GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2025

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

RE: License #: AS820068803
Investigation #: 2025A0992008
Glenwood 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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068803
Investigation #:	2025A0992008
Complaint Receipt Date:	11/22/2024
Investigation Initiation Date:	11/25/2024
Report Due Date:	01/21/2025
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:	Glenwood Home
Facility Address:	29803 Glenwood Inkster, MI 48141
Facility Telephone #:	(734) 721-5552
Original Issuance Date:	12/18/1995
License Status:	REGULAR
Effective Date:	04/27/2023
Expiration Date:	04/26/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/21/2024, Resident A was left home alone, there was no staff present. There is inadequate supervision.	Yes

III. METHODOLOGY

11/22/2024	Special Investigation Intake 2025A0992008
11/22/2024	APS Referral Denied
11/25/2024	Special Investigation Initiated - Face to Face Home manager, Sam Okunawo and Resident A.
11/26/2024	Contact - Telephone call made Resident A's Supports Coordinator with Hegira, Alaya Smith. She was not available, message left.
01/03/2025	Contact - Telephone call made Ms. Smith was not available. Message left.
01/08/2025	Contact - Telephone call made Ms. Smith
01/08/2025	Contact - Telephone call made Licensee designee, Andrew Akunne
01/09/2025	Referral - Recipient Rights

ALLEGATION: On 11/21/2024, Resident A was left home alone, there was no staff present. There is inadequate supervision.

INVESTIGATION: On 11/25/2024, I completed an unannounced onsite inspection and interviewed home manager, Sam Okunawo and Resident A regarding the allegation. Resident A confirmed the allegation. He stated Mr. Okunawo had to take Resident C to an appointment and asked him to keep an eye on Resident C, who had just returned from the hospital while he was gone. Resident A stated Mr. Okunawo was gone for approximately two hours. Resident A stated while he was gone, his supports coordinator, Alaya Smith with Hegira services visited him. I asked if he is left alone often, and he said no. Resident A stated he has not been left alone

in the past and that there is always one staff on shift. Resident A stated he does not have a guardian, and he denied having any concerns.

I interviewed Mr. Okunawo. Initially he denied the allegation and stated he ran to the gas station. I asked if there was another staff on shift when he went to the gas station and he said no, he immediately returned. I observed the calendar on the wall and noticed on 11/21/2024, “appointment” was documented. I referenced the calendar and asked Mr. Okunawo if he transported a resident to an appointment as outlined on the calendar. After reviewing the calendar, Mr. Okunawo stated he transported Resident C to an appointment and could not find coverage. He stated typically another staff would come in to cover or transport the resident, but no one was available. Mr. Okunawo stated the normal staff to resident ratio is 1:3.

On 01/08/2025, I contacted Ms. Smith and interviewed her regarding the allegation. Ms. Smith confirmed that on 11/21/2024 she conducted a home visit with Resident A and at the time of the visit there was no staff on shift. She stated she remained at the home for approximately an hour and twenty minutes and there was no staff present.

On 01/08/2025, I contacted licensee designee, Andrew Akunne and interviewed him regarding the allegation. Mr. Akunne stated he was not aware of the allegation and denied having any additional information. I made him aware that I had an opportunity to interview all parties and based on the information received, Mr. Okunawo left Resident’s A and B without proper supervision while he transported Resident C to an appointment. I stated there is sufficient evidence to support the allegation. Mr. Akunne denied having any questions, but stated he would speak with Mr. Okunawo regarding proper supervision. Based on the findings, I made Mr. Akunne aware that the allegation is substantiated, and a corrective action plan is required. Mr. Akunne agreed to review the report and respond accordingly.

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:	Based upon my investigation, which consisted of multiple interviews with facility staff members, supports coordinator and Resident A, there is enough evidence to support the allegation that on 11/21/2024, there was not staff on duty and Residents A and B were left without proper supervision. The allegation is substantiated.
CONCLUSION:	**VIOLATION STABLISHED**

IV. RECOMMENDATION

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

01/09/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

01/09/2025

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Ardra Hunter Date
Area Manager