GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2024

Andrew Akunne
Carnegie AFC Inc
Suite 1
3879 Packard Street
Ann Arbor, MI 48108

RE: License #: AL630279364
Investigation #: 2024A0465009
Freedom Haven

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630279364
Investigation #:	2024A0465009
Complaint Receipt Date:	01/11/2024
Investigation Initiation Date:	01/16/2024
Report Due Date:	03/11/2024
Licensee Name:	Carnegie AFC Inc
Licensee Address:	Suite 1 3879 Packard Street Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Freedom Haven
Facility Address:	700-738 Wanda Ferndale, MI 48220
Facility Telephone #:	(248) 548-3607
Original Issuance Date:	03/28/2007
License Status:	REGULAR
Effective Date:	08/01/2023
Expiration Date:	07/31/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
On an unknown date, Resident A was sexually assaulted by direct care staff, Kevin Johnson.	No
On 2/6/2024, Resident B was observed in the community, unsupervised, with an unknown male that was purchasing drugs. There is concern that the facility is not providing adequate supervision and protection.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/11/2024	Special Investigation Intake 2024A0465009
01/11/2024	APS Referral Adult Protective Services (APS) referral assigned to Tina Edens
01/16/2024	Special Investigation Initiated - Letter Email exchange with APS Worker, Tina Edens
01/17/2024	Inspection Completed On-site I conducted a walkthrough of the facility, reviewed resident files and interviewed direct care staff, Chinetha Wheeler
02/07/2024	Contact - Telephone call made I spoke to direct care staff, Gregory Castlebury, via telephone
02/09/2024	Comment – second Special Investigation Intake received
02/12/2024	Inspection Completed On-site Second onsite investigation; Interviewed Resident B, reviewed resident files and interviewed direct care staff, Michelle Howz
02/13/2024	Contact – Telephone call made I spoke to direct care staff, Kevin Johnson, via telephone
02/13/2024	Contact - Telephone call made I spoke to Guardian B1 via telephone

02/15/2024	Contact - Telephone call made I left a voice message for OCHN Case Manager, Kanyi Agdor-Daiyee; Requested return call
02/16/2024	Contact – Telephone call made I spoke to Ms. Wheeler via telephone
02/20/2024	Contact - Telephone call made I left a second voice message for OCHN Case Manager, Kanyi Agdor-Daiyee; Requested a return call
02/21/2024	Contact - Document Received Facility documents received via email
02/22/2024	Contact - Telephone call made I left a voice message for OCHN Supervisor, Deborah Danton; Requested a return call
02/23/2024	Contact - Document Received Facility documents received via email
02/26/2024	Contact - Telephone call made I left a message for OCHN Supervisor, Kim Gunberg. Requested a return call
02/26/2024	Contact - Telephone call made I spoke to direct care staff, Michael Olaoluwa via telephone
02/28/2024	Contact - Telephone call made I spoke to Guardian D1 and E1 via telephone
02/29/2024	Contact - Document Received Facility documents received via email
02/29/2024	Exit Conference I conducted an exit conference with Licensee Designee/ Administrator, Andrew Akunne, via telephone

ALLEGATION:

On an unknown date, Resident A was sexually assaulted by direct care staff, Kevin Johnson.

INVESTIGATION:

On 1/11/2024, a complaint was received, alleging that, on an unknown date, Resident A was sexually assaulted by direct care staff, Kevin Johnson. Mr. Johson went into Resident A's bedroom, closed the door and began to kiss her and rub all over her. The complaint stated that this same incident happened a few weeks prior as well.

On 1/16/2024, I spoke to Adult Protective Services (APS) worker, Tina Edens, via email exchange. Ms. Edens stated that she has completed an investigation of this complaint and determined that this complaint is false. Ms. Edens determined there is no resident residing at the facility by the name of Resident A. Ms. Edens also stated that she conducted a search in the Department of Health and Human Services database and was unable to locate a person by this name with accurate contact information. Ms. Edens stated that her investigation is now closed.

On 1/17/2024, I conducted a walkthrough of the facility, reviewed resident files, and interviewed direct care staff, Chinetha Wheeler. At the time of my onsite investigation, there were eight residents residing at the facility, two of whom are females. I reviewed the *Resident Registrar* and additional facility documents and was unable to locate any documentation to confirm that an individual by the name of Resident A is currently, or in the past, has ever resided at the facility. I observed the home to be clean and in good condition. I observed all of the residents to be properly dressed and with adequate hygiene.

I interviewed Resident B, who stated, "I like living here. Staff treat me good. Staff have never mistreated or hurt me." Resident B denied knowledge of knowing Resident A. Resident B denied knowledge of staff mistreating other residents.

I interviewed Resident C, who is a female resident. Resident C stated, "Staff are nice. No one here has ever hurt me or done anything bad to me. I haven't had any issues with the male staff." Resident C denied knowledge of knowing Resident A. Resident C denied knowledge of this complaint being true.

I interviewed Resident D, who is a female resident. Resident D stated, "I have not had any issues here. The staff help me with things if I need something. The male staff treat me good too. Staff have never mistreated or hurt me." Resident D denied knowledge of knowing Resident A. Resident D denied knowledge of this complaint being true.

I interviewed Resident F, who stated, "things are good here. The staff treat me nice. Staff have never mistreated or hurt me." Resident F denied knowledge of staff mistreating other residents.

I interviewed Resident G, who stated, "I like living here. Staff here are helpful and make sure I have what I need. No one has done anything to mistreat me. Staff treat me good." Resident G denied knowledge of staff mistreating himself or other residents.

I interviewed direct care staff, Chinetha Wheeler, who stated that she has worked at the facility for five years. Ms. Wheeler stated, “I have been working here for five years and there has never been a resident here by the name of Resident A. We do have a staff that works here by the name of Kevin Johnson, and we have two female residents living here. I have never observed any staff mistreat or cause harm to any resident. I do not know anything about this, and I don’t think it is true.” Ms. Wheeler denied knowledge of this complaint being true.

On 2/7/2024, I spoke to direct care staff, Gregory Castlebury, via telephone. Mr. Castlebury stated that he has worked at the facility for three years. Mr. Castlebury stated, “I have never heard of a person by the name of Resident A. I have never mistreated a resident and I have never heard of any staff member mistreating or causing harm to any resident.” Mr. Castlebury denied knowledge of this complaint being true.

On 2/12/2024, I conducted a second onsite investigation. I interviewed direct care staff, Michelle Howz, who stated that she has worked at the facility for two years. Ms. Howz stated, “I have worked here for two years, and I have never heard of a person living here by the name of Resident A. I have never mistreated a resident and I have never heard of any staff mistreating or being sexually inappropriate towards any resident.” Ms. Howz denied knowledge of this complaint being true.

On 2/13/2024, I spoke to direct care staff, Kevin Johnson, via telephone. Mr. Johnson stated, “This is not true. I have never heard of a person by the name of Resident A. I have never mistreated or been sexually inappropriate towards any resident. I have never caused harm or hurt a resident.” Mr. Johnson denied knowledge of this complaint being true.

On 2/13/2024, I spoke to Guardian B1 via telephone. Guardian B1 stated, “Resident B has not vocalized any concerns to me related to mistreatment or inappropriate behavior by staff.” Guardian B1 denied knowledge of this complaint.

On 2/26/2024, I spoke to direct care staff, Michael Olaoluwa via telephone. Mr. Olaoluwa stated that he has worked at the facility for four months. Mr. Olaoluwa stated, “There is no one that lives at the facility that matches the name of Resident A. I have never heard of anyone by this name. I always ensure I treat all residents appropriately. I have never hurt or mistreated a resident. I have never heard of any resident, male or female, complain of staff being inappropriate.” Mr. Olaoluwa denied knowledge of this complaint being true.

On 2/28/2024, I spoke to Guardian D1 and E1 via telephone. Guardian D1 and E1 stated, “Resident D and Resident E have not vocalized any concerns to me related to mistreatment or inappropriate behavior by staff.” Guardian D1 and E1 denied knowledge of this complaint.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	According to the *Resident Registrar*, there has never been a resident by the name of Resident A that has resided at the facility. I reviewed facility documents and was unable to locate any documentation to confirm that an individual by the name of Resident A is currently, or in the past, has ever resided at the facility. According to Resident B, Resident C, Resident D, Resident F, and Resident G, they have never been mistreated or harmed by staff." Resident B, Resident C, Resident D, Resident F, and Resident G B denied knowledge of this complaint being true. According to Ms. Wheeler, Mr. Castlebury, Ms. Howz, Mr. Johnson, and Mr. Olaluwa stated that they have never mistreated or been sexually inappropriate towards any resident. Ms. Wheeler, Mr. Castlebury, Ms. Howz, and Mr. Johnson denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that any staff, including Mr. Johnson, has mistreated, or intentionally caused harm to a resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 2/6/2024, Resident B was observed in the community, unsupervised, with an unknown male that was purchasing drugs. There is concern that the facility is not providing adequate supervision and protection.

INVESTIGATION:

On 2/9/2024, a complaint was received, alleging that on 2/6/2024, Resident B was observed in the community. The complaint stated that Resident B was unsupervised,

and with an unknown male that was purchasing drugs. The complaint stated that there is concern that the facility is not providing adequate supervision and protection to Resident A.

On 2/12/2024, I conducted a second onsite investigation. During this onsite investigation, I reviewed resident files, and interviewed Resident B and direct care staff, Michelle Howz.

The *Face Sheet* stated that Resident B was admitted to the facility on 9/14/2023 and has a legal guardian, Guardian B1. The *Health Care Appraisal* listed Resident B's medical diagnosis as Intellectual Disability. The *Assessment Plan for AFC Residents* stated that Resident A is able to be in the community unsupervised, independently completes self-care tasks and does not use assistive devices. The *Individual Plan of Services*, dated 3/3/2023, stated that Resident B is receiving case management services and is not receiving 1:1 specialized services. I reviewed the *Sign-In/Sign-Out Log,* which confirmed that Resident B signed out on 1/26/2024 at noon, 1/27/2024 at 9:15am, 1/31/2024 at 10:01am, 2/1/2024 at 1:40pm, 2/2/2024 at 8:40am, 2/3/2024 at 3:33pm, and 2/4/2024 at 8:45am.

I interviewed Resident B, who stated, "I used to be able to leave here whenever I wanted until a few days ago. I used to write my name in the sign out book and I could go wherever I wanted. Now, staff are saying I can't do that anymore and I'm mad. I like leaving and doing whatever I want and hanging with my friends. I don't sell drugs, but I have friends that do and if that's how they money, that's okay with me. It's none of my business what other people do to make money." Resident B acknowledged this complaint is true.

I interviewed Ms. Howz, who stated, "Up until recently, Resident B was allowed to come and go freely. All he had to do was sign out on the log and he could go out. We didn't have any stipulations on his access to the community unsupervised. I was told he was allowed to leave with family and friends. On 2/5/2024, Resident B left the home and forgot to sign out on the logbook, but he did tell us that he would be back later that night. He was supposed to come home later that evening, but he never did. Resident B was gone for three days, and we did not know where he was, and we didn't know what he was doing. On 2/6/2024, we found a phone number and were able to get ahold of Resident B, and we told him he had to come home, and he said he would. Resident B returned to the facility on the evening of 2/7/2024. During the time that Resident B was missing, we did not call the police and we did not complete an incident report. Since that time, we have been told by Guardian B1 that Resident B is not allowed to leave the facility unsupervised. So now, he cannot leave or sign himself out of the facility anymore without guardian's permission."

On 2/13/2024, I spoke to Guardian B1 via telephone. Guardian B1 stated, "Resident B has a history of elopement. He has left prior adult foster care facilities without permission for long durations of time. When I moved Resident B to this facility, I was under the impression that he would be receiving 1:1 supervision. I also told the facility of

Resident B's history of wandering and absconding. I never gave the facility permission to allow Resident B to leave the home unsupervised. I was not aware that staff were allowing him to leave the home unsupervised. I also was never notified by the facility when Resident B was missing for three days in February."

On 2/16/2024, I interviewed Ms. Wheeler, who stated "Resident B has been allowed to leave unsupervised. Earlier in February, Resident B left and didn't sign out. He was missing for three days before he returned to the facility. When he left, we did not know where he was or who he was with. We did not complete an incident report and we did not call the police. I am not sure if anyone called Guardian B1, but I did not. Ever since this incident, Resident B is now not allowed to leave the facility without staff supervision."

On 2/26/2024, I spoke to Mr. Olaoluwa via telephone. Mr. Olaoluwa stated, "Resident B has been leaving the facility unsupervised since he moved in. We have allowed Resident B to leave and go into the community. On 2/5/2024, he left and did not return that night like he was supposed to. I am not sure if an incident report was completed or if the guardian was contacted, but I don't think we called the police. He was missing for three days and then he came home. He is no longer allowed to leave without staff supervision."

APPLICABLE RULE	
R 400.15305	**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:	According to Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa, acknowledged that Resident B was missing from 2/5/2024 – 2/8/2024. Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa stated that the facility did not notify the police nor Guardian B1, and an incident report was not completed. Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa acknowledged that during the three days that Resident B was missing, they did not know his whereabouts and were unable to ensure his personal care, safety and protection needs were met. According to Guardian B1, Resident B has a prior history of elopement. Guardian B1 stated that she was never notified by the facility of Resident B's elopement. Guardian B1 stated she did not give approval for Resident B to leave the facility unsupervised and was unaware that he has been leaving unsupervised for the last several months.

	In summary, on 2/5/2024, Resident B, who has a past history of elopement, was allowed to leave the facility without completing the *Sign Out Log* and without providing detailed information on where he was going and with whom. Resident B was absent from the home for three days, returning to the home the evening of 2/8/2024, during which time the facility did not file a missing persons report and did not make any efforts to locate Resident B. During these three days, the facility also failed to notify Guardian B1 of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(e) Elopement from the home if the resident's whereabouts is unknown.** **(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.** **(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.**
ANALYSIS:	According to Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa, acknowledged that Resident B was missing from 2/5/2024 – 2/8/2024. Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa stated that the facility did not notify law enforcement nor Guardian B1. Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa stated that an incident report was not completed. Ms. Howz, Ms. Wheeler, and Mr. Olaoluwa stated that the facility did not conduct an immediate search to locate Resident B when he did not return home on the evening of 2/5/2024. According to Guardian B1, she was never notified by the facility of Resident B's elopement and did not receive a written incident report.

	Based on the information above, the facility did not properly adhere to the licensing rules related to incident reporting and elopement protocol.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite investigation on 1/17/2024, I reviewed resident files and interviewed Ms. Wheeler. I determined that the *Assessment Plans for AFC Residents* for all eight residents were not fully completed. I documented the following discrepancies:

- Resident B's assessment plan did not contain Guardian B1, responsible agency of licensee designee's signatures.
- Resident C's assessment plan did not contain Guardian C1 or licensee designee signatures.
- Resident D's assessment plan did not contain Guardian D1 or licensee designee signatures.
- Resident E's assessment plan did not contain Guardian E1 or licensee designee signatures.
- Resident F's assessment plan did not contain Resident D or licensee designee signatures.
- Resident G's assessment plan did not contain licensee designee's signature.
- Resident H's assessment plan did not contain licensee designee's signature.
- Resident I's assessment plan did not Resident I or licensee designee's signature.

I interviewed Ms. Wheeler, stated that the assessment plans are the most current ones that the facility has on file. Ms. Wheeler acknowledged that the assessment plans are all missing signatures and were not fully completed as required per licensing rules.

On 2/29/2024, I conducted an exit conference with licensee designee, Andrew Akunne, via telephone. Mr. Akunne acknowledged that the assessment plans have not been properly completed and signed as required per licensing rule. Mr. Akunne stated that he would ensure that assessment plans are properly completed in a timely manner and reviewed and signed by him.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or

	the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 1/17/2024, I observed the *Assessment Plans for AFC Residents* for all eight residents were missing resident, legal guardian, and licensee designee signatures. Based on the information above, the facility has not completed written assessment plans as required per licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

Stephanie Gonzalez 3/3/2024

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 03/21/2024

Denise Y. Nunn Date
Area Manager