GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2025

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

RE: License #: AS820412578
Investigation #: 2025A0121025
Huron River 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 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,

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 #:	AS820412578
Investigation #:	2025A0121025
Complaint Receipt Date:	04/18/2025
Investigation Initiation Date:	04/21/2025
Report Due Date:	06/17/2025
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:	Huron River Home
Facility Address:	901 West Huron River Dr., Belleville, MI 48111
Facility Telephone #:	(734) 686-9534
Original Issuance Date:	01/19/2023
License **Status:**	REGULAR
Effective Date:	07/19/2023
Expiration Date:	07/18/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff were not available to pick up Resident A from the hospital.	Yes

III. METHODOLOGY

04/18/2025	Special Investigation Intake 2025A0121025
04/21/2025	Special Investigation Initiated - Letter Email to Witness 1
04/22/2025	Contact - Telephone call made Call to licensee
04/22/2025	Contact - Telephone call made Nicole Poland with U of M hospital
04/22/2025	Contact - Document Received Email from Witness 1
05/07/2025	Inspection Completed-BCAL Sub. Compliance Interviewed home manager, Adeshola Hutchins and Resident A.
05/14/2025	Exit Conference Mrs. Nwachukwu
05/15/2025	Referral - Recipient Rights
05/16/2025	Contact - Telephone call made Avery Barnett, Recipient Rights Investigator
05/27/2025	APS Referral
06/03/2025	Contact - Telephone call received Eryn Sherman with APS

ALLEGATION: Staff were not available to pick up Resident A from the hospital.

INVESTIGATION: On 4/22/25, I spoke to Nicole Poland with U of M Hospital Social Work Department. Ms. Poland reported Resident A arrived at the E.R. on 4/17/25

around 4:17PM for evaluation. According to Ms. Poland, the AFC staff who accompanied Resident A to the hospital left at 5:30PM. At approximately 6:53PM, hospital staff contacted the facility to report Resident A was ready for pickup. Ms. Poland explained the "group home staff" (name unknown) informed the hospital that no one would be available to pick Resident A up until the next day. So, hospital staff arranged to have Resident A transported back to the group home in a ride share car. As a result, per Ms. Poland, Resident A was left alone at the hospital for approximately 3 hours, 5:30 – 8:30PM. Ms. Poland stated it is not appropriate for AFC group home workers to leave patients unattended until a disposition has been made to determine if they meet the admission criteria. In this case, Ms. Poland reported Resident A was not cleared for inpatient hospitalization. I received a follow up email from Witness 1 to confirm the AFC staff on the phone did not identify themselves by name. Witness 1 could only report the caller was male and he worked the night shift on this day. Witness 1 also reported she made attempts to reach home manager, Adeshola Hutchins (a.k.a. "Ola"), but Ms. Hutchins never returned her call.

On 4/22/25, I phoned licensee designee Mrs. Nwachukwu who added Ms. Hutchins to the call as a third party. Mrs. Nwachukwu reported Resident A constantly goes to the hospital because he misses the attention from his parents. Mrs. Nwachukwu reported Resident A is authorized 1:1 staffing 15 hours per day to be used as needed throughout the day. Mrs. Nwachukwu acknowledged that her staff left Resident A at the hospital with instructions for them to contact Ms. Hutchins when he's ready for pickup. Mrs. Nwachukwu also indicated the hospital staff contacted her when they couldn't get in contact with Ms. Hutchins; however, Mrs. Nwachukwu didn't get the notice until 10:00PM when she got out of church mass. Mrs. Nwachukwu explained she was informed Resident A was already home by the time she got in touch with Ms. Hutchins, so she didn't think much more of it knowing Resident A was at home safe. Ms. Hutchins acknowledged she left Resident A at the hospital while the resident was undergoing evaluation with the Nurse Practitioner. Ms. Hutchins said she left the hospital because direct care staff, Charles Ibeziako's accompanied them to the hospital and his work shift had ended. According to Ms. Hutchins, she and Mr. Ibeziako left Resident A at the hospital sometime after 6:00PM.

On 5/7/25, I conducted an unannounced onsite investigation at the facility. I reviewed Resident A's most recent *Individual Plan of Service* dated 5/10/24 and *Residential Assessment* dated 1/23/25. The *Residential Assessment* states, "Staff would need to monitor him closely to ensure that he remains safe both in the home and community." The assessments document Resident A's at risk behaviors are suicidal ideation as well as elopement risk. When I interviewed Resident A, he reported Ms. Hutchins and Mr. Ibeziako left him at the hospital on 4/17/25. Resident A stated, "That's not fair! … I wasn't going to spend the night at hospital." Resident A also reported his attempts to contact Ms. Hutchins on her cellphone to let her know that he was ready for pickup, but Ms. Hutchins' phone kept going straight to voicemail. Ms. Hutchins was at the facility on the day of investigation. Ms. Hutchins

identified Tony Okorie as the direct care staff on duty who informed the hospital no one was available to pick Resident A up from the hospital.

On 5/14/25, I completed an exit conference with Mrs. Nwachukwu. Mrs. Nwachukwu reported Ms. Hutchins admitted to leaving Resident A at the hospital because she had eaten all day, so Ms. Hutchins went home to eat.

On 5/15/25, I made a referral to the Office of Recipient Rights. The case was assigned to Recipient Rights Investigator, Avery Barnett. On 5/27/25, I made a referral to Adult Protective Services. On 6/3/25, I received a follow up call from Eryn Sherman to report the case was assigned to her for investigation.

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:	Resident A requires close supervision to ensure his safety in the home and community per his *Residential Assessment.* Resident A has a 1:1 staffing assignment in place for 15 hours per day according to licensee designee Nwachukwu. Therefore, the licensee did not provide the required supervision to Resident A for at least 3 hours on 4/17/25 when the staff left him unattended at the hospital with no AFC staff available to pick him up until the following day.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

06/11/2025

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Kara Robinson Date
Licensing Consultant

Approved By:

06/11/2025

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Dawn Timm Date
Area Manager