GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 22, 2026

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

RE: License #: AS500418053
Investigation #: 2026A0604016
Warner 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 972-9136.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500418053
Investigation #:	2026A0604016
Complaint Receipt Date:	04/23/2026
Investigation Initiation Date:	04/27/2026
Report Due Date:	06/22/2026
Licensee Name:	Tender Hearts, Inc.
Licensee Address:	2708 Oakman Court Detroit, MI 48238
Licensee Telephone #:	(248) 240-4413
Administrator:	Benneth Okonkwo
Licensee Designee:	Benneth Okonkwo
Name of Facility:	Warner Home
Facility Address:	27074 Warner Ave Warren, MI 48092
Facility Telephone #:	(313) 915-5719
Original Issuance Date:	06/23/2025
License Status:	REGULAR
Effective Date:	12/23/2025
Expiration Date:	12/22/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Someone from the facility was screaming at the neighbor across the street. It appears that a resident was alone without anyone to watch her. That same female was arrested outside the facility.	No
Additional Findings	Yes

III. METHODOLOGY

04/23/2026	Special Investigation Intake 2026A0604016
04/27/2026	Contact- Document Received Received intake email for Warner Home. Incorrect address in intake
04/27/2026	Special Investigation Initiated - Letter Email to Licensee Designee, Ben Okonkowo.
04/28/2026	Contact - Document Sent Email to Ben Okonkwo
04/28/2026	Contact - Telephone call made Text to and from Ben Okonkwo. Received message from Ben Okonkwo
04/28/2026	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Tonoa Carter, Krystal Monroe, and observed residents. Resident B declined interview and Resident C is non-verbal.
04/28/2026	Contact - Document Received Email from Ben Okonowo with client face sheet and incident report
04/29/2026	APS Referral Referral to Adult Protective Services (APS) Assigned for investigation to Laura DeCarlo
05/06/2026	Contact - Document Received Received copy of incident report
05/06/2026	Contact - Document Sent Email to licensee requesting resident and staff information

05/11/2026	Contact - Document Received Fax received with consent for treatment and court orders
06/03/2026	Contact - Document Received Email from APS Worker, Laura DeCarlo
06/04/2026	Contact - Document Sent Email to APS Worker, Laura DeCarlo
06/05/2026	Contact - Telephone call made TC to APS Worker, Laura DeCarlo. She has not found any concerns regarding homes actions at this time. Resident A had another incident and returned to hospital about one week ago.
06/05/2026	Contact - Document Sent Emailed request for police report to Warren Police Records Department
06/08/2026	Contact - Document Received Received police report by email from Warren Police Records
06/10/2026	Contact - Telephone call received Received message from APS worker, James Bellanger. Case has been re-assigned. Sent email with information
06/10/2026	Contact - Document Sent Email to Ben Okonkwo. Second request for documents
06/13/2026	Contact- Document Received Received emails from Ben Okonkwo with licensing documents
06/15/2026	Contact- Document Sent Sent email to Ben Okonkwo
06/17/2026	Contact- Document Sent Email to Resident A's public guardian, ARC of Macomb, Shelly Thompson and Mary Scarsella
06/22/2026	Exit Conference Completed exit conference with Licensee Designee, Ben Okonkwo. Sent email to Ben Okonkwo

ALLEGATION: Someone from the facility was screaming at the neighbor across the street. It appears that a resident was alone without anyone to watch her. That same female was arrested outside the facility.

INVESTIGATION:

I received a licensing complaint regarding Warner Home on 04/27/2026. The Complainant alleged that someone from the facility was screaming at the neighbor across the street. It appears that a resident was actually alone without anyone watching her. That same female was arrested outside the facility. The resident is unknown.

On 04/28/2026, I completed an unannounced onsite investigation. There were three staff present when I arrived at the home. I interviewed Home Manager, Tonoa Carter and Staff, Krystal Monroe. Staff, Satemo McGee, was providing 1:1 supervision for Resident B during onsite investigation. I attempted to interview Resident C.

On 04/28/2026, I interviewed Home Manager, Tonoa Carter. Ms. Carter stated that they currently have three residents; however, Resident A was not present. Ms. Carter indicated that complaint would be regarding an incident with Resident A. Resident A was hospitalized in Grand Rapids, MI as she reported she was feeling homicidal and suicidal. She stated that Resident A smokes and drinks alcohol, which they have been told is her right. She receives services through Community Mental Health. Ms. Carter stated that Resident A was intoxicated and yelling for someone to call 911. She believes one of the neighbors called the police. The police came and Resident A was taken to the hospital and later transferred to a psychiatric facility in Grand Rapids. Ms. Carter stated that she believed she was the staff present when incident occurred and that the home provides 24-hour care and supervision. She indicated that Resident A has had multiple behavioral issues at home. She stated that Resident A has a 1:1 staff until 8:00 pm. She believes that Resident A needs approval for 1:1 staff 24 hours a day.

On 04/28/2026, I interviewed Staff, Krystal Monroe. She stated that she was not present when the incident occurred.

On 04/28/2026, I observed Resident B. Resident B is non-verbal. Resident B was receiving 1:1 supervision from Staff, Satemo McGee, during the investigation.

On 04/28/2026, I attempted to interview Resident C. Resident C stated that she did not feel like talking and did not want to be interviewed. Resident C later stated that she was doing good and had no complaints.

On 04/28/2026, I received copy of incident report dated 04/22/2026 and copy of Macomb County Community Mental Health Client Face Sheet. Resident A has public guardian, ARC of Macomb. Incident report dated 04/22/2026 indicates that she was mad because she could not go to hospital. She started throwing chairs in

dining room and throwing things off table. Staff took vitals and called 911, providers and case manager. Resident A was taken to hospital.

On 06/05/2026, I spoke to APS Worker, Laura DeCarlo, by phone. Ms. DeCarlo stated that Resident A returned to hospital about a week ago. She indicated that Resident A returned to the home for about one month after she was discharged from hospital in Grand Rapids. Ms. DeCarlo stated that Resident A only receives 1:1 supervision during the day and the home does not receive funds to provide 1:1 supervision for 24 hours a day. She does not believe the home has done anything wrong. She indicated that Resident A exhibits difficult behaviors and guardian did not report any concerns.

On 06/08/2026, I received copy of police report from Warren Police records dated 04/22/2026. The report indicates that police were dispatched to the home at 8:04 PM. Upon arrival, Resident A was seated in chair in living room. Resident A reported that she was hearing voices and was homicidal. Resident A was asked if she wanted to go to the hospital and she indicated that she did. The police also interviewed Home Manager, Tonoa Carter, who also stated that Resident A had been hearing voices and telling her that she is homicidal. Resident A was transported to Henry Ford Warren.

On 06/13/2026, I received copies of incident reports for Resident A. Incident reported dated 05/05/2026 indicates that Resident A was taken to hospital because she was hearing voices and having homicidal and suicidal thoughts. She also had injury to ankle. Incident report dated 05/28/2026 indicates that Resident A was transferred to hospital by Warren Police Department. I also received copy of Resident A's Individual Plan of Service (IPOS) dated 07/01/2025. Her plan indicates that she is approved for 1:1 staffing for 12 hours per day. Her IPOS indicates that she presents behaviors that include self- harm, aggression, suicidal ideation, auditory hallucinations, property disruption, misuse of 911/EMS system, elopement, verbal aggression and bids to go to the hospital/urgent care and that many of these behaviors have been present in her new home.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct

	care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	There is not enough information to determine that the home does not have adequate staffing. On 04/28/2026, I completed an unannounced onsite investigation. There were two residents present with Home Manager and two staff at the home. One staff was providing 1:1 supervision for Resident B. There is also not enough information to determine that Resident A was alone on 04/22/2026 when police were called to the home. The police report indicates that when they arrived, Resident A was found in the living room. The home manager, Tonoa Carter, was present for interview.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	I received copy of Resident A's Individual Plan of Service dated 07/01/2025. Her plan indicates that she is approved for 1:1 staffing for 12 hours per day. Home Manger, Tonoa Carter, stated that that Resident A has a 1:1 staff until 8:00 pm. Warren Police records dated 04/22/2026 indicates that police were dispatched to the home at 8:04 PM. Upon arrival, Resident A was seated in chair in living room. Resident A reported that she was hearing voices and was homicidal. Resident A was asked if she wanted to go to the hospital and she indicated that she did. The police also interviewed Home Manager, Tonoa Carter, who stated that Resident A had been hearing voices and telling her that she is homicidal. Resident A was transported to Henry Ford Warren.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

I completed an unannounced onsite investigation. Staff, Satemo McGee, was providing 1:1 supervision for Resident B. Mr. McGee does not have a clearance in the workforce background check system.

I completed an exit conference with Licensee Designee, Ben Okonkwo, on 06/22/2026. I sent Mr. Okonkwo an email informing him of violation found and that a corrective action plan would be requested. I informed him that a copy of special investigation report would be mailed once approved. I also requested that he complete a workforce background check for Mr. McGee as soon as possible and that he contact me with any questions.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall notemploy or independently contract with an individual who has direct access to residents until the adult fostercare facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	On 04/28/2026, I completed an unannounced onsite investigation. Staff, Satemo McGee, was providing 1:1 supervision for Resident B. Mr. McGee does not have a clearance in the Workforce Background Check system as of 06/22/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.

06/22/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:

For 06/22/2026

Denise Y. Nunn Date
Area Manager