GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

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

RE: License #: AS820288921
Investigation #: 2024A0992032
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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820288921
Investigation #:	2024A0992032
Complaint Receipt Date:	05/03/2024
Investigation Initiation Date:	05/07/2024
Report Due Date:	07/02/2024
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:	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?
The staff-to-resident ratio is not adequate to properly care for the residents. There are two residents that require 1:1 staffing. On 2/10/2024, Resident A fell and there were two staff on shift.	Yes

III. METHODOLOGY

05/03/2024	Special Investigation Intake 2024A0992032
05/07/2024	Special Investigation Initiated - Telephone Complainant
05/07/2024	Contact - Telephone call made Sherry Underwood, Office of Recipient Rights (ORR)
05/07/2024	Contact - Telephone call made Unique Currington, Resident A's supports coordinator with Team mental Health. She was not available. Message left.
05/07/2024	Contact - Telephone call made William Saboto, Home and Community Based Services (HCBS)
05/07/2024	Contact - Telephone call made Nancy Foster, ORR
05/09/2024	Contact - Telephone call received Ms. Currington
05/09/2024	Contact - Document Received Resident A’s individual plan of assessment (IPOS).
05/14/2024	Contact - Telephone call made Appolonia Okonkwo, administrator
05/14/2024	Contact - Telephone call made Benneth Okonwko, licensee designee
05/17/2024	Contact - Telephone call made Ophelia Sumo, direct care staff, was not available. Message left.

05/21/2024	Contact - Telephone call received Ms. Sumo
06/03/2024	Contact - Telephone call made Tiffany Stoutermire, DCS, was not available. Message left.
06/04/2024	Contact - Telephone call received Ms. Stoutermire
06/05/2024	Contact - Telephone call made Mr. Okonwko
06/18/2024	Contact - Telephone call made Ms. Underwood
07/03/2024	Contact - Face to Face Ms. Sumo
07/03/2024	Contact - Telephone call made Mr. Okonwko
07/08/2024	Contact - Document Received Staffing schedule
07/08/2024	APS Referral
07/08/2024	Contact - Telephone call made Relative C1
07/08/2024	Exit Conference Mr. Okonwko

ALLEGATION: The staff-to-resident ratio is not adequate to properly care for the residents. There are two residents that require 1:1 staffing. On 2/10/2024, Resident A fell and there were two staff on shift.

INVESTIGATION: On 05/07/2024, I initiated telephone contact with the complainant and discussed the allegation. The complainant stated there is not adequate staffing during any of the shifts to properly care for the residents. The complainant stated Residents C and D require 1:1 staffing, which means the home should have a minimum of three staff per shift and there are never three staff. The complainant stated on 02/10/2024 when she arrived on shift, Resident B stated Resident A fell on the floor, and she notified direct care staff (DCS) Ophelia Sumo, but Ms. Sumo told her to mind their own business. The complainant stated there were only two staff on shift at that time which is not enough staffing. The complainant stated the staff on

shift were unable to provide Resident A with the care needed which led to her laying on the floor for a substantial amount of time.

On 05/07/2024, I contacted the Office of Recipient Rights (ORR), Sherry Underwood, and interviewed her regarding the allegation. Ms. Underwood confirmed she is also investigating similar allegations. She stated it was reported Ms. Sumo neglected to assist Resident A when she fell on 02/10/2024. Ms. Underwood said she interviewed the complainant, and she confirmed the allegation and made several additional allegations against the home. Ms. Underwood said it was also reported that Resident A's health declined due to not receiving adequate care while in the home. Ms. Underwood said she also spoke with Relative A1, Resident A's relative who agreed to accompany her to the nursing home to interview Resident A, but Resident A expired prior to her being interviewed. She said she attempted to contact Unique Currington, Resident A's supports coordinator with Team Mental Health regarding her knowledge of the allegation and Resident A's needs, but she was not available. Ms. Underwood stated William Saboto, Home and Community Based Services (HCBS) and Nancy Foster, ORR are also involved and might have additional insight.

On 05/072024, I contacted Mr. Saboto and interviewed him regarding the allegation. Mr. Saboto denied having any firsthand knowledge regarding the allegation. He stated he conducted a quality inspection at the home on 03/05/2024 with the complainant. He said the complainant made him aware that Resident A was hospitalized at the time. He said she did not mention any issues or concerns regarding adequate staffing or quality of care. He further stated that he did receive a follow-up call from the complainant on 4/11/2024 reporting quality of care concerns. Mr. Saboto stated he initiated an intake with the ORR compliance department. Mr. Saboto said the quality inspection is pending due to the compliance investigation.

On 05/07/2024, I contacted Ms. Foster and interviewed her regarding the allegation. Ms. Foster confirmed she is familiar with the allegation but stated she is currently investigating involving Resident B. She said it was reported that Mr. Okonwko threatened Resident B to not say anything about Resident A falling. Ms. Foster said there is currently a lot of issues between Mr. Okonwko and the complainant. She said the complainant was recently terminated.

On 05/09/2024, I contacted Ms. Currington and interviewed her regarding the allegation. Ms. Currington denied having any knowledge of the allegation. She said she is required to visit with Resident A monthly, but she has not visited with Resident A while she is in the nursing home. Ms. Currington agreed to provide me with a copy of Resident A's IPOS.

On 05/09/2024, I reviewed Resident A's IPOS. According to the IPOS, Resident A requires 24hr supervision but does not require 1:1 staffing.

On 05/14/2024, I contacted administrator, Appolonia Okonkwo, and interviewed her regarding the allegation. Mrs. Okonkwo denied the allegation and stated there is always sufficient staffing. She said Ms. Sumo was on shift and she responded appropriately. Mrs. Okonkwo stated Ms. Sumo called 911 and Resident A was transported to the hospital. She stated Resident A never returned to the home; from the hospital she was sent to a skilled nursing center. Mrs. Okonkwo provided me with a contact number for Ms. Sumo. She said Resident A does not have a guardian to her knowledge.

On 05/14/2024, I contacted licensee designee, Benneth Okonkwo, and interviewed him regarding the allegation. He stated when Resident A fell staff acted appropriately by calling 911 and Resident A was transported to the hospital. He stated although he was not on shift, he was notified by Ms. Sumo. He stated Resident A did not return to the home; she was admitted to a skilled nursing center. Mr. Okonkwo stated there is always adequate staffing on shift. He confirmed residents C and D require 1:1 staffing and there are three staff per shift. Mr. Okonkwo stated his former home manager does not like Ms. Sumo and kept suggesting she be terminated. Mr. Okonkwo stated multiple allegations have been reported against the home since the home manager was terminated on 04/17/2024.

On 05/21/2024, I received a telephone call from Ms. Sumo. I interviewed her regarding the allegation, which she denied. Ms. Sumo said it was early morning and she heard a loud noise. Ms. Sumo said her and direct care staff Tiffany Stoutermire, went in Resident A's bedroom and observed her on the floor. She said they assisted Resident A back on her bed, but Resident A was very weak. Ms. Sumo said she called 911 and Resident A was transported to the hospital. Ms. Sumo said it was early in the morning approximately 4:30 a.m.- 5:30 a.m. and the other residents were asleep.

On 06/04/2024, I received a telephone call from Ms. Stoutermire; I interviewed her regarding the allegation. Ms. Stoutermire stated that she was on shift along with Ms. Sumo when Resident A fell. Ms. Stoutermire statements were consistent with the statements Mrs. Okonkwo and Ms. Sumo provided me during their interview. Ms. Stoutermire stated she suspects the false allegation was reported by the complainant as retaliation for being terminated. She stated the complainant does not like Ms. Sumo and would do different things to try and jeopardize her employment.

On 07/05/2024, I completed an unannounced onsite and reviewed residents B-F's assessment plan and individual plan of service. According to resident B and E's adult foster care assessment plan, neither resident requires 1:1 staffing; Resident F's IPOS does not specify 1:1 staffing. As for residents C and D, both residents require 1:1 staffing. resident D's 1:1 staff must be within arms-length in the home and community.

Ms. Sumo was on shift, I asked her for a copy of the staff schedule. She stated the schedule is sent to the staff electronically. Ms. Sumo was able to access June 2024

schedule on her cell phone. Based on the schedule I observed two staff scheduled for the 12 a.m. to 8 a.m. shift; three staff for the 8 a.m. to 4 p.m. shift and two staff for the 4 p.m. to 12 a.m. shift.

On 07/05/2024, I contact Mr. Okonkwo regarding the staff schedule. He explained that he was using a paper schedule but had to change the system he was using for accuracy purposes. He stated the DCS were abusing the system and fraudulently reporting hours. He stated since 04/2024 he has been using an electronic scheduling system that he sends the staff weekly. Mr. Okonkwo stated he can send physical copies of the staffing schedule from 01/2024 through 04/2024, but he does not have physical copies from 05/2024 to present.

On 07/08/2024, I contacted Relative C1 and interviewed her regarding the allegation. Relative C1 denied having any concerns regarding adequate staffing. She explained that Resident C1 requires 1:1 staffing and based on her knowledge he has 1:1 at all times. She stated his 1:1 staff goes to the program with him on Monday, Wednesday, and Fridays. Relative C1 further stated that she picks Resident C1 up two days a week and there are always at least two staff in the home. She said it is possible there are more staff on shift but because the home is big, she does not see everyone. Relative C1 denied having any concerns.

On 07/08/2024, I completed an exit conference with Mr. Okonkwo and discussed my findings. I made him aware that although the schedule he provided indicates there were three staff on all shift, it has been determined that there are not three staff on every shift regularly. I told Mr. Okonkwo that he has to enforce the schedule. I further explained that although he is using an electronic system to generate the staff schedule, he must be able to physically print out the schedule; he agreed to look into it. I made him aware that there is evidence to support the allegation that was insufficient staff on duty for the supervision, personal care, and protection of residents as specified in the resident's assessment plan. Mr. Okonkwo explained that he has made some changes to the staffing schedule and to ensure there are always three staff on shift. Based on the findings, I made Mr. Okonkwo aware the allegation is substantiated, and a written corrective action plan is required. Mr. Okonkwo denied having any questions or concerns. He agreed to review the report and contact me if necessary.

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:	Based upon my investigation, which consisted of multiple interviews with Benneth Okonkwo, licensee designee; Appolonia Okonkwo, administrator; Ophelia Sumo and Tiffany Stoutermire, direct care staff; Sherry Underwood, ORR; William Saboto, HCBS, Nancy Foster, ORR; Unique Currington, Resident A's supports coordinator with Team Mental Health; Relative C1, Residents C's guardian; and a review of documentation including Residents A-F's IPOS and adult foster care assessment plan. There is sufficient evidence to substantiate the allegation that Mr. Okonkwo did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents as specified in the resident's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/10/2024

Denasha Walker Date
Licensing Consultant

Approved By:

07/11/2024

Ardra Hunter Date
Area Manager