GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2025

Regina Amadi
Luke Michaels, INC
31412 Kathryn St.
Garden City, MI 48135

RE: License #: AS820401949
Investigation #: 2025A0121008
Luke Michaels, Inc

Dear Mrs. Amadi:

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,

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820401949
Investigation #:	2025A0121008
Complaint Receipt Date:	12/02/2024
Investigation Initiation Date:	12/02/2024
Report Due Date:	01/31/2025
Licensee Name:	Luke Michaels, INC
Licensee Address:	31412 Kathryn St., Garden City, MI 48135
Licensee Telephone #:	(734) 330-3262
Administrator:	Regina Amadi
Licensee Designee:	Regina Amadi
Name of Facility:	Luke Michaels, Inc
Facility Address:	31412 Kathryn St., Garden City, MI 48135
Facility Telephone #:	(734) 337-4251
Original Issuance Date:	07/20/2020
License **Status:**	REGULAR
Effective Date:	01/20/2025
Expiration Date:	01/19/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Facility refusing to accept resident back from the hospital.	Yes

III. METHODOLOGY

12/02/2024	Special Investigation Intake 2025A0121008
12/02/2024	Special Investigation Initiated - Telephone Garden City Hospital
12/04/2024	Contact - Telephone call made Regina Amadi
12/06/2024	Contact - Telephone call made Left message for Sarith Witherspoon with Community Living Services; no response.
12/06/2024	Contact - Telephone call made Guardian A
12/09/2024	Contact - Telephone call received Mrs. Amadi
12/10/2024	Inspection Completed On-site Interviewed Resident B, Mrs. Amadi, and home manager, Krystal Mmamel
12/18/2024	Referral - Recipient Rights
12/18/2024	Contact - Telephone call received Avery Barnett, Recipient Rights Investigator (RRI)
12/19/2024	Contact - Telephone call received L. Steen with Adult Protective Services (APS)
01/16/2025	Contact – Telephone call made N. Howard-Asberry with APS
01/16/2025	Contact - Telephone call made Left message for Laura DeCarlo with APS

01/29/2025	Contact - Telephone call made Laura DeCarlo with APS
02/06/2025	Exit Conference Regina Amadi

ALLEGATION: Facility refusing to accept resident back from the hospital.

INVESTIGATION: On 12/2/24, I initiated the complaint with a phone call to Garden City Hospital. I spoke with ER Charge Nurse, Chyanne who reported Resident A is ready for discharge, but licensee, Regina Amadi is refusing to allow the resident to return to the group home. Nurse Chyanne reported Resident A is at her "baseline" behavior, so she's not "petitionable." Nurse Chyanne stated, "They did come up later and talked to the PA", referring to physician assistant, Jeff who was managing Resident A's care. Nurse Chyanne is adamant the home refused to "take her back" due to behavioral issues. Therefore, the hospital was forced to admit Resident A until a new placement could be secured. Nurse Chyanne expressed frustration with Mrs. Amadi stating, "This is not the first time they've done this … dumping!" Nurse Chyanne reported the group home has a history of refusing to accept residents back into the home when they are cleared for discharge.

On 12/4/24, I contacted Mrs. Amadi to discuss the case. Mrs. Amadi informed me that she "put in an emergency discharge notice" with the Detroit Wayne Integrated Health Network (DWIHN) because she determined Resident A was too dangerous to return to the home. Mrs. Amadi described Resident A as "violent." Mrs. Amadi acknowledged she told hospital workers, "… No, I'm not going to pick up a violent lady!" Mrs. Amadi also acknowledged that hospital workers informed her they would report her to the State for abandonment and she replied, "Okay." I asked Mrs. Amadi if she provided Resident A with a 30-day discharge notice, and she said, no.

On 12/6/24, I interviewed Guardian A by phone. Guardian A acknowledged Resident A is violent. Guardian A reported Resident A is diagnosed with Schizophrenia. Guardian A did not express any concerns about the placement.

On 12/9/24, I received a follow up call from Mrs. Amadi. Mrs. Amadi blamed Guardian A as the reason she refused to pick Resident A up from the hospital. According to Mrs. Amadi, Guardian A instructed her to leave Resident A at the hospital for in-patient psychiatric treatment. Mrs. Amadi insisted Resident A became a threat to others in the home. I asked Mrs. Amadi where is Resident A's 1:1 staff while she's attacking others. Mrs. Amadi explained Resident A is impulsive, so she "jumps up" and attacks quickly before staff can react.

On 12/10/24, I conducted an onsite inspection at the facility. I interviewed Resident B who confirmed Resident A would physically and verbally assault her for no reason. Resident B also reported staff would sit outside Resident A's bedroom door to supervise her at night. I also interviewed home manager, Krystal Mmamel. Ms. Mmamel explained Resident A's neurologist has discontinued some of her psychiatric medications because they tend to interfere with her seizure medications. Mrs. Amadi was also present on the day of inspection. I attempted to provide technical assistance to Mrs. Amadi regarding the rule requirements. When I handed Mrs. Amadi a printed copy of Rule 400.14302(5), Mrs. Amadi replied, "Why are you giving me that? … she's a lawyer", referring to Ms. Mmamel as a means to use intimidation tactics to deflect from the situation. Mrs. Amadi stated she had no knowledge Resident A was ready for discharge. Mrs. Amadi insisted that when she

and Ms. Mmamel went to the hospital to check on Resident A's status, they were instructed to leave because the treating physician planned to admit her. Mrs. Amadi was not able to identify said doctor by name; she could only report that it was a "tall, white" male. Mrs. Amadi also emphasized Resident A was not compliant with taking her medication. Mrs. Amadi insisted, "that is a lie" that she refused to pick Resident A up from the hospital when called.

On 1/16/25, I phoned APS Supervisor, N. Howard-Asberry. Mrs. Howard-Asberry reported Resident A was successfully relocated to a new group home in Detroit.

On 2/6/25, I completed an exit conference with Mrs. Amadi. Mrs. Amadi maintains that she was released to go home once an unidentified male doctor told her Resident A was being admitted to the hospital for further treatment. Mrs. Amadi argued the hospital had no right to not honor her request to have Resident A petitioned for in-patient treatment. I advised Mrs. Amadi that should she disagree with the investigative findings, upon receipt of the report she can attach a separate statement to the corrective action plan. To date, Mrs. Amadi has never accepted responsibility for improperly discharging Resident A. She continuously denies the allegation.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**

	(ii) The resident shall have the right to file a complaint with the department. **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	The medical staff at Garden City Hospital determined Resident A was not a candidate for petition based on her current mental state; however, Mrs. Amadi disagreed. Mrs. Amadi's original statement on 12/4/24 confirmed that she did refuse Resident A's return to the home. By her own admission, Mrs. Amadi stated, "I said, no, I'm not going to pick up a violent lady!" Therefore, Mrs. Amadi discharged Resident A without ensuring an appropriate setting was located to meet the resident's immediate needs in accordance with the rule requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/07/25

K. Robinson Date
Licensing Consultant

Approved By:

02/12/25

_____

Ardra Hunter Date
Area Manager