GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 16, 2026

Vincent Anwunah
ChiCares Assisted Living LTD
46908 Wareham Drive
Canton, MI 48187

RE: License #: AS820295005
Investigation #: 2027A0993002
Destined Place

Dear Mr. Anwunah:

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:

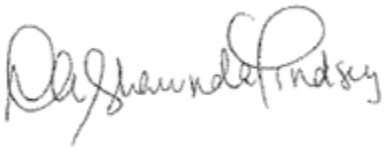
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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.

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.

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 #:	AS820295005
Investigation #:	2027A0993002
Complaint Receipt Date:	10/12/2026
Investigation Initiation Date:	10/14/2026
Report Due Date:	11/11/2026
Licensee Name:	ChiCares Assisted Living LTD
Licensee Address:	46908 Wareham Drive Canton, MI 48187
Licensee Telephone #:	(313) 408-3227
Administrator:	Chinyelu Anwunah
Licensee Designee:	Vincent Anwunah
Name of Facility:	Destined Place
Facility Address:	10012 Robson Street Detroit, MI 48227
Facility Telephone #:	(313) 397-9400
Original Issuance Date:	03/26/2008
License Status:	REGULAR
Effective Date:	07/17/2026
Expiration Date:	07/16/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are not following through with recommended medical appointments.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

10/12/2026	Special Investigation Intake 2027A0993002
10/14/2026	Special Investigation Initiated - Telephone Telephone call made to the Complainant. Left a message.
10/14/2026	Contact - Document Sent Emailed the Complainant.
10/14/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
10/15/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights investigator, Felicia Cole
10/15/2026	Contact - Telephone call made Telephone call made to the Complainant
10/16/2026	Inspection Completed On-site Conducted an unannounced onsite investigation with DWIHN recipient rights investigator Felicia Cole. We interviewed staff, Charles Alabi and Resident A.
10/19/2026	Contact - Telephone call made Telephone call made to supports coordinator, Dempstar Yallah
10/27/2026	Contact - Telephone call made Telephone call made to administrator Chinyelua Anwunah. Left a message.
10/29/2026	Contact - Telephone call made

	Telephone call made to administrator Chinyelua Anwunah. I was informed i had the wrong number.
10/29/2026	Contact - Telephone call made Telephone call made to staff, Charles Alabi. Left a message.
10/29/2026	Contact - Telephone call made Telephone call made to home manager, Richard Igbinobaro. Left a message.
10/29/2026	Contact - Telephone call made Telephone call made to Relative A1. Left a message.
10/29/2026	Contact - Telephone call made Telephone call made to supports coordinator, Dempstar Yallah. Left a message.
10/30/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights investigator, Felicia Cole
10/30/2026	Contact - Telephone call made Telephone call made to supports coordinator, Dempstar Yallah
10/30/2026	Contact - Telephone call made Telephone call made to the Complainant
10/30/2026	Contact - Telephone call made Telephone call made to staff, Charles Alabi
10/30/2026	Contact - Telephone call made Telephone call made to administrator Chinyelua Anwunah
11/02/2026	Contact - Document Received Received a copy of Resident A's identification card
11/04/2026	Contact - Telephone call made Telephone call made to home manager, Richard Igbinobaro
11/05/2026	Exit Conference Attempted to hold with licensee designee, Vincent Anwunah. Left a message.
11/06/2026	APS Referral Forwarded allegations to Adult Protective Services (APS)

11/09/2026	Exit Conference Voicemail received from licensee designee, Vincent Anwunah
11/10/2026	Exit Conference Attempted to hold with licensee designee, Vincent Anwunah. Left a message.
11/12/2026	Exit Conference Attempted to hold with licensee designee, Vincent Anwunah. Left a message.

ALLEGATION:

Staff are not following through with recommended medical appointments.

INVESTIGATION:

On 10/12/2026, I received allegations from Licensing and Regulatory Affairs Bureau of Community Health Systems Complaints.

On 10/14/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 10/15/2026, I conducted a telephone interview with DWIHN recipient rights investigator, Felicia Cole. She confirmed she is also investigating the allegations.

On 10/15/2026, I conducted a telephone interview with the Complainant. The Complainant stated staff have been informed about the recommendation for follow up appointments with specialists for Resident A, but staff have failed to follow through with those recommendations. The Complainant stated Resident A was visiting with his sister, and she transported him to Corewell Health Emergency Room in Livonia on 09/24/2026. Resident A was discharged that day with the recommendation of following up with a gastrologist. Resident A's sister transported Resident A back to the facility and informed staff of the ER's recommendation. The Complainant stated as of today Resident A has not had an appointment with the gastrologist. The Complainant stated staff has failed to follow up with other specialists in the past to address his Parkinson diagnosis as well as obtain outpatient sleep apnea testing.

On 10/16/2026 I conducted an unannounced onsite investigation with DWIHN recipient rights investigator, Felicia Cole. We interviewed staff, Charles Alabi and Resident A.

Mr. Alabi did not know that Resident A required a follow-up appointment with a gastrologist. Per Mr. Alabi, staff do not schedule appointments. Staff just transport the residents to the appointments. He stated home manager, Richard Igbinobaro schedules the appointments for the residents.

Resident A confirmed he was with his sister, and she took him to the ER due to diarrhea concerns. Resident A stated he has sand in his stool, and his stool is black, brown, yellow and oily. He has experienced this concern for years. Resident A stated he was prescribed medication to address it, but the medication is not working. Per Resident A, he has not been to a specialist to discuss the concern. Resident A stated he was supposed to complete a sleep study but was unable to due to not having an identification (ID) card. Resident A could not recall when it was recommended for him to complete the sleep study. Resident A stated he has asked staff to assist him with getting an ID card, but they refuse to help him. Resident A denied having a guardian.

While at the facility, Ms. Cole and I interviewed administrator Chinyelu Anwunah via telephone. Ms. Anwunah confirmed she was informed Resident A needed to follow up with a gastrologist. Ms. Anwunah stated an appointment was scheduled for 09/29/2026 at University Health Center, but they would not see Resident A because he did not have an ID card. Ms. Anwunah did not specify who scheduled the appointment for Resident A. Ms. Anwunah stated she had scheduled appointments with specialists in the past, but specialists will not see Resident A without an ID card. Ms. Anwunah stated she was working on getting Resident A an ID card but has not able to get it due to not having his birth certificate.

On 10/19/2026, I conducted a telephone interview with supports coordinator, Dempstar Yallah. Mr. Yallah stated he did not have knowledge of Resident A not being able to follow up with appointments with specialists due to not having an ID card. Mr. Yallah confirmed he can assist with getting an ID card for Resident A. Mr. Yallah denied that anyone from the facility reached out to him to ask for help with getting Resident A an ID card. Per Mr. Yallah, the facility should be able to obtain an ID card for Resident A independently as well. Mr. Yallah agreed to work with the facility to obtain an ID card for Resident A.

On 10/30/2026, I conducted a telephone interview with DWIHN recipient rights investigator, Felicia Cole. She stated she spoke with Mr. Igbinobaro. Mr. Igbinobaro confirmed Resident A has a paper ID card. He did not recall when staff took Resident A to obtain the ID card.

On 10/30/2026, I conducted a telephone interview with supports coordinator, Dempstar Yallah. Mr. Yallah stated he believes he contacted the facility and provided them with an agency that could not assist them with obtaining an ID card for Resident A. Mr. Yallah agreed to follow up with the facility to see where they were at with obtaining an ID card for Resident A.

On 10/30/2026, I conducted a telephone call with the Complainant. The Complainant stated staff took Resident A to get an ID card the day they learned of the investigation. The Complainant did not know if an appointment with the gastrologist was scheduled.

On 10/30/2026, I conducted a telephone interview with staff, Charles Alabi. Mr. Alabi confirmed Resident A received an ID card. He did not know if an appointment with the gastrologist was scheduled.

On 10/30/2026, I conducted a telephone interview with administrator, Chinyelu Anwunah. She acknowledged that Resident A could not attend the medical appointment with a specialist due to not having an ID card. Ms. Anwunah stated it is not the facility's responsibility to obtain an ID card for Resident A. She confirmed Resident A received an ID card, and she called the neurologist to schedule an appointment. She attempted to schedule an appointment with the gastrologist, but the script expired. She requested a new script. Once the new script is received, she will schedule the appointment.

On 11/02/2026, I received a copy of Resident A's ID card which was issued on 10/16/2026.

On 11/04/2026, I conducted a telephone interview with home manager, Richard Igbinobaro. He stated he did not know if an appointment to see the gastrologist was scheduled for Resident A.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident A visited his sister and she transported him to the ER on 09/24/2026. Resident A was discharged that day with the recommendation of following up with a gastrologist. Staff failed to schedule an appointment with the gastrologist. In addition, staff failed to schedule appointments with other specialists, in the past, to address Resident A's Parkinson diagnosis as well as to obtain outpatient sleep apnea testing. Ms. Anwunah acknowledged that Resident A could not attend medical appointments with specialists due to not having an ID card. Ms. Anwunah stated it was not the facility's responsibility to obtain an ID card for Resident A. Mr. Yallah stated he did not have knowledge of Resident A not being able to follow up with appointments with specialists due to not having an ID card. Mr. Yallah confirmed he can assist with getting an ID card for Resident A. Mr. Yallah denied that anyone from the facility reached out to him to ask help with getting Resident A an ID card.

	On 10/16/2026, I conducted an unannounced onsite investigation. That same day, Resident A was issued an ID card. Evidence supports that the licensee designee did not follow the instructions and recommendations of a resident's physician or other designated health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

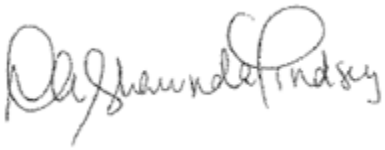
On 10/16/2026 I conducted an unannounced onsite investigation with DWIHN recipient rights investigator, Felicia Cole. We observed a cloud of gnats in the dining room.

On 11/12/2026, I contacted licensee designee, Vincent Anwunah and attempted to conduct an exit conference with no success. I left a message each time.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	On 10/16/2026 I conducted an unannounced onsite investigation with DWIHN recipient rights investigator, Felicia Cole. We observed a cloud of gnats in the dining room.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



11/12/2026

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DaShawnda Lindsey Date
Licensing Consultant

Approved By:



11/16/2026

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Ardra Hunter Date
Area Manager