

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

January 5, 2022

Mercy Igiogbe Triple J's Bettercare Inc. P.O. Box 13710 Detroit, MI 48213

> RE: License #: AS820277913 Investigation #: 2022A0901003

> > Triple J's Bettercare Inc

Dear Ms. Igiogbe:

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,

Regina Buchanan, Licensing Consultant Bureau of Community and Health Systems

Cadillac Pl. Ste 9-100 3026 W. Grand Blvd Detroit, MI 48202 (313) 949-3029

Regina Buchanon

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820277913
Leave at least and the	000040004000
Investigation #:	2022A0901003
Complaint Receipt Date:	10/21/2021
Investigation Initiation Date:	10/22/2021
Panart Dua Data	12/20/2021
Report Due Date:	12/20/2021
Licensee Name:	Triple J's Bettercare Inc.
Licensee Address:	P.O. Box 13710
	Detroit, MI 48213
Licensee Telephone #:	(313) 522-1421
Administrator:	Mercy Igiogbe
Licensee Designee:	Mercy Igiogbe
Licensee Designee.	Wercy iglogbe
Name of Facility:	Triple J's Bettercare Inc
Facility Address:	19222 Woodcrest Street
	Harper Woods, MI 48225
Facility Telephone #:	(313) 371-6429
Original Issuance Date:	11/07/2005
License Status:	REGULAR
Effective Date:	05/16/2020
Francisco Dete	05/45/0000
Expiration Date:	05/15/2022
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

II. ALLEGATION(S)

Violation Established?

Staff smoke marijuana and drink alcohol in the home.	No
Staff calls Resident A names.	Yes

III. METHODOLOGY

10/21/2021	Special Investigation Intake 2022A0901003
10/21/2021	Referral - Recipient Rights
10/22/2021	APS Referral
10/22/2021	Special Investigation Initiated - Telephone Resident A
10/26/2021	Contact - Telephone call made Case Manager, Susye Inez
10/28/2021	Inspection Completed On-site
12/14/2021	Contact - Telephone call made Staff, Rosetta Banks
12/15/2021	Inspection Completed-BCAL Sub. Compliance Home Manager, Eddie Ediagbonwa Resident A-D
12/15/2021	Contact - Telephone call made Staff, Tinay Walens
12/15/2021	Contact - Telephone call made Staff, Anthony Little
12/20/2021	Exit Conference Licensee Designee, Mercy Igiogbe

ALLEGATION:

Staff smoke marijuana and drink alcohol in the home.

INVESTIGATION:

On 10/22/2021, I made a telephone call to Resident A. She stated staff smoke marijuana in the home and drink alcohol while working. However, she denied witnessing this.

On 10/26/2021, I made a telephone call to Resident A's case manager Susye Inez, from Northeast Guidance Center. She stated she did not have any issues with the home and that Resident A never complained to her about staff smoking marijuana and drinking alcohol. Ms. Inez indicated that during her visits, she never smelled marijuana and staff never seemed intoxicated. She reported mostly older ladies work in the home, and they are very motherly. She stated she could not see them engaging in that type of behavior on the job. She further described Resident A as a pathological liar and stated she complains in every home she goes to and most of the complaint are not true.

On 10/28/2021, I conducted an onsite inspection at the facility. The home manager was present, Eddie Ediagbonwa. He denied the allegations. He stated he has never had an issue with staff drinking and smoking marijuana on the job and none of the residents have complained to him about this.

On 10/28/2021, I interviewed Residents B-D separately. They all denied any knowledge of staff smoking and drinking marijuana on the job.

On 12/14/2021, I made a telephone call staff, Rosetta Banks. She denied the allegations. She stated she and her co-workers would never engage in inappropriate behavior such as drinking or smoking marijuana on the job.

On 12/15/2021, I made a telephone call to staff, Tinay Walens. She denied the allegations. She stated she has never drunk alcohol or smoked marijuana on the job and has never witnessed her co-workers doing it.

On 12/15/2021, I made a telephone call to staff, Anthony Little. He denied smoking marijuana and drinking alcohol on the job and denied any knowledge of his coworkers doing this.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. Everyone interviewed denied the allegations and Resident A indicated she never witnessed staff smoking marijuana and drinking alcohol.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff calls Resident A names.

INVESTIGATION:

On 10/22/2021, I made a telephone call to Resident A. She stated staff curses at her and call her names. When asked specifically who she was referring to, she indicated Tinay Walens, Rosetta Banks, and Anthony Little. Resident A stated just recently Anthony called her a derogatory name and was sent home. She denied there being any witnesses but said she had recordings of this.

On 10/26/2021, I made a telephone call to Resident A's case manager Susye Inez, from Northeast Guidance Center. She stated she did not have any issues with the home and that Resident A never complained to her about staff talking to her inappropriately. She indicated mostly older ladies work in the home, and they do not seem as if they would do that. She also described Resident A as a pathological liar and stated she tends to complain a lot.

On 10/28/2021, I conducted an onsite inspection at the facility. The home manager was present, Eddie Ediagbonwa. He denied the allegations. He stated no one was mistreating Resident A. He said Resident A once told him staff, Anthony, call her a derogatory word, but he denied it. Mr. Ediagbonwa indicated he was very familiar with Resident A because she stayed with them in the past. He stated she complains a lot about everything and tends to fabricate a lot, especially when things are not going her way.

On 10/28/2021, I interviewed Resident A. I asked to see the recordings she claimed she had of staff talking inappropriately to her. She said she would send them to me instead, but I never received them.

On 10/28/2021, I interviewed Residents B-D separately. They all denied being talked to inappropriately by staff or witnessing staff talk to other residents inappropriately.

On 12/14/2021, I made a telephone call staff, Rosetta Banks. She denied the allegations. She sated she had been working at the home since 2014 and has never mistreated the residents. She also stated she never witness her co-workers talk to them inappropriately.

On 12/15/2021, I made a telephone call to staff, Tinay Walens. She denied talking inappropriately to Resident A or any of the other residents. She stated she would never do that. She indicated Resident A was very difficult to work with and once caused staff, Anthony, to get out of character and he said some inappropriate things to her.

On 12/15/2021, I made a telephone call to staff, Anthony Little. He admitted to talking to Resident A inappropriately. He stated there was a situation in which she was being very defiant and disrespectful towards him and he, in turn, used profanity towards her and called her a derogatory name. He stated he later apologized and was reprimanded by his boss.

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 obtained during this investigation, Resident A was not treated with dignity and respect. She reported being talked to inappropriately by staff and staff, Anthony Little, admitted to using profanity towards her and calling her a derogatory name.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Regina Buchanon	
,	12/20/2021
Regina Buchanan	Date
Licensing Consultant	
Approved By:	
Gettoner	
	01/05/2022
Ardra Hunter	 Date
Area Manager	