GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2022

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

RE: License #: AS820080100
Investigation #: 2022A0119025
Inkster Road Joak Home

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. 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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820080100
Investigation #:	2022A0119025
Complaint Receipt Date:	04/15/2022
Investigation Initiation Date:	04/18/2022
Report Due Date:	06/14/2022
Licensee Name:	Joak American Homes, Inc.
Licensee Address:	3879 Packard Road Unit A Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Inkster Road Joak Home
Facility Address:	3838 Inkster Road Inkster, MI 48141
Facility Telephone #:	(313) 561-7505
Original Issuance Date:	03/02/1998
License **Status:**	REGULAR
Effective Date:	11/25/2021
Expiration Date:	11/24/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A sustained an unexplained burn on his upper right arm. He was taken to the hospital, and he was treated for another condition. However, none of the staff knew about Resident A being burned.	Yes

III. METHODOLOGY

04/15/2022	Special Investigation Intake 2022A0119025
04/15/2022	APS Referral Received
04/15/2022	Contact- Document Sent Office of Recipient Rights
04/18/2022	Special Investigation Initiated – Telephone Home Manager- Chigor Nweke
04/18/2022	Contact- Telephone call Staff- Mark Etuk, left message
04/29/2022	Inspection Completed On-site Staff-Sam Edwa, Residents B- C, Observed Resident A
06/14/2022	Contact- Telephone call Resident A's guardian
06/14/2022	Contact- Telephone call Staff- Mark Etuk
06/15/2022	Contact- Document Received Resident A's health care appraisal/ doctor's visit
06/15/2022	Exit Conference Licensee Designee- Andrew Akunne

ALLEGATION:

Resident A sustained an unexplained burn on his upper right arm. He was taken to the hospital, and he was treated for another condition. However, none of the staff knew about Resident A being burned.

INVESTIGATION:

On 04/18/2022, I telephoned and interviewed Home Manager- Chigor Nweke regarding the above allegations. Ms. Nweke stated Resident A went to the hospital for chest pain, was treated for chest pain and was not seen for a skin burn. Ms. Nweke stated Resident A reported that he was burned with household cleaner - bleach. She stated Resident A was very uncooperative about getting additional treatment for the burn but was seen by Dr. Bryant for treatment of a skin burn. Ms. Nweke stated she took Resident A's words and sought to get him necessary medical treatment as soon as possible. She stated she has no idea when Resident A had bleach or when the incident occurred. Ms. Nweke stated residents do not have access to cleaning products and/or bleach. Ms. Nweke stated the Staff- Mark denies that Resident A had access to bleach.

On 04/29/2022, I completed an unannounced onsite inspection and interviewed Staff- Sam Edwa and Residents B- C. It should be noted that Resident A refused to be interviewed. Mr. Edwa stated he has no knowledge of Resident A having a skin burn.

Resident B stated he heard about Resident A being burned but never saw a skin burn. Resident B stated he has observed cleaning products including bleach left on the counter in the bathroom, kitchen, and throughout the house. Resident B stated he has observed disinfect spray kept out on the counter.

Resident C stated he has no knowledge of Resident A receiving a skin burn. Resident C stated he has never view cleaning products left out by staff.

On 06/14/2022, I telephoned and interviewed Staff- Mark Etuk and Resident A's guardian regarding the above allegations. Mr. Etuk stated Resident A called the emergency medical services because he was having chest pains. Mr. Etuk stated Resident A did not mention a burn to him. Mr. Etuk stated Resident A did return to the facility and stated to him that he had a chemical skin burn that came from a scratch. Mr. Etuk stated he has no knowledge how Resident A obtained a chemical skin burn. Mr. Etuk stated all cleaning products including bleach are locked in the basement.

Resident A's guardian stated she was not notified about Resident A being treated at the hospital for chest pain. Resident A's guardian stated she was aware that Resident A had a skin burn. Resident A's guardian stated Resident A reported that

he was scrubbing his skin with bleach. Resident A's guardian stated Resident A has received medical treatment from Dr. Bryant and Resident A is doing much better. Resident A's guardian stated Resident A told her that bleach was left in the bathroom. Resident A's guardian stated until this incident she did not have any concerns.

On 06/15/2022, I received health care appraisal dated 04/07/2022 from Dr. Everett Bryant for Resident A. The appraisal summary indicates that patient sustained a right upper/inner arm chemical or heat burn. Patient is a poor historian, which is secondary to his mental illness. This incident happened 3-4 weeks prior to appraisal. Currently, the skin lesion is clean and dry. No evidence of infection. Will order hydrocortisone and continue to follow.

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:	Home Manager- Chigor Nweke stated Resident A reported that he was burned with household cleaner - bleach. Resident A's guardian stated she was aware that Resident A had a skin burn. Resident A's guardian stated Resident A reported that he was scrubbing his skin with bleach. Resident A's health care appraisal dated 04/07/2022 from Dr. Everett Bryant indicates that patient sustained a right upper/inner arm chemical or heat burn. This incident happened 3-4 weeks prior to appraisal. Resident A was not treatment with dignity for his personal needs including protection and safety at all times because he had access to bleach which created a chemical burn on his skin.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Resident B stated he has observed cleaning products including bleach left on the counter in bathroom, kitchen, and throughout the house. Resident B stated he has observed disinfect spray kept out on the counter. Resident A's guardian stated Resident A told her that bleach was left in the bathroom. Resident received a chemical skin burn from using bleach. Therefore, caustics (bleach) was not properly safeguarded as Resident A gained access and suffered a chemical skin burn.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/15/2022

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Shatonla Daniel Date
Licensing Consultant

Approved By:

06/16/2022

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Ardra Hunter Date
Area Manager