



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27, 2025

Josephine Uwazurike
Kevdaco Human Services LLC
PO Box 4199
Southfield, MI 48037

RE: License #: AS820273307
Investigation #: 2025A0101014
Kevdaco Redford

Dear Ms. Uwazurike:

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) 456-0380.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson", is positioned above the typed name and address.

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 #:	AS820273307
Investigation #:	2025A0101014
Complaint Receipt Date:	02/11/2025
Investigation Initiation Date:	02/14/2025
Report Due Date:	04/12/2025
Licensee Name:	Kevdaco Human Services LLC
Licensee Address:	Suite 200 23999 Northwestern Hwy Southfield, MI 48075
Licensee Telephone #:	(248) 722-5004
Administrator:	Josephine Uwazurike
Licensee Designee:	Josephine Uwazurike
Name of Facility:	Kevdaco Redford
Facility Address:	14416 Beech Daly Road Redford, MI 48239
Facility Telephone #:	(248) 722-5004
Original Issuance Date:	12/12/2005
License Status:	REGULAR
Effective Date:	09/15/2024
Expiration Date:	09/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED
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II. ALLEGATION(S)

	Violation Established?
On 01/28/2025, direct care staff Chibuzor Onuoha physically assaulted Resident A.	Yes

III. METHODOLOGY

02/11/2025	Special Investigation Intake 2025A0101014
02/11/2025	Referral received from APS
02/11/2025	ORR referral made
02/14/2025	Special Investigation Initiated - On Site Interviewed Resident A Home manager, Neba Fontem
03/12/2025	Contact -Telephone call made Licensee designee, Josephine Uwazuike
03/12/2025	Inspection Completed On-site Reviewed former direct care staff, Chibuzon Onuoha employee's file, copies of Resident A's treatment, Resident A's behavior plan and incident reports
03/19/2025	Contact - Telephone call made Case manager NSO, Sonya Thurmond,
03/19/2025	Contact - Telephone call made Direct care staff, Henry Okafor
03/19/2025	Contact – Telephone call made Sonya Thurmond, Resident A's case manager Neighborhood Services Organization
03/25/2025	Contact – Telephone call made Direct care staff, Chibuzon Onuoha

ALLEGATION: On 01/28/2025, direct care staff, Chibuzor Onuoha physically assaulted Resident A.

INVESTIGATION: On 02/14/2025, I interviewed the home manager, Neba Fontem. Mr. Fontem stated that on 01/28/2025, he left worked but needed to return. Mr. Fontem stated he entered the home, and he observed direct care staff, Chibuzor Onuoha holding a lamp and Resident A was bleeding. Mr. Fontem stated that he called the police. According to Mr. Fontem when the police came, they took Resident A's and Mr. Onuoha's statements. Mr. Fontem stated Mr. Onuoha told the police that Resident A attacked him from behind. Mr. Fontem stated the police did not arrest Mr. Onuoha, however, they did come back to the facility later that day looking for Mr. Onuoha. Mr. Fontem further stated since then no one has been able to contact Mr. Onuoha. Mr. Fontem stated Resident A was taken to the hospital. Mr. Fontem stated Resident A received two staples in the back of his head and a cut on his right pinky finger.

On 02/14/2025, I interviewed Resident A. Resident A stated he was having a behavior but could not or would not articulate the details leading up to the altercation. Resident A stated Mr. Onuoha made him upset. Resident A stated Mr. Onuoha was cursing at him and then they started to fight. Resident A stated Mr. Onuoha picked up the lamp and hit him in the back of his head.

On 02/14/2025, I attempted to interview Resident B. According to Mr. Fontem Resident B was present when the altercation happened, and Resident B told the police that Mr. Onuoha hit Resident A with the lamp. However, when I attempted, to interview Resident B his responses were unintelligible. Mr. Fontem stated Resident B has issues with memory. I was also unable to interview the other residents residing in the home. They were either nonverbal or they did not have the mental capacity to be interviewed.

On 03/12/2025, I spoke with the licensee designee, Josephine Uwazuike. Ms. Uwazuike stated all attempts to contact Mr. Onuoha have been unsuccessful. Ms. Uwazuike stated Mr. Onuoha's absence is probably due to the fact that he could possibly be prosecuted.

On 03/12/2025, I reviewed Mr. Onuoha's employee record. When Mr. Onuoha was hired, Ms. Uwazuike properly ensured he met all the qualification for a direct care staff.

On 03/19/2025, I spoke with the second staff on duty when Resident A and Mr. Onuoha had the physical altercation, Henry Okafor. Mr. Okafor stated he was in the bathroom toileting Resident C. Mr. Okafor stated Resident C is a wheelchair bound resident, and he could not leave him alone in the bathroom. Mr. Okafor stated he heard Resident A and Mr. Onuoha arguing. Mr. Okafor stated he did not hear what they were arguing about. Mr. Okafor stated when he came out of the bathroom, he saw that Resident A was bleeding.

On 03/19/2025, I spoke with Resident A's case manager, Sonya Thurmond. Ms. Thurmond stated she became aware of the altercation between Resident A and Mr.

Onuoha when an officer at the Redford Police Department contacted her. Ms. Thurmond stated Resident A has a history of verbal aggression. Ms. Thurmond stated when she spoke with Resident A, he was unable to say what happened.

On 03/19/2025, I reviewed Resident A's treatment plan and behavior plan. According to Resident A's treatment plan he likes to speak with staff when he is upset. Resident A's behavior plan stated if no one is listening to him he will get verbally aggressive. The behavior plan further stated to deescalate Resident A's verbal aggression staff should redirect him with a calm voice.

On 03/19/2025, I reviewed the incident report Mr. Onuoha completed. The incident report stated, "When I arrived at 3 pm I was at staff section. I was attending to a client when [Resident A] came up behind me and attacked me. He grabbed the lamp to hit me, and we were struggling with the lamp, and he hit himself during the struggle and was bleeding."

On 03/26/2025, I conducted an exit interview with Ms. Uwazuike. Ms. Uwazuike agreed with my findings.

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
	<p>(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:</p> <ul style="list-style-type: none">(a) Use any form of punishment.(b) Use any form of physical force other than physical restraint as defined in these rules.(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.(e) Withhold food, water, clothing, rest, or toilet use.(f) Subject a resident to any of the following:<ul style="list-style-type: none">(i) Mental or emotional cruelty.(ii) Verbal abuse.(iii) Derogatory remarks about the resident or members of his or her family.(iv) Threats.(g) Refuse the resident entrance to the home.(h) Isolation of a resident as defined in R 400.14102(1)(m).

	(i) Any electrical shock device.
ANALYSIS:	Direct care staff Chibuzon Onuoha used physical force with Resident A. The incident report Mr. Onuoha completed stated "...[Resident A] came up behind me and attacked me. He grabbed the lamp to hit me, and we were struggling with the lamp and he hit himself...." However, the injury Resident A sustained was to the back of his head. According to Resident A's behavior plans staff should redirect him using a calm voice to prevent escalation of verbal aggression. However, Mr. Okafor stated he heard Mr. Onuoha arguing with Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Edith Richardson
Licensing Consultant

03/26/2025
Date

Approved By:

A handwritten signature in black ink, appearing to read "A. Hunter". The signature is written in a cursive, flowing style with a large initial "A" and a trailing flourish.

03/26/2025

Ardra Hunter
Area Manager

Date