GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

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

RE: License #: AS820406047
Investigation #: 2025A0121023
Dixie Home

Dear Mrs. 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 was required. On April 30, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

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 #:	AS820406047
Investigation #:	2025A0121023
Complaint Receipt Date:	03/28/2025
Investigation Initiation Date:	04/03/2025
Report Due Date:	05/27/2025
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:	01/11/2025
Expiration Date:	01/10/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/26/25, Resident A went to the bathroom and fell injuring himself. Resident A is on 1:1 restriction.	Yes

III. METHODOLOGY

03/28/2025	Special Investigation Intake 2025A0121023
03/28/2025	APS Referral Made by recipient rights
03/28/2025	Referral - Recipient Rights
04/03/2025	Special Investigation Initiated - On Site Interviewed Home Manager and Resident A and B.
04/03/2025	Contact - Telephone call made Left message for Recipient Rights Investigator (RRI), Domonique Moore
04/03/2025	Contact - Telephone call made Left message for case manager with Team Wellness, Unique Currington
04/03/2025	Contact - Telephone call made Left message for DCS, Ifeanyi Mikben (no response)
04/03/2025	Contact - Document Sent Email to Licensee designee
04/07/2025	Contact - Document Received Received staff schedules
04/14/2025	Contact - Telephone call made Team Wellness
04/15/2025	Contact - Telephone call received Return call from Tiffany Pernell with Team Wellness
04/15/2025	Contact - Document Received

	Resident A's Individual Plan of Service (IPOS)
04/18/2025	Contact - Document Sent Email to licensee; scheduled exit conference
04/21/2025	Exit Conference
04/30/2025	Corrective Action Plan Received/Approved

ALLEGATION: On 3/26/25, Resident A went to the bathroom and fell injuring himself. Resident A is on 1:1 restriction.

INVESTIGATION: On 4/3/25, I conducted an onsite inspection at the facility. Acting home manager, Philip Ogbuaku was on duty. Mr. Ogbuaku acknowledged Resident A does have a 1:1 staffing assignment due to exhibiting self-injurious behaviors. Mr. Ogbuaku said he was working when Resident A fell in the bathroom. However, Mr. Ogbuaku reported he had gone to his car when the fall happened. Per Mr. Ogbuaku, Resident A was taken to Beaumont Hospital for emergency medical treatment immediately following the fall.

When I arrived at the facility, I observed 2 direct care staff outside. Mr. Ogbuaku was sitting at the dining room table. Resident A was in his bedroom resting. Resident A's door was closed when I arrived. No staff was inside or outside of the bedroom providing supervision. Resident A stated, "I cracked my ankle." I observed Resident A wearing an ace bandage. I also observed a set of crutches at his bedside. When asked about the fall, Resident A explained, "When I got up off the toilet seat, I fell." Resident A further explained that he was not able to get off the floor on his own, so "I scooted" to the bedroom. According to Resident A, the fall happened between 3:30 – 4:00 AM. I asked Resident A what staff was on duty the night of his fall. Resident A reported direct care staff, Ifeanyi Mikben was on duty alone. Resident A stated, "Only 1 person works the night shift … every night", but there are 2 direct care staff during the day. I asked Resident A about his 1:1 staffing assignment. Resident A is adamant that he does not like being closely supervised, so staff will allow him to relax alone in his room. Resident A described his current mental state as "stable." I also interviewed Resident B. There are currently 3 residents in care. The third resident is fairly new, so he could not provide accurate testimony. However, Resident B confirmed that there is only 1 direct care staff on duty at night and 2 staff during the day.

After several failed attempts to reach the case manager at Team Wellness Center, I received a call back from Supervisor, Tiffany Pernell. Ms. Pernell verified Resident A is approved for 1:1 staffing 24 hours per day, 7 days a week. This enhanced staffing request was approved by Detroit Wayne Integrated Health Network on 1/28/25.

On 4/21/25, I completed an exit conference with licensee designee, Immaculata Nwachukwu. Mrs. Nwachukwu reported that she keeps 2 staff on duty at all times, including sleep hours. According to Mrs. Nwachukwu, Resident A refuses to allow staff to enter his room while he's sleeping or relaxing. Mrs. Nwachukwu agreed the door should remain open at all times. When I explained that I observed Resident A behind a closed door on 4/3/25, Mrs. Nwachukwu had no reasonable explanation other than to say, "Staff know they were supposed to leave that door open." On 4/30/25, Mrs. Nwachukwu submitted an approved corrective action plan to address the rule violation.

On 5/28/25, I made an unannounced follow up inspection at the facility to determine compliance with the corrective action plan. I observed direct care staff, Lucy Aniele

and Rita Cheke on duty. Resident A had no unusual problems to report. Resident A indicated that his recovery is going well.

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:	The licensee did not ensure Resident A was provided supervision at all times as specified in his written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

06/03/25

Kara Robinson Date
Licensing Consultant

Approved By:

For 06/04/2025

Ardra Hunter Date
Area Manager