GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 8, 2022

Andrew Akunne
Homestead Residences, Inc.
Suite A
3879 Packard
Ann Arbor, MI 48108

RE: License #: AS630014729
Investigation #: 2022A0605038
Cambria House

Dear Mr. Akunne:

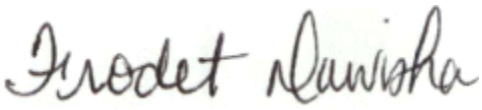
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630014729
Investigation #:	2022A0605038
Complaint Receipt Date:	07/13/2022
Investigation Initiation Date:	07/18/2022
Report Due Date:	09/11/2022
Licensee Name:	Homestead Residences, Inc.
Licensee Address:	Suite A 3879 Packard Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator/Licensee Designee:	Andrew Akunne
Name of Facility:	Cambria House
Facility Address:	6825 Barabeau Troy, MI 48098
Facility Telephone #:	(248) 879-2777
Original Issuance Date:	02/09/1993
License **Status:**	REGULAR
Effective Date:	10/23/2021
Expiration Date:	10/22/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL/AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is being physically and verbally abused by the home manager.	No
Additional Findings	Yes

III. METHODOLOGY

07/13/2022	Special Investigation Intake 2022A0605038
07/18/2022	APS Referral Adult Protective Services (APS) made referral.
07/18/2022	Special Investigation Initiated - Telephone Discussed allegations with APS worker Nina Higgins.
07/19/2022	Inspection Completed On-site I along with APS Nina Higgins conducted an unannounced on-site investigation.
08/04/2022	Contact - Telephone call made I interviewed direct care staff (DCS) Augustine Udewena, DCS Solomon Anifowoshe, DCS Joy Onyernforo and DCS Stephen Onyeka regarding the allegations.
08/15/2022	Contact - Telephone call made Left message for licensee designee Andrew Akunne to discuss findings.
08/30/2022	Contact – Document received Email from APS worker Nina Higgins.
08/30/2022	Exit Conference Left message for licensee designee Andrew Akunne with my findings.

ALLEGATION:

Resident A is being physically and verbally abused by the home manager.

INVESTIGATION:

On 07/13/2022, intake 188578 was referred by Adult Protective Services (APS), but not assigned for investigation until 07/18/2022 regarding Resident A being physically and verbally abused by the home manager (HM).

On 07/18/2022, I initiated the special investigation by contacting the assigned APS worker, Nina Higgins. Ms. Higgins interviewed Resident A at the hospital on 07/14/2022. Ms. Higgins stated that Resident A is new to Cambria House. Resident A is a registered sex offender; therefore, he has difficulty being placed in group homes. She stated that Resident A has a tendency of lying to get moved from group homes as this is what has happened in the past. Ms. Higgins agreed to a joint on-site investigation at Cambria House on 07/19/2022.

On 07/19/2022, I along with APS worker Nina Higgins conducted an unannounced on-site investigation at Cambria House. Present were the HM Odinaka (Odi) Nwosu, Residents B, C, D, E, and F. Resident A was still in the hospital during this visit.

Resident B was interviewed regarding the allegations. Resident B is his own guardian. He receives services through Easterseals and has lived at Cambria House for about two years. Resident B shares a bedroom with Resident A. Resident B stated that Resident A was in the hospital because Resident A was “complaining of pain in his side.” Resident B stated that he observed the HM, Odi hit Resident A on Resident A’s legs. Resident B stated that HM hit Resident A because “[Resident A] was not paying attention.” Resident B does not recall what Resident A was not paying attention to but stated that the HM punched Resident A with a closed fist. He then stated that Resident A was on the bedroom floor because of “pain,” and the HM yelled at Resident A and then “yanked,” Resident A’s arm to get Resident A up off the floor. Resident B did not observe the HM choke or put his hands on Resident A’s neck. Resident B stated that the HM has “anger issues,” but was unable to provide any details as to the HM’s anger. Resident B stated that the HM only hit Resident A and no other resident. Resident B stated the last time he witnessed the HM hit Resident A was a couple of days before Resident A went to the hospital. Resident B stated he is the only one to witness the HM hitting Resident A as the incidents only occurred in their bedroom.

Resident C was interviewed regarding the allegations. Resident C does not know if he has a guardian or not. Resident C has lived at Cambria House for about 14 years. Resident C shares a bedroom with Resident D. Resident C stated the staff here is “exceptional.” He stated that he has never witnessed in 14 years the HM ever putting his hands on any resident including Resident A. Resident C stated the HM has never yelled at him or any other resident. Resident C stated he has no concerns about the HM or any other staff member.

Resident D was interviewed regarding the allegations. Resident D is his own guardian and has lived here for 10 years. Resident D stated he has never witnessed the HM hit or yell at Resident A or any other resident at Cambria House. Resident D stated, “Odi don’t go around hitting people. In the 10 years I’ve lived here, I’ve never seen Odi hit or yell at anyone.” Resident D stated he has not heard from another resident that the HM hit or yelled at Resident A. Resident D stated he has no concerns about the HM or any other staff member here.

Resident E was interviewed regarding the allegations. Resident E shares a room with Resident F. Resident E does not know if he has a guardian or not. He has lived here for a while. Resident E stated he receives services through Easterseals. Resident E’s legs are amputated, and he is wheelchair bound. Resident E stated he has never witnessed the HM hit Resident A or any other resident. Resident E stated that the HM does not yell at him or any other resident and that he has no concerns about the HM or any other staff member.

Resident F was interviewed regarding the allegations. Resident F is his own guardian and has lived at Cambria House for about two years. Resident F receives services through Easterseals. Resident F stated he has never seen the HM hit anyone including Resident A. Resident F stated that the HM does not yell and that he has not heard any resident complain about the HM hitting or yelling at them. Resident F reported no concerns about the HM or the staff.

The HM, Odinaka Nwosu was interviewed regarding the allegations. The HM works the morning shift and has been employed with this corporation for 18 years. The HM stated Resident A was in the hospital because Resident A was complaining of “groin pain.” Resident A is recently moved into Cambria House. The HM has not had “problems with [Resident A].” The HM denied putting his hands on Resident A and denied punching Resident A on his legs and denied putting his hands on Resident A’s neck. The HM stated, “I’ve been doing this work for a long time, and I know what the consequences are if I were to put my hands on [Resident A] or any other resident. I never touch any resident even if they hit me or have behaviors.” The HM stated he has never yelled or raised his voice with Resident A or any other resident. He stated, “I talk to them like I’m talking to you.” The HM has a deep tone, but his tone is not aggressive or loud when he speaks. The HM stated Resident A is incontinent and wears adult briefs. Resident A wets his bed at times and instead of letting the HM or staff know, Resident A will cover it up until staff smell urine on Resident A’s bed. The HM stated even when Resident A has urine accidents, the HM helps clean it up and does not yell at Resident A or cause any issues with Resident A. The HM stated he understands his role as a HM and that he is here to help the residents, which he does. The HM reiterated that he never uses any physical discipline with any resident and does not verbally abuse any resident since he has been working at Cambria House.

On 08/04/2022, I interviewed direct care staff (DCS) Augustine Udewena via telephone regarding the allegations. Ms. Udewena has been with Cambria House for about three months. She works second shift; 4PM-8AM. Ms. Udewena has worked with the HM. She stated that she has never witnessed the HM hit Resident A or any other resident. Ms. Udewena stated that the HM is “good with all the residents and takes care of them.” She stated she has never heard the HM yell or raise his voice at Resident A or any other resident. Ms. Udewena stated that Resident A nor any other resident has informed her of any issues they had with the HM. Ms. Udewena stated that she was not working when Resident A went to the hospital, but that she was told by the HM that Resident A “wasn’t feeling well,” and taken to the hospital. Ms. Udewena stated she has no concerns to report about the HM.

On 08/04/2022, I interviewed DCS Solomon Anifowoshe via telephone regarding the allegations. Mr. Anifowoshe works second shift from 4PM-12AM. He has been with Cambria House for 10 years. Mr. Anifowoshe has worked with the HM. He denied witnessing the HM hit Resident A or any other resident. He too stated, “[The HM] takes good care of them.” He stated that Resident A nor any other resident has come to him to complain about the HM hitting them. Mr. Anifowoshe stated that the HM has never raised his voice to Resident A or yelled at Resident A. He stated that Resident A is hard of hearing and that staff must get very close to Resident A when speaking to Resident A and must repeat the words to Resident A, but that the HM nor any other staff have yelled at Resident A. He stated that he has no concerns about the HM to report.

On 08/04/2022, I interviewed DCS Joy Onyernforo via telephone regarding the allegations. Ms. Onyernforo works all shifts and has been with Cambria House for over 10 years. She has worked with the HM and stated, “[The HM] is really good with all the residents including [Resident A].” Ms. Onyernforo stated she has never witnessed [the HM] put his hands on [Resident A] or any other resident. Ms. Onyernforo stated Resident A has never reported to her that the HM hit him or yelled at him. She reported that the HM would never yell or raise his voice at Resident A or any other resident. Ms. Onyernforo stated Resident A is hard of hearing and because of that, the HM and all staff must get close enough to Resident A and speak loudly and repeat words to Resident A. She denied yelling at Resident A and denied witnessing the HM yell or raise his voice at Resident A. Ms. Onyernforo has no concerns about the HM to report.

On 08/04/2022, I interviewed DCS Stephen Onyeka Ogbodo via telephone regarding the allegations. Mr. Ogbodo has been with Cambria House for two years. He works the weekend shifts and has worked with the HM. Mr. Ogbodo stated he has never witnessed the HM put his hands on Resident A or any other resident. He stated that Resident A has never complained about the HM. Mr. Ogbodo also denied hearing the HM yell or raise his voice at Resident A or any other resident. He stated that Resident A is hard of hearing, so staff must stand close to Resident A and speak loudly, but never yell at Resident A. Mr. Ogbodo stated he has no concerns about the HM to report.

On 08/10/2022, I received an email from APS worker Nina Higgins with her interview with Resident A which is the following: “APS completed a face-to-face visit with Resident A at the hospital. Resident A was asleep but woke up to the sound of APS' voice calling out his name. APS attempted to have a conversation with Resident A, but Resident A appears to be delayed. He continued to blow out of his mouth as if he were puffing a cigarette. Although he could have a conversation with APS, the information he provided was not very helpful as he would not go into any details regarding the allegations when asked. Resident A could only describe to APS how the HM grabbed him by the neck a few times and yelled at him. Resident A did not state anything else otherwise and appeared to be frustrated. He is slow with speaking and getting his thoughts out verbally. He stated he did not want to go back to this home. He would only answer questions that APS asked specifically and did not offer any additional information. He was unable to tell APS who placed him at Cambria House. He stated he just did not want to go back to Cambria House.” Ms. Higgins stated she observed no injuries on Resident A.

On 08/15/2022, I left a message for licensee designee Andrew Akunne to discuss my findings.

On 08/30/2022, I received an email from APS worker Nina Higgins stating that she is not substantiating her case for physical abuse due to insufficient evidence.

On 08/30/2022, I attempted an exit conference and left a detailed message for licensee designee, Andrew Akunne, with my findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.

ANALYSIS:	Based on my investigation and information gathered, there is insufficient evidence to substantiate that the HM Odinaka Nwosu used any form of physical force towards Resident A. Resident A reported to APS that the HM choked him but was unable to provide any details. Resident A's roommate, Resident B stated that he observed the HM punch Resident A on the legs but denied witnessing the HM choke Resident A. The HM denied punching and choking Resident A. I interviewed all DCS and Residents C, D, E, and F at Cambria House and all the residents and DCS members denied witnessing the HM hit Resident A. Resident A did not have any marks/injuries.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse.
ANALYSIS:	Based on my investigation and information gathered, there is insufficient evidence to substantiate that the HM verbally abused Resident A. Resident A made a statement to APS that the HM yelled at him but was unable to provide further details. DCS reported that Resident A is "hard of hearing," and that DCS must speak loudly and repeat their words to Resident A but denied that the HM yells at him. Residents C, D, E, and F also denied the HM yelling at Resident A or at them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 07/19/2022, I observed no lid on the trash can in the kitchen. The HM stated they cannot locate the lid to the trash can but will get one. The tile in the kitchen and the hallway was chipped with missing pieces. I observed a hole in Resident A's bedroom taped with black duct tape. Resident B stated that Resident A punched a hole in the wall located near Resident A's bed

behind the door. While interviewing Resident C in his bedroom, I observed his blanket ripped, no pillowcase and his pillow was dirty, and Resident C's urinal container sitting on the nightstand full of urine. Also, in the same bedroom, Resident D's pillowcase and bedsheets were extremely dirty with black and yellow stains. The HM stated staff, including himself do laundry daily. Lastly, Residents E and F's bedroom door was not closing properly.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	During the on-site investigation on 07/19/2022, I observe the trash can without a tight-fitting lid.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the on-site investigation on 07/19/2022, I observed Resident C's urinal container full of urine sitting on Resident C's nightstand.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.

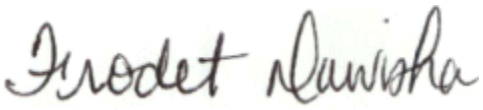
ANALYSIS:	During the on-site investigation on 07/19/2022, I observed the floor tiles throughout the home chipped and pieces of the tiles were missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	During the on-site investigation on 07/19/2022, I observed Resident C in his bedroom with a ripped blanket and no pillowcase. I observed Resident D's bed to have dirty linens, pillowcase, and sheets.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(2) A licensee shall provide at least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident bed.
ANALYSIS:	During the on-site investigation on 07/19/2022, I observed Resident C's and Resident D's pillow to not be clean and in good condition as they were stained.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



09/08/2022

Frodet Dawisha — Date
Licensing Consultant

Approved By:

09/08/2022

Ardra Hunter — Date
Area Manager