



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 19, 2026

Josephine Uwazurike  
ADA Homes, Inc.  
P O Box 4199  
Southfield, MI 48037

RE: License #: AS820379138  
Investigation #: 2026A0992019  
Westland III

Dear Josephine Uwazurike:

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,

A handwritten signature in black ink, appearing to read "Denasha Walker".

Denasha Walker, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 300-9922

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820379138
<b>Investigation #:</b>	2026A0992019
<b>Complaint Receipt Date:</b>	01/28/2026
<b>Investigation Initiation Date:</b>	01/29/2026
<b>Report Due Date:</b>	03/29/2026
<b>Licensee Name:</b>	ADA Homes, Inc.
<b>Licensee Address:</b>	#200 23999 Northwestern Hwy. Southfield, MI 48075
<b>Licensee Telephone #:</b>	(248) 569-1040
<b>Administrator:</b>	Josephine Uwazurike
<b>Licensee Designee:</b>	Josephine Uwazurike
<b>Name of Facility:</b>	Westland III
<b>Facility Address:</b>	4761 Westland Dearborn, MI 48126
<b>Facility Telephone #:</b>	(313) 429-9499
<b>Original Issuance Date:</b>	11/21/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/21/2025
<b>Expiration Date:</b>	11/20/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED



**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On January 15, 2026, the guardian observed a wound covering three-quarters of Resident A's left wrist, with no explanation provided. There are concerns regarding adequate supervision.	Yes

**III. METHODOLOGY**

01/28/2026	Special Investigation Intake 2026A0992019
01/29/2026	Special Investigation Initiated - Telephone Resident A's guardian, Amy Torony with Faith Connections.
01/29/2026	Inspection Completed On-site Chidinma "Chi-Chi" Nwkanma, Samuel Bassey and Resident A.
01/29/2026	Contact - Telephone call made Area manager, Lanetria Gibson
01/30/2026	Contact - Telephone call made Ms. Torony
02/02/2026	Contact - Telephone call made Office of Recipient Rights (ORR), April Dudley was not available. Message left.
02/02/2026	Contact - Telephone call made Home manager, Stephen Onedode
02/02/2026	Contact - Telephone call made Direct care staff, Nafisat Adeyemi
02/02/2026	Contact - Telephone call made Licensee designee, Josephine Uwazurike
02/04/2026	Contact - Telephone call received Ms. Dudley
02/23/2026	Contact - Telephone call received Adult Protective Services (APS), Charmaine Parks

03/12/2026	Contact - Telephone call made Ms. Parks
03/12/2026	Contact - Telephone call made Ms. Torony

**ALLEGATION:** On January 15, 2026, the guardian observed a wound covering three-quarters of Resident A's left wrist, with no explanation provided. There are concerns regarding adequate supervision.

**INVESTIGATION:** On 01/29/2026, I contacted Resident A's guardian, Amy Torony with Faith Connections regarding the allegation. Ms. Torony stated while visiting with Resident A on 01/15/2026 she observed a ligature mark that was  $\frac{3}{4}$  her left wrist and it appeared infected. Ms. Torony stated although Resident A has limited verbal skills, she tried to interview her, but she didn't engage. Ms. Torony stated she asked the home manager, Stephen Onedode what happened and he didn't have a clue. She stated she requested Mr. Onedode take Resident A to the doctor or to urgent care immediately. She stated Resident A wasn't seen until 1/22/2026 at urgent care and prescribed an antibiotic. Ms. Torony stated she doesn't understand why there was a delay in Resident A's medical care. Ms. Torony stated she didn't receive an incident report (IR) regarding the injury, and an IR was not available when she was onsite. She stated she received an IR following her visit and she believes it was completed after the fact. Ms. Torony stated Resident A has a history of pulling out her peg tube. She stated she intends to have Resident A removed from the home.

On 01/29/2026, I completed an unannounced on-site inspection and interviewed Chidinma "Chi-Chi" Nwkanma, Samuel Bassey and Resident A regarding the allegation. Ms. Chi-Chi denied having any knowledge of how Resident A sustained the injury. She stated she returned to work on 01/15/2026 and that's when she observed the mark. She stated it is documented in the daily log.

I interviewed Samuel Bassey, he stated he observed the injury on 01/06/2026. He stated he was working along with direct care staff, Nafisat Adeyemi. He stated he asked Nafisat about the injury and she explained that Resident A's shirt had a form of elastic at the end of the sleeves, in the wrist area. He stated the elastic left a mark on her wrist. I asked if there was elastic at the end of each sleeve, why there wasn't a mark on her left wrist as well; Mr. Bassey was unable to explain or answer.

I attempted to interview Resident A, but she did not engage. I observed a ligature mark that span  $\frac{3}{4}$  of her right wrist; the mark appeared to be healing. I observed Resident A's bed has handrails, only the right handrail is in the upright position. The way the bed is positioned against the wall, the left handrail is not functional.

I reviewed the IRs. IR dated 01/12/2026 was completed by Mr. Onadode. The IR referenced an injury to Resident A's ankle (I observed Resident A's ankles and did not observe any marks or bruises). It stated this injury was due to bound clothing. The IR dated 01/17/2026 was completed by direct care staff, Nafisat Adeyemi. According to the IR Ms. Adeyemi observed a bruise on Resident A's right hand; she applied ointment to the affected area. Another incident report dated 01/17/2026, was completed by direct care staff, Anthonia Ahaiwe. Ms. Ahaiwe stated she noticed a bruise on Resident A's wrist area; she wiped the area with a warm towel and applied vaseline to the area. It should be noted that I did not observe an IR dated prior to 01/12/2026, as previously stated by Mr. Bassey that he observed the injury on 01/06/2026. There were several IRs regarding Resident A pulling out her peg tube.

On 01/29/2026, I contacted area manager, Lanetria Gibson regarding the allegation. Ms. Gibson confirmed she was aware of the injury and was made aware by Mr. Onedode. She stated to her knowledge Mr. Onedode completed an IR. I made Ms. Gibson aware that I reviewed the IR, and the one completed on 01/12/2026, stated there was a mark on Resident A's ankle, not her wrist. I made Ms. Gibson aware that the IR referencing Resident A's wrist is dated 01/17/2026. Ms. Gibson stated when she spoke with Mr. Onedode about the injury, she instructed him to contact Resident A's doctor, which he did. She stated he attempted to contact the doctor, but the doctor never responded. She stated she instructed Mr. Onedode to take Resident A to urgent care when he did not hear back from the doctor.

On 01/30/2026, I made follow-up contact with Ms. Torony. I explained that there is some uncertainty as to when Resident A sustained the injury. Mr. Bassey stated he observed it on 01/06/2026, and Mr. Onedode was notified on 01/11/2026 or 01/12/2026. Ms. Torony stated when she visited the home on 01/15/2026, Mr. Onedode stated Resident A had the injury since 01/11/2026. Ms. Torony stated she is not pleased with the staff and their lack of urgency as it pertains to Resident A's medical needs. She stated she has initiated the process to have Resident A removed from the home and placed at another adult foster care home.

On 02/02/2026, I interviewed Mr. Onedode regarding the allegation. Mr. Onedode stated he does not know how Resident A sustained the injury. He stated he was off work and returned on 01/12/2026. He stated at that time it was reported to him by direct care staff Whytes Amieno, that Resident A had a mark on her wrist. He stated to his knowledge it was observed on 01/11/2026. Mr. Onedode stated once he was notified, he completed an IR and sent it to the area manager and Ms. Torony. I made Mr. Onedode aware that I reviewed the IRs and IR dated 01/12/2026 referenced Resident A's ankle, not her wrist. Mr. Onedode stated that must've have been a mistake. As far as medical attention is concerned, Mr. Onedode stated he called Resident A's doctor on 01/12/2026 and 01/13/2026 and left a message. He stated the doctor was supposed to contact Ms. Gibson to schedule an appointment. I stated according to the documentation, Resident A did not receive medical treatment until 01/22/2026, which Mr. Onedode confirmed. Mr. Onedode denied Ms. Torony instructed him to take Resident A to the doctor immediately.

On 02/02/2026, I contacted direct care staff, Nafisat Adeyemi, and interviewed her regarding the allegation. Ms. Adeyemi confirmed she observed the mark on Resident A's wrist and completed an IR on 01/11/2026. She stated she doesn't know how Resident A sustained the injury, but she documented it as soon as she saw it. Ms. Adeyemi stated she completed the IR form and put it in the manager's office. She stated there was no manager on shift at the time.

On 02/02/2026, I contacted licensee designee, Josephine Uwazurike and made her aware of the allegation. Ms. Uwazurike stated she was previously contacted by Ms. Gibson regarding the allegation. Ms. Uwazurike stated she spoke with Mr. Onedode and doesn't understand the delay between the time the injury was initially observed and the time Resident A received medical treatment. She stated Mr. Onedode contacted the doctor, but when he didn't hear back from him, he should have taken her to urgent care. I explained that there are some concerns regarding the IR not being completed timely and Resident A's guardian did not receive a copy of the IR until she questioned the injury during her monthly visit. I conducted an exit conference and made Ms. Uwazurike aware that based on the findings, there is sufficient evidence to support the allegation. Resident A sustained an injury, and no one provided a valid explanation as to how Resident A was injured. There was a delay in Resident A receiving medical treatment. Resident A is not ambulatory and has limited verbal skills. Ms. Uwazurike denied having any questions or concerns.

On 02/04/2026, I contacted Office of Recipient Rights (ORR) Investigator, April Dudley regarding the allegation. Ms. Dudley confirmed she is actively investigating the complaint. She stated she observed Resident A's injury. She stated Mr. Basse reported that the injury was caused by the elastic on one of Resident A's shirts. She stated the way it was described the shirt contained elastic in the wrists area, but only one of Resident A's wrists was bruised. Ms. Dudley stated the injury is not consistent with the explanation. She stated that she needs to interview two more direct care staff. She stated she reviewed the IRs and it seems as though the IR was completed after the fact.

On 02/23/2026, I received a telephone call from Adult Protective Services (APS), Charmaine Parks. Ms. Parks confirmed she is actively investigating the complaint. She stated she observed Resident A and her injury is in the healing stage. Ms. Parks stated she is actively investigating the complaint and will keep me updated as she completes the investigation.

On 03/12/2026, I contacted Ms. Parks regarding the status of her investigation. Ms. Parks stated that she substantiated the allegation due to lack of medical care in a timely manner.

On 03/12/2026, I made follow-up contact with Ms. Torony regarding Resident A. Ms. Torony stated she completed all the necessary paperwork for Resident A to be

removed from the home. She stated the process has been initiated, and she anticipates Resident A moving soon.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>During this investigation, I interviewed licensee designee, Josephine Uwazurike; home manager, Stephen Onedode; former direct care staff, Chidinma "Chi-Chi" Nwkanma, Samuel Bassey, Nafisat Adeyemi; Resident A's guardian, Amy Torony with Faith Connections; ORR, April Dudley; APS, Charmaine Parks regarding the allegation. All of which confirmed Resident A sustained an injury but was uncertain how it occurred.</p> <p>Resident A has limited communication skills. I observed a ligature mark that span <math>\frac{3}{4}</math> of her right wrist; the mark appeared to be healing.</p> <p>The IR I reviewed dated 01/12/2026, was not accurately completed and referenced an injury to Resident A's ankle. The IR dated 01/17/2026, was completed several days after the injury was observed.</p> <p>Based on the investigative findings, there is sufficient evidence to support that allegation that Residents A was not treated with dignity and respect, protected and safe. The allegation is substantiated.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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



03/19/2026

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Denasha Walker  
Licensing Consultant

Date

Approved By:



03/19/2026

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Ardra Hunter  
Area Manager

Date