GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2024

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

RE: License #: AS820080100
Investigation #: 2024A0119048
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.

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,

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 #:	2024A0119048
Complaint Receipt Date:	07/31/2024
Investigation Initiation Date:	08/02/2024
Report Due Date:	09/29/2024
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:	11/25/2023
Expiration Date:	11/24/2025
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per incident report dated June 29, 2024, Resident A suffered a head injury from a fall. Another incident report dated July 19, 2024, indicated Resident A was found unresponsive lying on the floor during bed checks. Resident A's Individual Plan of Services indicates Resident A should be assisted by staff for transfers and ambulation.	Yes
On June 29, 2024, Resident A went upstairs to use the bathroom and fell. The residents stated that the downstairs bathroom door was locked.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/31/2024	Special Investigation Intake 2024A0119048
07/31/2024	Referral - Recipient Rights Received
07/31/2024	APS Referral Made by Recipient Rights
08/02/2024	Special Investigation Initiated - Telephone Left message with Cindy Cline and attempted to contact the home.
08/05/2024	Contact - Telephone call made Home Manager- Chigor Nweke
08/05/2024	Contact - Document Received Resident A's Hospital discharge documents, incident reports, and Individual plan of service
08/20/2024	Contact - Telephone call made ORR Investigator- Nancy Foster, Staff- Kalu Ukaokive, and Resident A's case manager- Aleya Smith, left message
08/21/2024	Inspection Completed On-site Residents B- D, Home Manager- Chigor Nweke

08/28/2024	Another Special Investigation Intake Received Additional Allegations noted
08/29/2024	Contact - Telephone call made Resident A's case manager, left message and APS investigator- Rana Smith
08/29/2024	Contact- Document Received Letter from Maintenance Supervisor
09/18/2024	Inspection Completed On-site Home Manager- Chigor Nweke, Residents B- D, and Staff- Sam Egwu
09/18/2024	Inspection Completed-BCAL Sub. Compliance
09/25/2024	Contact - Face to Face Resident E
09/25/2024	Contact - Telephone call made Resident A's sister
09/25/2024	Exit Conference Licensee Designee- Andrew Akunne
10/03/2024	Inspection Completed On-site

ALLEGATIONS:

Per incident report dated June 29, 2024, Resident A suffered a head injury from a fall. Another incident report dated July 19, 2024, indicated Resident A was found unresponsive lying on the floor during bed check. Resident A's Individual Plan of Services indicates Resident A should be assisted by staff for transfers and ambulation.

INVESTIGATION:

On 08/05/2024, I telephoned and interviewed Home Manager- Chigor Nweke and regarding the above allegations. Ms. Nweke stated she has no knowledge of Resident A needing assistance with transfers and/or ambulation. I requested that Ms. Nweke send Resident A's incident reports, hospital discharge paperwork, health care appraisal, and individual plan of service (IPOS).

On 08/05/2024, I received incident report dated 06/29/2024, which indicated Resident A fell in the hallway, hit his head on the floor sustaining a bleeding wound. The incident report stated the Staff- Kalu Ukaokive administered first aid until the emergency medical services arrived. Resident A's IPOS dated 06/10/2024 from Hegira Health indicated Resident A needs assistance with transferring and ambulation along with Resident A should be reminded to use a walker as needed. Resident A's health care appraisal dated 02/14/2024 completed by Dr. Bryant indicates Resident A is fully ambulatory.

On 08/20/2024, I telephone and interviewed Office of Recipient Rights Investigator- Nancy Foster and Staff- Kalu Ukaokive regarding the above allegations. Ms. Foster stated she is substantiating her case. Ms. Foster stated Resident A is deceased and cause of death is still pending.

Mr. Ukaokive stated Resident A was able to walk on his own. Mr. Ukaokive stated he was not aware Resident A needed assistance with transfers or ambulation. He stated Resident A did not use a walker. Mr. Ukaokive stated Resident A fell in the upstairs hallway.

On 08/21/2024, I completed an unannounced onsite inspection and interviewed Home Manager- Chigor Nweke regarding the above allegations. Ms. Nweke again stated she was not aware that Resident A's IPOS indicated that he needed assistance with transfers and ambulation along with using a walker. Ms. Nweke stated Resident A came to the home in February 2024 and did have a staggered walk. Ms. Nweke stated Resident A was given a walker by his family, but he did not use it. Ms. Nweke stated Resident A was able to move about the facility and go to program daily. Ms. Nweke stated Resident A would not be allowed to live in the home if he had problems with walking. Ms. Nweke stated Resident A would often be found lying on the floor for no reason other than he wanted to be on the floor.

Resident B stated Resident A had a problem with walking and was not walking well. Resident B stated Resident A walked slow and complained that his legs bothered him. Resident B stated Resident A would fall often and the staff would help him off the floor.

Resident C stated Resident A fell often and staff was aware that Resident A had problems walking. Resident C stated Resident A would have problems lifting his feet.

Resident D stated Resident A was able to walk but that he walked slowly.

On 08/29/2024, I telephoned and interviewed Resident A's case manager- Aleya Smith of Hegira Health and Adult Protective Service Investigator- Rana Smith regarding the above allegations. Aleya Smith stated she does not have any knowledge of Resident A's cause of death. Aleya Smith stated Resident A had the ability to walk once he left the rehabilitation center.

Rana Smith stated she is still investigating her case. Rana Smith stated Resident A was in hospice care prior to death at the hospital. Rana Smith stated on 07/28/2024, Dr. Abdula Hafazz noted in hospital records the cause of death was due to cardiac arrest. However, Rana Smith stated she is awaiting the official cause of death.

On 09/18/2024, I completed an unannounced onsite inspection and interviewed Staff- Sam Egwu regarding the above allegations. Mr. Egwu stated Resident A walked in a bent down position and was not able to stand up straight. Mr. Egwu stated he was not aware that Resident A's IPOS indicated that he needed assistance with transfers and ambulation.

At this same onsite inspection, I was provided with Resident A's death certificate dated 07/26/2024 which indicates the manner of death is natural causes with Respiratory Failure, Circulatory Collapse, and sepsis due to Pneumonia.

On 09/24/2024, I completed a face-to-face interview with Resident E regarding the above allegations. Resident E stated, "(Resident A) walked very slow." Resident E stated, "(Resident A) was able to a make it up the stairs but had a very hard time coming down the stairs."

On 09/25/2024, I completed an exit conference with Licensee Designee- Andrew Akunne regarding the above allegations. Mr. Akunne did not provide a response to this citation. I specifically asked Mr. Akunne did he have anything to add to this investigation. He replied, "I do not, and I will make a statement once I review the report."

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Home Manager- Chigor Nweke, Staff- Kalu Ukaokive, and Staff- Sam Egwu stated they were not aware Resident A's IPOS indicated that he needed assistance with transfers or ambulation. Mr. Egwu stated Resident A walked in a bent down position and was not able to stand up straight. Resident A's IPOS dated 06/10/2024 from Hegira Health indicated Resident A needs assistance with transferring and ambulation along with Resident A should be reminded to use a walker as needed. Residents B -C, E stated Resident A had a problem with walking. Therefore, Resident A was not provided with supervision and protection as indicated in his individual plan of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

On June 29, 2024, Resident A went upstairs to use the bathroom and fell. The residents stated that the downstairs bathroom door was locked.

INVESTIGATION:

On 08/20/2024, I telephoned and interviewed Staff- Kalu Ukaokive regarding the above allegations. Mr. Ukaokive stated Resident A shuffled when he walked and did not stand up straight.

On 08/21/2024, I completed an unannounced onsite inspection and interviewed Residents B- D regarding the above allegations. Resident B stated Resident A had a problem with walking and was not walking well. Resident B stated Resident A walked slow and complained that his legs bothered him. Resident B stated Resident A would fall often and the staff would help him off the floor.

Resident C stated Resident A fell often and staff was aware that Resident A had problems walking. Resident C stated Resident A would have problems lifting his feet.

Resident D stated Resident A was able to walk but that he walked slowly.

On 09/18/2024, I completed an unannounced onsite inspection and interviewed Home Manager- Chigor Nweke, Staff- Sam Egwu, and Residents B- D regarding the above allegations. Ms. Nweke stated she instructed staff to not lock the downstairs bathroom. Ms. Nweke stated she has no direct knowledge of the downstairs bathroom being locked by staff. Ms. Nweke stated at times there were problems with the locking mechanism with the door. Ms. Nweke stated there is one bedroom downstairs for two residents and there are two bedrooms upstairs for three residents. Ms. Nweke stated Resident A resided on the first floor.

Mr. Egwu denied locking the downstairs bathroom door. Mr. Egwu denied having any knowledge of the downstairs bathroom being locked by staff.

Resident B stated the downstairs bathroom was locked because Resident A would use that bathroom. Resident B stated, “(Resident A) would make a mess of the bathroom and the staff did not like it.” Resident B stated, “We all had to use the upstairs bathroom.” Resident B stated, “The downstairs bathroom is the staff bathroom which we were told that by Sam.”

Resident C stated the downstairs bathroom was locked. Resident C stated Resident A would have to go upstairs to use the bathroom. Resident C stated, “All of the staff locked the downstairs bathroom and did not want any of us to use it.”

Resident D stated, “The downstairs bathroom is locked because of (Resident A).” Resident D stated Resident A would defecate all around the bathroom and the staff did not want to clean up after him.

On 09/24/2024, I completed a face-to-face interview with Resident E regarding the above allegations. Resident E stated, “(Resident A) walked very slow. Resident E stated Resident A was able to a make it up the stairs but had a very hard time coming down the stairs.” Resident E stated all of the residents had to use the upstairs bathroom. Resident E stated, “We could only use the downstairs bathroom if someone was using the upstairs bathroom, and we had to ask for permission to use that bathroom.” Resident E stated the downstairs bathroom was only for staff use. Resident E stated Resident A could not use the downstairs bathroom at all.

On 09/25/2024, I completed an exit conference with Licensee Designee- Andrew Akunne regarding the above allegations. Mr. Akunne did not provide a response to this citation. I specifically asked Mr. Akunne did he have anything to add to this investigation. He replied, “I do not, and I will make a statement once I review the report.”

APPLICABLE RULE	
R 400.14407	**Bathrooms.**
	(5) At least 1 toilet and 1 lavatory that are available for resident use shall be provided on each floor that has resident bedrooms.
ANALYSIS:	Residents B- E stated the downstairs bathroom was locked by staff. Residents B- D stated the staff did not want to clean up after Resident A would use the bathroom. Resident E stated Resident A could not use the downstairs bathroom at all. Therefore, there is a preponderance of evidence that staff were not allowing the residents to use the bathroom on the first floor and would lock the door because they did not want to clean up after Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14405	**Living space.**
	(3) Living, dining, bathroom, and sleeping areas used by residents who have impaired mobility shall be accessible and located on the street floor level of the home that contains the required means of egress.

ANALYSIS:	Home Manager- Chigor Nweke stated there is one bedroom downstairs for two residents and there are two bedrooms upstairs for three residents. Ms. Nweke stated Resident A resided on the first floor. Resident B- E stated no resident could use the downstairs bathroom. Residents B -C, E stated Resident A had a problem with walking. Resident E stated Resident A could not use the downstairs bathroom at all. Therefore, Resident A did not have access to the downstairs bathroom despite having mobility issues.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/05/2024, I received Resident A's discharge report dated for 06/29/2024 from Corewell Health Wayne Hospital. The hospital report indicated Resident A was treated for a laceration that required staples.

On 08/20/2024, I telephone and interviewed Staff- Kalu Ukaokive regarding the above allegations. Mr. Ukaokive stated Resident A fell in the upstairs hallway. Mr. Ukaokive completed the incident report on 06/29/2024. Mr. Ukaokive stated Resident A suffered a wound to his face. Mr. Ukaokive stated he administered first aid and called emergency medical services for assistance for Resident A. I asked Mr. Ukaokive what caused Resident A's head wood. He stated Resident A fell on a wood floor because the carpet had been removed, just an exposed wood floor. Mr. Ukaokive stated Resident A was a large man. I asked Mr. Ukaokive the reasons why Resident A was upstairs prior to falling. He stated Resident A's bedroom is downstairs and Resident A likes to visit with other consumers.

On 08/21/2024, I completed an unannounced onsite inspection and interviewed Residents C- D regarding the above allegations. Resident C stated Resident A fell around 10:00 p.m. that night and hurt his head. Resident C stated the home was putting in a new floor and Resident A hit his head on a metal plate on the floor. Resident C stated Resident A broke his head because it was so late at night when he fell.

Resident D stated Resident A fell and wounded his head by falling on nails sticking out of the floor. Resident D stated the home was having the carpet removed and Resident A fell onto carpet nails. Resident D stated Resident A fell during the middle of the night. Resident D stated the staff called emergency services for Resident A and Resident A returned home later that day.

On 08/29/2024, I received a letter from Steve Huntington, Maintenance Supervisor of Joak American Homes, Inc which indicates all of the carpet and tack strips were removed between June 25 to June 27, 2024. The letter further indicates new vinyl plank flooring began getting installed July 1, 2024, which included the first and second floor of the facility. The letter noted that all work was completed around July 18, 2024.

On 09/18/2024, I completed an unannounced onsite inspection and interviewed Staff- Sam Egwu and re-interviewed Residents B- D regarding the above allegations. Mr. Egwu stated he did not observe any nails or carpet nails on the floor while the floor was being repaired. Mr. Egwu stated he reminded the workers to cover the floor because of the disability of the residents.

Resident B stated Resident A tripped on a metal piece on the floor and hit his head on a nail which he had indicated previously. Resident B was unable to provide a time frame which the repairmen were working on the flooring in the home.

Resident C stated the floor was being repaired for about a month and there were carpet nails on the floor for most of that time.

Resident D stated the workmen were putting in a new floor and they left nails and carpet sticks on the floor. Resident D stated the floor installation took at least three weeks.

On 09/25/2024, I completed an exit conference with Licensee Designee- Andrew Akunne regarding the above allegations. Mr. Akunne did not provide a response to this citation. I specifically asked Mr. Akunne did he have anything to add to this investigation. He replied, “I do not, and I will make a statement once I review the report.”

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Resident A’s discharge report dated for 06/29/2024 from Corewell Health Wayne Hospital. The hospital report

	indicated Resident A was treated for a laceration that required staples. Staff- Kalu Ukaokive stated Resident A fell in the upstairs hallway. Mr. Ukaokive stated Resident A suffered a wound to his face. He stated Resident A fell on a wood floor because the carpet had been removed, just an exposed wood floor. Resident C stated the home was putting in a new floor and Resident A hit his head on a metal plate on the floor. Resident C stated the floor was being repaired for about a month and there were carpet nails on the floor for most of that time. Resident D stated Resident A fell and wounded his head by falling on nails sticking out of the floor. Resident D stated the home was having the carpet removed and Resident A fell onto carpet nails. Resident D stated the floor installation took at least three weeks. On 08/29/2024, I received a letter from Steve Huntington, Maintenance Supervisor of Joak American Homes, Inc which indicates all of the carpet and tack strips were removed between June 25 to June 27, 2024. The letter further indicates new vinyl plank flooring began getting installed July 1, 2024, which included the first and second floor of the facility. The letter noted that all work was completed around July 18, 2024. Resident A fell and sustained a laceration to his head requiring staples during new vinyl plank flooring installation on the first and second floor. Therefore, there is a preponderance of evidence that the home was not arranged, and maintained to provide adequately for the health, safety, and well-being of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/21/2024, I completed an unannounced onsite inspection and interviewed Home Manager- Chigor Nweke regarding the above allegations. As I entered the home, I observed an office space with a desk, office chair, two file cabinets, fax machine in an area that is designated at the dining room. The home as a long linear

space for a combined living and dining room. With the addition of an office space, the facility has removed half of the living/dining room space.

Ms. Nweke stated the residents eat in the kitchen. She stated there as always been a table in the kitchen.

On 08/22/2024, I reviewed the original licensing study report dated 03/02/1998 which indicates the facility has a living/dining room combination with an eat-in kitchen. There is no mention of other living space and no office space is mentioned. The measurements of the living/dining room is 275 sq. ft. on the licensing inspection report.

On 09/25/2024, I completed an exit conference with Licensee Designee- Andrew Akunne regarding the above allegations. Mr. Akunne did not provide a response to this citation. I specifically asked Mr. Akunne did he have anything to add to this investigation. He replied, “I do not, and I will make a statement once I review the report.”

On 10/03/2024, I completed an unannounced onsite inspection regarding the above allegations. I measured the current livable floor space of the living room and it was 10.75 feet by 13 feet for a total of 139.75. The capacity for the facility is 6, however, with the addition of the office space, the livable floor space has been reduced to 23.29 square feet per resident. The current usable floor space with the added office space impedes on the resident’s usable floor space.

APPLICABLE RULE	
R 400.14405	**Living space.**
	(1) A licensee shall provide, per occupant, not less than 35 square feet of indoor living space, exclusive of bathrooms, storage areas, hallways, kitchens, and sleeping areas.

ANALYSIS:	The original licensing study report dated 03/02/1998 which indicates the facility has a living/dining room combination with an eat-in kitchen. I observed an office space with a desk in the area that was originally designated at the dining room. With the addition of an office space, the facility has removed half of the living/dining room space. Therefore, the residents do not have sufficient indoor living space.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	The home's useable floor space was reconfigured to include an office area instead of a dining room area. This is a significant change from the original licensing study report. The licensee failed to provide the department with written notification of this change within five business days after the change.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license be changed to a six-month provisional license.

09/25/2024

_____

Shatonla Daniel Date
Licensing Consultant

Approved By:

10/8/2024

_____

Ardra Hunter Date
Area Manager