GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2023

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

RE: License #: AS820288921
Investigation #: 2023A0119024
Lonia Home Care

Dear Mr. 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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820288921
Investigation #:	2023A0119024
Complaint Receipt Date:	02/10/2023
Investigation Initiation Date:	02/13/2023
Report Due Date:	04/11/2023
Licensee Name:	Tender Heart Quality Care Services LLC
Licensee Address:	5083 Bedford Street Detroit, MI 48224
Licensee Telephone #:	(248) 240-4413
Administrator:	Benneth Okonkwo
Licensee Designee:	Benneth Okonkwo
Name of Facility:	Lonia Home Care
Facility Address:	2246 W. Philidelphia Detroit, MI 48206
Facility Telephone #:	(313) 221-1939
Original Issuance Date:	03/29/2007
License **Status:**	REGULAR
Effective Date:	08/29/2022
Expiration Date:	08/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 02/04/2023, Staff- Shalonda Davis was assigned to Resident A for 1:1 staffing. Resident A was able to leave the home and put herself at risk in the community.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/10/2023	Special Investigation Intake 2023A0119024
02/10/2023	APS Referral Received
02/13/2023	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Benneth Okonkwo
02/14/2023	Inspection Completed On-site Staff- Tamika Smith, Home Manager- Liz Cole, Observed Resident A due to her disability
02/14/2023	Contact - Telephone call made Licensee Designee/ Administrator- Benneth Okonkwo
03/27/2023	Contact - Telephone call made Staff- Shalondo Davis and Ophelia Sumo
03/29/2023	Contact - Telephone call made Resident A's guardian- Monica Hernandez of Michigan Guardian Services
03/29/2023	Referral- Recipient Rights Made
03/30/2023	Exit Conference Licensee Designee- Benneth Okonkwo

ALLEGATION:

Staff- Shalonda Davis was assigned to Resident A for 1:1 staffing. Resident A was able to leave the home and put herself at risk in the community.

INVESTIGATION:

On 02/14/2023, I completed an onsite inspection and interviewed Staff- Tamika Smith and Home Manager- Liz Cole regarding the above allegations. It should be noted that I observed Resident A due of her refusal to be interviewed. Ms. Smith stated staff is supposed to be in visual sight of Resident A at all times. Ms. Smith stated if Resident A leaves the home, the staff person is supposed to go with her.

Ms. Cole stated staff is to be in visual sight of Resident A at all times. She stated Resident A usually has a behavior with evening and midnight staff. Ms. Cole stated Resident A is usually calmer during the daytime hours.

On 02/14/2023, I telephoned and interviewed Licensee Designee/ Administrator- Benneth Okonkwo regarding the above allegations. Mr. Okonkwo stated Resident A has a habit of running away and requires 1:1 staffing at all times. He stated Staff- Shalonda Davis was working as Resident A's 1:1 staff on 02/04/2023. I requested a copy of staff schedule and individual plan of service.

On 02/15/2023, I received Resident A's psychological evaluation and behavior plan dated 09/28/2022 from Wayne Center. According to Resident A's psychological evaluation and behavior plan, Resident A requires 24 hour 1:1 staffing to be within arm's length in the home and community settings. Staff supervising Resident A should remain in her immediate proximity to ensure that they can intervene in a timely and effective manner in order to ensure the safety of Resident A and/or others.

The psychological evaluation and behavioral plan further states, in the event that Resident A is going to elope from the facility or evade supervision, the following procedures should be used: either through verbal statements or physical actions, staff will attempt to direct her into a positive activity while encouraging her to remain with them. Should Resident A fail to respond to attempts to have her remain with staff and continues efforts to evade supervision, staff will follow her while encouraging her to return. If it is evident that Resident A is not going to voluntarily return to the home with assigned staff, assigned staff will contact their supervisor and the police, appraising them of the situation, and the potential risk of harm to Resident A and/or others, and will continue to follow her and maintain visual contact in order to keep the police informed of her current location and direction of travel.

The psychological evaluation and behavioral plan goes on to indicate that in the event that Resident A does evade supervision in the community and/or elopes from the home, immediately call "911", providing information in regards to her physical

description, the clothes she is wearing, and her direction of travel if known. After calling “911”, make every effort to locate Resident A and encourage her to return with staff. It is also strongly suggested that persons attempting to locate Resident A have a cell phone in their possession in order to contact police should they locate her and she continues her efforts to evade staff and/or becomes physically aggressive.

On 03/27/2023, I telephoned and interviewed Staff- Shalondo Davis and Ophelia Sumo regarding the above allegations. Ms. Davis stated she was able to see Resident A through the front window while she was outside smoking. Ms. Davis stated staff is to be in visual sight of Resident A at all times. She stated she observed Resident A go out the back door. Ms. Davis stated Resident A was on her way to the bathroom which is near the kitchen. She stated Resident A somehow exited the rear of the facility through the kitchen. Ms. Davis stated Resident A’s 1:1 staffing was with Resident A as she exited the facility. She stated she was unable to remember if she was Resident A’s 1:1 staff or if was someone else. Ms. Davis stated Resident A is known to elope to two locations either a local party store or gas station. Ms. Davis stated she put on her coat and got into her car headed to both of those locations. Ms. Davis stated Resident A could not be located and was not at either location. Ms. Davis stated she immediately called the police. She stated Resident A was returned to the facility by the police.

Ms. Sumo stated she was not able to remember the incident because Resident A often runs off from the facility. Ms. Sumo stated she recently had a surgery and is still recovering personally. Ms. Sumo stated staff often drove behind Resident A when she leaves the facility. Ms. Sumo stated staff are supposed to go after Resident A.

On 03/29/2023, I telephoned and interviewed Resident A’s guardian- Monica Hernandez of Michigan Guardian Services. Ms. Hernandez stated there are no concerns about the care of Resident A in the facility.

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:	Licensee Designee/ Administrator- Benneth Okonkwo stated Resident A has a habit of running away and requires 1:1 staffing. Mr. Okonkwo stated Ms. Davis was Resident A's 1:1 staff on 02/04/2023. Home Manager- Liz Cole, Staff- Tamika Smith, Staff- Shalonda Davis and Staff- Ophelia Sumo stated staff are supposed to be in visual sight of Resident A at all times. Ms. Smith stated if Resident A leaves the home, the staff person is supposed to go with her. Ms. Sumo stated staff are supposed to go after Resident A if she leaves the facility. According to Resident A's psychological evaluation and behavior plan, Resident A requires 24 hour 1:1 staffing to be within arm's length in the home and community settings. Staff persons supervising Resident A should remain in her immediate proximity to ensure that they can intervene in a timely and effective manner in order to ensure the safety of Resident A and/or others. Therefore, Resident A was not provided with supervision and protection as defined in the act and as specified in the resident's written assessment plan, specifically, Resident A's psychological evaluation and behavior plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/14/2023, I completed an onsite inspection and interviewed Staff- Tamika Smith regarding the above allegations. Ms. Smith was the only staff working in the facility at 10:50 a.m. the time of my arrival. Ms. Smith stated she was providing 1:1 staffing for Resident A. She stated the Home Manager- Liz Cole had recently gone to the grocery store. Ms. Smith stated there was a total of five residents in the home.

On 02/14/2023, I telephoned and notified Licensee Designee/ Administrator- Benneth Okonkwo regarding the lack of sufficient staffing in the facility. Mr. Okonkwo stated he would ensure that staff returned to the facility immediately.

I observed that Liz Cole returned to the facility at 11:03 a.m. Ms. Cole stated she left the home to get Valentine decorated food items for lunch to celebrate with the residents.

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:	At 10:50 a.m., I arrived at the facility and Staff- Tamika Smith was the only staff working in the facility at the time and there were five residents in the home. Staff- Tamika Smith stated she was providing 1:1 staffing for Resident A. She stated the Home Manager- Cole had recently went to the grocery store. At 11:03 a.m., Liz Cole returned to the facility. Ms. Cole stated she left the home to get Valentine decorated food items for lunch to celebrate with the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/29/2023

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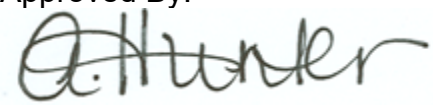
Shatonla Daniel Date
Licensing Consultant

Approved By:



03/29/2023

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Ardra Hunter Date
Area Manager