GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2025

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

RE: License #: AS820401949
Investigation #: 2025A0121014
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820401949
Investigation #:	2025A0121014
Complaint Receipt Date:	02/03/2025
Investigation Initiation Date:	02/03/2025
Report Due Date:	04/04/2025
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?
Resident A's perineal area has layers of skin falling off from her diaper being wet and not changed in a timely manner.	Yes
On 2/2/25, direct care staff, Debra Oni was overheard by hospital staff yelling and laughing at Resident A in a belittling manner. Debra was also observed grabbing Resident A's arm so hard that the resident's hand started to turn blue.	Yes

III. METHODOLOGY

02/03/2025	Special Investigation Intake 2025A0121014
02/03/2025	APS Referral (Adult Protective Services) Received
02/03/2025	Referral - Recipient Rights Made by APS
02/03/2025	Special Investigation Initiated - Telephone Call to Trinity Health Hospital; spoke to the ER Charge Nurse Matt
02/03/2025	Contact - Telephone call received E. Sherman with APS
02/03/2025	Contact - Document Sent Email to licensee. Requested Resident A's records.
02/03/2025	Contact - Document Received Email response from Mrs. Amadi.
02/03/2025	Contact - Telephone call made Left message for Recipient Rights Investigator (RRI), T. Burgess
02/04/2025	Contact - Telephone call received Return call from Nurse Chance with Trinity Hospital.
02/04/2025	Contact - Telephone call received Return call from RRI, T. Burgess

02/05/2025	Contact - Telephone call received APS Investigator, E. Sherman
02/05/2025	Contact - Telephone call made Debra Oni, direct care staff
02/06/2025	Contact - Telephone call made Guardian A
02/06/2025	Inspection Completed On-site Interviewed Guardian A, Observed Resident A.
02/06/2025	Contact - Telephone call made Supports Coordinator with Community Living Services (CLS)
02/06/2025	Contact - Telephone call made Regina Amadi, licensee designee
02/10/2025	Contact - Telephone call made Video conference with Ms. Sherman and Ms. Burgess
02/14/2025	Contact - Telephone call received Witness 1
04/11/2025	Contact - Telephone call made Guardian A
04/11/2025	Exit Conference Regina Amadi

ALLEGATION: Resident A's perineal area has layers of skin falling off from her diaper being wet and not changed in a timely manner.

INVESTIGATION: On 2/3/25, I received a call from Adult Protective Services Investigator, E. Sherman. Ms. Sherman reported that she's substantiating several complaints at this facility. According to Ms. Sherman, the current complaint is pursuant to Resident A being admitted to the hospital on 2/1/25 for possible Osteomyelitis; however, further testing showed Resident A did not have the disease. Per Ms. Sherman, Resident A was observed with "peeling skin" from sitting in urine for a prolonged period. On 2/3/25, I contacted the Emergency Room Charge Nurse at Trinity Hospital; Nurse Matt stated he would have the nurse responsible for Resident A's care contact me. On 2/4/25, I received a follow up call from Nurse Chance. Nurse Chance reported she was responsible for Resident A's care upon her admission to the hospital. Nurse Chance stated Debra Oni would inform her

when Resident A needed a diaper change rather than assist the resident herself. Nurse Chance said the first time she opened Resident A's diaper, "We were in disbelief!", referring to herself and an unnamed colleague. Nurse Chance further stated, "When we wiped her, basically layers of skin peeled off." Nurse Chance explained, "It's from her being wet in those diapers … She had skin breakdowns because she's moist for a long period of time … She has to be wet at home for this to happen." I asked Nurse Chance if it's possible the skin breakdown happened while waiting in the emergency room for a bed and she replied, "No, it's chronic" and that it's safe to conclude the problem existed before she was admitted to the hospital. Nurse Chance reasoned that skin breakdowns don't happen overnight.

On 2/5/25, I received a follow up call from Ms. Sherman who reported Guardian A informed her the facility did not attend to Resident A's personal care as required. According to Ms. Sherman, Guardian A reported staff failed to bathe Resident A for at least one week although the resident requires assistance with all activities for daily living as specified in the treatment plan dated 6/13/24 and written assessment plan dated 1/16/24. Mrs. Amadi signed Resident A's AFC Assessment Plan on 1/16/24 with an understanding the resident requires daily assistance with toileting, bathing, and personal hygiene.

On 2/6/25, I followed up with Guardian A regarding Resident A's care at the facility. Guardian A was emotional as he spoke, even becoming tearful as he shared details about the placement. Guardian A reported he asked case manager, Candice Jones 6 months ago to move Resident A to a new home because he was dissatisfied with the quality of care at the Luke Michaels home. However, Guardian A indicated he agreed to give the placement another chance after Mrs. Amadi convinced him that she would make improvements, including firing Home Manager, Crystal Mmamel. Guardian A reported that he had to insist Resident A be taken out of the home for emergency medical treatment on 2/1/25 when he noticed the resident's thumb was severely infected. According to Guardian A, the home staff were only treating the infection in-house despite the wound worsening. In addition to the wound on Resident A's thumb, Guardian A reported Resident A's vaginal area is "really red" and he has photos to prove it. Guardian A shared the photo image with me via text moments later. As a result, I made plans to meet Guardian A at Trinity Hospital that afternoon.

On 2/6/25, I conducted an onsite inspection at Trinity Hospital to interview Guardian A and Resident A. Resident A is non-verbal. With Guardian A's permission, I observed Resident A without a diaper. I observed Resident A with patches of reddened skin near her lower buttocks and inner thighs. I took additional photos of Resident A's skin damage with Guardian A's permission.

On 2/6/25, I phoned Resident A's case manager with Community Living Services, Candice Jones. Ms. Jones acknowledged Guardian A did express concerns to her in the past about Resident A's medical care. Ms. Jones indicated Guardian A

requested that Resident A be moved to a different AFC home, but relocation plans were stalled when the guardian decided to keep the placement intact.

On 4/11/25, I made a follow up call to Guardian A. Guardian A reported Resident A has been discharged from the facility. Guardian A maintains staff at the Luke Michaels home did not bathe Resident A as required. Guardian A reported Resident A would often smell like “urine” when he visited her at the facility. Guardian A explained the situation got so bad that he would bring extra diapers to the facility for staff to use to change Resident A more often. In addition, Guardian A stated he observed Resident A with oily hair on occasion as proof her hair hadn’t been washed and presumably the body not showered.

On 4/11/25, I completed an exit conference with licensee designee, Regina Amadi. Mrs. Amadi vehemently denied the allegation. Mrs. Amadi insists her staff bathed and showered Resident A as required. Mrs. Amadi stated Resident A never experienced skin tears since her placement in the home on 7/7/23. Mrs. Amadi stated, “When she left my home, she didn’t have any skin tears.” Mrs. Amadi reported she requires daily body checks of all residents especially those residents that are nonverbal.

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 on Nurse Chance and Guardian A’s witness statements, in addition to, my observation of Resident A, there is a preponderance of evidence that Mrs. Amadi did not ensure the Resident A’s personal needs were attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 2/2/25, direct care staff, Debra Oni was overheard by hospital staff yelling and laughing at Resident A in a belittling manner. Debra was also observed grabbing Resident A's arm so hard that the resident's hand started to turn blue.

INVESTIGATION: On 2/3/25, Ms. Sherman with APS reported that staff at Trinity Hospital expressed concern over direct care staff, Debra Oni's interaction with Resident A while at the hospital. On 2/3/25, I contacted E.R. Charge Nurse, Matt. Nurse Matt indicated Nurse Chance was not available, but he would have her give me a call. On 2/4/25, I received a return call from Nurse Chance who was off duty at the time of the call. Nurse Chance reported she was very bothered by what happened to Resident A while under the care of Ms. Oni. Nurse Chance reported seeing Ms. Oni act aggressively with Resident A. When taking Resident A's blood pressure, Nurse Chance reported she observed Ms. Oni hold onto the resident's wrist so tight that Resident A's hand turned blue. Nurse Chance explained she tried to diffuse the situation by assuring Ms. Oni that "it's okay, I can take another reading," but Ms. Oni paid her no attention and didn't release Resident A's hand. Nurse Chance stated she returned a few hours later to take another reading of Resident A's blood pressure. Nurse Chance said it was clear that Resident A didn't like getting her blood pressure taken as she began to cry and move her arm away. Nurse Chance said that's when she observed Ms. Oni laugh and ask Resident A, "What are you a fucking baby!" Also, as Resident A reached out to Ms. Oni for comfort, Nurse Chance reported Ms. Oni responded by telling Resident A to "Get your hands away from me, don't fucking touch me!" Nurse Chance stated that she was in shock by Ms. Oni's behavior. Nurse Chance described Ms. Oni's interaction with Resident A as "hard to watch … I couldn't believe the things she was saying and doing." Nurse Chance reported the situation troubled her so much that, "To be honest, I went home and cried." Nurse Chance described Resident A as "helpless" and child-like due to her low cognition. She said it was bothersome to witness someone so helpless being treated in such a reckless manner especially in the public eye.

On 2/5/25, I interviewed Ms. Oni by phone. Ms. Oni stated she's been working at the facility since November 2024, and that she currently works in the capacity as Acting Home Manager. Ms. Oni acknowledged she was at the facility when Resident A was taken to Trinity Hospital the morning of 2/1/25. Ms. Oni explained she stayed overnight at the hospital with Resident A due to the long wait time for examination and testing. Ms. Oni stated, "I hold her down," so the doctor can perform the examination. Ms. Oni further explained Resident A tried to pull her I.V. out, so she was there to "keep her calm and in one position," so the resident could receive the necessary treatments. I asked Ms. Oni if she cursed at, belittled, mishandled, or abused Resident A in any way while at the hospital and Ms. Oni denied all the allegations. In fact, Ms. Oni said she believes the nurse has a misinterpretation of her interaction with Resident A. Ms. Oni replied, "I would never do that … I did not rough handle her at any point … No way … I did not … I would

never … that did not happen." Ms. Oni then suggested that I contact Resident A's father as a character witness on "How I treat {Resident A}."

On 2/6/25 and 4/11/25, I interviewed Guardian A by phone. Guardian A acknowledged that Ms. Oni was a newer staff at the facility, so the guardian stated he's had little contact with Ms. Oni and therefore couldn't form an opinion about her work. However, Guardian A did report observing Resident A's skin had turned blue. Guardian A explained he left the hospital momentarily and when he returned Resident A "looked like someone grabbed her." Guardian A reported, "If you're tough on her, it goes to blue." Guardian A stated he asked a nurse about Resident A's injury and the nurse "didn't know what happened." Guardian A insisted Resident A was "fine" when he left, but when he returned "she was blue." Guardian A also reported that only he and Ms. Oni were allowed in the exam room with Resident A to reduce overcrowding in that area of the hospital.

On 2/6/25, I contacted Mrs. Amadi to discuss the newest complaint allegations at this facility. Mrs. Amadi quickly dismissed the seriousness of the abuse allegation as she stated, "She did not do what they said she did," referring to Ms. Oni. Mrs. Amadi indicated that she knows Ms. Oni to be of good character. Mrs. Amadi insisted that I "pull the cameras" at the hospital when conducting my investigation to obtain proof of Ms. Oni's alleged behavior. I received a follow up email from Mrs. Amadi on 2/6/25 at 5:39PM with the following message: "*Please note that MS. Deborah Oni has been terminated since 2/2/2025 due to alleged abuse of {Resident A}. Deborah has been mandated to do the abuse and neglect training to be proactive.*"

On 2/10/25, I had a case conference with 2 additional investigators on the case. They are Recipient Rights Investigator, T. Burgess and Adult Protectives Services Specialist, E. Sherman. Ms. Sherman was in direct contact with the hospital. Ms. Sherman advised the hospital staff to release Ms. Oni from her duties due to the egregious nature of the allegation.

On 4/11/25, I completed an exit conference with Mrs. Amadi. Mrs. Amadi maintains "Debra would not say something like this." According to Mrs. Amadi, Ms. Oni is a nurse by profession, and that Ms. Oni is pursuing doctoral studies in the field. Mrs. Amadi suggested the staff at the hospital fabricated the allegation with malicious intent. Mrs. Amadi was adamant the abuse did not occur as she stated, "I know that Debbie will not do that." Mrs. Amadi also acknowledged she was not at the hospital with Ms. Oni and Resident A; however, based on her previous observation of Ms. Oni and Resident A, Mrs. Amadi reported Ms. Oni treated Resident A with "dignity and respect." Mrs. Amadi repeatedly referred to Resident A as a "sweet girl." Mrs. Amadi reasoned it doesn't make sense for someone to mistreat such a "sweet child."

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	I determined Nurse Chance is a credible witness with nothing to gain or lose by disclosing what she observed between Ms. Oni and Resident A. In addition, when Guardian A left Resident A under the care and supervision of Ms. Oni, he observed Resident A with an unexplainable injury upon his return to further support Nurse Chance's account of the events. Mrs. Amadi has continuously expressed she does not believe Ms. Oni harmed Resident A at the hospital. Therefore, based on the preponderance of evidence, Mrs. Amadi failed to ensure Ms. Oni didn't mistreat Resident A. On or around 2/1/25, Ms. Oni intentionally exposed Resident A to serious physical and emotional harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Continue the recommendation for a provisional license pursuant to Special Investigation Report # 2025A0121013.

04/16/25

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Kara Robinson — Date
Licensing Consultant

Approved By:

04/16/25

_____

Ardra Hunter — Date
Area Manager