STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 15, 2021

Appolonia Okonkwo
Tender Heart Quality Care Services LLC
5083 Bedford Street
Detroit, MI 48224

RE: License #: AS820312395
Investigation #: 2021A0782020
Bedford Home

Dear Ms. Okonkwo:

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,

Andrea Green, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 236-0832

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820312395
Investigation #:	2021A0782020
Complaint Receipt Date:	03/26/2021
Investigation Initiation Date:	03/30/2021
Report Due Date:	05/25/2021
Licensee Name:	Tender Heart Quality Care Services LLC
Licensee Address:	5083 Bedford Street Detroit, MI 48224
Licensee Telephone #:	(248) 240-4413
Administrator:	Appolonia Okonkwo
Licensee Designee:	Appolonia Okonkwo
Name of Facility:	Bedford Home
Facility Address:	5083 Bedford Street Detroit, MI 48224
Facility Telephone #:	(313) 886-2125
Original Issuance Date:	10/22/2012
License **Status:**	REGULAR
Effective Date:	09/29/2020
Expiration Date:	09/28/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The complainant stated that the home failed to seek medical attention for Resident A for couple of days after she refused to eat or drink anything and became responsive.	Yes

III. METHODOLOGY

03/26/2021	Special Investigation Intake 2021A0782020
03/26/2021	Contact - Document Received APS complaint received.
03/30/2021	Special Investigation Initiated - Telephone Telephone call to complainant. Message left.
03/30/2021	Contact - Telephone call made Telephone call to complainant.
04/16/2021	Contact - Telephone call made Telephone call to Resident A's guardian Jordan Colovaj.
04/16/2021	Contact - Telephone call made Telephone call to licensee designee Appolonia Okonkwo. Message left.
04/19/2021	Contact - Telephone call received Telephone call from licensee designee Appolina Okonkwo. Message left.
06/10/2021	Contact - Telephone call made Telephone call to Resident A;s guardian.

06/10/2021	Contact - Telephone call made Telephone call to licensee designee, Appolinia Okonkwo.
06/10/2021	Contact - Telephone call made Telephone call to Erynn Sherman at Adult Protective Service.
07/13/2021	Exit Conference Exit conference call with licensee designee Appolonia Okonkwo.

ALLEGATION:

The complainant stated that the home failed to seek medical attention for Resident A for a couple of days after she refused to eat or drink anything and became unresponsive.

INVESTIGATION:

No onsite due to Covid 19.

A complaint was received from Adult Protective Service on 3/26/2021. I interviewed Erynn Sherman at APS by telephone on 3/30/2021. Ms. Sherman stated that she received the complaint from the hospital stating that the home failed to seek medical attention for Resident A in a timely manner. Ms. Sherman stated that she spoke with Resident A's guardian Jordan Colovaj. Ms. Sherman stated that Ms. Colovaj reported that she arrived at the home and observed that Resident A was unresponsive so she called 911 and had her transported to the hospital. Ms. Sherman stated that she spoke with Resident A but she could not remember anything about the incident. Ms. Sherman reported that Resident A was discharged from the hospital to Heartland Livonia nursing home and will not be returning to the AFC home. Ms. Sherman provided me with the telephone number for Resident A's guardian.

I interviewed Resident A's guardian Jordan Colovaj by telephone on 4/16/2021 and again on 6/10/2021. Ms. Colovaj stated that she had gone to the home to see Resident A on 12/28/202 and found her unresponsive. Ms. Colovaj stated that she then called 911 and had Resident A transported to the hospital. Ms. Colovaj stated that she feels the home failed to seek medical attention for Resident A in a timely manner because Resident A appeared to have been ill for a while to be at the point she was when Ms. Colovaj arrived. Ms. Colovaj stated that it was determined that Resident A was dehydrated and had a urinary tract infection after she was taken to the hospital. Ms. Colovaj stated that she did not return Resident A to the home after

her discharge from the hospital due to her concerns about the home's failure to seek timely medical attention for her.

I interviewed the licensee designee, Appolonia Okonkwo by telephone on 6/10/2021. Ms. Okonkwo stated that Resident A had been in the hospital the previous week and she was given antibiotics to treat a urinary tract infection. Ms. Okonkwo reported that Resident A was returned to the home and getting medication. Ms. Okonkwo acknowledged that Resident A had been refusing to eat or drink anything for a couple of days and had started displaying some confusion the day she was taken back to the hospital. Ms. Okonkwo stated that Resident A's guardian arrived at the home and 911 was called. Ms. Okonkwo stated that they were in agreement with Resident A's guardian about calling 911 and would have done so if she had not. Ms. Okonkwo acknowledged that Resident A's health had been deteriorating for a couple of days before the decision to call 911 was made.

I interviewed Erynn Sherman at APS again on 6/10/2021. Ms. Sherman reported that she had substantiated the complaint that the home failed to seek medical attention for Resident A immediately in a timely manner after she started to display a deterioration in her health.

I conducted an Exit conference call with licensee designee, Appolonia Okonwo, by telephone on 7/13/2021.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my interview with the Ms. Sherman at APS, Ms. Colovaj, Resident A's guardian and the licensee designee, Appolonia Okonwo, it does appear that the home did not seek medical attention immediately after there was a sudden adverse change in Resident A's physical condition. 911 was not called until Ms. Colovaj arrived at the home and spoke with the staff, therefore, violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

7/13/2021

Andrea Green — Date
Licensing Consultant

Approved By:

7/15/2021

Ardra Hunter — Date
Area Manager