GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 26, 2024

Sulayman Aninure
Anikare AFC
323 E Glenguile
Parchment, MI 49004

RE: License #: AM030412015
Investigation #: 2024A0464055
Anikare's Home

Dear Mr. Aninure:

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 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 (616) 356-0183.

Sincerely,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS INAPPROPRIATE LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AM030412015
Investigation #:	2024A0464055
Complaint Receipt Date:	08/22/2024
Investigation Initiation Date:	08/22/2024
Report Due Date:	10/21/2024
Licensee Name:	Anikare AFC
Licensee Address:	323 E Glenguile Parchment, MI 49004
Licensee Telephone #:	(269) 254-0241
Administrator:	Sulayman Aninure
Licensee Designee:	Sulayman Aninure
Name of Facility:	Anikare's Home
Facility Address:	328 E Morrell St Otsego, MI 49078
Facility Telephone #:	(269) 254-0241
Original Issuance Date:	06/30/2022
License Status:	REGULAR
Effective Date:	12/31/2022
Expiration Date:	12/30/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has a history of aggressive behaviors and has assaulted other residents. Recently, Resident A assaulted Resident B.	Yes

III. METHODOLOGY

08/22/2024	Special Investigation Intake 2024A0464055
08/22/2024	APS Referral
08/22/2024	Special Investigation Initiated - Face to Face Officer Judd Sikkema (Otsego PD), Detective Aaron LaLone (Otsego PD) & Michael McClellan (Allegan APS)
08/22/2024	Contact-Document received Otsego Police Report
08/22/2024	Inspection Completed On-site Micheal McClellan (APS), Sulayman Aninure (Licensee Designee) and Resident A
08/23/2024	Contact-Document received Facility Records
09/26/2024	Exit Conference Sulayman Aninure, Licensee Designee

ALLEGATION: Resident A has a history of aggressive behaviors and has assaulted other residents. Recently, Resident A assaulted Resident B.

INVESTIGATION: On 08/22/2024, I received a complaint from Adult Protective Services (APS), stating the police have been called to the home on numerous occasions, regarding Resident A. Recently, they were called to the home due to an incident where Resident A “strangled” Resident B. There is concern staff are not protecting Resident A from himself or other residents.

On 08/22/2024, Allegan County APS worker, Micheal McClellan and I arrived at the Otsego Police Department. We met with Officer Judd Sikkema and Detective Aaron LaLone. Both Officer Sikkema and Detective LaLone reported Resident A has called the police department on numerous occasions. He has contacted the police for something as simple as facility staff will not give him a pop. Officer Sikkema and Detective LaLone stated Resident A engages in self-harming behavior, by banging

his head on the wall. He has also assaulted other residents. Recently, officers responded to a call that Resident A had “strangled” Resident B. Both expressed concerns that the facility is unable to adequately meet the care needs of Resident A. Detective LaLone provided the emergency call list. The police department has responded to 24 calls between 05/01/2024 and 08/21/2024.

On 08/22/2024, I received and reviewed the Otsego Police Department report #24-1703. The police report stated that on 08/10/2024, Officer Michael Gudith responded to a complaint regarding physical assault. It was reported Resident A was having one of his “episodes” and he physically assaulted Resident B in the facility. When Officer Gudith arrived, she could hear yelling from inside the facility and the door was wide open. When Officer Gudith walked inside the facility, she saw Resident A standing, holding a lamp. Officer Gudith instructed Resident A to put down the lamp, and Resident A complied.

Officer Gudith interviewed Resident B, privately. Resident B is unable to walk and utilizes a wheelchair to ambulate. Resident B stated she had upset Resident A by calling him a “nigger”. Resident A then became extremely upset and proceeded to take both of his hands, wrapping them around her neck, squeezing tightly. Resident B stated she could not breathe. Resident B told Officer Gudith she no longer wanted to live in the facility, as she did not feel safe. Resident B declined medical attention. Officer Gudith documented seeing no injuries on Resident B.

Officer Gudith then interviewed staff person, Mkama Martine. Mr. Martine stated he heard Resident B screaming, and immediately ran into the living room. He saw that Resident A had both of his hands wrapped around Resident B’s neck. Mr. Martine intervened and contacted law enforcement. The officer noted that he had spoke to Mr. Martine numerous times, related to other incidents. Mr. Martine stated he no longer wants to work at the facility, as he feels unsafe due to Resident A’s behavior.

Officer Gudith then interviewed Resident A. He reported Resident B made him mad because she called him the “n” word. Resident A admitted to using his hands to strangle Resident B. Resident A then became upset and expressed suicidal ideation to the officer. As a result, Emergency Medical Services (EMS) transported Resident A to the hospital.

Officer Gudith contacted Resident A’s legal guardian Sheldon Schuritek to inform him of the incident. Officer Gudith explained to Mr. Schuritek that the facility is unable to meet the needs of Resident A due to his aggressive behaviors. Officer Gudith explained he has responded to several complaints concerning Resident A, including a recent incident when Resident A was banging his head so hard it started to bleed and then Resident A fled the facility. Mr. Schuritek stated after speaking with the AFC owner, he was under the impression things were getting better with Resident A living in the home. Mr. Schuritek agreed with Officer Gudith that the facility was no longer an appropriate placement for Resident A.

On 08/22/2024, Mr. McClellan and I completed an unannounced, onsite inspection at the facility. We interviewed licensee designee, Sulayman Aninure. He reported Resident B has been moved to a different facility. Mr. Aninure reported on 08/10/2024, Resident A and Resident B got into a verbal altercation. Resident A then became angry and tried to strangle Resident B. Mr. Aninure stated the police were contacted. Resident A was taken to the hospital. He was later discharged back to the facility. Mr. Aninure reported he previously gave Resident A a thirty-day discharge notice, but then his behaviors began to improve after a medication change. Mr. Aninure stated his behaviors have escalated again and facility staff are no longer able to manage his behaviors. Mr. Aninure stated he is going to give Resident A another discharge notice.

Face-to-face contact was made with Resident A. He was leaving to go out on an outing, therefore an interview was not completed. Resident A was observed to be clean and appropriate dressed. No marks or bruises were observed.

On 08/23/2024, I received Resident A's Individual Plan of Services (IPOS), which was signed and completed on 02/27/2024. The plan reflects that Resident A struggles with behavioral outbursts and will often bang his head against the wall. He also has a history of breaking things. The IPOS states staff are to attempt to keep Resident A safe, when he engages in these behaviors. Staff are to be trained in MANDT holds in order to keep Resident A safe as well as other residents and staff.

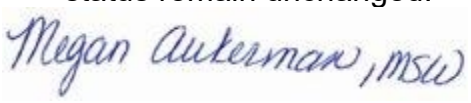
On 09/26/2024, I completed an exit conference with licensee designee, Sulayman Aninure. He was informed of the investigation findings and recommendations. Mr. Aninure stated he understands the rule violation. He stated Resident A has been moved to another facility.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 08/22/2024, a complaint was received stating Resident A "strangled" Resident B. There is concern that the facility is not able to adequately meet Resident A's needs due to his behaviors. On 08/22/2024, Detective Aaron LaLone and Officer Judd Sikkema reported the Otsego Police Department responded to multiple complaints at the facility regarding Resident A. They reported Resident A frequently harms himself and has assaulted other residents in the facility. Recently, officers responded to a

	complaint of assault in which Resident A had choked Resident B. Both Detective LaLone and Officer Gillion reported facility staff are not able to provide adequate care for Resident A. Licensee designee, Sulayman Aninure reported Resident A does engage in self-harming behaviors and has assaulted Resident B. Mr. Aninure reported he previously gave Resident A a discharge notice, but later retracted the notice. Mr. Aninure acknowledge staff are no longer able to manage Resident A's behaviors. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff are unable to provide adequate care and supervision for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.



09/26/2024

Megan Aukerman Date
Licensing Consultant

Approved By:

09/26/2024

Jerry Hendrick Date
Area Manager