



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

February 12, 2026

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

RE: License #: AS820312395  
Investigation #: 2026A0778011  
Bedford Home

Dear Mr. Okonkwo:

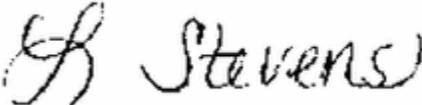
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 456-0439.

Sincerely,

A handwritten signature in black ink that reads "L Stevens". The "L" is stylized with a large loop, and "Stevens" is written in a cursive script.

LaKeitha Stevens, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 949-3055

enclosure

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

**I. IDENTIFYING INFORMATION**

|                                       |   |
|---------------------------------------|---|
| <b>License #:</b>                     | AS820312395   |
| <b>Investigation #:</b>               | 2026A0778011  |
| <b>Complaint Receipt Date:</b>        | 12/15/2025  |
| <b>Investigation Initiation Date:</b> | 12/17/2025  |
| <b>Report Due Date:</b>               | 02/13/2026  |
| <b>Licensee Name:</b>                 | Tender Heart Quality Care Services LLC  |
| <b>Licensee Address:</b>              | 5083 Bedford Street<br>Detroit, MI 48224  |
| <b>Licensee Telephone #:</b>          | (248) 240-4413  |
| <b>Administrator:</b>                 | Benneth Okonkwo   |
| <b>Licensee Designee:</b>             | Benneth Okonkwo   |
| <b>Name of Facility:</b>              | Bedford Home  |
| <b>Facility Address:</b>              | 5083 Bedford Street<br>Detroit, MI 48224  |
| <b>Facility Telephone #:</b>          | (313) 886-2125  |
| <b>Original Issuance Date:</b>        | 10/22/2012  |
| <b>License Status:</b>                | REGULAR   |
| <b>Effective Date:</b>                | 09/29/2024  |
| <b>Expiration Date:</b>               | 09/28/2026  |
| <b>Capacity:</b>                      | 6   |
| <b>Program Type:</b>                  | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED<br>TRAUMATICALLY BRAIN INJURED |

**II. ALLEGATION(S)**

|  | <b>Violation<br/>Established?</b> |
|--|-----------------------------------|
| Prescribed medication was withheld by staff despite being provided by the residents' family. | Yes                               |

**III. METHODOLOGY**

|            |   |
|------------|---|
| 12/15/2025 | Special Investigation Intake<br>2026A0778011  |
| 12/15/2025 | APS Referral<br>Received  |
| 12/16/2025 | Referral - Recipient Rights<br>Made   |
| 12/17/2025 | Special Investigation Initiated - On Site<br>Face to face with staff Tatiana Reed, Quanesha Grier and<br>Resident A |
| 01/20/2026 | Contact - Telephone call made<br>Telephone interview with home manager, Appolonia Okonkwo                           |
| 01/20/2026 | Contact - Telephone call made<br>Telephone interview with Office of Recipient Rights, Charles<br>Carter             |
| 01/20/2026 | Exit Conference<br>Telephone exit conference with licensee designee, Benneth<br>Okonkwo                             |

**ALLEGATION: Prescribed medication was withheld by staff despite being provided by the residents' family.**

**INVESTIGATION:** On 12/17/2025, I completed an unannounced onsite inspection. I interviewed staff, Tatiana Reed and Resident A. Staff, Tatiana indicated Resident A was admitted to the facility on October 9, 2025. She stated when he was admitted he came to the facility with a bunch of bags and some medications. She stated she called the manager, Appolonia Okonkwo, regarding his medications and was informed to only give him medication that was listed on his discharge paperwork from Guardian City Hospital. Tatiana indicated Appolonia informed her if the

medication was not on the list, it cannot be administered. Tatiana further stated Resident A informed her his doctor prescribed him Oxycodone. However, she did not administer it due to the directions of Appolonia.

While onsite I interviewed Resident A. Resident A stated he is his own guardian. He indicated he is prescribed several medications for pain management. He indicated the facility refused to give him his Oxycodone medication because it was not listed on his hospital discharge form. Resident A indicated he submitted a letter from his doctor and that's when he was able to obtain his prescribed medication. According to Resident A, he went a month without his pain medication.

During my onsite inspection I reviewed Resident A's medication log. Resident A is prescribed Oxycodone Acetaminophen 1-2 tablets a day as needed. The first day Resident A received his medication was November 15, 2025, even though he was admitted to the facility on October 9, 2025.

On 01/20/2026, I completed a telephone interview with Office of Recipient Rights Officer, Charles Carter. He stated his complaint was substantiated. Mr. Carter stated he received his complaint a couple of months ago and was able to complete an onsite inspection. He stated Resident A should have received his medication. According to Mr. Carter, Resident A's medication was in original packaging from CVS pharmacy. He stated the medication was prescribed by another doctor and was not documented on his discharge sheet from the hospital. However, the facility could have called to verify since it was in its original packaging with the doctor's information listed. According to Mr. Carter, when he went to the facility in November of 2025, the medication was locked in a drawer but unadministered.

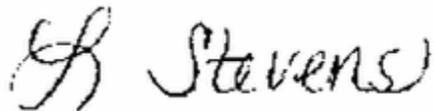
On 01/20/2026, I completed a telephone interview with the home manager, Appolonia Okonkwo. She indicated she advised staff, Tatiana, to give Resident A prescribed medication or medication with a doctor's note. She indicated staff did not understand her directions. She stated Resident A should have received his medication, but her directions were not appropriately adhered to.

On 01/20/2026, I completed a telephone exit conference with licensee designee, Benneth Okonkwo. He was informed this complaint will be substantiated. I informed Benneth, Resident A did not receive medication that he was prescribed. He indicated he was aware of the violation and will submit a corrective action plan. He indicated staff are now aware of the need to verify all medication even if it's not listed on a hospital discharge form. He indicated staff was confused because the medication came from Resident A's mother and did not think to call the pharmacy to verify.

|                        |  |
|------------------------|--|
| <b>APPLICABLE RULE</b> |  |
| <b>R 400.675</b>       | <b>Resident medications.</b>   |
|                        | <b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>  |
| <b>ANALYSIS:</b>       | <p>Resident A is prescribed Oxycodone Acetaminophen take 1-2 tablets a day as needed. Resident A was admitted to the facility on October 9, 2025, and did not receive his medication until November 15, 2025.</p> <p>Resident A stated the facility had his prescribed medication but made him go a month without receiving it. Resident A stated he was in tremendous pain.</p> <p>Office of Recipient Rights, Charles Carter, indicated he observed the medication to be in its original pharmacy container with all required documentation on the label. He stated staff did not call to verify validity, instead they refused to administer.</p> <p>Appolonia Okonkwo indicated staff did not clearly understand her directive when she advised them of the administration of Resident A's medication.</p> |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>   |

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend this complaint is closed and the status of the license remains unchanged.



02/10/2026

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LaKeitha Stevens  
Licensing Consultant

Date

Approved By:



02/12/2026

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Ardra Hunter  
Area Manager

Date