GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2022

Charles Udanoh
Angel Care Homes Inc
16565 Sunderland Road
Detroit, MI 48219

RE: License #: AS820299055
Investigation #: 2022A0119007
Cherry AFC Home

Dear Mr. Udanoh:

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) 456-0380.

Sincerely,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820299055
Investigation #:	2022A0119007
Complaint Receipt Date:	12/08/2021
Investigation Initiation Date:	12/09/2021
Report Due Date:	02/06/2022
Licensee Name:	Angel Care Homes Inc
Licensee Address:	16565 Sunderland Road Detroit, MI 48219
Licensee Telephone #:	(313) 995-2426
Administrator:	Charles Udanoh
Licensee Designee:	Charles Udanoh
Name of Facility:	Cherry AFC Home
Facility Address:	30214 Cherry Avenue Romulus, MI 48174
Facility Telephone #:	(734) 941-4033
Original Issuance Date:	10/15/2009
License **Status:**	REGULAR
Effective Date:	03/23/2021
Expiration Date:	03/22/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has left the facility without staff knowledge. Staff has to file a missing person report and the local police has picked up Resident A due to his inability to find his way back home. Resident A is currently at Beaumont Hospital in Taylor in the emergency room due to group home refusing to take him back at this time.	Yes

III. METHODOLOGY

12/08/2021	Special Investigation Intake 2022A0119007
12/09/2021	APS Referral Received
12/09/2021	Contact- Document Sent Office of Recipient Rights Complaint made
12/09/2021	Special Investigation Initiated - Telephone Licensee Designee- Charles Udanoh
12/16/2021	Inspection Completed On-site Administrator- Charles Udanoh
12/21/2021	Contact - Telephone call made Resident A's guardian/sister
01/26/2022	Exit Conference Licensee Designee- Charles Udanoh
02/03/2022	Contact- Telephone call made Adult Protective Service Investigator Paula Hernandez

ALLEGATION:

Resident A has left the facility without staff knowledge. Staff has to file a missing person report and the local police has picked up Resident A due to his inability to find his way back home. Resident A is currently at Beaumont

Hospital in Taylor in the emergency room due to group home refusing to take him back at this time.

INVESTIGATION:

On 12/09/2021, I telephoned and interviewed the Licensee Designee/ Administrator-Charles Udanoh regarding the above allegations. Mr. Udanoh stated Resident A was admitted into the hospital on 11/30/2021. He stated Resident A has been given two emergency discharges on 10/12/2021 and again on 12/02/2021. He stated he has been in constant contact with Detroit Wayne Integrated Health Network (DWIHN) regarding Resident A's behavior and need for another placement. Mr. Udanoh stated he cannot properly care for Resident A and meet Resident A's basic care needs because of his behavior. He stated he has submitted numerous incident reports of Resident A's uncontrolled behavior. He stated this has been ongoing prior to sending Resident A to the hospital. Mr. Udanoh stated the hospital did contact him on 12/03/2021 to pick up Resident A and he informed the hospital to contact DWIHN. He stated he has no idea of the location of where Resident A is currently residing.

On 12/09/2021, I telephoned and interviewed assigned Licensing Consultant-Denasha Walker regarding the whether or not she has received any incident reports regarding Resident A. Mrs. Walker stated she has received numerous incident reports regarding Resident A destroying property, leaving the facility without informing staff of his general whereabouts and staff contacting the police numerous times because of Resident A's behavior.

On 12/16/2021, I completed an unannounced onsite inspection and interviewed Mr. Udanoh regarding the above allegations. He provided me with Resident A's discharge paperwork and Resident A's guardian/sister contact information. He stated he had asked the police several times to have Resident A petitioned to the hospital. Mr. Udanoh stated he had reached out to DWIHN for assistance with relocating Resident A due to the facilities inability of being able to properly care for him. Mr. Udanoh again reiterated Resident A exhibited severe disruptive behavior and his staff could not properly meet his care needs.

I also reviewed both emergency discharges dated 10/11/2021 and 11/30/2021 that were provided to Resident A. Both discharge requests were due to aggressive behavior to staff and other residents and destruction of property.

On 12/21/2021, I telephoned and interviewed Resident A's guardian/sister regarding the above allegations. Resident A's guardian/sister stated Resident A is not appropriate for the adult foster care setting. She stated Resident A needs a nursing home setting and she has made several requests for DWIHN to assist with placing him to no avail. Resident A's guardian/ sister stated Resident A needs more care due to being very manic and having violent behavior along with refusing medication compliance. She stated Resident A has been admitted into the hospital nineteen

times since being admitted into the facility. She stated Mr. Udanoh has done all that he could to assist Resident A. Resident A's guardian/sister stated it is not fair for Mr. Udanoh or Resident A, for Resident A to remain at Cherry Home because Resident A is not getting the proper care. Resident A's guardian/sister stated Mr. Udanoh did refuse to pick up Resident A from the hospital in December 2021.

On 02/03/2022, I telephoned and interviewed Adult Protective Services worker- Paula Hernandez regarding the above allegations. Ms. Hernandez stated Resident A was left at the hospital by Mr. Udanoh and was medically stable to be discharged. Ms. Hernandez stated Resident A was subsequently placed into another facility.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: (a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information: (i) The reason for the proposed discharge, including the specific nature of the substantial risk. (ii) The alternatives to discharge that have been attempted by the licensee. (iii) The location to which the resident will be discharged, if known. (b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: (i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.

	(ii) The resident shall have the right to file a complaint with the department. (iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.
ANALYSIS:	Licensee Designee/ Administrator- Charles Udanoh stated he cannot properly care for Resident A and met Resident A's basic care needs because of his behavior. Therefore, he did not pick up Resident A from the hospital despite being ready for discharge. Resident A's guardian/sister stated Resident A is not appropriate for adult foster care setting. She stated Resident A needs a nursing home setting and she has made several request for DWIHN to assist with placing him but to no avail. She stated Resident A has been admitted into the hospital nineteen times since being admitted into the facility. She stated Resident A was not picked up by Mr. Udanoh despite being ready for discharge. Adult Protective Services worker- Paula Hernandez stated Resident A was left at the hospital by Mr. Udanoh and was medical stable to be discharged. Therefore, Resident A was not provided with an appropriate placement prior to being discharged from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the status of the license remains the same.

02/03/2022

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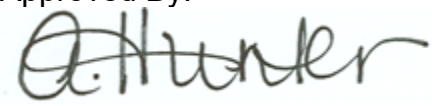
Shatonla Daniel — Date
Licensing Consultant

Approved By:



02/03/2022

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Ardra Hunter — Date
Area Manager