GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2026

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

RE: License #: AS820379138
Investigation #: 2026A0993018
Westland III

Dear Ms Uwazurike:

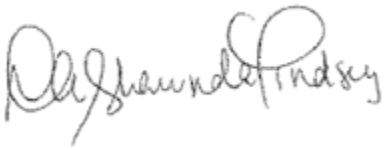
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820379138
Investigation #:	2026A0993018
Complaint Receipt Date:	06/17/2026
Investigation Initiation Date:	06/18/2026
Report Due Date:	08/16/2026
Licensee Name:	ADA Homes, Inc.
Licensee Address:	#200 23999 Northwestern Hwy. Southfield, MI 48075
Licensee Telephone #:	(248) 569-1040
Administrator:	Josephine Uwazurike
Licensee Designee:	Josephine Uwazurike
Name of Facility:	Westland III
Facility Address:	4761 Westland Dearborn, MI 48126
Facility Telephone #:	(313) 429-9499
Original Issuance Date:	11/21/2016
License Status:	REGULAR
Effective Date:	11/21/2025
Expiration Date:	11/20/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 6/12/2026, Resident A eloped from the facility, walking almost two miles away from the facility.	Yes

III. METHODOLOGY

06/17/2026	Special Investigation Intake 2026A0993018
06/18/2026	APS Referral Allegations received from Adult Protective Services (APS). APS denied the intake.
06/18/2026	Referral - Recipient Rights Forwarded allegations to Detroit Integrated Health Network (DWIHN) Office of Recipient Rights
06/18/2026	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation. I interviewed staff, Whyte Amieno.
06/18/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights officer, Phoenicia Jackson
06/18/2026	Contact - Telephone call made Telephone call made to area manager, Lanetria Gibson
06/18/2026	Contact - Telephone call made Telephone call made to Guardian A1. Mailbox was full.
06/18/2026	Contact - Telephone call made Telephone call made to home manager, Kingsley Iwuh
06/18/2026	Contact - Telephone call made Telephone call made to staff, Nneke Asumah. Left a message.
06/18/2026	Contact - Document Received Received a copy of Resident A's assessment plan. Also, received a copy of the incident report.
06/18/2026	Inspection Completed-BCAL Sub. Compliance

06/23/2026	Contact - Telephone call made Telephone call made to staff, Nneke Asumah
06/23/2026	Contact - Telephone call made Telephone call made to Guardian A1. Mailbox was full.
06/29/2026	Contact - Telephone call made Telephone call made to Services to Enhance Potential (STEP) site manager, Noreen Sarlauskas
06/29/2026	Contact - Telephone call made Telephone call made to Guardian A1. Mailbox was full.
07/01/2026	Contact - Face to Face Observed Resident A in the facility
07/09/2026	Exit Conference Held with licensee designee Josephine Uwazurike

ALLEGATION:

On 6/12/2026, Resident A eloped from the facility, walking almost two miles away from the facility.

INVESTIGATION:

On 06/18/2028, I received allegations from Adult Protective Services (APS). APS denied the intake.

On 06/18/2026, I forwarded allegations to the Detroit Integrated Health Network (DWIHN) Office of Recipient Rights.

On 06/18/2026, I conducted an unannounced onsite investigation. I interviewed staff, Whyte Amieno. Mr. Amieno stated he was not working when the alleged incident occurred. Mr. Amieno did not provide any information about the incident.

On 06/18/2026, I conducted a telephone interview with DWIHN recipient rights officer, Phoenicia Jackson. Ms. Jackson confirmed she is also investigating the allegations. She stated staff, Nneke Asumah was Resident A's assigned 1:1 staff on 06/12/2026. Ms. Asumah did not know how or when Resident A eloped from the facility.

On 06/18/2026, I conducted a telephone interview with area manager, Lanetria Gibson. Ms. Gibson confirmed Resident A eloped from the facility on 06/12/2026 and was located by Services to Enhance Potential (STEP) staff. Home manager Kingsley Iwuh and Ms. Asumah were on shift at the time of the incident. Ms. Gibson stated Resident A

has a history of trying to elope from the facility, and staff are supposed to always monitor him. Per Ms. Gibson, Mr. Iwuh and Ms. Asumah did not know how or when Resident A eloped from the facility.

On 06/18/2026, I conducted a telephone interview with home manager, Kingsley Iwuh. Mr. Iwuh confirmed he was working with Ms. Asumah on 06/12/2026 when Resident A eloped from the facility. Ms. Asumah was Resident A's 1:1 staff. Mr. Iwuh denied knowing how or when Resident A eloped from the facility. He confirmed STEP staff notified the facility after finding Resident A outside their facility.

On 06/18/2026, I received a copy of Resident A's assessment plan. I also received a copy of the incident report (IR). Per the assessment plan, Resident A cannot move independently in the community. Resident A requires staff assistance while in the community. Per the IR, STEP staff located Resident A outside of their facility. By working with DWIHN Access, Customer Service and Dearborn Police Department, they were able to identify Resident A and notify his facility.

On 06/23/2026, I conducted a telephone interview with staff, Nneke Asumah. Ms. Asumah confirmed she was working with Mr. Iwuh on 06/12/2026 when Resident A eloped from the facility. Ms. Asumah confirmed she was Resident A's 1:1 staff. Ms. Asumah denied knowing how or when Resident A eloped from the facility.

On 06/29/2026, I conducted a telephone interview with STEP site manager, Noreen Sarlauskas. She confirmed STEP staff located Resident A outside of their facility. By working with DWIHN Access, Customer Service and Dearborn Police Department, they were able to identify Resident A and notify his facility.

On 06/29/2026 as well as on 06/18/2026 and 06/23/2026, I attempted to interview Guardian A1 with no success.

On 07/01/2026, I observed Resident A in the facility. I was unable to interview him due to his limited cognitive abilities.

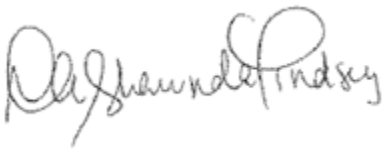
On 07/09/2026, I contacted licensee designee Josephine Uwazurike and conducted an exit conference. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	On 06/12/2026, Resident A eloped from the facility. Mr. Iwuh and Ms. Asumah were working in the facility but did not know how or when Resident A eloped from the facility. Per Resident A's assessment plan, Resident A cannot move independently in the community. Resident A requires staff assistance while in the community. Evidence supports that the licensee did not provide supervision, protection, and personal care as specified in a resident's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



07/14/2026

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DaShawnda Lindsey Date
Licensing Consultant

Approved By:

07/15/2026

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Ardra Hunter Date
Area Manager