GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 22, 2024

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

RE: License #: AS820068905
Investigation #: 2024A0116012
Whitehorn 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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068905
Investigation #:	2024A0116012
Complaint Receipt Date:	12/20/2023
Investigation Initiation Date:	12/20/2023
Report Due Date:	02/18/2024
Licensee Name:	Joak American Homes, Inc.
Licensee Address:	Unit A 3879 Packard Road Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Whitehorn Home
Facility Address:	8845 Whitehorn Romulus, MI 48174
Facility Telephone #:	(734) 729-0363
Original Issuance Date:	07/17/1996
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff abandoned Resident A at hospital after being informed that she was ready for discharge.	Yes

III. METHODOLOGY

12/20/2023	Special Investigation Intake 2024A0116012
12/20/2023	Referral - Recipient Rights
12/20/2023	Special Investigation Initiated - Telephone Consultant, Kara Robinson. interviewed home manager, Onyinye Ene.
12/20/2023	Contact - Telephone call made Left a message for the complainant requesting a return call.
12/20/2023	APS Referral Made.
01/08/2024	Inspection Completed On-site Interviewed home manager, Onyinye Ene, and visually observed Resident A.
01/08/2024	Inspection Completed-BCAL Sub. Compliance
01/22/2024	Exit Conference With licensee designee, Andrew Akunne.

ALLEGATION:

Staff abandoned Resident A at hospital after being informed that she was ready for discharge.

INVESTIGATION:

On 12/20/23, Consultant, Kara Robinson interviewed home manager, Onyinye Ene, and reported that Resident A went to the hospital by EMS with complaints of abdominal pain. She left in the afternoon on 12/18/23. The hospital called that

evening to say Resident A is ready for discharge, but Ms. Ene reported she couldn't pick her up at that time because she was the only staff on duty. Ms. Ene reported that the hospital notified the police who came to the home. Ms. Ene explained to the officer that she could not leave the other residents unattended and reported an agreement was made to pick up Resident A the following day. Ms. Ene reported that she picked Resident A up Tuesday morning 12/19/23 and that she is home safe. Ms. Ene reported being short-staffed due to the holiday vacations; many staff are off work.

On 12/20/23, I called the complainant and left a message requesting a return call.

On 01/08/24, I conducted an unscheduled onsite inspection and interviewed home manager, Onyinye Ene. Ms. Ene reported that on 12/18/23 Resident A called 911 stating that her stomach was hurting and that she needed to go to the hospital. Ms. Ene reported that Resident A does this on a weekly basis. Ms. Ene reported that later that same evening the hospital called and reported that Resident A was fine and ready for discharge. Ms. Ene reported that she told the hospital social worker that she was the only staff on shift and was unable to leave the other residents in the home. She asked if she could give her a few hours to make some calls to try to get another staff to come in or to come pick up Resident A. Ms. Ene reported that she called around for three hours trying to get a staff to assist to not avail. Ms. Ene reported that a lot of staff were off work for the holidays and that contributed to her inability to get assistance. Ms. Ene reported that the next morning when the a.m. staff arrived, she went to the hospital and picked up Resident A around 9:30 a.m. I asked Ms. Ene did she contact the licensee designee for assistance or guidance in efforts to get Resident A picked up once she was medically ready, and she reported that she did not. I informed Ms. Ene, that while I understand the staffing issues the home was dealing with, it is still the homes responsibility to have sufficient staffing on shift at all times to meet the needs of the residents. Ms. Ene reported an understanding. I also advised her to contact her manager to put a plan in place and/or to get guidance on the existing process to prevent this from happening again. Ms. Ene reported that she would.

I attempted to interview Resident A, but she was asleep and did not wish to talk when Ms. Ene tried to wake her.

On 01/22/24, I interviewed and conducted the exit conference with licensee designee, Andrew Akunne. Mr. Akunne reported that Ms. Ene should have contacted the program manager after her attempts to get another staff to the home failed. Mr. Akunne reported that he will make sure moving forward that Ms. Ene is aware of the process and who to contact, especially because Resident A calls 911 to go to the hospital on a weekly basis.

I informed Mr. Akunne of the rule violation and his responsibility to ensure that the home has sufficient staffing on duty at all times to meet the needs of the residents.

Mr. Akunne reported an understanding and stated that upon receipt of the report he would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	This violation is established as the staff left Resident A at the hospital for the night, after being made aware that she was medically ready for discharge. Ms. Ene reported that due to a staffing shortage they were unable to pick Resident A up in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/22/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

01/22/24

Ardra Hunter
Area Manager

Date