GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2024

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

RE: License #: AS820312395
Investigation #: 2024A0992047
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) 456-0380.

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 #:	AS820312395
Investigation #:	2024A0992047
Complaint Receipt Date:	08/01/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	09/30/2024
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:	Bedford Home
Facility Address:	5083 Bedford Street Detroit, MI 48224
Facility Telephone #:	(313) 886-2125
Original Issuance Date:	10/22/2012
License Status:	REGULAR
Effective Date:	09/29/2022
Expiration Date:	09/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 06/22/2024, Resident A was not properly supervised, he eloped from the home. Resident A requires 1:1 staffing.	Yes

III. METHODOLOGY

08/01/2024	Special Investigation Intake 2024A0992047
08/01/2024	APS Referral Denied
08/01/2024	Special Investigation Initiated - Telephone Resident A's case manager, Nichole Birk with Neighborhood services organization (NSO), was not available. Message left.
08/06/2024	Contact - Telephone call made Ms. Birk
08/06/2024	Contact - Telephone call made Probate Legal Assistant, Tamiko Smith was not available. Message left.
08/07/2024	Contact - Telephone call received Ms. Smith
08/07/2024	Contact - Document Received Resident A's individual plan of services (IPOS) addendum.
08/13/2024	Inspection Completed On-site Direct care staff Tatiana Reed; direct care staff Gabriel Komolafe and Resident A.
08/13/2024	Contact - Telephone call made Licensee designee, Benneth Okonkwo
09/11/2024	Contact - Telephone call made Mr. Okonkwo was not available. Message left.
09/13/2024	Contact - Telephone call made Mr. Komolafe

09/13/2024	Exit Conference Mr. Okonkwo was not available. Message left.
09/16/2024	Exit Conference Mr. Okonkwo

ALLEGATION: On 06/22/2024, Resident A was not properly supervised, he eloped from the home. Resident A requires 1:1 staffing.

INVESTIGATION: On 08/06/2024, I contacted Resident A's case manager, Nichole Birk with Neighborhood Services Organization (NSO) regarding the allegation. Ms. Birk stated Resident A has behavioral issues and requires 1:1 staffing. She stated Resident A is not receiving adequate supervision at the home and that is concerning. Ms. Birk stated Kemp Law is Resident A's guardian and can provide additional information.

On 08/07/2024, I contacted Kemp Law Probate Legal Assistant, Tamiko Smith regarding the allegation. Ms. Smith stated Resident A continuously elopes from the home, although he is supposed to have 1:1 staffing at all times. Ms. Smith stated 1:1 staffing was implemented in 2018 and there are some concerns that he is not receiving adequate supervision, which is evidenced by multiple elopements. Ms. Smith stated on 06/22/2024, Resident A eloped from the home and suffered a heat stroke while in the community. She stated he was transported to the hospital by the police and/or the emergency medical services (EMS). I asked Ms. Smith if she has a copy of Resident A's individual plan of service (IPOS), and she said yes. Ms. Smith agreed to provide me with a copy of his IPOS.

On 08/07/2024, I reviewed Resident A's IPOS. According to the IPOS "Client (Resident A) will decrease behaviors with the assistance of 1:1 care in their AFC home." The IPOS does not specify 1:1 staffing detail such as timeframes, line if sight, arm's length, etc.

On 08/13/2024, I completed an unannounced on-site inspection. I interviewed direct care staff Tatiana Reed; direct care staff Gabriel Komolafe and Resident A were present. Ms. Reed confirmed Resident A did elope and she provided me a copy of the incident report (IR). She stated she was not on shift when the incident occurred and denied having any additional information, other than what is documented on the IR. Ms. Reed stated at the time the incident occurred, direct care staff, Gabriel Komolafe was Resident A's 1:1 staffing. However, Ms. Reed stated she is assigned as Resident A's 1:1 staff on Wednesday, Thursday and Sunday from 8:00 a.m. to 9:00 p.m. She stated Mr. Komolafe assigned days are Monday, Tuesday, Friday and Saturday from 8:00 a.m. to 9:00 p.m. Mr. Komolafe and Resident A arrived at the home during the interview. Mr. Komolafe was tending to Resident A and unable to

be interviewed at the time. Resident A appeared to be clean and adequately dressed.

On 09/13/2024, I contacted Mr. Komolafe and interviewed him regarding the allegation. Mr. Komolafe confirmed Resident A eloped on 06/22/2024. He stated on the day in question, he was assigned as Resident A's 1:1 staff. He stated at the time Resident A was sitting on the couch and direct care staff, Adekunle Adedoyin arrived with groceries. Mr. Komolafe stated he went to help the staff bring the groceries in the home and into the basement to sort. Mr. Komolafe stated Resident A said he was tired and wanted to go to his room and go to bed. Mr. Komolafe stated while in the basement sorting groceries, he went to check on Resident A and he was in his bedroom laying down. Mr. Komolafe stated by the time he was finished sorting groceries he went checked on Resident A again, and he was not in his bedroom. Mr. Komolafe stated he went in the community looking for Resident A. He stated he checked the hospital and Resident A was at Saint John's hospital. Mr. Komolafe stated the hospital staff made him aware that Resident A was found walking two blocks away from the home by EMS. Mr. Komolafe stated Resident A stated he was trying to go to Wayne County Community College but got lost.

On 0916/2024, I completed an exit conference with Mr. Okonkwo. I made him aware that based on the investigative findings, there is sufficient evidence to support the allegation. Mr. Komolafe confirmed he was assigned as Resident A's 1:1 staffing, and he was in the basement sorting groceries when Resident A eloped. Mr. Komolafe did not provide adequate supervision to prevent Resident A from eloping. Mr. Okonkwo stated arrangements have been made with the Office of Recipient Rights, Edna Green to come out to the home on 09/23/2024 to provide training as it pertains to 1:1 staffing. I made Mr. Okonkwo aware that due to the violation identified in the report, a written corrective action plan is required. Mr. Okonkwo agreed to review the report and submit the corrective action plan as requires. He denied having any questions.

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; direct care staff Tatiana Reed; direct care staff, Gabriel Komolafe; Resident A's guardian/ probate legal assistant, Tamiko Smith; Resident A's supports coordinator with NSO, Nichole Birk; and a review of documentation including Residents A's IPOS and adult foster care incident report. It has been determined the direct care staff did not provide Resident A with supervision and protection as specified in his IPOS on 06/22/2024. There is sufficient evidence to substantiate the allegation that Resident A did not have sufficient supervision, personal care, and protection as specified in his 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.

09/16/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

09/25/2024

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Ardra Hunter Date
Area Manager