GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2025

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

RE: License #: AS820412578
Investigation #: 2025A0121030
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 #:	2025A0121030
Complaint Receipt Date:	05/13/2025
Investigation Initiation Date:	05/14/2025
Report Due Date:	07/12/2025
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?
Group home owner is refusing to take a resident back into her home from the hospital.	Yes

III. METHODOLOGY

05/13/2025	Special Investigation Intake 2025A0121030
05/14/2025	Special Investigation Initiated - Telephone Corewell Health Wayne Hospital
05/14/2025	Contact - Telephone call made Adeshola Hutchins, Home Manager
05/14/2025	Contact - Telephone call received Mrs. Nwachukwu, licensee designee
05/14/2025	Exit Conference Mrs. Nwachukwu
05/15/2025	Referral - Recipient Rights
05/16/2025	Contact - Telephone call made Recipient Rights Investigator, Avery Barnett
05/27/2025	APS Referral
06/03/2025	Contact - Telephone call received Eryn Sherman with APS

ALLEGATION: Group home owner is refusing to take a resident back into her home from the hospital.

INVESTIGATION: I initiated the complaint with a phone call to Laurel Lasser, Care Manager with Corewell Health. Ms. Lasser reported Resident A was admitted to Corewell Health Wayne Hospital 5/7/25 – 5/9/25. After being released on 5/9/25, Resident A returned to the hospital only a few short hours later. Resident A was initially admitted to the hospital on 5/7/25 after a failed suicide attempt. Ms. Lasser indicated Resident A tried to run into traffic directly in front of the group home. On

5/10/25, Ms. Lasser stated, “Psych cleared him” for discharged at 11:45AM. However, when hospital staff notified licensee designee Mrs. Nwachukwu that Resident A was ready for pickup, Mrs. Nwachukwu refused to do so. Therefore, Resident A remained in the emergency unit as hospital staff worked closely with Detroit Wayne Integrated Health Network to locate a new placement for the resident.

On 5/14/25, I interviewed home manager, Adeshola Hutchins. Ms. Hutchins stated that Resident A was “triggered” by my visit to the home on 5/7/25, so shortly after I left, he tried to end his life by running into oncoming traffic. Ms. Hutchins confirmed Resident A was taken to the hospital where he was admitted for 2 days. On 5/9/25, Resident A returned to the facility around noon, then by 2 o’clock, he threatened to kill himself again. Ms. Hutchins further explained Resident A was transported back to the hospital by EMS in the afternoon on 5/9/25.

I made a follow up call to Mrs. Nwachukwu on 5/14/25. Mrs. Nwachukwu acknowledged that she informed the hospital Resident A could not return to her home for safety reasons. Mrs. Nwachukwu indicated that Resident A not only placed himself at risk of harm, but her staff was almost injured while trying to redirect Resident A away from traffic. Mrs. Nwachukwu emphasized that with the home being located on a busy road, the opportunity always exists for Resident A to harm himself by running into traffic as he’s done several times since being placed in the home on 4/10/25. Therefore, Mrs. Nwachukwu is adamant that she would rather accept the rule violation than place Resident A at continued risk of harm. Mrs. Nwachukwu insists Resident A requires inpatient hospitalization, but the local hospitals will not petition him for inpatient treatment. According to Mrs. Nwachukwu the hospitals are “Doing him a disservice” by failing to admit him for psychiatric treatment. I asked Mrs. Nwachukwu if she completed an emergency discharge notice to share with the department and the guardian, and she replied, “I failed because I was traveling.” Mrs. Nwachukwu explained in her haste to leave for vacation, she forgot to complete an emergency discharge notice. Therefore, I informed Mrs. Nwachukwu that she acted in noncompliance with the discharge requirements as outlined in the rules. Mrs. Nwachukwu does not dispute the findings and recommendation of this investigation. She said she will return to the USA on 6/5/25 and at such time, she will submit an acceptable corrective action plan to address the violation.

It should be noted that a subsequent onsite inspection was not conducted to reduce the likelihood of trauma to Resident A based on my interview with the staff responsible for his care.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**

ANALYSIS:	Mrs. Nwachukwu failed to notify LARA/AFC Licensing in writing of Resident A's emergency discharge on 5/10/25. In addition, Mrs. Nwachukwu discharged Resident A from the facility before a new placement had been secured causing the resident to remain in the E.R. indefinitely.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/11/25

Kara Robinson Date
Licensing Consultant

Approved By:

06/12/2025

Dawn Timm Date
Area Manager