GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

Immaculata Nwachukwu
Friman Homes Inc
Suite A-7
42000 Koppernick Road
Canton, MI 48187

RE: License #: AS820406047
Investigation #: 2024A0992051
Dixie Home

Dear Ms. Nwachukwu:

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 #:	AS820406047
Investigation #:	2024A0992051
Complaint Receipt Date:	09/05/2024
Investigation Initiation Date:	09/09/2024
Report Due Date:	11/04/2024
Licensee Name:	Friman Homes Inc
Licensee Address:	8281 Barrington Drive Ypsilanti, MI 48198
Licensee Telephone #:	(734) 254-0092
Administrator:	Immaculata Nwachukwu
Licensee Designee:	Immaculata Nwachukwu
Name of Facility:	Dixie Home
Facility Address:	15575 Dixie Redford, MI 48239
Facility Telephone #:	(734) 829-7421
Original Issuance Date:	01/11/2022
License Status:	REGULAR
Effective Date:	01/11/2023
Expiration Date:	01/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the hospital.	Yes
An unknown staff poisoned Resident B's food. It was a sharp object in his food and the seasoning was poisoned because it came from the African store. Resident B didn't receive medical treatment. Resident B was stabbed in the neck and shot by an unknown staff while sleeping.	No

III. METHODOLOGY

09/05/2024	Special Investigation Intake 2024A0992051
09/09/2024	Special Investigation Initiated - Telephone Office of Recipient Rights (ORR), Alexa Fischer
09/09/2024	Inspection Completed On-site Resident A
09/10/2024	Contact - Telephone call made Home manager, Phillip Ogbuaku
09/17/2024	Contact - Telephone call made Resident A's guardian, Shavonne Rippy with Guardian Care
09/17/2024	Contact - Telephone call received Adult Protective Services (APS), Alexa Fischer
09/25/2024	Contact - Telephone call made Complainant
09/25/2024	Contact - Telephone call made Resident B's guardian, Bridget Lovejoy with Family Options
10/18/2024	Contact - Telephone call made Licensee designee, Immaculata "obi" Nwachukwu, was not available. Message left.
10/18/2024	Contact - Telephone call received Obi (Exit Conference)

10/23/2024	Contact - Face to Face Mr. Ogbuaka, Resident A, B, C, and D.
10/23/2024	Contact - Telephone call made Ms. Obi was not available, a message was left

ALLEGATION: Resident A eloped from the hospital.

INVESTIGATION: On 09/09/2024, I contacted the Office of Recipient Rights (ORR) Investigator, Alexa Fischer. Ms. Fischer stated she has not had contact with Resident A regarding the allegations. However, she stated she is familiar with Resident A from previous investigations. Ms. Fischer stated Resident A's requires 1:1 staffing, and the home manager is Phillip Ogbuaku. Ms. Fischer stated Resident A's guardian is Shavonne Rippy with Guardian Care. She agreed to provide updated information once she interviews Resident A.

On 09/09/2024, I completed an unannounced onsite inspection and interviewed Resident A. Resident A stated on the day in question, he was in the community with his 1:1 staffing, Gift Bufford when he started experiencing pain in his back and arm. Resident A stated he called 911 and was transported to the hospital by the emergency medical service (EMS). Resident A stated Ms. Bufford did not ride along with him. He stated Ms. Bufford went back to the facility to get his medical information and the vehicle to come to the hospital. Resident A stated once he arrived at the hospital, he refused to wait and left walking. He stated he walked back to the facility before the staff arrived at the hospital. I confirmed he walked from Farmington, MI to Redford, MI, which Resident A confirmed. Resident A stated he left against medical advice because he became anxious and did not want to stay. I asked if his back and arm feel better and he said somewhat. He stated he receives an injection in his arm every two weeks and believe that may contribute to his discomfort. Resident A stated he is prescribed Tylenol to take as needed for pain. Resident A denied having any concerns. He stated he is treated well, and he is assigned 1:1 staffing as required.

On 09/10/2024, I made telephone contact with Mr. Ogbuaku and interviewed him regarding the allegation. Mr. Ogbuaku statements were consistent with the statements provided by Resident A during my interview with him. In addition, Mr. Ogbuaku stated once Ms. Bufford returned to the home, he went to the hospital to be with Resident A as his 1:1 staff. Mr. Ogbuaku stated he spoke with the hospital personnel to locate Resident A's room, but they could not find him. Mr. Ogbuaku stated he was there for 45 minutes getting the runaround when he received a call from the staff at the facility stating Resident A had returned. Mr. Ogbuaku stated Resident A left the hospital against medical advice and walked back to the facility.

On 09/17/2024, I contacted Resident A's guardian, Shavonne Rippy with Guardian Care regarding the allegation. Ms. Rippy confirmed the allegation. She stated from her understanding Resident A was in the community with the staff when he called 911. She said staff did not accompany Resident A in the EMS but arrived at the hospital. She stated Mr. Ogbuaku went to the hospital but Resident A was not there. Ms. Rippy stated she spoke with Resident A, and he stated the hospital staff were wasting his time, so he left. Ms. Rippy stated Resident A frequently visits the hospital which is a part of his behavior.

On 09/17/2024, I received a follow-up call from Ms. Fischer. She stated she interviewed Resident A, and he stated although he was in pain he was nervous that the hospital was going to admit him into the psychiatric department, so he left. Ms. Fischer stated she is aware Resident A was transported by EMS and Mr. Ogbuaku arrived at the hospital shortly thereafter Resident A, but Resident A had already left. Ms. Fischer stated she does not have any concerns and is not substantiating the allegation.

On 10/18/2024, I contacted licensee designee, Immaculata "Obi" Nwachukwu regarding the allegation, which she confirmed. Ms. Obi stated she disciplined Ms. Bufford for not immediately returning to the facility to notify staff and ensure Resident A’s 1:1 staffing at the time he arrived at the hospital. Ms. Obi stated there was a short delay in his 1:1 staffing. She further stated Mr. Ogbuaku did arrive at the hospital shortly thereafter and was unable to locate Resident A. She stated after receiving the runaround trying to locate Resident A, he returned to the facility. I proceeded to conduct an exit conference with Ms. Obi. I made her aware that based on the investigative findings, there is sufficient evidence to support the allegation. Due to Ms. Bufford’s delay in returning to the home, Resident A was transported to the hospital and was without 1:1 staffing for a significant time. Resident A eloped from the hospital and walked from Farmington, MI to Redford, MI. I made Ms. Obi aware that due to the violation identified in the report, a written corrective action plan is required, and she agreed to review the report and submit the corrective action plan as required. Ms. Obi denied having any questions.

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 Immaculata "Obi" Nwachukwu, licensee designee; home manager, Phillip Ogbuaku; Office of Recipient Rights (ORR), Alexa Fischer; Resident A's guardian, Shavonne Rippy with Guardian Care; Resident A. It has been established that direct care staff did not provide Resident A with supervision and protection as specified in his individual plan of services (IPOS) on 08/31/2024, Resident A eloped from the hospital and walked back to the facility. There is sufficient evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: An unknown staff poisoned Resident B's food. It was a sharp object in his food and the seasoning was poisoned because it came from the African store. Resident B didn't receive medical treatment. Resident B was stabbed in the neck and shot by an unknown staff while sleeping five months ago.

INVESTIGATION: On 09/25/2024, I contacted the Complainant regarding the allegations. The Complainant stated he experienced the reported information firsthand. I asked if he is Resident B, he went on to say he has two names, a slave name and a name he was given at birth. (It should be noted that the Complainant's name and Resident B's names are different, although the Complainant stated he is Resident B). The Complainant stated that he was poisoned, stabbed in the neck and shot. I asked if he sought medical attention, and he said no. I asked if there were any witnesses, and he said he was asleep when it happened. He said he does not know who shot him and the police were not called. I asked if he has a guardian, and he said yes. The Complainant provided me with the guardian's name and contact information.

On 09/25/2024, I contacted Resident B's guardian, Bridget Lovejoy with Family Options. Ms. Lovejoy stated Resident B is incapacitated and has extreme delusional behaviors. She stated their office just received a call from him and he continuously makes delusional statements. Ms. Lovejoy stated Resident B was not stabbed or shot five months ago. She stated a representative from their office visited with him last month. Ms. Lovejoy denied having any concerns.

On 10/18/2024, I contacted licensee designee, Immaculata "obi" Nwachukwu regarding the allegation, which she denied. Ms. Obi stated she has never heard such information regarding him being poisoned, shot or stabbed. Ms. Obi stated Resident B is delusional and often accuses her of stealing his money and buying houses. She stated he does not like African and often tells her to go back to her country. She stated when he is out of money, he becomes very irrational, delusional and accuses the entire house of stealing from him.

On 10/23/2024, I completed an unannounced onsite inspection and conducted separate interviews with Resident A, B, C, and D. Resident A, C, and D denied the allegation and stated the food is good. Resident A, C, and D stated the direct care staff are helpful and attentive. Resident A stated he is vegetarian, and meals are prepared to his liking. Resident B provided me with his alias name “Tony Bamu” and stated he is still having problems with the staff’s cooking, it’s African. He stated he needs help navigating through the world and requested I contact the State of Michigan and provide his name and date of birth to obtain more information about him.

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:	Based upon my investigation, which consisted of multiple interviews with Immaculata "Obi" Nwachukwu, licensee designee; Resident B’s guardian, Bridget Lovejoy with Family Options; Resident A, B, C, and D, other than what was reported by Resident B, there is no evidence to substantiate the allegations Resident B has extreme delusional behaviors and a history of reporting false allegations. There is insufficient evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

10/21/2024

_____

Denasha Walker Date
Licensing Consultant

Approved By:

11/18/2024

_____

Ardra Hunter Date
Area Manager