GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 21, 2026

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

RE: License #: AS820293763
Investigation #: 2026A0116036
Wyandotte AFC Home 2

Dear Ms. 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 responsi 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) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820293763
Investigation #:	2026A0116036
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/25/2026
Report Due Date:	08/23/2026
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?
Resident A observed and photographed the medication cart with the keys left in it twice this month (June). This same thing happened a few months back and Resident A got in the medicine cabinet and almost overdosed on pills after having suicidal ideations. Medication is also kept in the basement and the keys to the basement are in the office.	Yes

**All allegations reported were not addressed as they were previously investigated under SIR# 2025A0992021 and 2026A0116032. **

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A0116036
06/25/2026	Special Investigation Initiated - Telephone Resident A's case manager, Susan Wiley.
06/26/2026	Inspection Completed On-site Home manager, Resident A-B.
06/26/2026	Referral - Recipient Rights Made.
06/29/2026	Contact - Telephone call received Licensee designee, Bose Ogbeifun, left a message requesting a return call.
06/29/2026	APS referral Received.
06/30/2026	Contact - Telephone call made Licensee designee, Bose Ogbeifun.
07/16/2026	Contact - Telephone call made Staff, Vera Odjugo.
07/16/2026	Contact - Telephone call made Staff, Oluwafemi Olesiji.
07/16/2026	Inspection Completed-BCAL Sub. Compliance

07/16/2026	Exit Conference With licensee designee, Bose Ogbeifun.

ALLEGATION:

Resident A observed and photographed the medication cart with the keys left in it twice this month (June). This same thing happened a few months back and Resident A got in the medicine cabinet and almost overdosed on pills after having suicidal ideations. Medication is also kept in the basement and the keys to the basement are in the office.

INVESTIGATION:

On 06/25/26, I interviewed Resident A's case manager, Susan Wiley. Ms. Wiley reported that Resident A has a cell phone that he uses to take pictures and record staff in efforts to get them in trouble as he continually expresses that he wants the staff fired and for them to live in fear of him. Ms. Wiley reported during her site visit with Resident A he informed her that on 2 separate occasions (06/02/26 and 06/09/26) he was able to capture pictures of the medication closet with the keys still in the door and no staff in sight. She reported Resident A reported 8 to 10 minutes elapsed before staff came and retrieved the keys. Ms. Wiley reported Resident A did not get into the medication cabinet this time, however, there was a similar incident last year, and Resident A gained access to the medication cabinet after staff left the keys in the door. Resident A ingested several pills and had to be transported to the hospital. Ms. Wiley reported that the keys should not have been left unattended in the door.

On 06/26/26, I conducted an unscheduled onsite inspection and interviewed home manager, Lashonda Wilson, Resident A and C. Ms. Wilson reported that Resident A and his case manager Ms. Wiley informed her of the incident. Ms. Wilson reported that staff are fully trained and aware that all medications are required to be locked and that the keys to the medication closet are to remain on their person. Ms. Wilson reported that she and the licensee designee, Bose Ogbeifun, have addressed this over and over in staff meetings and during in-service trainings to no avail. Ms. Wilson reported that Ms. Ogbeifun updated the internal policy regarding the matter after the keys were left in the medication door unattended last year and Resident A went in the closet and attempted to overdose on medication. Ms. Wilson confirmed that there are additional medications stored in the basement, however, reported that the basement door remains locked and that key is also on the staff assigned to

medications on each shift. She denied that the key is left in the office as residents have access to the office.

I reviewed the staff schedules, and the medication administration records (MARs) for 06/02/26 and 06/09/26 and was able to identify the staff responsible for administering medication and responsible for the keys. On 06/02/26, staff, Oluwafemi Olesiji, administered 8:00 p.m. medications and was responsible for the keys. On 06/09/26, staff, Vera Odjugo, administered a.m. medications and was responsible for the keys. Ms. Wilson provided me with their contact information.

I interviewed Resident A and he reported that he is sick of the lazy staff and he wants them to do their jobs. He reported that on 06/02/26 and 06/09/26 the keys were left in the medication closet door unattended. He reported both times over 8 to 10 minutes passed before staff returned to retrieve the keys. He reported that he is in a better place mentally and so he did not go into the medication closet and attempt suicide by ingesting medication like he did last year. Resident A reported that he could have easily been in and out of the medication closet prior to staff ever noticing. He reported that this is a common practice but this time he decided to take a picture so that he has proof. Resident A showed me the pictures on his cell phone. One was taken on 06/02/26 at 8:07 pm. and the other was taken on 06/09/26 at 7:52 a.m. Resident A reported he does not remember what staff left the keys in the door on 06/09/26, however, reported that staff, Oluwafemi "Femi" Olesiji, left the keys in the door on 06/02/26. Resident A reported that on occasion he has also observed the keys to the basement door in the office not locked and accessible to residents. Resident A reported medications are also stored in the basement.

I interviewed Resident B and he reported that he has not observed the keys to the medication in the door unattended. He reported that staff usually unlock the closet and immediately put the keys in their pockets. He reported that he also doesn't go looking around to see what staff is or isn't doing. He reported that the staff at the home are good and do the best they can. He reported that Resident A makes it difficult for the staff and keeps up confusion. He reported that they are losing a lot of good staff because of Resident A's constant recording and picture taking.

On 06/30/26, I received a telephone call from licensee designee, Bose Ogbeifun, and she reported she was informed by her home manager, LaShonda Wilson, that I had been the home. Ms. Ogbeifun reported that it is not acceptable for Resident A to be violating staff privacy by constantly recording and taking pictures of them and she is losing staff as a result. I informed Ms. Ogbeifun, that while I understand her concerns, it does not negate the fact that Resident A captured pictures that are in direct violations of the licensing rules and her internal policy. I informed Ms. Ogbeifun that this is a serious oversight on the part of two different staff on two separate occasions that places the health and safety of the residents at risk. Further, the same thing occurred last year, and Resident A actually got in the medication closet and attempted to overdose after ingesting a handful of medication. Ms. Ogbeifun reported understanding the seriousness of the incidents and reported that

she has continually addressed this with staff and they continue to do what they want to do. She reported that she would be addressing the matter yet again.

On 07/16/26, I interviewed staff, Vera Odjugo, and she reported that she was covering a shift at the home on 06/09/26 after a call off. She reported that she does not routinely work in this home. Ms. Odjugo reported that she had worked a double, beginning at 3:00 p.m. on 06/08/26 and was scheduled to get off at 7:00 a.m. the morning of 06/09/26. Ms. Odjugo reported that she ended up having to stay a little past 8:00 a.m. when her relief staff arrived. She reported that she did administer the a.m. medications and was right next to the medication closet. Ms. Odjugo reported it was not unattended at any time. Ms. Odjugo reported that she was taking the medications out of the closet and placed them on the counter in the kitchen which is right by the medication closet. She reported after placing the medication baskets down she retrieved the keys. She reported Resident A purposely angled the camera to make sure she would not be seen in the picture. Ms. Odjugo reported that Resident A's end goal is to get all staff fired and the home closed. I informed Ms. Odjugo that based on my observation of the picture, which shows the hallway and entire closet door, there was no staff observed nearby. Additionally, once the door was unlocked, medications removed, the door should have been locked and keys removed. Ms. Odjugo agreed and reported that this will not happen again regardless of the home she is working in. Ms. Odjugo denied any knowledge of the keys to the basement door being left in the office unlocked. She reported having all keys on her during her shift.

On 07/16/26, I interviewed staff, Oluwafemi Olesiji, and he reported that he worked the afternoon shift on 06/02/26 from 3:00 p.m. to 11:00 p.m. Mr. Olesiji confirmed he passed the medications and was responsible for the keys to the medication closet. Mr. Olesiji reported that he has worked in the home for five years and knows and does his job well. He repeatedly denied that he left the keys in the door unattended. I informed Mr. Olesiji that I observed the date and time stamped photo of the keys left unattended and hanging out the doorknob. He continued to deny that it happened. He also reported that the keys to the basement door are also kept on their person and not unattended in the office as reported. I concluded the interview.

On 07/16/26, I conducted the exit conference with licensee designee, Bose Ogbeifun, and informed her of the findings of the investigation and the specific rule cited. Ms. Ogbeifun reported that staff, Oluwafemi Olesiji, and Vera Odjugo have been re-in serviced on their internal policy specific to ensuring keys remain on their person at all times and the licensing rules requiring medications to be safeguarded/locked at all times. Ms. Bose reported that if staff actually did what they are trained to do consistently, these issues would not exist.

APPLICABLE RULE	
R 400.675	**Resident 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:	Based on the findings of the investigation, which included interviews with case manager, Susan Wiley, home manager LaShonda Wilson, Resident A, staff, Oluwafemi Olesifi and Vera Odjugo, and my observation, there is a preponderance of evidence to substantiate that on 06/02/26 and 06/09/26, resident medications were not kept locked. ***Repeat Violation Established; Previous Rule# 400.14312 (1) prior to promulgation of new rules 11/03/25. SIR#2025A0992021 dated 05/14/25 CAP dated 06/03/25.***
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/20/26
Date

Pandrea Robinson
Licensing Consultant

Approved By:

07/21/26
Date

Ardra Hunter
Area Manager