GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 29, 2025

Andrew Akunne
Joak American Homes, Inc.
3879 Packard Road, Unit A
Ann Arbor, MI 48108

RE: License #: AS820068803
Investigation #: 2026A0901008
Glenwood Home

Dear Andrew 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 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) 456-0439.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068803
Investigation #:	2026A0901008
Complaint Receipt Date:	11/14/2025
Investigation Initiation Date:	11/17/2025
Report Due Date:	01/13/2026
Licensee Name:	Joak American Homes, Inc.
Licensee Address:	Unit A 3879 Packard Road Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Glenwood Home
Facility Address:	29803 Glenwood Inkster, MI 48141
Facility Telephone #:	(734) 721-5552
Original Issuance Date:	12/18/1995
License Status:	REGULAR
Effective Date:	04/27/2025
Expiration Date:	04/26/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/22/25, the home manager Sam, put his hands on Resident A. On 11/13/2025 Sam left the residents alone in the van with the keys and Resident A drove off with the other residents.	Yes

III. METHODOLOGY

11/14/2025	Special Investigation Intake 2026A0901008
11/14/2025	Adult Protective Services (APS) Referral
11/17/2025	Special Investigation Initiated - On Site
11/18/2025	Referral - Recipient Rights
11/18/2025	Contact - Document Sent Emailed APS
11/19/2025	Contact - Telephone call received APS
12/03/2025	Contact - Telephone call made Alyea Smith, Case manager
12/16/2025	Contact - Telephone call made Residents B-D
12/18/2025	Contact - Telephone call made Resident E
12/29/2025	Inspection Completed-BCAL Sub. Compliance
12/29/2025	Exit Conference Licensee designee, Andrew Akunne

ALLEGATION:

On 10/22/25, the home manager Sam, put his hands on Resident A. On 11/13/2025 Sam left the residents alone in the van with the keys and Resident A drove off with the other residents.

INVESTIGATION:

On 11/17/2025, I conducted an onsite inspection at the facility. The home manager, Samuel Okunawo, was present and was interviewed. He denied physically assaulting Resident A and stated nothing happened on 10/22/2025, besides Resident A repeatedly calling 911 and wanting to go to the hospital. Samuel indicated Resident A had not been himself since September 2025 and had been having behavior issues since then. He stated Resident A's medications were recently changed and the change in his behavior could be a result of that. Samuel showed me incident reports. They were dated 10/22/2025 and were completed by Samuel. At 4:33 a.m., Resident A requested to be taken to the hospital because staff refused to give him his discontinued medications. He was taken to Garden City hospital and was given a Benadryl shot and prescribed Benztropine. At 9:16 a.m., he called 911 and told them he wanted to go to the hospital because he was shaking. The EMS arrived and found nothing wrong with him. At 10:53 a.m., he called 911 again stating staff would not give him his medication and that he wanted to sue the company. He was told by the dispatcher to stop abusing the system. Samuel did not know Resident A's current whereabouts because he left on 11/13/2025. He indicated that on 11/13/2025 he took the residents to Hegira and on the way back to the facility, Resident A's behavior became problematic, so he pulled over at a gas station to call the police for help. As Samuel was on the phone, Resident A tried to fight him, so he stood outside the van to continue talking to the 911 dispatcher and all the residents were left in the van. Resident A got out of the van and continued to try to fight him. He said he did not realize he left the keys in the van until Resident A got back in the van and dangled the keys at him. Samuel opened the door and tried to get the keys from Resident A but he kicked him away and drove off with the other residents. He remained at the gas station until the police arrived. When they got to the facility all the residents were inside, and Resident A was gone with the van. A police report (25-55790) was made but thus far, Resident A and the van have not been located. Samuel also showed me the incident report he completed on 11/13/2025 detailing what he reported to me.

On 11/18/2025, I emailed Tierra Metcalf, from APS for additional information. I received a telephone call from her on 11/19/2025. She stated Resident A's whereabouts were still unknown and that the company's van was still missing. Regarding the 10/22/2025 incident, she stated Resident A told her that Samuel was trying to prevent him from sitting down and grabbed his pocket and pulled at him.

On 12/03/2025, I made a telephone call to Alyea Smith, Resident A's case manager from Hegira. She stated Resident A was located before Thanksgiving and was

currently at Walter Ruether psychiatric hospital. He was expected to be there for quite a while because he already had legal issues and now the current incident with the facility. She indicated Resident A had been spiraling since October and was not compliant with his medications. Regarding the 10/22/2025 incident, Aleya doubted the validity. She said Resident A's story kept changing and that he told her several different accounts of what happened. She stated her knowledge of the van incident was the same as what Samuel reported to me.

On 12/16/2025, I made a telephone call to the facility and interviewed Residents B-D. They each denied every witnessing staff mistreat Resident A but everyone said Resident A mistreated staff. They stated he did not listen to staff, would say bad things to staff, called staff names, and sometimes tried to fight staff. Regarding the van incident, Resident B and D said Samuel was outside the van on the phone and Resident A got the key and was in the driver's seat. Sameul tried to get the key from him, but Resident A was fighting him and drove off. They stated he took them to the facility and let them inside, then he left in the van. Resident D stated he did not know what happened because he was not paying attention. He said all he remembered was that Resident A drove them to the facility.

On 12/18/2025, I made a telephone call to the facility and interviewed Resident E. He stated he never observed staff mistreat Resident A but that Resident A did not always listen to staff. Regarding the van incident, he said Samuel was outside the van and Resident A got the keys and was about to drive off. Samuel tried to take the keys from him and Resident A punched him. He kept fighting Samuel until he let loose and fell. Resident A then drove off and took the residents to the facility and left.

On 12/29/2025, I made a telephone call to the licensee designee, Andrew Akunne, for an exit conference. The voicemail did not come on so I sent him an email informing him of my investigative findings and welcoming him to call me if he had questions.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Based on the information I obtained during this investigation, the residents' protection and safety was not attended to. The residents' safety was endangered when Samuel left the keys in the van and left the residents alone in the van with Resident A, who was having a behavioral episode, and subsequently drove off in the van with the other residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____12/29/2025
Regina Buchanan Date
Licensing Consultant

Approved By:

12/29/2025
_____
Ardra Hunter Date
Area Manager