GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 23, 2025

Hyginus Ezeokobe
4539 Palisades Ct
Ypsilanti, MI 48197

RE: License #: AS820404903
Investigation #: 2025A0119051
Divine Grace AFC

Dear Mr. Ezeokobe:

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820404903
Investigation #:	2025A0119051
Complaint Receipt Date:	08/28/2025
Investigation Initiation Date:	08/29/2025
Report Due Date:	10/27/2025
Licensee Name:	Hyginus Ezeokobe
LicenseeAddress:	26921 Kitch St Inkster, MI 48141
Licensee Telephone #:	(734) 834-8156
Administrator:	N/A
Licensee Designee:	Hyginus Ezeokobe
Name of Facility:	Divine Grace Afc
Facility Address:	26921 Kitch St Inkster, MI 48141
Facility Telephone #:	(313) 722-4286
Original Issuance Date:	03/11/2021
License **Status:**	REGULAR
Effective Date:	09/11/2024
Expiration Date:	09/10/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the home wearing no shirt with pajama pants and house slippers.	No
Additional Findings	Yes

III. METHODOLOGY

08/28/2025	Special Investigation Intake 2025A0119051
08/28/2025	APS Referral Received
08/29/2025	Referral - Recipient Rights Made
08/29/2025	Special Investigation Initiated - Telephone Adult Protective Services Investigator- Shantel Johnson
09/04/2025	Inspection Completed On-site Residents A- D and Staff- Jason Ezeokobe
09/05/2025	Contact - Telephone call made Licensee Designee- Hyginus Ezeokobe
09/05/2025	Contact- Telephone call made Recipient Rights Investigator- April Dudley
10/21/2025	Contact - Telephone call made Resident A's case manager- Cheryl Henry with Lincoln Behavioral
10/21/2025	Contact- Document Received Incident Report
10/22/2025	Exit Conference Licensee Designee- Hyginus Ezeokobe

ALLEGATION:

Resident A eloped from the home wearing no shirt with pajama pants and house slippers.

INVESTIGATION:

On 08/29/2025, I telephoned and interviewed Adult Protective Services Investigator- Shantel Johnson regarding the above allegations. Shantel stated Resident A is allowed to leave the home.

On 09/04/2025, I completed unannounced on-site inspection and interviewed Staff- Jason Ezeokobe and Residents A- D regarding the above allegations. Jason stated he has no knowledge of the incident as he was not working. Jason stated all residents sign in and out the facility for staff to be aware of their whereabouts.

Resident A stated he left the home and got lost trying to return home. Resident A stated he can leave the home whenever he wants to leave. Resident A stated he signs in and out when he leaves the home.

Resident B stated all residents are required to sign in and out of the home. Resident B stated he went to look for Resident A when he did not return home.

Resident C stated he has no knowledge of Resident A leaving the home. Resident C stated he is required to sign in and out when he leaves the home.

Resident D stated he left Resident A at the party store. Resident D stated he asked Resident A to leave with him but Resident A refused. Resident D stated he is required to sign in and out when he leaves the home.

I observed Resident A to be fully dressed while lying in the bed. He had a jacket, long pants and a t-shirt. I reviewed the sign in and out logs for the facility. The sign in and out logs show Resident A signed out on 08/17/2025.

On 09/05/2025, I telephoned and interviewed licensee designee- Hyginus Ezeokobe and Recipient Rights Investigator- April Dudley regarding the above allegations. Hyginus stated he feels that Resident A went out with a friend and came home when he got ready. Hyginus stated Resident A is able to leave the home whenever he wants and does not require additional supervision while in the community. Hyginus stated Resident A does not have a guardian. Hyginus provided the information for Resident A's community mental health case manager with Lincoln Behavioral.

April stated she is not going to substantiate this case. April stated Resident A is allowed to freely move independently in the community without staff support.

On 10/21/2025, I telephoned and interviewed Resident A's case manager- Cheryl Henry with Lincoln Behavioral regarding the above allegations. Cheryl stated she has visited Resident A on two occasions and she has no problems about the care Resident A is receiving in the home. Cheryl stated Resident A does often dress inappropriately and does not want to wear proper clothing. Cheryl stated Resident A is aware of what clothing is appropriate but rather he is making a poor choice for himself. Cheryl stated the staff cannot make Resident A wear different clothing. Cheryl stated Resident A is freely able to move independently in the community without staff support.

On 10/21/2025, I telephoned and completed an exit conference with licensee designee- Hyginus Ezeokobe regarding this allegation. Hyginus did not have anything additional to add to this allegation.

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:	Licensee designee- Hyginus Ezeokobe, Recipient Rights Investigator- April Dudley, Resident A's case manager- Cheryl Henry, and Residents A agree that Resident A is able to move freely in the community without staff support. Staff- Jason Ezeokobe and Residents A- D stated all residents sign in and out when they leave the home. Therefore, there is insufficient evidence that Resident A did not receive proper protection and safety at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/29/2025, I telephoned and interviewed Adult Protective Services Investigator- Shantel Johnson regarding the above allegations. Shantel stated Resident A left the home at 9:00am on 08/17/2025. Shantel stated Resident A was returned home by a stranger the next day at 4:00pm.

On 09/04/2025, I completed unannounced on-site inspection and I reviewed the sign in and out logs for the facility. The sign in and out logs show Resident A signed out of the home on 08/17/2025 at 9:06am.

On 10/21/2025, I received an incident report dated 08/18/2025 with a time of 4:40pm which indicated that Resident A was returned home by a stranger. I received the incident report from Resident A's case manager- Cheryl Henry. It should be noted that the incident report did not mention that Resident A had left the home on 08/17/2025 but rather he returned to the facility by a stranger. Additionally, there was no indication that the police was contacted due to Resident A not returning to the facility.

On 10/21/2025, I telephoned and completed an exit conference with licensee designee- Hyginus Ezeokobe regarding this investigation. Hyginus stated in times past, he was told by the police to only make a missing person's report after an individual is gone from the home for more than 48 hours. Therefore, Hyginus stated he did not call the police when Resident A did not return home. Hyginus stated no one was aware of Resident A's whereabouts while he out of the facility.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.
ANALYSIS:	Resident A left the facility on 08/17/2025 at 9:06am and did not return to 08/18/2025 at 4:40pm. Therefore, Resident A was gone from the facility for more than 30 minutes and the local police department was not contacted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the status of the license remains the same.

10/22/2025

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Shatonla Daniel — Date
Licensing Consultant

Approved By:

10/23/2025

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Ardra Hunter — Date
Area Manager