GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2025

Regina Amadi
Platinum Care, Inc.
3129 Golfview Drive
Saline, MI 48176

RE: License #: AS820297237
Investigation #: 2025A0101015
Syracuse TLC

Dear Ms. 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) 456-0439.

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 #:	AS820297237
Investigation #:	2025A0101015
Complaint Receipt Date:	02/19/2025
Investigation Initiation Date:	02/21/2025
Report Due Date:	04/20/2025
Licensee Name:	Platinum Care, Inc.
Licensee Address:	3129 Golfview Drive Saline, MI 48176
Licensee Telephone #:	(734) 330-3262
Administrator:	Kingsley Amadi
Licensee Designee:	Regina Amadi
Name of Facility:	Syracuse TLC
Facility Address:	31415 Conway Drive Westland, MI 48185
Facility Telephone #:	(734) 956-5470
Original Issuance Date:	01/12/2009
License **Status:**	REGULAR
Effective Date:	08/29/2023
Expiration Date:	08/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/12/2025, Resident A was transported to the Garden City Hospital Emergency Room after he was physically assaulted by his roommate, name unknown. Resident A had a laceration on his left eyebrow.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/19/2025	Special Investigation Intake 2025A0101015
02/19/2025	APS Referral Received from APS
02/20/2025	Special Investigation Initiated - Face to Face Interviewed Resident A at the Kinloch AFC
03/12/2025	Inspection Completed On-site Interviewed Home manager, Stanley Uchend and administrator, Kingsley Amadi Obtain copies of Resident B’s assessment plan, Incident report
03/18/2025	Contact - Telephone call made Direct care staff, Michael Obidare
03/26/2025	Comment – ORR referral made, already received
03/26/2025	Contact - Telephone call made Administrator, Kingsley Amadi
03/26/2025	Contact - Telephone call made Resident B's case worker, Bianca Carr
03/26/2025	Contact – Telephone call made Mr. Amadi
03/26/2025	Contact - Telephone call made Relative A1
03/27/2025	Contact – Telephone call made Relative A2

03/27/2025	Contact – Telephone call made Direct care staff, Micheal Figueroa
03/27/2025	Contact – Documents received Incident report for assault that occurred on 12/10/2025 Screen shot of the text to Resident B's case worker Ms. Carr
03/27/2025	Exit conference with Mr. Amadi
03/28/2025	Contact – Document received A screenshot of a text message to Relative A1 from the home manager
05/07/2025	Contact – Document received Resident B's treatment plan dated 12/10/2024

ALLEGATION: On 01/12/2025, Resident A was transported to Garden City Hospital Emergency Room after he was physically assaulted by his roommate, name unknown. Resident A had a laceration on his left eyebrow.

INVESTIGATION: On 02/20/2025, I interviewed Resident A. Resident A stated that he lived in the Syracuse Home for eight years and a couple of months ago he got a new roommate. Resident A stated that while he was asleep in bed, his roommate assaulted him two times. Resident A stated the first attack happened on 12/10/2024, and the second attack happened on 01/11/2025. Resident A stated after the second attack he refused to return to the Syracuse Home because he did not feel safe. Resident A stated his roommate "punched" him in his left eye that required two stitches to close the wound.

On 03/12/2025, I interviewed home manager, Stanley Uchend and administrator, Kingsley Amadi. They stated Resident B was Resident A's roommate. They further stated that after the first assault, which occurred on 12/10/2024, Resident B was approved for one-on-one staffing. They stated the one-on-one staffing was put in place to protect Resident A. Mr. Amadi stated prior to implementing the one-on-one staffing, he put a canvas dividing wall in between the beds to protect Resident A. Mr. Amadi stated, "The dividing wall would stop Resident B from seeing Resident A." Mr. Uchend stated on 01/11/2025, Resident B's one-on-one staff was Micheal Obidare.

On 03/12/2025, I reviewed Resident B's resident record. According to Resident B's resident record he was placed in the Syracuse Home on 09/26/2024. Resident B's resident record did not contain a written assessment completed prior to placement to determine if the home can meet his needs.

On 03/12/2025, I reviewed Resident B's treatment plan dated 10/01/2024. According to the treatment plan, "[Resident B] is currently on court ordered Assisted Outpatient Treatment… [Resident B] displays an unwillingness to voluntarily participate in treatment which is a risk to self and others…. [Resident B] has schizophrenia, poor impulse control and cannot control his behavior." Resident B's treatment plan did not state he requires one-on-one staffing. However Resident B's treatment plan stated the following supervision needs, "During sleeping hours 9:00 p.m. – 5:00 a.m. staff are to do a visual check every 15 minutes and during awake hours staff should know his whereabouts at all times…. If Resident B is in his bedroom during awake hours staff is to check on him every 15 minutes."

On 03/12/2025, I attempted to interview Resident B but he is not competent. According to Resident B's assessment plan dated 09/26/2024 completed at the time of placement, Resident B's communication skills are documented as limited, and he rarely responds when spoken to. However, this assessment was deemed incomplete because Ms. Amadi and the guardian did not sign it.

On 03/26/2025, I spoke with Resident B's case worker Bianca Carr. Ms. Carr stated Resident B was approved for one-on-one staffing. Ms. Carr stated Resident B's one-on-one staffing should have been put in place on 12/22/2024. Ms. Carr stated she did not know that one-on-one staffing had not been implemented on 12/22/2024 and she became aware of this on 01/02/2025. Ms. Carr stated on 01/02/2025, she received a text message from home manager, Stanley Uchend, stating that the authorization for one-on-one staffing for Resident B was put in the system on 01/02/2025, and that he would start the one-on-one staffing on 01/03/2025.

On 05/07/2025, I reviewed Resident B's amended treatment plan, dated 12/20/2024. Resident B's treatment plan was amended to include one-on-one staffing for Resident B.

On 03/26/2025, I spoke with the one-on-one staff assigned to Resident B on 01/11/2025, Mr. Obidare. Mr. Obidare stated he did not see Resident B hit Resident A. Mr. Obidare stated he was sweeping the floor and went to throw away the trash he had swept up. I asked Mr. Obidare who was the other staff on duty with him, and he stated that there was no other staff present when Resident B attacked Resident A.

On 03/26/2025, I spoke with Mr. Amadi. I informed Mr. Amadi that Mr. Obidare told me that no other staff was on duty with him. Mr. Amadi stated he did not understand why Mr. Obidare would tell me that because there were two staff on duty. Mr. Amadi stated he would find out why Mr. Obidare told me that. Shortly afterward I received a phone call from Mr. Amadi. Mr. Amadi stated Mr. Obidare did not understand the question I asked. Mr. Amadi stated he thought I was asking if Resident B had two staff.

On 03/26/2025, I spoke with Resident A. Resident A stated that there were two staff

in the home on 01/11/2025, when Resident B assaulted him while he was asleep. Resident A further stated that staff was not in the bedroom when he was attacked on 01/11/2025.

On 03/26/2025, I spoke with Relative A1. Relative A1 was very upset that her son had to be relocated to another home. She stated that her son had lived in that group home for eight years and it was only three blocks away from her home. Relative A1 stated my son was the victim and the perp who was recently placed in the home was allowed to stay. Relative A1 stated, “The perp viciously attacked my son not once but twice.” Relative A1 stated she believed that there were two staff on duty when her son was attacked on 01/11/2025. Relative A1 stated Relative A2 went to the home after the attack.

On 03/27/2025, I spoke with Relative A2. Relative A2 stated she did not go to the group home that night. Relative A2 stated she went to the hospital. Relative A2 stated there were two staff on duty because when she spoke with staff at the group home, via telephone, she heard them speaking to each other. Relative A2 stated she also knows that staff was not in Resident A and B’s bedroom because she asked if her brother returns to the group home tonight how are you going to ensure his safety? Relative A2 stated she was told that staff would be instructed to be in the bedroom throughout the night.

On 03/27/2025, I spoke to direct care staff, Micheal Figueroa. Mr. Figueroa stated on 01/11/2025, he was in the living room and Micheal Obidare was sitting in Resident A’s and B’s bedroom. Mr. Figueroa stated he heard the commotion and rushed to the bedroom to assist Mr. Obidare. However, this is inconsistent with what he wrote in the incident report he completed. The incident report Mr. Figueroa wrote states, “Staff rushed to the room to handle the situation.” Furthermore Mr. Figueroa could not provide any details of why Mr. Obidare was unable to prevent the attack.

On 03/27/2025, I conducted an exit conference with the administrator/designated person Mr. Amadi. Mr. Amadi stated he did not know the whereabouts of his wife licensee designee, Regina Amadi. Initially, Mr. Amadi did not agree with my findings. I had a lengthy discussion with him on the importance of assessing residents for care, discharging a resident when the home is no longer able to meet his or her needs, crisis intervention and his responsibility for providing protection when an unacceptable behavior has been identified, and the professionals have not developed an intervention to address the behavior. After our discussion Mr. Amadi expressed an understanding of the violations.

On 03/28/2025, Relative A1 forwarded me a text message she received from Mr. Uchend on 01/12/2025. The message stated, “Hi really sad [Resident A] had to go through this again and as you know I don’t determine who stays in the house and who doesn’t however if [Resident A] does come back I have instructed my staff that one of them have to be in that room through the night until I can figure out a solution with my boss and his roommate’s medical team. This is really all I can do at the

moment."

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:	Resident A was not treated with dignity and his personal needs, including protection and safety were not attended to at all times. On 09/26/2024, Ms. Amadi accepted Resident B for care. According to his treatment plan 10/01/2024. Resident B has poor impulse control and cannot control his behavior. Resident B shared a double occupancy bedroom with Resident A. On 12/10/2024, Resident B had an unacceptable behavior. Resident A was asleep in his bed and Resident B got up and assaulted him. Mr. Amadi stated he contacted the responsible agency and put a canvas dividing wall between the beds so that Resident B could not see Resident A. However, Ms. Amadi did not implement an effective intervention that would protect Resident A from any additional assaults. On 12/20/2024, Resident B's treatment plan was amended to include that Ms. Amadi should be providing one-on-one staffing for Resident B. According to the home manager's text to the case worker, one-on-one staffing for Resident B did not start until 01/03/2025. On 01/11/2025, Resident B attacked Resident A again while he was asleep. According to Resident B's one-on-one staff Mr. Obidare, he was not in Resident A and Resident B's bedroom when the second attack happened.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the preponderance of evidence, Ms. Amadi did not provide supervision and protection as defined in the act and as specified in Resident B's written assessment plan dated 12/20/2024. Resident B requires one-on-one staffing. According to Resident B's case worker, Ms. Amadi was supposed to be providing one-on-one staffing for Resident B as of 12/20/2024. Mr. Obidare was Resident's B one-on-one staff on 01/11/2025. Mr. Obidare stated he did not witness Resident B attack Resident A because he was throwing away the trash that he had swept up. Mr. Obidare also stated that he was the only staff on duty when the assault took place. Resident A stated that there was two staff on duty but there were no staff in his bedroom when he was assaulted by Resident B on 01/11/2025. Relative A2 stated there were two staff on duty because when she spoke with staff at the group home, via telephone, she heard them speaking to each other. Relative A2 stated she also knows that staff was not in Resident A and B's bedroom because she asked if her brother returns to the group home tonight how are you going to ensure his safety? Relative A2 stated she was told that staff would be instructed to be in the bedroom throughout the night. Relative commented, "Why would it be offered as a method to ensure Resident A's safety if it was already being utilized." On 01/12/2025, Mr. Uchend sent Relative A1 a text message indicating that the plan to ensure Resident A's safety upon returning to the home would be instructing his staff that they must stay in Resident A and B's bedroom throughout the night.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 03/12/2025, I reviewed Resident B's resident record. Resident B's resident record did not contain a written assessment prior to placement to determine that Resident B was suitable, and the home could meet his needs.

On 03/12/2025, I interviewed Mr. Amadi. Mr. Amadi stated when he accepted Resident B for care he called Resident B's family, the case worker and the guardian.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home. (b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home. (c) The resident appears to be compatible with other residents and members of the household.
ANALYSIS:	On 03/12/2025, I reviewed Resident B's resident record. Resident B's resident record did not contain a written assessment that was completed before accepting him for care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 03/12/2025, I reviewed Resident B's resident record. At the time of Resident B's admission Ms. Amadi attempted to complete an assessment plan. However, the assessment plan was deemed incomplete because Ms. Amadi and the guardian did not sign it.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	At the time of Resident B's admission Ms. Amadi attempted to complete an assessment plan. However, the assessment plan was deemed incomplete because Ms. Amadi and the guardian did not sign it.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/20/2025
Edith Richardson Date
Licensing Consultant

Approved By:

05/21/2025
Ardra Hunter Date
Area Manager