GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2022

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

RE: License #: AS820295443
Investigation #: 2022A0101010
Five C's Manor

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820295443
Investigation #:	2022A0101010
Complaint Receipt Date:	02/04/2022
Investigation Initiation Date:	02/04/2022
Report Due Date:	04/05/2022
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:	Five C's Manor
Facility Address:	24476 Schoolcraft Redford, MI 48239
Facility Telephone #:	(313) 408-3227
Original Issuance Date:	07/31/2008
License Status:	REGULAR
Effective Date:	11/05/2021
Expiration Date:	11/04/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/14/2022, Resident A wandered away from the facility. He was found three days later suffering from severe frostbite requiring amputation.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

02/04/2022	Special Investigation Intake 2022A0101010
02/04/2022	APS and ORR referrals
02/04/2022	Special Investigation Initiated - Telephone Administrator/Designated person, Chinyelu Anwunah
02/21/2022	Contact - Document Received
03/16/2022	Contact - Document Received
03/17/2022	Contact - Telephone call made Redford Police Department
03/31/2022	Contact - Telephone call made Administrator/Designated person, Chinyelu Anwunah
03/312022	Contact - Telephone call made Relative 1
03/31/2022	Contact - Telephone call made Relative 2
03/31/2022	Contact - Telephone call made Resident A's case manager Daniel Diskin, left voice mail message
03/31/2022	Contact - Document Received Police Reports
03/31/2022	Contact - Telephone call made Chidindu Ihedigbo, direct care staff (DCS)

04/06/2022	Inspection complete onsite
04/07/2022	Contact - Telephone call made Resident A's case manager Daniel Diskin, left voice mail message
04/07/2022	Contact - Telephone call made Richard Iybinobaro, Home manager
04/07/2022	Contact - Telephone call made Vincent Anwunah, Licensee Designee. However, all calls go to the Administrator/Designated person, Chinyelu Anwunah
04/08/2022	Contact - Telephone call made ORR Nicole Williams, left voice mail message
04/12/2022	Contact - Telephone call made ORR Nicole Williams, stated she would call me back, but did she did not.
04/21/2022	Comment – Sent email to Ms. Williams
04/21/2022	Contact -Telephone call made Relative 3's case worker at Lincoln Behavioral Services; Relative 3 receives case management services.
04/21/2022	Contact - Telephone call made Resident A's case manager Daniel Diskin, left voice mail message
04/21/2022	Comment – Received e-mail from Ms. Williams
04/21/2022	Contact - Telephone call made Chinyelu Anwunah
04/22/2022	Contact -Telephone call received Vincent Anwunah, consultant unavailable
04/26/2022	Contact -Telephone call made Vincent Anwunah, left message
04/26/2022	Exit Conference Contact -Telephone call received Vincent Anwunah
04/26/2022	Comment- Sent email to Ms. Williams
04/26/2022	Comment – Received e-mail from Ms. Williams

04/26/2022	Contact -Telephone call received Ms. Williams
04/26/2022	Contact -Telephone call made Chinyelu Anwunah
04/26/2022	Resident A's case manager Daniel Diskin, left voice mail message Contact -Telephone call made
04/26/2022	Contact - Telephone call made Sara Sides, Supervisor Lincoln Behavioral Services
04/26/2022	Contact -Telephone call received Daniel Diskin
04/27/2022	Comment-Document sent Nicole Williams
O4/27/2022	Comment-Document received Nicole Williams
04/29/2022	Contact -Telephone call made Chinyelu Anwunah
04/29/2022	Contact - Telephone call made Chidindu Ihedigbo, direct care staff (DCS)
04/29/2022	Contact -Telephone call received Chinyelu Anwunah
05/02/2022	Contact- Document received Vincent Anwunah

ALLEGATION: On 01/14/2022, Resident A wandered away from the facility. He was found three days later suffering from severe frostbite requiring amputation.

INVESTIGATION: According to the incident report, on 01/14/2022, Resident A went to the "conference hall" to smoke a cigarette. After some minutes, direct care staff (DCS), Chidindu Ihedigbo, went to get him. Ms. Ihedigbo discovered Resident A was not in the "conference hall." Ms. Ihedigbo checked the premises and could not find Resident A. Ms. Ihedigbo contacted the home manager, Richard Igbinebaro. According to the incident report, Ms Ihedigbo and Mr. Igbinebaro searched the

neighborhood but was unable to find Resident A. They contacted the Redford Police Department, and the police were dispatched to the home.

On 02/04/2022, I spoke with the Administrator/designated person Chinyelu Anwunah. Ms. Anwunah stated Resident A resided in the home for five years. He was able to travel independently in the community. He goes to the store and to his mother's home. Ms. Anwunah stated it has never been a problem with him not returning to the home. Ms. Anwunah also stated "conference hall" is a room they allow the residents to smoke in during the winter months. "Conference hall" is an attached, heated garage with an exit door to the outside of the home. I advised Ms. Anwunah "On 12/18/2009, the governor signed 2009 PA 88 which amended Part 126 (smoking in public places) and Part 129 (Food Service Establishment) of the Public Health Code (Code), prohibiting smoking in public places, places of employment, and in food service establishment. The ban took effect May 1, 2010." Since your home is a workplace smoking is prohibited inside of the home.

On 02/21/2022, I reviewed Resident A's assessment plan [dated] and his Crisis Plan [dated] which addresses his Individualized Plan of Service (IPOS), goals. Resident A was working toward independent living. He can move independently in the community, communicate needs, understands verbal communication, is alert to surroundings, reads and writes, tells time, manages money, and follows directions. Resident A's assessment plan and Crisis Plan did not indicate he requires one on one supervision or is an elopement risk.

On 03/17/2022, I contacted the Redford Police Department to verify if a missing person report was filed because Ms. Anwunah stated there was no written report. A missing person report was filed on Resident A on 01/14/2022.

On 03/31/2022, I spoke with Relative 1 and Relative 2, and they both stated Resident A wandered away from the group home and he was found 3 days later with frostbite requiring amputation of his left foot and right leg below the knee. Relative 2 had his attorney forward me all police reports from the Redford Police Department regarding Resident A. At the time of this incident Resident A did not have a guardian. Resident A is currently residing at SKLD Nursing Home in Livonia.

On 03/31/2022, I reviewed the police reports from the Redford Police Department regarding Resident A. On 07/10/2020, and 05/24/2021, Resident A eloped from the Five C's AFC Home and was unable to find his way back to the group home.

The police report dated 01/14/2022, states on the said date Officer Hill was dispatched to the Five C's AFC Home for a missing person. The report reads:

> *"On 01/14/2022, at about 2300 hours I was dispatched to 24476 Schoolcraft (Group Home) for a missing person report.*
>
> *On scene I spoke with Chidindu Ihedigbo who stated about 2000 hours [Resident A] walked away from the group home and has not returned. Ihedigbo states she gave [Resident A] some*

cigarettes to smoke and when she went back out to check on [Resident A] he was not in the smoking area Ihedigbo stated she walked around the whole house and did not locate him, Ihedigbo stated she got into her car and drove around the area but could not locate him. Ihedigbo contacted the house manager and he advised her to call the police to have [Resident A] reported missing.

Ihedigbo stated [Resident A] was last seen wearing a brown coat and black pants. [Resident A] is about 6" tall medium build [sic] white complexion.

I canvassed the area and could not locate [Resident A]. A 911 was made about a [sic] elderly male looking lost seen walking e/b on Chicago from Beech Daly wearing a dark colored coat or robe. I canvassed the area due to the description given but was unable to locate any person in area…."

Ms. Ihedigbo completed a written Witness Statement for Officer Hill. Her written Witness Statement also states she looked for Resident A in the neighborhood.

On 03/31/2022, I spoke with Ms. Ihedigbo. Ms. Ihedigbo made several inconsistent statements. Ms. Ihedigbo stated the home manager drove around the neighborhood looking for Resident A. Which is inconsistent with the police report, the written Witness Statement she wrote, and the incident report submitted. The police report, her written statement and the incident report all indicate Ms. Ihedigbo searched the neighborhood looking for Resident A. If Ms. Ihedigbo searched the neighborhood, the other residents residing in the home were left alone. Ms. Ihedigbo stated Resident A was wearing a brown coat. However, the police report states when Resident A was found he was wearing a light sweatshirt, pants, socks, one shoe and a light blanket.

On 04/06/2022, I conducted an onsite investigation and reviewed Resident A's resident record. Resident A's resident record did not contain any information to address his elopement behavior.

On 04/06/2022, I interviewed the home manager, Richard Igbinebaro. Mr. Igbinebaro stated on 01/14/2022, he drove around the neighborhood looking for Resident A. Mr. Igbinebaro stated he had no contact with the police on 01/14/2022.

On 04/07/2022, I spoke with Ms. Anwunah. I informed Ms. Anwunah I needed to speak with the licensee designee, Vincent Anwunah. Ms. Anwunah informed me Vincent Anwunah is her husband. On 04/26/2022, I received a phone call from a man who identified himself as Mr. Anwunah. I informed Mr. Anwunah of my findings and my recommendation to modify the license to a first provisional. Mr. Anwunah stated he is not willing to accept a provisional license and indicated he would investigate this matter.

I spoke with the Office of Recipient Rights Advisor/Investigator, Nicole Williams on 04/26/2022. Ms. Williams stated Resident A's elopement behavior was not addressed in his treatment plan. Ms. Williams further stated the licensee never reported Resident A's elopement on 01/14/2022.

On 04/26/2022, I received a phone call from Resident A's case manager, Daniel Diskin. Mr. Diskin stated he was unable to find any documentation from the licensee addressing Resident A's elopement behavior, including any incident reports.

On 04/26/2022, I spoke with DCS Chidindu Ihedigbo again. Ms. Ihedigbo stated she did not tell the police officer and did not provide a witness statement and did not write in the incident report that she drove around the neighborhood looking for Resident A.

On 05/02/2022, I received a written response from Mr. Anwunah. Mr. Anwunah' s response negated my findings and did not provide any evidence to dispute the findings.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	The licensee failed to adequately protect Resident A. The licensee failed to address Resident A's elopement behavior in his assessment plan and the licensee did not employ a plan to address this behavior. Resident A had a history of elopement.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 04/06/2022, I conducted an onsite investigation and reviewed Resident A's resident record. Resident A's resident record did not contain an incident report regarding his elopement on 07/10/2020 and 05/24/2021. Pursuant to licensing rule 400. 14311(7) incident reports, if completed, should have been maintained in the record for a period not less than 2 years.

On 04/12/2022, I spoke with Ms. Anwunah. Ms. Anwunah stated she would forward me the incidents reports regarding Resident A's elopement on 07/10/2020 and 05/24/2021.

On 04/21/2022, I spoke with Relative 3's case worker at Lincoln Behavioral Services. Relative 3's case worker stated on 02/03/2022, Relative 3 informed her that on 01/14/2022, Resident A wandered away from his group home and he was found 3 days later with frostbite requiring amputation of his left foot and right leg below the knee. Relative 3's caseworker filed a complaint with Adult Protective Services.

On 04/21/2022, I reviewed the incident report Ms. Anwunah submitted to me on 03/16/2022, however, it was requested 02/04/2022, when the complaint was received. The incident report was incomplete, the incident report did not indicate the date and time the required parties were notified of the incident. I called Ms. Anwunah and requested confirmation of when the incident report was submitted to all required parties. Ms. Anwunah stated she would not be able to provide that information.

On 04/21/2022, and again on 05/03/2022, I spoke with Relative 1. Relative 1 stated on 01/15/2022, she called the group home to talk with Resident A. She was told he was not at home. Later in the day she received a phone call from the home manager stating Resident A eloped last night; 01/14/2022.

I spoke with the Office of Recipient Rights Advisor/Investigator, Nicole Williams on 04/26/2022, and again on 05/03/2022. Ms. Williams stated the licensee never reported Resident A's elopement that occurred on 01/14/2022.

On 04/26/2022, I received a phone call from Resident A's case manager, Daniel Diskin. Mr. Diskin stated he was unable to find any documentation from the licensee addressing Resident A's elopement behavior, including any incident reports.

On 05/03/2022, I spoke with Relative 2. Relative 2 stated on 01/15/2022, Relative 1 informed him Resident A was missing. Resident A's relatives began searching for him, calling local hospitals and the morgue. On 01/17/2022, Relative 2's wife called Garden City Hospital again and was informed a gentleman fitting their description was just brought in and it was Resident A. Relative 2 stated Relative 1 informed Ms. Anwunah of Resident A's hospitalization. According to Relative 2, Relative 1 also informed Ms. Anwunah that Resident A would not be returning to the home due to him being a double amputee, therefore, it would be no reason to hold his bed. Relative 2 also stated he discussed Resident A's condition with Ms. Anwunah when he went to retrieve Resident A's belongings.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of

	any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	The licensee failed to make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and failed to follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours. On 04/21/2022, I reviewed the incident report Ms. Anwunah submitted. The incident report did not indicate the appropriate parties were notified. Therefore, it is concluded that the licensee failed to notify the appropriate parties of Resident A's hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.

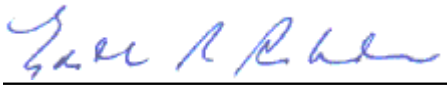
ANALYSIS:	The licensee failed to submit a written report to the resident's designated representative and responsible agencies within 24 hours of his elopement. The responsible agencies representatives stated they did not receive a written report within 24 hours when Resident A went absent without notice. Furthermore, the licensee to date has not submitted a written report.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved, and the care given. (d) The name of the individuals who were notified and the time of notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved. (f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	On 04/06/2022, I conducted an onsite investigation and reviewed Resident A's resident record. Resident A's resident record did not contain an incident report regarding him eloping on 07/10/2020, and 05/24/2021. On 03/16/2022, Ms. Anwunah submitted an incident report regarding the 01/14/2022 incident. The incident report was incomplete, the name of the individuals who were notified and the time of notification were not included on the incident report.

	I called Ms. Anwunah and requested confirmation of when the incident report was submitted to all required individuals. Ms. Anwunah stated she would not be able to provide that information. Furthermore, the parties to be notified stated they did not receive a verbal or written incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

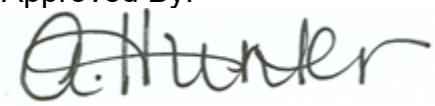
Contingent upon receipt of an acceptable corrective action plan, I recommend the license be modified to a first provisional license.



05/05/2022

Edith Richardson — Date
Licensing Consultant

Approved By:



05/09/2022

Ardra Hunter — Date
Area Manager