GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2023

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

RE: License #: AS820400485
Investigation #: 2023A0901024
Phipps Manor

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,

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 #:	2023A0901024
Complaint Receipt Date:	04/04/2023
Investigation Initiation Date:	04/05/2023
Report Due Date:	06/03/2023
Licensee Name:	Tender Hearts, Inc.
Licensee Address:	2708 Oakman Court Detroit, MI 48238
Licensee Telephone #:	(248) 240-4413
Administrator:	Appolonia 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:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 04/01/2023, direct care staff, Demario Metcalf went outside to smoke. Resident A locked him outside and began to stab other residents.	Yes

III. METHODOLOGY

04/04/2023	Special Investigation Intake 2023A0901024
04/05/2023	Special Investigation Initiated - Telephone Licensee Designee, Benneth Okonkwo
04/05/2023	Referral - Recipient Rights
04/06/2023	APS Referral
04/11/2023	Inspection Completed On-site Residents B and C
04/12/2023	Contact - Telephone call made Resident A's Case Manager
04/13/2023	Contact - Telephone call made Staff, Demario Metcald
05/16/2023	Exit Conference Licensee Designee, Benneth Okonkwo
05/17/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 04/01/2023, direct care staff, Demario Metcald went outside to smoke. Resident A locked him outside and began to stab other residents.

INVESTIGATION:

On 04/05/2023, I reviewed the incident report, which was received by the assigned licensing consultant, D. Walker. It was dated for 04/01/2023 and was written by staff, Demario Metcald. It indicated that Mr. Metcald went outside to smoke and Resident A came outside and attempted to punch him. Resident A went in the house and came back outside with a knife and tried to stab Mr. Metcald. He then went back in the house and locked Mr. Metcald outside and began to stab other residents. Mr. Metcald went to the neighbor's house and called 911. The police arrived and kicked the door in. Resident A barricaded himself and Resident B in the room. He was removed from the home and the two residents that were stabbed were transported to the hospital. They were treated for their injuries and are back at the facility.

On 04/05/2023, I made a telephone call to the licensee designee, Benneth Okonkwo. He explained that on 04/01/2023, Demario Metcald, was the only staff on duty during the time of the incident. He was on the porch having a cigarette break at the time. Resident A came outside and tried to punch him. He then went in the house and came back with a knife and tried to stab Mr. Metcald. Resident A quickly went back inside the house and locked the door. Since Mr. Metcad could not get back inside, he went to a neighbor's house and called the police. The police came and kicked that door in, and it was discovered that Resident A had stabbed Residents B and C, who were taken to the hospital. Resident A was taken by the police. It was unknown if he was in jail or in the psychiatric hospital. Mr. Okonkwo indicated he would not be returning to the facility. He further reported that there was no indication that something of this nature would occur. Since being in the home, Resident A was sometimes verbally aggressive toward staff, but was never violent and always got along well with the other residents.

On 04/11/2023, I conducted an onsite inspection at the above facility and interviewed Resident C. He stated he was in his bedroom asleep at the time of the incident. Resident A came in there and began beating him and cutting him with a butcher knife. He was cut on his right arm and stomach. Resident C ran to the bathroom and locked the door and screamed for help until the police came. He also stated he was very surprised this happened because Resident A was a very nice guy. He described him as being one of the nicest people you could ever meet. He stated all the residents got along well with Resident A and he was a very helpful person.

On 04/12/2023, I interviewed Resident B. She stated she was in her bedroom taking a nap during the incident occurred. She heard Resident C yell "he got a knife." She

cracked opened her door and saw Resident C running to the bathroom and he was covered with blood. She went back inside her room. She looked out the window and saw Mr. Metcald at the neighbor's house. Resident A came in her room and stabbed her on the arm. After he cut her, he sat on her bed and rocked back and forth with the knife in his hand. She was scared to move because she did not want him to attack her again. When she heard the police outside, she yelled that she had been stabbed. The police kicked in the door, tased Resident A, and took him away. Resident C further stated that she never had any problem with Resident A. Although he was sometimes argumentative with staff, he got along well with her and everyone else in the home.

On 04/12/2023, I made a telephone call to Resident A's case manager, Nina Orlowski, from Washtenaw Community Mental Health. She stated Resident A did not require 1:1 supervision and did not have a history of assaultive behavior. She indicated this was his first time in residential placement. There was an incident in the past in which he had punched someone but during this time he was living in the community and had substance abuse issues and was not receiving mental health services. Since his placement in the home, he was doing very well. He was compliant with services and was not having behavior issues. She also stated Resident A was currently at the Wayne County jail.

On 04/13/2023, I made a telephone call to Mr. Metcald. He reiterated what was previously reported by Mr. Okonkwo and what was documented in the incident report. He said he was the only staff on duty at the time and was taking a cigarette break when the incident occurred. He indicated Resident A was never aggressive toward the residents before and his behavior that day was totally unpredictable.

On 05/17/2023, I made a telephone call to Mr. Okonkwo for an exit conference. I informed him of my investigative findings, which he disagreed with. I explained that AFC requires 24-hour supervision and when Mr. Metcald, who was the only staff on duty, went outside for a break, that left the residents unsupervised. He felt that since Mr. Metcald was on the porch, the residents were not unsupervised.

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 on the information obtained during this investigation, there was not sufficient staff on duty at the time of the incident. Mr. Metcald was the only staff on duty when he took a cigarette break on the porch, leaving the residents inside the house unsupervised. This subsequently led to him being locked out of the house and Residents B and C being injured.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/17/2023

Regina Buchanan — Date
Licensing Consultant

Approved By:

05/18/2023

Ardra Hunter — Date
Area Manager