated and Rule 400.633 is equivalent to Rule 400.14206 (1) and (2) cited in SIR#2024A0466009.*

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	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: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based on interviews and an onsite investigation, licensee Yewande Okubanjo did not ensure that sufficient direct care staff were on duty at all times to provide for the supervision, personal care, and protection of residents. Multiple residents and Complainant reported instances in which no direct care staff were present in the facility. Residents confirmed that they were left unsupervised on more than one occasion. Consequently there was always not sufficient staff in the facility as required.
CONCLUSION:	**VIOLATION ESTABLISHED; REPEAT VIOLATION ESTABLISHED [SEE SIR DATED 12/27/23 AND CAP dated 01/17/2024]**

ALLEGATION: Breakers in the bedrooms are often tripping.

INVESTIGATION:

On April 24, 2026, a complaint was received alleging electrical issues within the facility, specifically that breakers in resident bedrooms frequently trip.

On April 27, 2026, I interviewed Complainant who reported that Resident A stated the breaker trips when he attempts to make coffee, causing the entire upstairs to lose power. Complainant also reported that during a visit on April 22, 2026, they observed multiple extension cords in Resident A's bedroom. Complainant provided photographs showing extension cords plugged into outlets and secured to the wall with duct tape.

On May 7, 2026, during the onsite investigation, administrator Olufemi Okubanjo reported that Residents A and B each have a coffee maker, gaming system, computer, and television in their bedrooms, and that the electrical system cannot support all devices operating simultaneously. Mr. Okubanjo stated residents must notify each other before using their coffee makers so only one is used at a time. He denied any issues with the facility's electrical system, attributing the problem to the wattage draw of two coffee makers running concurrently. Residents B, C, and D reported the breaker only trips when Residents A and B use their coffee makers at the same time. Resident B stated he and Resident A coordinate coffee use to prevent power loss.

A physical plant inspection confirmed that both Residents A and B have coffee makers, gaming systems, televisions, and stereos in their bedrooms. Multiple extension cords and non-surge-protected power strips were observed in use.

On May 14, 2026, Resident A reported having at least two extension cords in his bedroom and confirmed that using his coffee maker while other electronics are operating causes the breaker to trip. Resident A also reported that simultaneous use of both residents' coffee makers results in the upstairs losing power.

APPLICABLE RULE	
R 400.649	**Electrical service.**
	Electrical service must be maintained in a safe condition. Where conditions indicate a need for inspection, and on all new or remodeled projects, the electrical service must be inspected by a qualified electrical inspection service and a copy of the inspection report must be maintained for 2 years.

ANALYSIS:	Based on interviews, photographs, and onsite observations, licensee Yewande Okubanjo did not maintain the facility's electrical service in a safe condition. Residents reported that the electrical breaker frequently trips when multiple appliances are used, resulting in loss of power to the upstairs. During the onsite inspection, multiple extension cords, non–surge-protected power strips, and high-wattage appliances including coffee makers, gaming systems, televisions, and computers were observed in residents' bedrooms. Administrator Olufemi Okubanjo acknowledged that the electrical system cannot support the combined load of these devices and that residents must coordinate appliance use to prevent breaker failure. No documentation was provided to show that the electrical system had been inspected by a qualified electrical inspection service as required when conditions indicate a need for inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is not being served a soft diet as prescribed.

INVESTIGATION:

On April 24, 2026, a complaint was received alleging that Resident A was not being provided with a soft diet despite having no teeth.

On April 27, 2026, I interviewed Complainant who reported that Resident A has difficulty eating meat served at the facility due to being edentulous. Complainant was unsure if Resident A had been prescribed a soft diet.

During the onsite investigation on May 5, 2026, I reviewed Resident A's *Health Care Appraisal*, completed January 14, 2026, by Sarala Masti, MD. The section titled *Special Dietary Instructions and Recommended Caloric Intake* was left blank. I also reviewed Resident A's *Assessment Plan for AFC Residents*, completed January 19, 2026, which documents "No" under *Special Diets*.

On May 14, 2026, I interviewed Resident A, who reported he can eat the meals provided. Resident A stated that administrator Olufemi Okubanjo prepares meat in a tender manner that he can eat, and if he is unable to eat a particular item, he prepares an alternative for himself. Resident A stated he does not want a different meal from what is served to other residents, saying, "I am just fine eating what everyone else eats."

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	Resident A's *Health Care Appraisal*, completed January 14, 2026, contained no prescribed dietary instructions, and Resident A's *Assessment Plan for AFC Residents*, completed January 19, 2026, documented no special diet. Resident A reported he is able to eat the meals provided, that meats are prepared in a tender manner he can consume, and that he does not wish to receive a diet different from other residents. There is no evidence that a soft diet has been prescribed by a licensed health care professional. Because Resident A does not have a prescribed diet, the facility is not required to provide one under this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident are administering their own medications and not being supervised.

INVESTIGATION:

During the interview with Complainant on April 27, 2026, Complainant reported while at the facility on April 22, 2026, Complainant observed resident medications sitting on top of the medication cabinet, an Ozempic pen on Resident A's bed, and resident medications sitting on the desk. Complainant reported asking Resident A about the Ozempic pen on his bed and Resident A reported that administrator Olufemi Okubanjo provides Resident A with his Ozempic pen for Resident A to administer when needed. Complainant reported that Resident A also stated that residents are provided their evening mediations after supper to take to their bedrooms and take them before they go to bed with no supervision from direct care staff.

On May 07, 2026, during the onsite investigation, I did not observe any medications on top of the medication cabinet, on the desk, or sitting out in common areas. Upon entering Resident B's bedroom, I did see a bottle of Ibuprofen and Resident B reported that he is able to keep the Ibuprofen in his bedroom. Resident B, Resident C, and Resident D confirmed that Mr. Okubanjo provides residents with their evening medications and allows residents to administer the medications themselves prior to going to bed.

During the onsite investigation, I interviewed administrator Olufemi Okubanjo who acknowledged that he provides residents with their evening mediations in a cup and allows them to take the cup of medications to their bedroom to administer independently. Mr. Okubanjo acknowledged that he does not supervise the administration of evening medications for any resident. Mr. Okubanjo also admitted that he provides Resident A with his prescribed Ozempic injection pen for Resident A to administer independently. Mr. Okubanjo reported that none of the residents have a physicians order to administer their own medications. I also reviewed the resident files and there was no documentation from a health care provider allowing any resident to self-administer their own medications.

On May 14, 2026, I interviewed Resident A who reported he self-administers his own insulin medications Ozempic and Humalog. Resident A reported that he is provided the Ozempic pen by Mr. Okubanjo on the day that it is to be administered and Resident A stated he then administers the medications when he wants. Resident A reported he has the needles in his room for the administration of the Ozempic and Humalog insulin medications and Mr. Okubanjo give Resident A these medication for Resident A to administer independently without direct care staff supervision. Resident A reported that he is legally blind and relies on the audible “clicks” of the Ozempic and Humalog medication pens to ensure accurate dosing.

On May 18, 2026, I interviewed Concerned Citizen 1 who reported that Resident A is prescribed the insulin medications Ozempic and Humalog. Concerned Citizen 1 reported upon Resident A moving into the facility Mr. Okubanjo told Concerned Citizen 1 that he does not administer insulin shots. Concerned Citizen 1 stated Mr. Okubanjo stated administration of insulin shots is the resident’s responsibility. Concerned Citizen 1 reported she has shown Resident A how to properly administer his insulin himself. Concerned Citizen 1 reported on many visits to the facility, Concerned Citizen 1 observed medications set up in cups or sitting on the dining room table for residents to administer independently. Concerned Citizen 1 reported Mr. Okubanjo provides residents with their evening medications to administer independently in their bedrooms around 10PM.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.

ANALYSIS:	Based on the information gathered through interviews with residents and Olufemi Okubanjo, Olufemi Okubanjo admitted providing residents with prescribed medications without supervising the administration of these medications. This specifically occurs with bedtime medications. None of the resident records documented that Residents A- D can self-administer their own medications. Olufemi Okubanjo also admitted to not supervising Resident A taking his Ozempic injection despite Resident A being legally blind and unable to visibly assure proper dosage prior to administration. Olufemi Okubanjo reported that he provides Resident A with the injection pen for Resident A to administer himself even though Resident A does not have a written physician's order to administer his own medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A slept in a homeless shelter after being locked out of the facility.

INVESTIGATION:

On April 24, 2026, the complaint reported that Resident A slept in a homeless shelter due to being told he could not return to the facility because it was after curfew.

On April 27, 2026, Complainant reported that they received a phone call from Concerned Citizen 1 notifying Complainant that Resident A spent the night at a homeless shelter due to Olufemi Okubanjo told Resident A he could not come home past the facility curfew. Complainant reported that Resident A told Concerned Citizen 1 that Olufemi Okubanjo locks the facility doors at curfew and does not let the residents in if they arrive past curfew.

On May 07, 2026, during the onsite investigation, I interviewed Olufemi Okubanjo who reported per the house rules the curfew for the facility is 7:30pm, at which time the facility doors are locked, and the residents are expected to call Mr. Okubanjo if they are going to be out past curfew with an expected return time. Olufemi Okubanjo confirmed Resident A spent the night at a homeless shelter because Resident A chose to do so. Olufemi Okubanjo reported Resident A had called him to report he was going to be out past curfew. Olufemi Okubanjo reported Resident A called later in the night and said that he was going to be staying at a homeless shelter instead of returning the facility.

On May 15, 2026, I interviewed Resident A, who reported he has only stayed at the homeless shelter one time since moving into the facility in January 2026. Resident A reported he was visiting family and was going to be returning to the facility past curfew, 7:30pm. Resident A reported he spoke with Olufemi Okubanjo's earlier that evening and

notified him that he would be out past curfew due to being at a church event. Resident A reported he arrived at the facility a little after 10:00pm, knocked on the door and no one answered. Resident A reported that he called Olufemi Okubanjo's cell phone and the facility phone several times with no answer. Resident A reported he does not have a house key and was unable to get into the facility so he went and stayed at a homeless shelter.

On May 18, 2026, I interviewed Concerned Citizen 1 who reported Resident A stayed the night at a relative's home, but the next night on his way back to the facility he called Concerned Citizen 1 and reported that he got cold and was hungry so he stopped at a homeless shelter and would be staying the night there. Concerned Citizen 1 reported Resident A refused to let Concerned Citizen 1 pick him up from the homeless shelter and take him to the facility. Concerned Citizen 1 reported that Resident A did not report to her that he had gone to the facility before going to the homeless shelter. Concerned Citizen 1 reported a homeless shelter is a 'safe place' for Resident A as he has spent much of his life in and out of homeless shelters due to the lifestyle his family has lived.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(g) Refuse entrance to the facility.**
ANALYSIS:	Based on the information gathered during the investigation, it has been found that at one point, Resident A stayed at a homeless shelter but there was insufficient evidence that this was due to Olufemi Okubanjo's refusal to let Resident A into the facility after Resident A arrived past curfew.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is made to do chores, even though Resident A is legally blind.

INVESTIGATION:

On April 24, 2026, the complaint reported that Resident A is made to do chores which specifically includes cleaning the resident bathroom. The complaint reported that Resident A is legally blind and should not clean the bathroom.

On April 27, 2026, I interviewed Complainant who reported Resident A is required to clean the resident bathroom one time per week and Complainant does not feel that this is right with Resident A being legally blind. Complainant reported there are no gloves for Resident A to use while cleaning the bathroom. Complainant provided me with a photo of a bathroom/hallway/stairs chore schedule documenting Resident A's day of week to

clean these items. Complainant reported telling Resident A that he does not need to clean the bathrooms moving forward due to Resident A being legally blind.

On May 07, 2026, during the onsite investigation I reviewed and received a copy of Resident A's *AFC-Resident Care Agreement and Assessment Plan for AFC Residents,* which was completed and signed on January 19, 2026, by Resident A's previous guardian upon moving into the facility. Resident A's *AFC-Resident Care Agreement* documents under title Resident or Resident Representative Check All Boxes Below That Apply, box checked, "I have received a copy of the house rules (if applicable) and agree to follow them." I also received and reviewed a copy of Resident A' s *Assessment Plan for AFC Residents* which documented the section, "B. Participates in Household Chores" it was checked "Yes" and specified Resident A's chores as sweeping, wiping table, dishes and cleaning counter tops but not mopping due to Resident A's visual impairment.

I also reviewed and received a copy of the *House Rules* which document "Residents shall partake in house chores such as mowing of grass, clearing snow and leaves, as applicable."

On May 14, 2026, I interviewed Resident A who reported he was aware of needing to clean the bathroom as a chore. Resident A reported he is legally blind and cannot see in the bathroom to clean. Resident A reported Guardian A1 told Resident A that he does not need to clean the bathroom so Resident A has not been cleaning the bathroom. Resident A reported at his work program he does not clean the bathroom due to being legally blind, they have him complete other chores like wiping counter tops and sweeping. Resident A reported that Olufemi Okubanjo tells Resident A to clean the bathroom, but Resident A refuses to do this chore.

On May 18, 2026, I interviewed Concerned Citizen 1 who reported that Resident A should not be cleaning the floor or the shower of the bathroom due to Resident A's vision impairment. Concerned Citizen 1 reported residents are expected to squeeze out the mop with their hands and no gloves are provided. Concerned Citizen 1 confirmed telling Resident A that Resident A does not need to clean the bathroom and if there are any issues to let Concerned Citizen 1 know and she will handle them. Concerned Citizen 1 reported she spoke with Olufemi Okubanjo regarding Resident A not being able to clean the bathroom.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(2) A licensee may establish house rules on the expectations for resident conduct that do not conflict with the act or these rules. If established, a licensee shall provide the rules in writing to the resident, resident's

	designated representative, or responsible agency on admission to the facility and when modified.
ANALYSIS:	Licensee Yewande Okubanjo has established *House Rules* that include residents performing household chores. Resident A's guardian received and agreed to the *House Rules*, including the expectation of household chores, as documented in Resident A's *Resident Care Agreement* and *Assessment Plan for AFC Residents* dated January 19, 2026. Based on the documents reviewed and interviews conducted, there is not a preponderance of evidence that residents are forced to complete household chores.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on May 07, 2026, I observed Resident A's medications set up in a weekly pill box and his Ozempic pens sitting in the door of the refrigerator unsecured. I inquired with Olufemi Okubanjo regarding whose medications were in the pill box as there was no name on the weekly pill box. Olufemi Okubanjo stated that Resident A's medications are set up in a weekly pill box due to Resident A being legally blind and this makes it easier for Resident A to take his medications because he is not able to read the labels. Olufemi Okubanjo reported that he understood that medications in the refrigerator needed to be kept in a locked container. I also observed that Resident B had ibuprofen in his bedroom to be administered as needed and this medication was not secured. Resident B verified that the bottle was ibuprofen and that he administers the ibuprofen to himself when needed.

APPLICABLE RULE	
R 400.675	**Resident medications. medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.

ANALYSIS:	On May 07, 2026, I observed Resident A's medications preset in a weekly pill box and not kept in the original pharmacy container labeled specifically for Resident A. I also observed Resident A's Ozempic injection pen kept in the refrigerator unsecured. Resident B also had unsecured ibuprofen in his bedroom to administer to himself as needed. A violation has been established due to Resident A and Resident B's medications not being secured in a locked cabinet and Resident A's medications not being kept in the original pharmacy containers as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On May 11, 2026, Complainant reported that Resident A is prescribed two forms of insulin which are all administrated in shot form. Complainant reported upon reviewing Resident A's *Medication Administration Record* (MAR) for May 2026, the only insulin medication listed was Ozempic. Complainant stated the May 2026 MAR was missing the Humalog Kwik Pen medications. Complainant provided me with a copy of Resident A's May 2026 MAR and the physician orders which prescribed the following for Resident A: Humalog Kwik Pen 100unit/ml-inject 20 units by subcutaneous route every 3 days; Ozempic 1mg dose by subcutaneous route weekly on same day; and Humalog Kwik Pen 100unit/ml-inject 10-15 units by subcutaneous route before each meal.

I reviewed Resident A's May 2026 MAR provided by Complainant and confirmed the Humalog Kwik pens were not listed as a medication to be administered. I also noted that Resident A's May 2026 MAR documented Ozempic 1 mg to be injected subcutaneously once weekly; however, there were no staff initials documenting that this medication was administered thus far during May 2026.

On May 18, 2026, I interviewed Concerned Citizen 1 who reported that Resident A is prescribed two insulin medications, Ozempic and Humalog. Concerned Citizen 1 reported Resident A is responsible for administering his own insulin shots, stating, "so I can see why these medications would not be the MAR to be marked as administered by the direct care staff."

APPLICABLE RULE	
R 400.675	**Resident medications. 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.**
ANALYSIS:	Upon review of Resident A's May 2026 MAR, I noted it did not include the name of the Humalog medication, dosage, label instructions of use, time to be administered or the initials of the direct care staff who administered the medication. Resident A's May 2026 MAR also did not document the time the Ozempic pen was administered or the initials of the staff who administered this insulin medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On April 27, 2026, Complainant reported Resident A was awarded a new guardian in February 2026 and Resident A's guardian has not completed an *Assessment Plan for AFC Residents and Resident Care Agreement* since being awarded guardianship of Resident A.

During the onsite investigation on May 07, 2026, I reviewed and received copies of Resident A, Resident B, Resident C, and Resident D's current *Assessment Plans for AFC Residents and Resident Care Agreements* which were signed only by administrator Olufemi Okubanjo and not licensee Yewande Okubanjo.

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:	Upon review of Resident A, Resident B, Resident C, and Resident D's current *Assessment Plan for AFC Residents,* I determined these were not signed by licensee Yewande Okubanjo as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, due to the quality of care and physical plant violations, I recommend modification of the license to a six month provisional license.

Bridget Vermeesch

05/22/2026

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

05/26/2026

_____

Dawn N. Timm Date
Area Manager