GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2025

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

RE: License #: AS820414407
Investigation #: 2025A0901021
Luke Michaels, Inc 1

Dear Regina 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 party responsible 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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414407
Investigation #:	2025A0901021
Complaint Receipt Date:	03/11/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/10/2025
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 1
Facility Address:	5861 Hipp St. Taylor, MI 48180
Facility Telephone #:	(734) 633-1796
Original Issuance Date:	08/31/2023
License Status:	REGULAR
Effective Date:	02/29/2024
Expiration Date:	02/27/2026
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

I. **ALLEGATION(S)**

	Violation Established?
Resident A had a physical altercation with staff, Angela Ihebom.	No
The facility is understaffed. Angela worked alone with Resident A.	Yes

II. METHODOLOGY

03/11/2025	Special Investigation Intake 2025A0901021
03/12/2025	Special Investigation Initiated – Telephone Home manager, Crystal Mmamel
03/13/2025	Adult Protective Services Referral
03/13/2025	Contact - Telephone call made Guardian
03/21/2025	Referral - Recipient Rights (ORR)
03/24/2025	Inspection Completed On-site
03/24/2025	Contact - Telephone call made Licensee Designee, Regina Amadi
03/24/2025	Contact – Document received Email
03/25/2025	Contact - Telephone call made Staff, Angela Ihebom
03/28/2025	Contact - Telephone call made Staff, John Agwaze
03/31/2025	Contact - Telephone call made Staff, Michael Obidare

04/02/2025	Contact - Telephone call received Staff, Michael Obidare
04/30/2025	Contact - Telephone call made ORR, Michelle Livous
04/30/2025	Contact - Telephone call made Guardian
04/30/2025	Contact - Telephone call made Case Manager, Tanisha Blevins
05/06/2025	Exit Conference ORR, Licensee Designee, Regina Amadi

ALLEGATION:

Resident A had a physical altercation with staff, Angela Ihebom.

INVESTIGATION:

On 03/12/2025, I made a telephone call to the Crystal Mmamel, the home manager during the time of the incident. She stated the incident happened in October 2024 and she was not present when the assault happened. Crystal explained that she got a phone call from Resident B. He was in panic mode stating, Resident A was hurting staff, Angela Ihebom. She also heard a lot of screaming in the background, but did not understand what was being said. Crystal said she called the police and rushed to the facility. When she got there, Angela was sitting in a chair seemingly disoriented, with her head held back, and holding strands of hair in her hand. She reported that Angela had a bald spot in her head due to Resident A pulling her hair out, her hand was swollen, and her face was red. When the police arrived, Resident A was arrested, and Angela was taken to the hospital. Crystal stated based on her interviews with the other residents, Resident A was upset because she wanted coffee while Angela was passing the medications. She did not want to wait so she attacked Angela from behind by grabbing her hair and fighting her. She also said Resident C tried to get Resident A off Angela and she bit him on the hand. Crystal stated she no longer works at the facility. She left in January 2025 and said Resident A was discharged in December 2024.

On 03/13/2025, I made a telephone call to Amy Torrony, Resident A's guardian case manager from Faith Connections. She stated Resident A has really bad behavioral outbursts and becomes very physical. Regarding the incident, she stated Resident A was the aggressor and attacked Angela and Resident C. She also said Resident A has a history of not telling the truth and being very delusional. Amy indicated

Resident A is currently hospitalized at Receiving hospital in the psychiatric unit and has been there since December 2024. She reported Resident A is still in a very delusional state and is not stable enough to be interviewed.

On 03/24/2025, I conducted an onsite inspection at the facility and interviewed Resident B and C separately. Resident B explained that Angela just got to work and Resident A wanted coffee. Angela told her to wait, and she would make her some. Resident A got upset and grabbed Angela from behind by the hair and threw her on the floor and started hitting, kicking, and punching her. He stated Angela was screaming for help, so he called Crystal. Resident B said Resident C also tried to help by attempting to pull Resident A off Angela. He also said Resident A was very violent and out of control and that he was glad she was no longer at the facility.

On 03/24/2025, I interviewed Resident C. He stated Resident A was all over Angela fighting her and pulled her hair out because she wanted coffee. He said Angela was screaming for help, so he pulled Resident A off her and she bit him. Resident C indicated the attack was over when the police arrived, but they still took Resident A to jail.

On 03/24/2025, I made a telephone call to the licensee designee, Regina Amadi. She stated Resident A had a history of violence and that she attacked Angela and had her bleeding from the head. She stated this was due to her not wanting to wait for coffee. Regina further said Angela no longer works for her and she believed the number she had is no longer valid.

On 03/24/2025, I received an email from Regina. It consisted of the incident report and emergency discharge notice. The discharge notice was dated 10/06/2024 and the reason for discharge was due to the attack and her violent behaviors. The incident report was dated 10/05/2024 and was completed by Regina. It indicated that around 6:45 p.m., Resident A, unprovoked, became violent and aggressive towards Angela. She attacked her by pulling her hair, scratching, and assaulting her. Based on the incident report staff, John Agwaze and Michael Obidare, were present during the attack and intervened.

On 03/25/2025, I made a telephone call to Angela, but the number was no longer in service.

On 03/28/2025, I made a telephone call to John. He stated the incident happened on a Saturday morning and he, Angela, and Michael were working at the time. He stated he heard Angela scream and ran to see what was happening. He saw Resident A attacking Angela by pulling her hair and hitting, kicking, punching, and scratching her. According to John, he and Michael pulled her off Angela and Michael called the police.

On 03/31/2025, I made a telephone call to Michael. He stated he was working at the time but was in another area of the facility. He heard a noise and rushed to the

living room. He saw Resident A pulling Angela's hair. He said he and John separated them and he called the police. He later contradicted what he said by indicating that the attack was already over when he went to see what was wrong. When questioned about the discrepancy he was unable to explain.

On 04/02/2025, I received a telephone call from Michael. He stated he wanted to let me know that the information he had previously given me was wrong. He stated he was not working at the time of the incident. When questioned about why he gave false information, he repeatedly said what he told me was wrong and that it was a mix up but gave no further detail.

On 04/30/2025, I made a telephone call to Amy. She stated Resident A is still in the hospital and is still very delusional. Due to her not being mentally stable at the time and her violent unpredictable behavior, she felt it was not safe to interview her. According to Amy, Resident A has been refusing her medications and is very easily triggered, which is why she is still in the hospital. She stated simply speaking with her could "set her off."

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 the information I obtained during this investigation, there is a lack of evidence to confirm that Resident A's protection and safety was not attended to. Despite discrepancy with the incident report, and statements given by John and Michael, on 10/05/2025 Resident A was the aggressor and attacked Angela and Resident C. This was confirmed by Crystal, Residents B and C, who witnessed the incident, and Resident A's guardian.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is understaffed. Angela worked alone with Resident A.

INVESTIGATION:

On 03/12/2025, I made a telephone call to the Crystal Mmamel, the former home manager of the facility. She was the home manager during the time Resident A assaulted staff, Angela Ihebom. She stated Resident A requires 2:1 staffing and that Angela was working alone during the time of the incident.

On 03/24/2025, I conducted an onsite inspection at the facility and interviewed Resident B and C separately. They were both present during the time of the incident and both stated that Angela was the only staff working. Resident B said this was why he called Crystal for help.

On 03/24/2025, I received an email from Regina. It consisted of the incident report, which was dated 10/05/2024. Based on the incident report Angela, John Agwaze, and Michael Obidare were working.

On 03/25/2025, I made a telephone call to Angela, but the number was no longer in service.

On 03/28/2025, I made a telephone call to John. He stated he was working with Angela and Michael during the time of the incident on 10/05/2024.

On 03/31/2025, I made a telephone call to Michael. He initially stated he was working with Angela and John on 10/05/2024 but called me back on 04/02/205 and stated what he previously told me was not true. He insisted he was not there and that the assault had already took place when he arrived.

On 04/30/2025, I made a telephone call to Crystal for clarity. She insisted Angela was working alone with Resident A during the time of the assault. She also said when she rushed to the facility, no other staff were present besides Angela. Crystal indicated John worked the day shift on 10/05/2025 and was already gone and that Michael came to work about four hours after the incident. She further stated although Resident A required 2:1 staffing, due to staffing issues, it often was not provided.

On 04/30/2025, I made a telephone call to Michelle Livous, from ORR. She stated her investigation was complete and she was substantiating due to a lack of staffing. Michelle stated Resident A requires 2:1 staffing and it was not provided the day of the incident.

On 04/30/2025, I made a telephone call to Resident A's case manager, Tanisha Blevins, from Community Living Services. She confirmed Resident A requires 2:1 staffing and sent me a copy of Resident A's behavior treatment plan to confirm it.

On 05/06/2025, I conducted an exit conference with Regina. I informed her of my investigative findings. She stated her residents do not always tell the truth and

described Crystal as a disgruntle employee, but stated she would send a corrective action plan.

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 on the information obtained during this investigation, the allegations are confirmed. Resident A's behavior treatment plan specified she required 2:1 staffing and there were not sufficient staff on duty on 10/05/2024. According to Crystal, and Residents B and C, Angela was the only staff on duty. Michael recanted his initial statement and stated he was not working at the time. Although there is discrepancy regarding John being on duty, even if he was, the facility was still understaffed. Due to the other residents that were present there should have been at least three staff on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____05/06/2025

Regina Buchanan
Licensing Consultant

Date

Approved By:

05/08/2025

_____

Ardra Hunter
Area Manager

Date