



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2026

Caroline Anyanetu
Eliza Home Care
10821 Continental Dr.
Taylor, MI 48180

RE: License #: AS820367743
Investigation #: 2026A0116010
Frazier Home

Dear Mrs. Anyanetu:

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,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is written in a cursive style with a large initial 'P'.

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820367743
Investigation #:	2026A0116010
Complaint Receipt Date:	12/30/2025
Investigation Initiation Date:	12/30/2025
Report Due Date:	02/28/2026
Licensee Name:	Eliza Home Care
Licensee Address:	10821 Continental Dr. Taylor, MI 48180
Licensee Telephone #:	(313) 204-3930
Administrator:	Caroline Anyanetu
Licensee Designee:	Caroline Anyanetu
Name of Facility:	Frazier Home
Facility Address:	456 Frazier Street River Rouge, MI 48218
Facility Telephone #:	(313) 438-6302
Original Issuance Date:	06/30/2015
License Status:	REGULAR
Effective Date:	12/31/2025
Expiration Date:	12/30/2027
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 12/27/2025, Resident A sat in the dining area and was eating a hamburger assisted by staff. During the meal the resident grabbed another resident's hamburger and put it into his mouth. Resident A began to cough and choke. Staff contacted 911. Emergency responders arrived and Resident A was pronounced deceased on scene. There are concerns regarding adequate supervision at the time of the incident.	No
Additional Findings	Yes

III. METHODOLOGY

12/30/2025	Special Investigation Intake 2026A0116010
12/30/2025	Special Investigation Initiated - Telephone ORR
12/30/2025	APS Referral Not required as the resident is deceased.
01/05/2026	APS referral received Complaint denied for investigation.
01/06/2026	Inspection Completed On-site Home manager, Charles Ugboajah, staff, Emeka Oguguo, Resident B, visually observed Residents C-D, reviewed December menu and staff schedule.
01/06/2026	Inspection Completed-BCAL Sub. Compliance
01/07/2026	Contact - Document Received Received and reviewed individual plans of service (IPOS) for Residents A-D.
01/07/2026	Contact - Telephone call made Licensee designee, Caroline Anyanetu.
01/15/2026	Contact - Telephone call made Staff, Kingsley Okora.

01/15/2026	Contact - Telephone call made Diega Salas, Case manager at Wayne Center.
01/20/2026	Contact - Telephone call made Public Guardian, Paul Torony. Left a message requesting a return call.
01/20/2026	Contact-Telephone call made Recipient rights investigator, Avery Barnett.
01/20/2026	Exit Conference With licensee designee, Caroline Anyanetu.

ALLEGATION:

On 12/27/2025, Resident A sat in the dining area and was eating a hamburger assisted by staff. During the meal the resident grabbed another resident's hamburger and put it into his mouth. Resident A began to cough and choke. Staff contacted 911. Emergency responders arrived and Resident A was pronounced deceased on scene. There are concerns regarding adequate supervision at the time of the incident

INVESTIGATION:

On 01/06/26, I conducted an unscheduled onsite inspection at the home and interviewed home manager, Charles Ugboajah, staff Emeka Oguguo, Resident B, visually observed Residents C-D and reviewed December 2025 staff schedule and menu. Home manager, Charles Ugboajah, reported that he was on shift on 12/27/25, along with staff Kingsley Okoro, Emeka Oguguo and Rojeta Park. Mr. Ugboajah reported that at the time the home had a total of four residents, three of which require 1:1 staffing. He reported Mr. Kingsley was Resident A's 1:1 Mr. Oguguo was Resident B's 1:1 and Ms. Park was Resident D's 1:1.

Mr. Ugboajah reported that Resident A was sitting at the table along with Resident C and Ms. Park and Mr. Oguguo were with Resident B and D getting them prepared to come to the table to eat dinner. He reported Mr. Okoro had chopped Resident A's hamburger into about 10-12 pieces and was feeding him. He reported that Resident A does not have oral dysphasia or eating guidelines, however, they cut his food up and feed him so that he doesn't stuff his mouth and choke. He reported that while Mr. Okoro was feeding Resident A, he reached over and grabbed Resident C's hamburger and stuffed the entire sandwich in his mouth. Mr. Ugboajah reported that Mr. Okoro dropped the food he had in his hands that he was preparing to feed Resident A and grabbed him trying to get the hamburger out his mouth. Resident A would not spit the food out of his mouth. Resident A began coughing and choking.

Mr. Ugboajah reported that Mr. Okoro immediately began abdominal thrusts and back blows while staff, Mr. Oguguo called 911. Mr. Ugboajah reported that EMS arrived within 5 minutes and took over. He reported that they were unable to get the sandwich dislodged and Resident A passed away. Mr. Ugboajah reported that Resident A was always properly supervised and the staff at the home go over and beyond to ensure the safety and well-being of the residents. He reported that Resident A's IPOS only requires that they cut his food up, he reported that they started feeding him as he would attempt to stuff the cut-up food in his mouth. Mr. Ugboajah reported that occasionally Resident A would attempt to grab other residents' food, but they were able to intervene before he got it in his mouth, most times.

I interviewed staff, Emeka Oguguo, and he reported that he worked the 3:00 p.m. to 11:00 p.m. shift on 12/27/25. He reported that he was the 1:1 staff assigned to Resident B. Mr. Oguguo reported that was in Resident B's bedroom getting him up so that he could come to the table to eat dinner when he heard Mr. Okoro yelling, "help call 911." He reported he immediately called 911 while Mr. Okoro was doing abdominal thrust and back blows to Resident A. He reported the police and EMS arrived in about five to six minutes and took over. He reported Resident A was still alive when they arrived because he was coughing. Mr. Oguguo reported that EMS took over but their attempts to dislodge the food and keep him alive were unsuccessful. Mr. Oguguo reported that all staff knew and would cut Resident A's food up and would feed it to him slowly to prevent him from stuffing his mouth. Mr. Oguguo reported that they served hamburgers, french fries, and some fruit, Mr. Oguguo could not recall what fruit the residents were served that day. He reported he was so focused on getting help for Resident A that everything from that day is now a blur.

I interviewed Resident B and all he was able to do was report that the police came to the home because Resident A was coughing. He reported Resident A was on the floor and the staff were trying to help him. Resident B was unable to provide any additional information.

I visually observed Residents C-D as they are non-verbal. They were neatly dressed and groomed.

I reviewed the staff schedule and confirmed that Mr. Ugboajah, Mr. Okoro, Mr. Oguguo, and Mr. Park were all on the schedule on 12/27/25, working the 3:00 p.m. to 11:00 p.m. shift. I asked Mr. Ugboajah to email me copies of Residents A-D current IPOSs.

On 01/07/26, I received and reviewed Resident A's IPOS. Resident A's plan documents that his food is to be cut up by staff. Resident A does not have eating

guidelines and no diagnosis of oral dysplasia. The IPOS also documents that Resident A required 1:1 staffing 24 hours per day.

I also reviewed the IPOSs for Residents B-D and confirmed that Residents B and D also require 1:1 staffing. Resident C does not require 1:1 staffing.

On 01/07/26, I interviewed licensee designee, Caroline Anyanetu, and she reported she was made aware of the incident by home manager, Charles Ugboajah, and was saddened to hear of Resident A's passing. Ms. Anyanetu reported that Resident A was family to her and the staff. She reported that he had no family and they were his family. Ms. Anyanetu reported that while Resident A had some health issues, he was doing much better. She reported that her staff were aware of Resident A's behaviors and the need for his food to be cut up, as he was known to overfill his mouth. Ms. Anyanetu reported that the staff not only cut his food up, but they also took the time to feed it to him as an extra precaution to prevent him from overfilling his mouth and possibly choking.

On 01/15/26, I interviewed staff, Kingsley Okora, and he reported that on 12/27/25, he was assigned to Resident A as his staff. He reported that Resident A was sitting at the kitchen table and he had cut his hamburger into about 10-12 pieces. He reported that he was standing to the left of Resident A and was feeding him. He reported that after Resident A would fully chew and swallow a piece of the hamburger, he would feed him another piece. Mr. Okoro reported that Resident A and Resident C were the only two at the table, as staff, Ms. Park, was in the bathroom assisting Resident D and Mr. Oguguo was in Resident B's bedroom getting him up and prepared to come to the table to eat. Mr. Okoro reported all of sudden Resident A reached over to Resident C's plate, grabbed his hamburger and put the entire hamburger in his mouth. He reported he dropped the plate of food he was feeding Resident A and tried to get Resident A to spit the hamburger out, however, it appeared that he had swallowed it whole. Mr. Okoro reported that Resident A began coughing and choking so he immediately got him up from the table and started abdominal thrust and back blows while yelling to the other staff to call 911. Mr. Okoro began to get emotional and cry while providing his account of what happened. He reported that when EMS arrived Resident A was still alive. He reported they took over working on Resident A to no avail. Mr. Okoro reported they were unable to dislodge the food, and they pronounced him deceased in the home. Mr. Okoro reported that Resident A was like family to him and he is overwhelmed with sadness due to his passing.

On 01/15/26, I interviewed Resident A's case manager, Diega Salas, and he reported that home manager, Mr. Ugboajah, informed him of the incident that led to Resident A's passing. Mr. Salas confirmed that Resident A did not have eating guidelines or issues with swallowing. He reported he added in Resident A's IPOS that staff should cut his food up as a way to assist Resident A with not overfilling his

mouth. He reported that the staff was not only was cutting the food up but was feeding it to him as an added precaution.

Mr. Salas reported that Resident A had a stroke in 2020 which caused some cognitive delays. He reported that although Resident A was slowly making progress, within the last few months he was becoming more impulsive.

Mr. Salas reported that he has not had any concerns regarding the care the staff provided to Resident A.

On 01/20/26, I interviewed Resident A's public guardian, Paul Torony, with Faith Connections. Mr. Torony reported that he was surprised to hear of Resident A's passing. Mr. Torony reported that the staff at the home worked really well with Resident A and that after some health issues he was making strides in the right direction. Mr. Torony reported when he visited Resident A at the home last month he was doing extremely well and reported he was answering his questions and wasn't yelling or upset. He reported that in past visits with Resident A he was echolalic (repeating or echoing what he said). Mr. Torony reported Resident A was really improving and he was glad to see the progress. Mr. Torony reported the news of his unfortunate passing is shocking and sad.

On 01/20/26, I interviewed assigned recipient rights investigator, Avery Barnett, and he reported that he has completed his investigation and did not substantiate neglect. Mr. Barnett reported that the staff was not negligent in any way and that i was really an unfortunate incident.

On 01/20/26, I conducted the exit conference with licensee designee, Caroline Anyanetu, and informed her of the findings of the investigation. Ms. Anyanetu agreed with the findings.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.

ANALYSIS:	<p>Based on the findings of the investigation, which included interviews of home manager, Charles Ugboajah, staff, Emeka Oguguo, staff, Kingsley Okoro, case manager, Diego Salas, and public guardian, Paul Torony, there is not a preponderance of evidence to substantiate the allegation.</p> <p>Resident A's IPOS documented that he required 1:1 staffing and his food should be cut up. On the day in question. Staff, Kingsley Okoro was Resident A's assigned staff who cut up his food and was feeding him, when he grabbed Resident C's hamburger, stuffed it in his mouth, swallowed it, began choking and subsequently passed away.</p> <p>This violation is not established as the licensee had sufficient staff on duty for the supervision, personal care and protection of the residents who provided the services specified in Resident A's IPOS.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/06/26, I conducted an unscheduled onsite inspection at the home and interviewed home manager, Charles Ugboajah. Mr. Ugboajah reported that on 12/27/25, the residents were fed hamburgers with cheese, lettuce, tomatoes, french fries, and mixed vegetables or broccoli. I reviewed the December 2025 menu and observed that on 12/27/25 dinner as documented on the menu was baked fish, sweet potato, baked beans, bread and milk or water. Mr. Ugboajah reported that they didn't have all of the items in the home to prepare that meal so they made a substitution to the menu. I asked Mr. Ugboajah if the substitution was documented anywhere and he reported that it was not. I informed Mr. Ugboajah that there is space on the front of their menu under each day that allows any changes to the menu to be documented. He reported that he is aware and just did not write in the substitution as required.

On 01/20/25, I conducted the exit conference with licensee designee, Caroline Anyanetu, and informed her of the findings of the investigation. Ms. Anyanetu reported an understanding and stated that she has already completed in-service training with all staff reiterating the rule requirement to document all changes to the menu in the space provided on the front of every menu.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	Based on the findings of the investigation, which included an interview with home manager, Charles Ugboajah, and my review of the December 2025 menu, there is a preponderance of evidence to substantiate that the staff did not document any change or substitutions that occurred on 12/27/25 to the dinner menu.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Pandrea Robinson
Licensing Consultant

01/21/26
Date

Approved By:



01/21/26

Ardra Hunter
Area Manager

Date