GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2026

Andrew Akunne
Homestead Residences, Inc.
Suite A
3879 Packard
Ann Arbor, MI 48108

RE: License #: AM820010073
Investigation #: 2026A0101026
Beechwood Living Center

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820010073
Investigation #:	2026A0101026
Complaint Receipt Date:	03/20/2026
Investigation Initiation Date:	03/24/2026
Report Due Date:	05/19/2026
Licensee Name:	Homestead Residences, Inc.
Licensee Address:	Suite A 3879 Packard Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Beechwood Living Center
Facility Address:	10470 Beech Daly Road Taylor, MI 48180
Facility Telephone #:	(313) 292-6690
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	03/07/2025
Expiration Date:	03/06/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff Ibrahima Toure and Melisha Miles did not provide supervision, protection, and personal care as specified in Resident A's assessment plan.	No
Additional Findings	Yes

III. METHODOLOGY

03/20/2026	Special Investigation Intake 2026A0101026
03/24/2026	Special Investigation Initiated - Telephone Relative A1
04/17/2026	Onsite investigation Spoke with the home manager Sandra Brown
04/21/2026	APS Referral
04/21/2026	Contact-Telephone call made Ms. Brown
04/21/2026	Contact-Telephone call made Direct care staff Jamal Gold and Melisha Miles no answer left message
04/21/2026	Contact - Document Received from Ms. Brown Resident A's assessment plan Ibrahima Toure's written statement Termination letters
04/21/2026	APS referral
04/21/2026	Contact – Telephone call made Mr. Toure, designated person Cindy Cline
04/21/2026	City of Taylor non-emergency 911 administrative office
05/15/2026	Contact – Telephone call made Ms. Brown and Mr. Gold

05/15/2026	Exit conference with designated person Ms. Cline

ALLEGATION: Direct care staff Ibrahima Toure and Melisha Miles did not provide supervision, protection, and personal care as specified in Resident A's assessment plan.

INVESTIGATION: On 03/21/2026, I spoke with Relative A1. Relative A1 stated on 01/27/2026, she received a telephone call from the home manager. According to Relative A1 the home manager was calling to let her know that they could not get her father up off of the couch for breakfast and lunch. Relative A1 stated she went to the group home around 1:00 p.m. Relative A1 stated her father had dementia and was unable to tell her what happened. Therefore, she had her father transported via EMS to Corewell Hospital Taylor. Relative A1 stated at the hospital her father started expressing signs of pain, "he started crying out due to severe pain".
Relative A1 stated her father's hip and pelvis were broken. Relative A1 stated surgery was performed to repair the hip, however, there was nothing they could do for the fracture pelvis. Relative A1 stated her father returned to the Beechwood group home on 01/31/2026, and he passed away on 02/17/2026. Relative A1 stated the home manager assumed her father fell on the midnight shift but no one on the midnight shift reported that he fell. Relative A1stated that she had concerns as to what happened to her father.

On 04/17/2026, I spoke with the home manager, Sandra Brown. Ms. Brown stated Resident A fell during the midnight shift, and they did not do an incident report or share this information with the staff on the day shift. Ms. Brown stated they were immediately removed from the schedule and eventually terminated. Ms. Brown further stated that the licensee conducted an internal investigation and direct care staff Ibrahima Toure admitted and wrote a written statement that Resident A had fallen during his shift the morning of 01/27/2026. On 04/21/2026, I spoke with Ms. Brown again. Ms. Brown stated she arrived to work on 01/27/2026, at 7:00 a.m. Ms. Brown stated when she arrived to work, she sent Resident A to the hospital because they could not get him up off the couch for breakfast. A little later Ms. Brown called me back and stated that she was mistaken about what time Resident A was sent to the hospital. Ms. Brown stated, "it might have been after lunch." On 05/15/2026, I spoke to Ms. Brown. Ms. Brown stated breakfast is served "anywhere between 8:00 a.m. and 9:30 a.m." but she could not recall at what time it was served on the date of the incident. Ms. Brown further stated that she did not send Resident A to the hospital when they could not get Resident A up off the couch for breakfast because people with dementia/Alzheimer Disease may not perform a task upon request and later on complete the task. Ms. Brown further stated Resident A kept nodding that, he was okay and did not communicate that something was wrong.

On 04/21/2026, I spoke with direct care staff, Jamal Gold. Mr. Gold stated he worked the day shift on 01/27/2026. Mr. Gold stated he arrived to work around 7:00a.m. Mr. Gold stated staff could not get Resident A to the table for breakfast and lunch. Mr.

Gold further stated Resident A was sent to the hospital around 1:30 p.m. On 05/15/2026, I spoke with Mr. Gold again. Mr. Gold stated breakfast is usually served at “8:00 a.m. and at the latest 9:30 a.m.” Mr. Gold stated that on 01/27/2026, breakfast was served between “8:00 a.m. and 8:30 a.m.”.

On 04/21/2026, I spoke with Mr. Toure. Mr. Toure stated that on 01/27/2026, he started getting Resident A dressed at approximately 5:30 a.m. Mr. Toure stated after he got him dressed Resident A used his walker to go into the living room. Mr. Toure stated he walked behind him. According to Mr. Toure, before helping Resident A transfer onto the couch he went to grab a blue pad to place underneath him. Mr. Toure stated when he went to get the blue pad, Resident A fell. Mr. Toure stated Resident A did not appear to be injured. Mr. Toure stated that he asked the other direct care staff on duty, Melisha Miles to help him get Resident A up and onto the couch. Mr. Toure stated that he did not write an incident report because, “I’m 21 years old and I made a bad decision.” Mr. Toure also stated he did not tell the staff on the day shift that resident A fell. Mr. Toure was very remorseful.

On 04/21/2026, I reviewed Resident A’s assessment plan. According to the assessment plan Resident A could ambulate with a walker. The assessment plan did not indicate that there were any restrictions or precautions regarding Resident A utilizing his walker.

On 05/15/2026, I conducted an exit conference with the designated person Ms. Cline. Ms. Cline agreed with my findings. The required supervision, protection and personal care as specified in Resident A’s assessment plan was provided.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident’s record.

ANALYSIS:	Based upon the preponderance of evidence, the required supervision, protection and personal care as specified in Resident A's assessment plan was provided. Resident A's assessment plan stated that he could ambulate with a walker. Resident A's assessment plan did not indicate that there were any restrictions or precautions regarding him using his walker. Mr. Toure admitted that Resident A fell on his shift the morning of 01/27/2026.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 03/21/2026, I spoke with Relative A1. Relative A1 stated on 01/27/2026, she received a telephone call from the home manager. According to Relative A1 the home manager was calling to let her know that they could not get her father up off of the couch for breakfast and lunch. Relative A1 stated she went to the group home around 1:00 p.m. Relative A1 stated her father had dementia and was unable to tell her what happened. Therefore, she told staff to send him to the hospital. Relative A1 stated at the hospital her father started expressing signs of pain, "He started crying out due to severe pain."

On 04/17/2026, I spoke with the home manager, Sandra Brown. Ms. Brown stated Resident A fell during the midnight shift, and they did not do an incident report or share this information with the staff on the day shift when they left the group home.

On 04/21/2026, I spoke with direct care staff, Ibrahima Toure. Mr. Toure stated on 01/27/2026, he started getting Resident A dressed at approximately 5:30 a.m. Mr. Toure stated after getting Resident A dressed Resident A used his walker to go into the living room. Mr. Toure stated he walked behind him. According to Mr. Toure, before helping Resident A transfer onto the couch he went to grab a blue pad to place underneath Resident A. Mr. Toure stated when he went to get the blue pad, Resident A had fallen. Mr. Toure stated Resident A did not appear to be injured. Mr. Toure stated that he asked the other direct care staff on duty, Melisha Miles, to help him get Resident A up and they sat him on the couch. Mr. Toure stated when his shift ended at 7:00 a.m. he left the home and did not report Resident A had fallen.

On 04/21/2026, I spoke with direct care staff, Jamal Gold. Mr. Gold stated he worked the day shift on 01/27/2026. Mr. Gold stated he arrived to work around 7:00 a.m. Mr. Gold stated staff could not get Resident A to the table for breakfast and lunch. Mr.

Gold stated Resident A was sent to the hospital around 1:30 p.m. by home manager, Sandra Brown. On 05/15/2026, I spoke with Mr. Brown again. Mr. Gold stated that on 01/27/2026, breakfast was served between “8:00 a.m. and 8:30 a.m.”

On 04/21/2026, I spoke with home manager, Sandra Brown. Ms. Brown stated she arrived to work on 01/27/2026, at 7:00 a.m. Ms. Brown stated when she arrived to work, she sent Resident A to the hospital because they could not get him off the couch for breakfast. A little later Ms. Brown called me back and stated that she was mistaken about what time Resident A was sent to the hospital. Ms. Brown stated Resident A was sent to the hospital after lunch. On 05/15/2026, I spoke with Ms. Brown. Ms. Brown stated breakfast is served “anywhere between 8:00 a.m. and 9:30 a.m.” but she could not recall at what time it was served on the date of the incident.

On 04/21/2026, I contacted the City of Taylor’s non-emergency 911 administrative office. According to the dispatcher on 01/27/2026, Resident A was transported to the hospital at 1:30 p.m.

On 04/21/2026, I reviewed Resident A’s assessment plan. According to the assessment plan Resident A could ambulate with a walker.

On 05/15/2026, I conducted an exit conference with the designated person Ms. Cline. Ms. Cline agreed that after Resident A fell, staff did not obtain immediate medical attention.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	In case of an accident or sudden adverse change in a resident’s health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on the preponderance of the evidence, Resident A had an accident where he fell, had a sudden adverse change in his health condition, and the licensee didn't obtain needed health care immediately. Not providing immediate medical care when there is an adverse change in a resident's health condition can jeopardize the health, safety and well-being of the resident. On 01/27/2026, sometime after 5:30 a.m. Resident A fell. Prior to the fall he was ambulating with his walker. According to Mr. Toure, on 01/27/2026, at 5:30 a.m. he started getting Resident A dressed. After getting him dressed Resident A used his walker to go into the living room. Mr. Toure stated before assisting Resident A with sitting on the couch he went to get a blue pad. Mr. Toure stated when he went to get the blue pad Resident A fell. Mr. Toure stated he and Ms. Miles picked Resident A up off the floor and sat him on the couch. Mr. Toure stated Resident A did not appear to be injured. Mr. Toure stated he did not complete an incident report or tell the day shift staff that Resident A's fall. Furthermore, Ms. Brown and Mr. Gold stated they started work at 7:00 a.m. According to Mr. Gold breakfast was served between "8:00 a.m. and 8:30 a.m." and they could not get Resident A up off of the couch for breakfast. Even though Mr. Toure did not report that Resident A had fallen when Ms. Brown and Mr. Gold realized they could not get Resident A, who could ambulate, up off the couch for breakfast they should have immediately sent Resident A to the hospital. According to Mr. Gold and the 911 dispatcher on 01/27/2026, Resident A was transported to the hospital at 1:30 p.m. Therefore it is concluded Resident A fell sometime between 5:30 a.m. and 7:00 a.m. and he did not received medical attention until 1:30 p.m.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/15/2026

Edith Richardson — Date
Licensing Consultant

Approved By:

05/28/2026

Ardra Hunter — Date
Area Manager