GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2022

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

RE: License #: AS810401660
Investigation #: 2022A0575020
Country Lane

Dear Mr. 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 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810401660
Investigation #:	2022A0575020
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	06/19/2022
Licensee Name:	Joak American Homes, Inc.
Licensee Address:	3879 Packard Road Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne, Designee
Licensee Designee:	Andrew Akunne, Designee
Name of Facility:	Country Lane
Facility Address:	5623 Thomas Rd Ann Arbor, MI 48108
Facility Telephone #:	(734) 975-0385
Original Issuance Date:	12/02/2019
License **Status:**	REGULAR
Effective Date:	06/02/2022
Expiration Date:	06/01/2024
Capacity:	6
Program Type:	PH; DD

II. ALLEGATION(S)

	Violation Established?
Resident A's medical needs were not attended to by home staff.	Yes
Resident A's medical records were unavailable for review.	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A0575020
05/20/2022	Special Investigation Initiated – Telephone-Rebecca Dillworth- home manager
05/20/2022	APS Referral-received
05/25/2022	Inspection Completed On-site-interviews with (a) Resident A and (b) Rebecca Dillworth- home manager
05/25/2022	Corrective Action Plan Requested and Due on 06/17/2022
05/26/2022	Contact - Telephone call made- (a) Dee Hall-Resident A's guardian/social worker, and (b) Linda Achatz-licensee's home supervisor
05/26/2022	Exit conference- with Andrew Akunne

ALLEGATION:

Resident A's medical needs were not attended to by home staff.

INVESTIGATION:

On 5/20/2022, an APS referral was received. The complaint alleges Resident A's left hip wound was left untreated, she had missed medical appointments, and her catheter was not changed for two months.

On 5/25/2022, I interviewed Resident A who stated she wanted a different residential placement and had requested same from her guardian numerous times. I also viewed her pressure ulcer on her left hip.

On 5/25/2022, I interviewed Rebecca Dillworth who stated Resident A was hospitalized on 5/19/2022 for an untreated left hip wound. She also stated Resident A had missed a wound care appointment scheduled for 5/4/2022 and re-scheduled a urology appointment scheduled for 3/18/2022. Additionally, she also stated the wound care and catheter supplies are ordered by a visiting nurse, so she has no control over whether supplies arrive or not. Finally, she stated Resident A regularly refuses medical appointments, which Ms. Dillworth stated, the CMH recipient rights officer advises Resident A she has the right to do, which results in Resident A being hospitalized and the facility staff being accused of providing negligent care.

On 5/26/2022, I interviewed Dee Hall, who stated she was aware Resident A wanted to relocate to a different residential placement, but she stated Resident A cannot live alone and alternative CMH placements are limited. However, she stated she would request Resident A be relocated to a vacancy at another Washtenaw Co CMH facility pending receipt of a 30-day written discharge notice from the licensee.

On 5/26/2022, I interviewed Linda Achatz who stated the licensee has issued a 30-day discharge notice to Resident A, Resident A's guardian, and Resident A's CMH case manager.

On 5/26/2022, I conducted an exit conference with Andrew Akunne, who agreed to issuing Resident A's 30-day discharge notice.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Even though the facts place the licensee and the staff in the position of being accused of providing negligent care to which they could have a made reasonable defense (see rule violation cited below), Resident A was hospitalized because her personal needs, specifically wound care, was not attended to in a timely manner. That responsibility falls on the licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medical records were unavailable for review.

INVESTIGATION:

On 5/25/2022, as part of my interview with Rebecca Dillworth, I requested documentation regarding Resident A's medical appointments, wound care, facility visits by outside/contractual health care providers e.g., nurses, OT, PT, etc. She could not produce any documentation to prove that staff had provided for Resident A's medical needs in the facility, even if they had done it properly.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all the following information: **(d) Health care information, including the following:** **(iii) Statements and instructions for individual special medical procedures.** **(iv) A record of physician contacts.**
ANALYSIS:	There were no available medical records, specifically Resident A's records for wound care, medical appointments, facility visits by outside health care providers, and documentation of refusal to keep appointments which could have refuted the allegation of negligent care discussed above.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable correction action plan within 15 days, I recommend the status of the license remain unchanged.

Jeffrey J. Bozsik
Licensing Consultant
Date: 6/1/2022

Approved By:

Ardra Hunter
Area Manager
Date: 6/1/2022