GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 11, 2026

Benneth Okonkwo
Tender Hearts, Inc.
2708 Oakman Court
Detroit, MI 48238

RE: License #: AS820400485
Investigation #: 2026A0901013
Phipps Manor

Dear Benneth 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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820400485
Investigation #:	2026A0901013
Complaint Receipt Date:	12/15/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/13/2026
Licensee Name:	Tender Hearts, Inc.
Licensee Address:	2708 Oakman Court Detroit, MI 48238
Licensee Telephone #:	(248) 240-4413
Administrator:	Benneth Okonkwo
Licensee Designee:	Benneth Okonkwo
Name of Facility:	Phipps Manor
Facility Address:	27229 Phipps Street Inkster, MI 48141
Facility Telephone #:	(313) 451-8771
Original Issuance Date:	10/23/2020
License Status:	REGULAR
Effective Date:	04/23/2025
Expiration Date:	04/22/2027
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

I. ALLEGATION(S)

	Violation Established?
Staff left the medication cabinet unsecured.	Yes
Staff failed to administer medication and falsified medication records.	No
Staff, Ophelia, antagonizes Resident A and yells at her.	No

II. METHODOLOGY

12/15/2025	Special Investigation Intake 2026A0901013
12/15/2025	APS Referral
12/17/2025	Special Investigation Initiated - On Site
12/18/2025	Referral - Recipient Rights
12/18/2025	Contact - Telephone call made Guardian, Damon Watkins
12/18/2025	Contact - Telephone call made Staff, Angel Oke
12/18/2025	Contact - Telephone call made Case Manager, Bianca Carr
01/06/2026	Exit Conference Licensee designee, Benneth Okonkwo

ALLEGATION:

Staff left the medication cabinet unsecured.

INVESTIGATION:

On 12/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. She said on 12/08/2025, the medication cabinet was open, and she grabbed her medication logbook while meeting with her nurse and guardian.

During the onsite inspection on 12/17/2025, I interviewed the home manager Ophelia Sumo. She explained that Angel Oke was the staff working at the time. Ophelia took another resident on an appointment and called Angel to get some information she needed out the resident's book, which was in the medication cabinet. When Angel got the book out of the cabinet, she forgot to lock it back and Resident A was able to access it.

On 12/28/2025, I made a telephone call to Damon Watkins, Resident A's guardian case manager from Faith Connections. He confirmed the allegations. He stated he was present at the facility, along with Resident A's nurse, when Resident A opened the cabinet and got her own medication and logbook.

On 12/18/2025, I made a telephone call to Angel. She stated she was initially sitting at the table next to the medication cabinet doing paperwork. Ophelia called and needed her to get something out of the cabinet. She got what she needed and moved to the living room with the papers to search for the information Ophelia needed and because Resident A was having a meeting at the table. Angel said she forgot to lock the cabinet back and Resident A opened it and took her medication book out.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.

ANALYSIS:	Based on the information obtained during this investigation, the allegations are confirmed. The residents' prescription medications were not kept locked in a cabinet or drawer as required. Angel forgot to lock the medication cabinet after accessing it, thus Resident A was able to retrieve her medication and medication logbook from it.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff failed to administer medication and falsified medication records.

INVESTIGATION:

On 12/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. She denied the allegations. She said she thought staff forgot to administer her antibiotic, but she actually finished it and stated one day she refused to take it.

On 12/17/2025, I interviewed the home manager Ophelia Sumo. She stated they gave Resident A her antibiotic as prescribed and that she refused one of the doses. Ophelia showed me the medication log sheets which showed her medications initialed as administered and it documented that on 12/09/2025 Resident A refused her morning dose of antibiotic, Azithromycin.

On 12/18/2026, I made a telephone call to Damon Watkins, Resident A's guardian case manager from Faith Connections. He stated initially he thought there were medication errors but realized he misread what he saw on the log sheets. He stated there were no errors and that Recipient Rights did not find medication errors either.

On 12/18/2025, I made a telephone call to Resident A's case manager, Bianca Carr, from Community Living Services. She had no concerns with the care Resident A is receiving at the facility. She said to her knowledge she is getting her medications as prescribed and Resident A has not reported the contrary.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A is not getting her medication as prescribed and that staff is not completing the medication log as required. Resident A and her guardian denied the allegations and the medication log sheets were observed to be accurately filled out.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff, Ophelia, antagonizes Resident A and yells at her.

INVESTIGATION:

On 12/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. She denied the allegations. She stated she did not have any problems with Ophelia but felt she liked some of the other residents better than her. Resident A could not explain why she felt this way.

On 12/17/2025, I interviewed the home manager, Ophelia Sumo. She denied the allegations and stated she never mistreated Resident A.

On 12/18/2026, I made a telephone call to Damon Watkins, Resident A's guardian case manager from Faith Connections. He stated Resident A never mentioned any mistreatment to him and that he did not suspect any.

On 12/18/2025, I made a telephone call to Resident A's case manager, Bianca Carr, from Community Living Services. She said Resident A never reported any mistreatment by staff to her.

On 01/06/2026, I made a telephone call to the licensee designee, Benneth Okonkwo, for an exit conference. I informed him of my investigative findings, which he conveyed he understood and would send a corrective action plan.

APPLICABLE RULE	
Rule 681. (1)	**Resident rights; licensee responsibilities.**
	A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information obtained there is a lack of evidence to confirm the allegations. There is no indication that Resident A was not treated with dignity and respect. She denied being yelled at and antagonized by Ophelia and Ophelia denied the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

_____02/05/2026

Regina Buchanan — Date
Licensing Consultant

Approved By:

02/11/2026

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Ardra Hunter — Date
Area Manager