GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Appolonia Okonkwo
Tender Heart Staffing Inc
828 Cherry Avenue
Royal Oak, MI 48073

RE: License #: AS630408454
Investigation #: 2025A0991015
Cherry Oak Inn

Dear Appolonia 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 972-9136.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202

(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630408454
Investigation #:	2025A0991015
Complaint Receipt Date:	04/18/2025
Investigation Initiation Date:	04/21/2025
Report Due Date:	06/17/2025
Licensee Name:	Tender Heart Staffing Inc
Licensee Address:	828 Cherry Avenue Royal Oak, MI 48073
Licensee Telephone #:	(313) 790-6835
Licensee Designee:	Appolonia Okonkwo
Name of Facility:	Cherry Oak Inn
Facility Address:	828 Cherry Avenue Royal Oak, MI 48073
Facility Telephone #:	(313) 790-6835
Original Issuance Date:	03/25/2022
License Status:	REGULAR
Effective Date:	09/25/2024
Expiration Date:	09/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/05/25, Resident A was being pushed in a wheelchair. She fell out of the wheelchair and hit her head. She broke her neck in two places. Staff did not write an incident report or call EMS.	Yes
Resident A experienced significant weight loss while living in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/18/2025	Special Investigation Intake 2025A0991015
04/21/2025	Special Investigation Initiated - Telephone Call to Resident A’s power of attorney (POA)
04/22/2025	Contact - Telephone call received From Resident A's POA - placed on hospice
04/23/2025	APS Referral Referred to Adult Protective Services (APS) - Centralized Intake
04/23/2025	Inspection Completed On-site Interviewed home manager
05/09/2025	Contact - Document Received Email to/from assigned APS worker, John Cavanaugh
05/13/2025	Contact - Telephone call made To Resident A's POA
05/13/2025	Contact - Document Sent Request for medical records
05/19/2025	Contact - Document Received Medical records for Resident A
05/19/2025	Exit Conference Via telephone with licensee designee, Appolonia Okonkwo

ALLEGATION:

- **On 03/05/25, Resident A was being pushed in a wheelchair. She fell out of the wheelchair and hit her head. She broke her neck in two places. Staff did not write an incident report or call EMS.**
- **Resident A experienced significant weight loss while living in the home.**

INVESTIGATION:

On 04/21/25, I received a complaint alleging that on 03/05/25 Resident A was being pushed to lunch in a wheelchair when she fell onto the floor and hit her head. She broke her neck in two places. There was no incident report written and EMS (emergency medical services) was not called. Resident A's power of attorney (POA) had asked that Resident A not be put in a wheelchair, and that she should walk to the table. I referred the complaint to Adult Protective Services (APS) centralized intake, and it was assigned to John Cavanaugh for investigation.

I initiated my investigation on 04/21/25 by contacting Resident A's POA. She stated that Resident A is her own guardian, but she serves as Resident A's POA for medical and financial issues. Resident A has a wheelchair that she is supposed to use for long distances only, as she walks very slowly. Resident A's POA stated that she was not sure if they were using the wheelchair in the home on a regular basis. There were times when Resident A did not want to walk. Resident A told her POA that staff would tell her to get in the wheelchair. Resident A's POA stated that the home manager, Sonja, told her that Resident A was in her wheelchair rolling herself and fell out of the wheelchair. She stated that this could not be true, as Resident A could not propel a wheelchair on her own. Resident A's POA stated that another resident in the home told her that they sometimes push Resident A's wheelchair. Resident A's POA also stated that staff tell Resident A to put her feet up, but she gets tired and puts them down. She said that Resident A must have fallen forward out of the wheelchair onto her face. Resident A hit her chest and her face in the fall. The home manager did not call 911 or contact Resident A's POA immediately following the fall. Resident A had a knot on her head, which Resident A's POA observed when she visited her the following day. The home manager, Sonja, told Resident A's POA that she checked Resident A's vitals and gave Resident A Tylenol for the pain. Resident A's POA had Resident A sent out to the hospital on 03/06/25. She was found to have broken her neck/vertebrae in two places. The hospital stated that Resident A was not a candidate for surgery. They put a brace on her, but she did not like the brace and kept trying to take it off. Resident A's POA stated that Resident A would not be returning to the home. She was moved to a rehabilitation facility in West Bloomfield. Resident A does not recall what happened at the time of the fall. Her health is going downhill, and she is refusing to eat. Resident A's POA stated that Sonja never completed an incident report regarding the fall.

Resident A's POA also expressed concern that Resident A lost a significant amount of weight. She stated that Resident A's weight had dropped to 70 pounds while she was living at Cherry Oak Inn and is now down to 60 pounds. She stated that she did not realize Resident A was losing that much weight. Staff at the facility were using rubber bands to make her clothes appear less baggy.

On 04/22/25, I received a follow-up phone call from Resident A's POA indicating that Resident A was taken to the hospital from her rehabilitation facility and was being placed on hospice. On 05/13/25, I spoke with Resident A's POA. She stated that Resident A passed away on hospice at the hospital on 04/29/25.

On 04/23/25, I conducted an unannounced onsite inspection at Cherry Oak Inn. I interviewed the home manager, Sonja Jackson-Burroughs. Ms. Jackson-Burroughs stated that she has worked in the home for approximately three years. Ms. Jackson-Burroughs stated that on 03/05/25, she assisted Resident A out of bed and into a wheelchair. Resident A typically uses a walker, but at times she would say that she could not walk. After breakfast, Resident A was wheeling herself out of the kitchen, and she fell out of the wheelchair. No other residents were in the kitchen area, and nobody else witnessed Resident A's fall. Ms. Jackson-Burroughs stated that she was not pushing the wheelchair. Resident A was maneuvering it on her own. She was able to use her arms and feet to propel the wheelchair. Resident A hit her head when she fell out of the wheelchair. She had a knot on the left side of her head. Ms. Jackson-Burroughs stated that she helped Resident A back into her wheelchair and took her to her bedroom. She assisted her into the bed. Ms. Jackson-Burroughs stated that she was not sure if Resident A's assessment plan stated that she needs a wheelchair or if it was prescribed by the doctor. She stated that Resident A was not supposed to use the wheelchair and her POA said not to use it, but about a month ago Resident A stated that she could not walk. Ms. Jackson-Burroughs stated that this decline in Resident A's ability to walk happened at the end of January or beginning of February and they never discussed it with a doctor. Resident A stayed in bed most of the time and only got up for meals. Ms. Jackson-Burroughs stated that she did not call Resident A's POA or 911 after Resident A's fall despite knowing that Resident A hit her head. She asked Resident A if she wanted to go to the hospital, and Resident A said no. Ms. Jackson-Burroughs stated that there have been times when EMS came to the home and a resident refused to go to the hospital, and they could not force them to go, so Ms. Jackson-Burroughs "just said okay" when Resident A stated that she did not want to go to the hospital. Ms. Jackson-Burroughs stated that Resident A only agreed to go to the hospital the following day when her POA was visiting. They called EMS and Resident A was transported to the hospital. Ms. Jackson-Burroughs stated that she did not speak with Resident A or anyone at the hospital after Resident A left the home. Ms. Jackson-

Burroughs stated that she completed an incident report following Resident A's fall; however, she could not locate it during the onsite inspection.

With regards to Resident A's weight loss, Ms. Jackson-Burroughs stated that Resident A started losing weight about seven months ago. She stated that it was not a drastic weight loss, as Resident A was only losing one or two pounds each month. She stated that Resident A had a very good appetite, and the weight loss was gradual.

I reviewed a copy of Resident A's weight record. Her weight in September 2024 was recorded as 104 pounds. No weight was recorded in October or November 2024. Resident A's weight in December 2024 was recorded as 83 pounds. Her weight in January 2024 was recorded as 63 pounds. I advised Ms. Jackson-Burroughs that Resident A lost over 40 pounds in a four-month period, which is more than "one or two pounds a month." Ms. Jackson-Burroughs stated that she did discuss Resident A's weight loss with someone, but she could not recall if it was Resident A's POA or her doctor. She did not have any documentation regarding this conversation or any documentation to show that a medical professional was consulted regarding Resident A's weight loss.

I reviewed a copy of Resident A's assessment plan dated 02/01/2024. The assessment plan notes that Resident A requires assistance with walking/mobility and uses a walker. The only assistive device/special equipment noted is a walker. The assessment plan does not specify the use of a wheelchair.

I reviewed copies of Resident A's health care appraisals dated 02/08/24 and 08/27/24. The health care appraisals note that Resident A has severe gait impairment, poor balance, dizziness, and a history of falls. The health care appraisals note that Resident A uses a walker for mobility. There is no indication on the health care appraisals that Resident A uses a wheelchair. There was no authorization on file from a physician for Resident A to use a wheelchair.

I received and reviewed copies of Resident A's imaging result reports from Corewell Health William Beaumont University Hospital. On 03/07/25, a CT (computed tomography) spine cervical without contrast exam was completed on Resident A. The CT scan showed that there were nondisplaced fractures of the posterior arch of C1 bilaterally (first cervical vertebra at the top of the spine) and a minimally displaced fracture at the base of the odontoid (bony peg on the second vertebra) consistent with a type II fracture. There was posterior angulation of the odontoid process with approximately 2.5cm of separation of the fracture fragments along its anterior aspect. A mild impaction fracture of the base of the odontoid into the C2 body was also noted. On 03/07/25, a CT head without contrast exam was also conducted. The images showed no acute intracranial process and mild anterior right frontal scalp swelling.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's protection and safety were not attended to at all times. On 03/05/25, Resident A fell out of a wheelchair and sustained injuries to her head and neck including nondisplaced fractures of the C1 vertebra, a displaced fracture at the base of the odontoid, and an impaction fracture at the base of the odontoid into the C2 vertebra. She also had right frontal scalp swelling. The home manager, Sonja Jackson-Burroughs, stated that Resident A was propelling herself in a wheelchair at the time of the accident. However, Resident A's POA stated that Resident A would not be able to physically maneuver a wheelchair on her own. Resident A's assessment plan did not indicate that she is supposed to use a wheelchair for mobility purposes. Resident A's health continued to decline after her fall, and she passed away on 04/29/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's assessment plan did not specify the use of a wheelchair. Resident A's assessment plan dated 02/01/24 indicated that she uses a walker for mobility. A walker was the only assistive device listed in the assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that there was no authorization from a licensed physician on file for Resident A to use a wheelchair. Resident A's health care appraisal dated 08/27/24 noted the use of a walker, but did not include use of a wheelchair. There was no additional documentation on file to authorize the use of a wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's weight was not recorded monthly. Resident A's weight record did not have a weight documented for October 2024, November 2024, or February 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that needed care was not obtained immediately following Resident A's fall or significant weight loss. The home manager, Sonja Jackson-

	Burroughs, did not call 911 or contact Resident A's POA following Resident A's fall from a wheelchair on 03/05/25. She stated that Resident A hit her head and had a knot on her forehead; however, she did not call 911 because Resident A told her she did not want to go to the hospital. Resident A was not taken to the hospital until her POA visited the following day. As a result of the fall, Resident A sustained injuries to her head and neck including nondisplaced fractures of the C1 vertebra, a displaced fracture at the base of the odontoid, and an impaction fracture at the base of the odontoid into the C2 vertebra. She also had right frontal scalp swelling. Resident A also lost over 40 pounds from September 2024 to January 2025. The home manager, Sonja Jackson-Burroughs, did not have any documentation showing that a health care professional was contacted regarding Resident A's weight loss. Ms. Jackson-Burroughs also stated that Resident A began having difficulty walking at the end of January or beginning of February. She did not have any documentation showing that a health care professional was contacted regarding the change in Resident A's health status.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (b) Unexpected and preventable inpatient hospital admission.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that an incident report was not completed following Resident A's fall on 03/05/25 and subsequent hospitalization on 03/06/25. Resident A's POA stated that she did not receive an incident report and was not contacted regarding the fall. The home manager, Sonja Jackson-Burroughs, stated that she completed an incident report, but she could not locate the document.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my interview with the home manager, Sonja Jackson-Burroughs, she stated that Resident A's health had been declining since the end of January 2025. Resident A typically used a walker, but she started refusing to walk and stayed in bed most of the day. Staff began using a wheelchair to bring Resident A to the bathroom, as well as to and from the table for meals. I reviewed the original licensing study report for Cherry Oak Inn dated 03/25/22, as well as the facility's information in the Bureau Information Tracking System (BITS). The original licensing study report and BITS indicate that the home is not approved for residents who use wheelchairs.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the types of services and physical accommodations required to meet Resident A's needs were not available in the home. Per the home manager, Sonja Jackson-Burroughs, Resident A's health had been deteriorating since the end of January and she was refusing to walk. Resident A was using a wheelchair inside the home due to her increasingly impaired mobility. I reviewed the original licensing study report for Cherry Oak Inn dated 03/25/22, as well as the facility's information in the Bureau Information Tracking System (BITS). The original licensing study report and BITS indicate that the home is not approved for residents who use wheelchairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

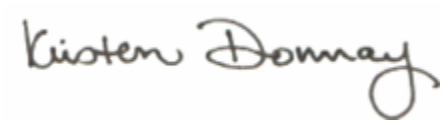
During the investigation, I requested and reviewed a copy of Resident A's assessment plan. The assessment plan on file was dated 02/01/24. It was not updated in February 2025. The home manager, Sonja Jackson-Burroughs, stated that Resident A moved out of the home before her assessment plan could be updated. However, Resident A did not move out of the home until she was hospitalized on 03/06/25.

On 05/19/25, I conducted an exit conference via telephone with the licensee designee, Appolonia Okonkwo, and reviewed the findings. Ms. Okonkwo stated that she would submit a corrective action plan to address the rule violations and would not contest the issuance of a six-month provisional license.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's assessment plan was not updated annually. The assessment plan on file was dated 02/01/24. It was not updated annually in February 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

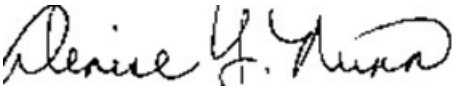
Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.



05/19/2025

Kristen Donnay — Date
Licensing Consultant

Approved By:



05/20/2025

Denise Y. Nunn — Date
Area Manager