



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 9, 2025

Vincent Anwunah
ChiCares Assisted Living LTD
46908 Wareham Drive
Canton, MI 48187

RE: License #: AS820295005
Investigation #: 2025A0778022
Destined Place

Dear Mr. Anwunah:

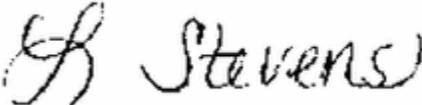
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 456-0439.

Sincerely,

A handwritten signature in black ink that reads "L Stevens". The "L" is stylized with a large loop, and the name "Stevens" is written in a cursive script.

LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS
 SPECIAL INVESTIGATION REPORT
 THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS820295005
Investigation #:	2025A0778022
Complaint Receipt Date:	04/11/2025
Investigation Initiation Date:	04/14/2025
Report Due Date:	06/10/2025
Licensee Name:	ChiCares Assisted Living LTD
Licensee Address:	46908 Wareham Drive Canton, MI 48187
Licensee Telephone #:	(313) 408-3227
Administrator:	Vincent Anwunah
Licensee Designee:	Vincent Anwunah
Name of Facility:	Destined Place
Facility Address:	10012 Robson Street Detroit, MI 48227
Facility Telephone #:	(313) 397-9400
Original Issuance Date:	03/26/2008
License Status:	REGULAR
Effective Date:	07/17/2024
Expiration Date:	07/16/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident did not receive medical services. Inappropriate handling of emergency.	Yes
Staff was not available at the time of a resident's death.	No
Staff did not assist resident with personal care.	Yes

III. METHODOLOGY

04/11/2025	Special Investigation Intake 2025A0778022
04/14/2025	Special Investigation Initiated - Telephone call to Complainant
04/14/2025	APS Referral- Completed by Complainant
04/14/2025	Referral - Recipient Rights- Referred by complainant
04/21/2025	Inspection Completed On-site- Face to face interviews with Residents B-D.
04/22/2025	Contact - Telephone call made- Telephone interview with case manager, Fatima Hammoud.
04/22/2025	Contact - Telephone call made- Telephone interview with administrator, Chinyelu Anwunah.
04/23/2025	Contact - Telephone call made- Telephone interview with Resident B's case manager, Mr. Dempster.
04/28/2025	Contact - Telephone call made- Telephone interview with Resident B's sister.
04/29/2025	Contact - Telephone call made- Telephone interview with staff, Khadidiatou Thiam.
06/04/2025	Contact - Telephone call made- Telephone interview with staff, Wencelaus Obi.
06/04/2025	Contact - Telephone call made to medical examiner's office.

06/04/2025	Exit Conference with license designee Vincent Anwunah via telephone.
06/04/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident B did not receive medical services. Inappropriate handling of emergency.

INVESTIGATION: On 04/14/2025, I completed a telephone interview with Complainant who indicated case manager, Fatima Hammoud went to the facility and observed Resident B to appear unwell. Complainant indicated Ms. Hammoud informed her staff, Khadidiatou Thiam dismissed the concern. She further stated Ms. Hammoud contacted 911 and had Resident B transported to the hospital.

On 04/21/2025, I completed an unannounced onsite inspection. I interviewed Residents B-D. During my interview with Resident B, he stated he had a seizure, but I was unable to understand him in entirety. Resident B speaks limited English, and I was unable to go forth with interviewing him. I completed an interview with Resident D. According to Resident D he told staff, Khadidiatou Thiam that Resident B had a seizure, and she didn't want to listen to him. Resident D stated he was concerned about Resident B falling out as he's done in the past. Resident C had no information regarding this incident.

On 04/22/2025, I completed a telephone interview with case manager, Fatima Hammoud of American's Community Council. I informed Ms. Hammoud I attempted to interview Resident B but was unable to understand him. She stated he has limited English speaking abilities, and his sister is often used as a translator. Ms. Hammoud indicated on April 4, 2025, at 2:30p.m. she entered the facility and immediately noticed Resident B did not look well. According to Ms. Hammoud Resident B was staring blank into space and not responding verbally. She further indicated he appeared to be disoriented and weak. Ms. Hammoud stated Resident D informed her Resident B had been in this condition since the previous day. Ms. Hammoud stated she called administrator Chinyelu Anwunah and was informed by her that she told staff to call emergency the previous night and have Resident B transported to the hospital. According to Ms. Hammoud, when the emergency medical team arrived, they informed her his current symptoms were symbolic of someone who had a seizure. Resident B was transported to the hospital. Ms. Hammoud stated Resident B has history of seizure disorder. However, he is doing fine. She stated he was treated and discharged from the hospital.

On 04/22/2025, I completed a telephone interview with administrator, Chinyelu Anwunah. According to Mrs. Anwunah, on the evening of April 3, 2025, she received a call from Resident B's sister stating he had a seizure. She indicated she asked Resident B's sister when the seizure occurred and Resident B's sister was uncertain

of the time. Ms. Anwunah stated she called the facility, spoke with staff, Khadidiatou Thiam and directed staff to call 911 for Resident B. Mrs. Anwunah called the following morning to check on Resident B and was told he was doing fine. She further indicated she was unaware of any changes and failure of staff to contact emergency until she received the call from Ms. Hammoud.

On 04/28/2025, I completed a telephone interview with Resident B’s sister. She indicated her brother has history of having seizures and has had moments of having one or two seizures a month. She indicated on afternoon of April 3, 2025, her brother called and said he hurt his head and neck. She stated he told her he had a seizure and fell. According to the sister she spoke with staff, Khadidiatou Thiam and requested for him to go to the hospital. She stated she was informed by staff that Resident B appeared fine. Resident B’s sister indicated she then called administrator Chinyelu Anwunah. She stated Mrs. Anwunah informed her she would have staff call 911 for Resident B. Resident B’s sister indicated she was thought her brother had been taken to the hospital until she received a call from Ms. Hammoud.

On 04/29/2025, I completed a telephone interview with staff, Khadidiatou Thiam. She indicated Resident B’s sister called and asked if emergency could be called for Resident B because he had a seizure. She indicated she went to Resident B’s bedroom, and he had fallen asleep. According to Ms. Thiam, she woke him up, asked if he wanted to go to the hospital and he said no. Ms. Thiam stated during this time she spoke with the administrator Mrs. Anwunah who also advised she call 911. Ms. Thiam stated she did not call 911 because Resident B was asleep, appeared well and stated he didn’t want to go to the hospital.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications: (b) Be capable of appropriately handling emergency situations.

<p>ANALYSIS:</p>	<p>Staff Khadidiatou Thiam did not possess the qualifications of appropriately handling an emergency. Ms. Thiam was asked by Resident B's sister and administrator Mrs. Anwunah to call 911 and have Resident B transported to the hospital. Ms. Thiam failed to do so.</p> <p>Resident B's sister indicated Resident B called and informed her he had a seizure resulting in a fall. During the fall it is believed Resident B hurt his head and neck.</p> <p>Administrator Chinyelu Anwunah, indicated she received a call from Resident B's sister informing her Resident B had a seizure. She stated she called staff, Ms. Thiam and instructed her to call 911. Mrs. Anwunah stated the following day she received a telephone call from case manager, Fatima Hammoud indicating Resident B had the appearance of having a seizure and staff failed to seek medical treatment.</p> <p>Case Manager, Fatima Hammoud indicated she entered the facility to observe Resident B to appear unwell. She indicated he was looking blank into space and verbally nonresponsive. She stated he appeared disoriented and weak. Ms. Hammoud stated she called emergency, and they informed her Resident B had symptoms of having a seizure. Resident B was transported to the hospital for care and treatment.</p> <p>Resident B was not provided medical treatment from staff after notification of having had a seizure. Resident B did not receive treatment until his case manager came to facility the following afternoon.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

ALLEGATION: Staff was not available at the time of resident's death.

INVESTIGATION: On 04/14/2025, I completed a telephone interview with the complainant. She stated she was informed Resident A died while in the community.

On 04/22/2025, I completed a telephone interview with case manager, Fatima Hammoud. She stated the agency was informed Resident A died after being hit by a car while in the community. According to Ms. Hammoud, Resident A did not require 1:1 staffing or any type of specialized supervision. She indicated Resident A was highly functional and independent. Further stating he was able to come and go into

the community as he desired. She stated she was informed Resident A signed out to go to the store and did not return.

On 04/22/2025, I completed a telephone interview with administrator Chinyelu Anwunah. Mrs. Anwunah stated Resident A loved to frequent one of the community stores. Therefore, she previously provided her telephone number to the owner to maintain communication and in case of an emergency. Mrs. Anwunah informed me she immediately filed a police report when Resident A had not returned home during his normal time. She stated she later received a call from the store owner stating Resident A was accidentally hit by a car. Mrs. Anwunah indicated she notified all required individuals.

On 06/04/2025, I completed a telephone interview with Wayne County Medical Examiner. The medical examiner informed me Resident A died on March 12, 2025. He stated the cause of death was accidental due to multiple injuries sustained from a vehicle. Resident A was hit by a car.

I reviewed Resident A's assessment plan dated 01/22/2025. Per his plan Resident A could move independently in the community unsupervised. In addition, Resident A worked two jobs: one at a family restaurant and another at the gas station.

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:	<p>There is no evidence Resident A's personal needs including protection and safety were not adhered too. Case Manager, Fatima Hammoud indicated Resident A was high functioning and able to independently go into the community. Furthermore, Resident A did not have 1:1 staffing.</p> <p>Administrator, Chinyelu Anwunah indicated Resident loved to go into the community and frequent a local store. As a result, she provided the owner with her contact information in case of an emergency. Mrs. Anwunah stated the owner called and told her Resident A was hit by a car. Mrs. Anwunah called and notified all required representatives.</p> <p>I called the Wayne County Medical Examiner's office and was informed Resident A died on March 12, 2025. The cause of death was accidental, due to multiple injuries from a vehicle accident.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff did not assist Resident C with personal care.

INVESTIGATION: I completed a telephone interview with Complainant. She stated Resident C is not a client of their agency. However, staff frequently send him into the agency with the other residents of the facility who are clients. According to the complainant on April 3, 2025, Resident C defecated on himself and spread the feces on the agency's bathroom wall and floor. She indicated staff was in the car and did not come inside to assist Resident C when asked. She stated Resident C later came out of the bathroom without any pants or undergarments on, exited the building, and went outside to the curb until he located staff.

I completed a face-to-face interview with Residents C and D during my onsite inspection. Resident D stated Resident C used the bathroom on himself. He stated he tried to help clean him, but it was too much. He indicated staff Obi (Wenceslaus Obi Echefeu) was mean to Resident C and called him names. According to Resident D, staff Obi call Resident C a "nasty motherfucker" and "shitty." I interviewed Resident C who stated he sometimes has an upset stomach that will give him diarrhea. He stated he went on himself and all over the floor. He stated he sat in the bathroom for over an hour but couldn't get any help. According to Resident C he didn't wear underwear on this day and took off his pants to clean them of feces. Thus, he was naked. Resident C stated staff Obi called him names, but he knew it was because he was frustrated that he had to clean him up. Resident C stated he

did not want to repeat the names he was called. He indicated staff Obi took him to the facility to shower and change clothes.

On 06/04/2025, I completed a telephone interview with staff Wenceslaus Obi Echefeu. Staff Obi stated all the residents of the facility rode with him to the agency because several residents had an appointment. He indicated he let residents out and went to park the vehicle. He stated Resident C came out of the agency with only a shirt on and feces in his hand. Staff Obi indicated he covered Resident C with emergency plastic from the vehicle, took him to the facility and let him shower. He denied allegations of not being available or willing to assist Resident C. He also denied agency staff coming to the vehicle asking for assistance. In addition, he denied using profanity toward Resident C.

On 06/04/2025, I completed a telephone exit conference with license designee, Vincent Anwunah. I informed him this complaint will be substantiated in two areas. I provided him an outline regarding the violations. He had no questions of me.

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:	<p>There is sufficient evidence to indicate Resident C was not treated with dignity and respect. The complaint indicated Resident C defecated on himself inside of the agency. Complainant stated staff refused to assist him. According to the complaint Resident C remained in the agency until he walked outside with only his shirt on and pants in his hand.</p> <p>Resident D stated staff Obi was mean, did not help Resident C and called him names. According to Resident D, staff, Obi called Resident C a “nasty motherfucker” and “shitty”. Resident D stated he tried to help Resident C, but it was too much.</p> <p>Resident C indicated his stomach was upset causing him to have diarrhea. He stated he used the bathroom on himself and the agency floor. Resident C stated he stayed in the bathroom for over an hour but came out when he couldn’t get assistance. He indicated he did not have on underwear and defecated in his pants, therefore he took his pants off to clean them. Resident C stated staff Obi called him names, but he did not want to repeat what he was called.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

L Stevens

06/06/2025

LaKeitha Stevens
Licensing Consultant

Date

Approved By:

Dawn Timm

06/09/2025

Dawn Timm
Area Manager

Date