



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2026

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

RE: License #: AS820312395
Investigation #: 2026A0778011
Bedford Home

Dear Mr. Okonkwo:

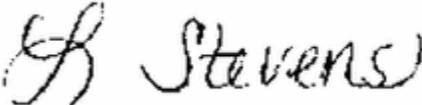
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 456-0439.

Sincerely,

A handwritten signature in black ink that reads "LaKeitha Stevens". The signature is written in a cursive style with a large, stylized initial "L".

LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820312395
Investigation #:	2026A0778011
Complaint Receipt Date:	12/15/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/13/2026
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:	09/29/2024
Expiration Date:	09/28/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Prescribed medication was withheld by staff despite being provided by the residents' family.	Yes

III. METHODOLOGY

12/15/2025	Special Investigation Intake 2026A0778011
12/15/2025	APS Referral Received
12/16/2025	Referral - Recipient Rights Made
12/17/2025	Special Investigation Initiated - On Site Face to face with staff Tatiana Reed, Quanesha Grier and Resident A
01/20/2026	Contact - Telephone call made Telephone interview with home manager, Appolonia Okonkwo
01/20/2026	Contact - Telephone call made Telephone interview with Office of Recipient Rights, Charles Carter
01/20/2026	Exit Conference Telephone exit conference with licensee designee, Benneth Okonkwo

ALLEGATION: Prescribed medication was withheld by staff despite being provided by the residents' family.

INVESTIGATION: On 12/17/2025, I completed an unannounced onsite inspection. I interviewed staff, Tatiana Reed and Resident A. Staff, Tatiana indicated Resident A was admitted to the facility on October 9, 2025. She stated when he was admitted he came to the facility with a bunch of bags and some medications. She stated she called the manager, Appolonia Okonkwo, regarding his medications and was informed to only give him medication that was listed on his discharge paperwork from Guardian City Hospital. Tatiana indicated Appolonia informed her if the

medication was not on the list, it cannot be administered. Tatiana further stated Resident A informed her his doctor prescribed him Oxycodone. However, she did not administer it due to the directions of Appolonia.

While onsite I interviewed Resident A. Resident A stated he is his own guardian. He indicated he is prescribed several medications for pain management. He indicated the facility refused to give him his Oxycodone medication because it was not listed on his hospital discharge form. Resident A indicated he submitted a letter from his doctor and that's when he was able to obtain his prescribed medication. According to Resident A, he went a month without his pain medication.

During my onsite inspection I reviewed Resident A's medication log. Resident A is prescribed Oxycodone Acetaminophen 1-2 tablets a day as needed. The first day Resident A received his medication was November 15, 2025, even though he was admitted to the facility on October 9, 2025.

On 01/20/2026, I completed a telephone interview with Office of Recipient Rights Officer, Charles Carter. He stated his complaint was substantiated. Mr. Carter stated he received his complaint a couple of months ago and was able to complete an onsite inspection. He stated Resident A should have received his medication. According to Mr. Carter, Resident A's medication was in original packaging from CVS pharmacy. He stated the medication was prescribed by another doctor and was not documented on his discharge sheet from the hospital. However, the facility could have called to verify since it was in its original packaging with the doctor's information listed. According to Mr. Carter, when he went to the facility in November of 2025, the medication was locked in a drawer but unadministered.

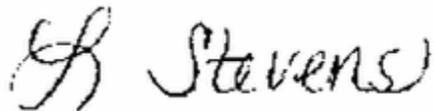
On 01/20/2026, I completed a telephone interview with the home manager, Appolonia Okonkwo. She indicated she advised staff, Tatiana, to give Resident A prescribed medication or medication with a doctor's note. She indicated staff did not understand her directions. She stated Resident A should have received his medication, but her directions were not appropriately adhered to.

On 01/20/2026, I completed a telephone exit conference with licensee designee, Benneth Okonkwo. He was informed this complaint will be substantiated. I informed Benneth, Resident A did not receive medication that he was prescribed. He indicated he was aware of the violation and will submit a corrective action plan. He indicated staff are now aware of the need to verify all medication even if it's not listed on a hospital discharge form. He indicated staff was confused because the medication came from Resident A's mother and did not think to call the pharmacy to verify.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	<p>Resident A is prescribed Oxycodone Acetaminophen take 1-2 tablets a day as needed. Resident A was admitted to the facility on October 9, 2025, and did not receive his medication until November 15, 2025.</p> <p>Resident A stated the facility had his prescribed medication but made him go a month without receiving it. Resident A stated he was in tremendous pain.</p> <p>Office of Recipient Rights, Charles Carter, indicated he observed the medication to be in its original pharmacy container with all required documentation on the label. He stated staff did not call to verify validity, instead they refused to administer.</p> <p>Appolonia Okonkwo indicated staff did not clearly understand her directive when she advised them of the administration of Resident A's medication.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend this complaint is closed and the status of the license remains unchanged.



02/10/2026

LaKeitha Stevens
Licensing Consultant

Date

Approved By:



02/12/2026

Ardra Hunter
Area Manager

Date