



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AS820288921
Investigation #: 2023A0992033
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,

A handwritten signature in black ink, appearing to read 'D Walker', with a horizontal line extending to the right.

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 #:	2023A0992033
Complaint Receipt Date:	07/18/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	08/17/2023
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

II. ALLEGATION(S)

	Violation Established?
On 07/10/2023, while visiting Tender Heart Quality Care Services, LLC the menu was not dated, raw vacuum-packed fish was thawing in the sink, the bathroom downstairs had no shower curtain, no towels and the wall by the sink was rotted. The bathroom upstairs had no towels, and 2 of the 3 bulbs were missing.	Yes
One resident was not well groomed, was missing teeth and had facial hair on her face.	No
Additional Findings	Yes

III. METHODOLOGY

07/18/2023	Special Investigation Intake 2023A0992033
07/19/2023	Contact - Telephone call made Complainant, not available. Unable to leave a message.
07/19/2023	Special Investigation Initiated - Face to Face Liza Cole, home manager
07/21/2023	APS Referral
07/21/2023	Contact - Telephone call made Complainant
07/21/2023	Contact - Telephone call made Benneth Okonkwo, licensee designee
07/24/2023	Referral - Recipient Rights
07/24/2023	Contact - Telephone call received Jerri Sterrett, Office of Recipient Rights (ORR)

ALLEGATION: On 07/10/2023, while visiting Tender Heart Quality Care Services, LLC the menu was not dated, raw vacuum-packed fish was thawing in the sink, the bathroom downstairs had no shower curtain, no towels and the wall by the sink was rotted. The bathroom upstairs had no towels, and 2 of the 3 bulbs were missing.

INVESTIGATION: On 07/19/2023, I completed an unannounced onsite inspection and interviewed Liza Cole, home manager regarding the allegations. Ms. Cole said the menu is always posted. She said she recently updated to include more variety, but it remains posted on the refrigerator daily, which I observed. Although the menu is not dated, the dishes (breakfast, lunch, and dinner) are listed by the day (Monday, Tuesday, Wednesday and etc) for the month. Ms. Cole said she was not present on 07/10/2023 and denied having any knowledge of food thawing out in the sink. She said typically the food thaws out in the refrigerator so that it can be prepared for dinner. Ms. Cole confirmed there are two full bathrooms, one on each level of the home. She escorted me to the bathroom on the second floor. The shower/bathtub area was not equipped with a shower curtain for individual privacy. Ms. Cole said she had to throw the shower curtain away because of Resident E's incontinence. She further stated that Resident E often destroys the shower curtain. I suggested purchasing plastic shower liners to protect the actual curtain which can be easily replaced. The wall on the right side of the sink was not in good repair, it appears as though black tape or some black material was applied to the wall and painted in attempt to repair it. Underneath the sink the access panel to the water pipes was not securely fastened to the wall. The blinds in the bathroom were broken and not in good repair. I did not observe any towels in the bathroom. I asked Ms. Cole about the towels and linen. She showed me the linen closet, the linen closet did not contain any washcloths and the towels were minimal. Ms. Cole agreed the towel supply is limited; she said the dryer is broke. She said last week it was making a loud noise and stopped working. I observed the broken dryer in the basement. Ms. Cole said Benneth Okonkwo, licensee designee is aware and is in the process of replacing the dryer. She the residents have towels in their bedroom, which I observed. Ms. Cole said normally the linen closet is fully stocked. The shower/bathtub area in the bathroom on the main level was not equipped with a shower curtain for individual privacy. Accurate lightening was observed in both bathrooms.

On 07/21/2023, I contacted the Complainant regarding the allegation. The Complainant explained home visits are conducted as a part of an audit on behalf of social security. The Complainant further stated that during the audit the reported deficiencies were observed.

On 07/24/2023, I received a call from Jerri Sterrett, ORR. Ms. Sterrett made me aware that she was assigned the intake and will be investigating the allegations.

APPLICABLE RULE	
R 400.14402	Food service.
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	<p>During this investigation, I interviewed Benneth Okonkwo, licensee designee and Liza Cole, home manager regarding the allegation. All of which denied the allegation. Ms. Cole denied having any knowledge of food thawing out in the sink and said typically the food thaws out in the refrigerator so that it can be prepared for dinner.</p> <p>At the time of arrival, I did not observe any food thawing on the sink.</p> <p>There is insufficient evidence to support the allegation that the food was not protected from contamination while being stored, prepared, or served. The allegation is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	Resident nutrition.
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	<p>At the time of arrival, I observed the menu posted on the refrigerator. Although the menu is not dated, the dishes (breakfast, lunch, and dinner) are listed by the day (Monday, Tuesday, Wednesday and etc) for the month.</p> <p>There is insufficient evidence to support the allegation that the menu was not written at least 1 week in advance and posted. The allegation is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14407	Bathrooms.
	(2) Toilets, bathtubs, and showers shall provide for individual privacy.
ANALYSIS:	At the time of arrival, I observed the shower/bathtub areas in both bathrooms were not equipped with a shower curtain for individual privacy. There is sufficient evidence to support the allegation and the allegation is substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	At the time of arrival, the wall on the right side of the sink in the bathroom on the second level was not in good repair, it appears as though black tape or some black material was applied to the wall and painted in attempt to repair it. There is sufficient evidence to support the allegation, the wall is not finished, easily cleanable or in good repair. The allegation is substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14411	Linens.
	(3) A licensee shall provide bath towels and washcloths. Towels and washcloths shall be changed and laundered not less than twice weekly or more often if soiled.

ANALYSIS:	<p>During this investigation, I interviewed Benneth Okonkwo, licensee designee and Liza Cole, home manager regarding the allegation. Ms. Cole agreed the towel supply is limited because the dryer is broke.</p> <p>I did not observe any towels in the bathroom. The linen closet did not contain any washcloths and the towels were minimal. I observed the broken dryer in the basement. Based on the investigative findings, there is sufficient evidence to support the allegation. The allegation is substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: One resident was not well groomed, was missing teeth and had facial hair on her face.

INVESTIGATION: On 07/19/2023, I completed an unannounced onsite inspection and interviewed Liza Cole, home manager regarding the allegations. Ms. Cole denied the allegation and escorted me to the bedrooms of the female residents. I observed personal items hygiene items including combs, brushes, mouth wash, toothbrush, toothpaste, and female products. Ms. Cole said all the residents, especially the women are afforded grooming opportunities. She said she have a good relationship with all the residents, and they can come to her for anything. Ms. Cole said she will provide instructions and assistance when needed. She said 2 of 6 residents are considered medically fragile and sometimes require more assistance than others. She also mentioned that 2 of 6 residents require 1:1 staffing, and they receive assistance from their assigned staff. I observed Residents A-F, all of which appeared to be clean, well-groomed and adequately dressed. Residents A, B, C and E denied the allegation and having any concerns. I observed Resident D sleeping and Resident F was observed walking in the community with her 1:1 staff.

On 07/21/2023, I contacted the Complainant regarding the allegation. The Complainant was unable to provide me with identifying information regarding the reported resident. The Complainant said due to confidentiality the resident cannot be identified. I explained that without identifying information, I am unable to address the allegation; the Complainant said unfortunately she cannot provide any additional information.

On 07/21/2023, I contacted Mr. Benneth Okonkwo and made him aware of the reported allegations. Mr. Okonkwo confirmed he is aware of the reported allegations and is working on the repairs. I made Mr. Okonkwo aware while onsite, I observed broken blinds throughout the home, the chirping smoke detector, the broken coffee table, and the dust throughout the home. Mr. Okonkwo said he will repair all the violations. As it pertains to food thawing on the sink, menus not being dated and the

residents not having sufficient grooming opportunities; I made aware that there is insufficient evidence to support those allegations. I conducted an exit conference and made Mr. Okonkwo aware that based on the cited violations, a corrective action plan is required, which he agreed to submit.

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(3) A licensee shall afford a resident opportunities, and instructions, when necessary, to obtain haircuts, hair sets, or other grooming processes.
ANALYSIS:	<p>During this investigation, I interviewed Benneth Okonkwo, licensee designee and Liza Cole, home manager, Resident A -E and the Complainant regarding the allegation.</p> <p>The Complainant was unable to provide any additional information including the identity of the resident due to confidentiality.</p> <p>I observed Residents A-F, all of which appeared to be clean, well-groomed and adequately dressed. I also observed personal items hygiene items including combs, brushes, mouth wash, toothbrush, toothpaste, and female products.</p> <p>Based on the investigative findings, there is insufficient evidence that the licensee failed to afford the residents opportunities, and instructions, when necessary, to obtain haircuts, hair sets, or other grooming processes. The allegation is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/19/2023, I completed an unannounced onsite inspection at the facility. Ms. Cole escorted me through the home, I noticed the blinds in residents A, B and C bedrooms were broken and not in good repair. The walls and ceiling in Resident B's bedroom are heavily stained. The flooring in residents D and E is stained and worn. Resident E's mattress protector was discolored and dirty. The leg on the coffee table in the living room is broken and the table was leaning. The microwave in the kitchen

does not work. The smoke detectors were chirping throughout the home. There was a heavy presence of dust throughout the home.

APPLICABLE RULE	
R 400.14505	Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions and changes of category.
	(4) Detectors shall be tested, examined, and maintained as recommended by the manufacturer.
ANALYSIS:	At the time of inspection, I could hear a smoke detector chirping throughout the home.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	At the time of inspection, the furnishings and housekeeping standards did not present a comfortable, clean, and orderly appearance.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



07/26/2023

Denasha Walker
Licensing Consultant

Date

Approved By:



07/31/2023

Ardra Hunter
Area Manager

Date