GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2025

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

RE: License #: AS820401949
Investigation #: 2025A0121013
Luke Michaels, Inc

Dear Mrs. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

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 #:	AS820401949
Investigation #:	2025A0121013
Complaint Receipt Date:	01/10/0205
Investigation Initiation Date:	01/10/2025
Report Due Date:	03/09/0205
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
Facility Address:	31412 Kathryn St Garden City, MI 48135
Facility Telephone #:	(734) 337-4251
Original Issuance Date:	07/20/2020
License **Status:**	REGULAR
Effective Date:	01/20/2025
Expiration Date:	01/19/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Licensee, Regina Amadi purposely understaffs the home especially at night and on the weekends. Many of the residents require 1:1 or 2:1 staffing. Regina Amadi does not meet these staffing requirements, so she can pad her pockets with the additional cash.	Yes
Resident A is being restrained at night, so she doesn't get out of bed.	Yes

III. METHODOLOGY

01/10/2025	Special Investigation Intake 2025A0121013
01/10/2025	Special Investigation Initiated - Telephone
01/10/2025	Adult Protective Service Referral
01/13/2025	Contact - Telephone call received Witness 1
01/14/2025	Inspection Completed On-site Interviewed Resident B
01/15/2025	Contact - Document Sent Email to licensee requesting copies of resident assessment plans.
01/15/2025	Contact - Telephone call made Detroit Wayne Integrated Health Network (DWIHN)
01/15/2025	Contact - Document Sent Garden City Police Records dept.
01/23/2025	Contact - Telephone call made Sgt. Miller with Garden City Police
01/23/2025	Contact - Telephone call made E. Sherman with Adult Protective Services (APS)
01/27/2025	Contact - Telephone call made Witness 2

01/31/2025	Contact - Telephone call made Witness 3
01/31/2025	Referral - Recipient Rights
02/07/2025	Contact - Telephone call received Witness 4
02/10/2025	Contact - Telephone call made via Teams Case Conference with E. Sherman (APS) and T. Burgess (DWIHN)
02/10/2025	Contact - Document Sent Email to LARA's Workforce Background Unit
02/11/2025	Contact - Document Received Email received from Workforce Background Unit
02/14/2025	Contact - Telephone call received Witness 2
02/25/2025	Contact - Telephone call received Witness 5
03/13/2025	Contact - Telephone call made Candice Jones, Resident A's Supports Coordinator
03/13/2025	Exit Conference Regina Amadi

ALLEGATION: Licensee, Regina Amadi purposely understaffs the home especially at night and on the weekends. Many of the residents require 1:1 or 2:1 staffing. Regina Amadi does not meet these staffing requirements, so she can pad her pockets with the additional cash.

INVESTIGATION: On 1/10/25, I initiated the complaint with a referral to Adult Protective Services (APS). The case was assigned to Eryn Sherman for investigation. On 1/10/25 and 1/13/25, I received calls from an anonymous caller who will be referred to in this report as Witness 1. Witness 1 asked to remain anonymous out of fear that licensee designee, Regina Amadi would retaliate and possibly cause bodily harm to the witness. According to Witness 1, the home has experienced staffing shortages for the last 2 years. Witness 1 indicated that Mrs. Amadi failed to staff the home properly. Witness 1 reported there are currently 5

residents in care now that Resident F has been discharged. Witness 1 reported 4 out of 5 residents have 1:1 or 2:1 staffing assignments in place. I verified each staffing assignment with the Detroit Wayne Integrated Health Network (DWIHN). Mr. Avery Barnett with DWIHN reported Resident A and B have 2:1 staffing assignments and Resident D and E have 1:1 staffing assignments.

On 1/14/25, I interviewed Resident C face-to-face. Resident C reported that although "not often", direct care staff, Binta Jarjou has been the only staff on duty to care for residents with the most recent occurrence happening 2 nights ago. Resident C reported the police were called to the home during sleep hours on 1/12/25. Resident C explained Binta woke her up to speak to the police since Binta cannot speak English well. Resident C said she was "so nervous" when talking to the police. Resident C acknowledged that no other staff were on duty, so that's why the police needed to speak with her. Resident C explained the other residents in the home do not talk or do not talk well enough to understand. On 1/23/25, I received an email confirmation from Sgt. Steve Miller with the Garden City Police Department. Sgt. Miller confirmed Binta was the only staff on duty when officers went to the home on 1/12/25.

On 1/20/25, Mrs. Amadi emailed me a copy of the staff schedule upon request. Per Mrs. Amadi the schedule covered Dec 2024 and Jan 2025. On 2/10/25, I forwarded the names of 19 direct care staff listed on the schedule to the bureau's Workforce Background Unit to determine if each employee had been fingerprinted and entered into our system as hired employees. The results showed only 4 direct care staff (Kiana Amadi, Stanley Uchendu, Regina Amadi, and Mariam Sylla) were entered into our database with "hired" status for this facility.

On 1/27/25 and 2/14/25, I interviewed Witness 2. Witness 2 was hesitant to speak with me; however, Witness 2 did later acknowledge the home is frequently short staffed because Mrs. Amadi knowingly does not staff the home to meet the staffing requirements as specified in the residents' treatment plans. Witness 2 stated Mrs. Amadi would falsify the staff schedules to make it appear like there was sufficient staffing on duty. According to Witness 2, the home is typically staffed with 2 direct care staff during the day and 1 direct care staff at night unless Mrs. Amadi is expecting visitors. Witness 2 explained Mrs. Amadi will temporarily increase staffing at the home if she knows someone like a social worker or guardian is coming to visit. Witness 2 also reported Mrs. Amadi would provide additional staffing to go on appointments to see the doctor or mental health professionals. As a result, Witness 2 reported it wasn't uncommon for the staff to get attacked by residents with behavior problems, like Resident F. Witness 2 admitted Resident F "had to go" because she was fighting the staff on a regular basis causing severe injuries (See Special Investigation Report #2025A0121008).

On 1/31/25, I attempted to interview Witness 3 by phone. Witness 3 reported Resident F would frequently attack the staff due to a lack of staffing at the facility.

Witness 3 ended the call abruptly stating she no longer wanted to talk to me because she was “really, really scared” of Mrs. Amadi.

On 2/7/25, I received an anonymous call from Witness 4 who reported Mrs. Amadi is not providing sufficient staffing to meet Resident A’s 2:1 staffing assignment. Witness 4 stated Resident A’s needs are frequently left unmet since she is not within eyesight of staff at all times as specified in the resident’s treatment plan.

On 2/25/25, I received a phone call from Witness 5. Witness 5 is a former direct care staff at the facility. Witness 5 indicated that most of the staff there are afraid of Mrs. Amadi, so they refuse to cooperate with investigators. Witness 5 reported Mrs. Amadi did not provide adequate staffing in accordance with the resident care agreements or assessment plans. Witness 5 further acknowledged Mrs. Amadi would bring direct care staff from her other group homes to Luke Michaels home whenever there was a planned visit from investigators to make it look like the home had enough staff. Witness 5 reported she was one of the staff Mrs. Amadi would call to come to the home to “trick” investigators, making it appear as though there were more staff on duty than it really was.

On 3/13/25, I completed an exit conference with Mrs. Amadi. Mrs. Amadi denied the allegations. Mrs. Amadi reported the allegations are being made by disgruntled staff who no longer work at the facility. Mrs. Amadi insisted she does staff the home properly, but she stated sometimes the workers call in or don’t show up for work, leaving the home short staffed. Mrs. Amadi reasoned, “What am I supposed to do if I schedule people to work and they don’t show?” I informed Mrs. Amadi that it was highly unlikely that 4-5 staff would routinely call in on the same day and time. I asked Mrs. Amadi to explain why the police had to talk to a resident if there were additional staff on duty with Binta on the night of 1/12/25. Mrs. Amadi’s reply is that the other staff were in the bedroom with their respective 1:1 client(s). Mrs. Amadi stated, “They can’t prove it” because the police did not search each bedroom to look for more staff. Mrs. Amadi also reported the police contacted her daughter, Kiana Amadi who is also a direct care staff. Kiana Amadi was not on duty when the police arrived, but they called her since Mrs. Amadi was out of the country on vacation. Mrs. Amadi stated she was away on vacation until January 13, 2025.

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 statements from Witness 1-5, Resident C, and Sgt. Miller, plus, the results from our Workforce Background Unit there is a preponderance of evidence that Mrs. Amadi did not provide sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents as specified in their individual plans of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is being restrained at night, so she doesn't get out of bed.

INVESTIGATION: Witness 1 reported Resident A is "restrained to her bed after being put to bed at 8:00 p.m. with no staff supervision." A video was forwarded with evidence to show Resident A's posey bed was zipped which subsequently created an enclosure to restrict the resident's movement. I reviewed Resident A's individual plan of service dated 6/13/24. The plan states Resident A requires 24-hour staffing with a two-to-one staffing ratio. Resident A is "diagnosed with a cognitive delay, cerebral palsy, seizure disorder, and Angelman Syndrome." On 3/13/25, I interviewed Candice Jones with Community Living Services (CLS). Ms. Jones provides case management services to Resident A. Ms. Jones reported Resident A's posey bed should never be zipped per instruction from CLS's Behavioral Treatment Plan Restrictive Committee (BTPRC). Ms. Jones vehemently stated, "They know they're not supposed to have the bed zipped." In addition, Ms. Jones said she frequently reminds the staff not to zip the bed when she goes to the home to visit Resident A. However, Witness 2 confirmed staff would zip-tie the bed's zippers together to prevent Resident A from getting out the bed especially at night. Witness 2 acknowledged that staff were instructed to keep the bed unzipped at all times, but they ignored these instructions. Witness 2 further explained Resident A could get out of bed and crawl throughout the home if the bed was left unzipped which staff did not want. Because there weren't enough staff present to constantly supervise Resident A, they often restricted her movement by locking the posey bed.

It should be noted Resident A is nonverbal, so there was no opportunity to gather information directly from the resident.

On 3/13/25, Mrs. Amadi acknowledged the bed was not supposed to be zipped. Mrs. Amadi denied that staff would zip the bed. On 3/18/25, Mrs. Amadi sent me a follow up email to report all staff were in-serviced on Resident A's bed use, including any restrictions. Mrs. Amadi indicated the allegation was made out of pure malice and likely initiated by former disgruntled employees.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(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: **(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.**
ANALYSIS:	Witness 1 and 2 provided credible statements that staff used Resident A's posey bed to restrict her movement despite there being a 2:1 staffing requirement in place. Video evidence is available to demonstrate the bed in restrictive mode. Therefore, the direct care staff at Luke Michaels facility did restrict Resident A's movement by tying the bed's zippers closed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the willful and substantial violations, I recommend the license be modified to a 1st provisional.

03/21/25

K. Robinson — Date
Licensing Consultant

Approved By:

03/25/25

Ardra Hunter — Date
Area Manager