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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 12, 2022

Angela Agodu
Triple C's Care Inc.
11353 Grandville
Detroit, MI 48228

RE: License #: AS820285612
Investigation #: 2022A0121027
Triple C's Care Inc.

Dear Mrs. Agodu:

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,

A handwritten signature in blue ink that reads "K. Robinson". The signature is written in a cursive style with a large, stylized "K" and "R".

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820285612
Investigation #:	2022A0121027
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/23/2022
Report Due Date:	07/19/2022
Licensee Name:	Triple C's Care Inc.
Licensee Address:	6897 Greenview Detroit, MI 48228
Licensee Telephone #:	(313) 948-0512
Administrator:	Angela Agodu, Designee
Name of Facility:	Triple C's Care Inc.
Facility Address:	6897 Greenview Detroit, MI 48228
Facility Telephone #:	(313) 982-9710
Original Issuance Date:	11/20/2006
License Status:	REGULAR
Effective Date:	01/31/2022
Expiration Date:	01/30/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The owner did not take resident to the dentist or eye doctor even at the insistence of the guardian.	No
The food provided by the home is not healthy. The residents are too often given Ramen noodles and hotdogs to eat. The meal portions are not adequate for grown men.	No
There is concern the dishes and what little silverware they have is not clean. The dishwashing liquid is watered down, in an effort, to stretch it.	No
There is a lack of bedding and most times no sheets are on the beds.	No
Additional Findings	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A0121027
05/23/2022	Special Investigation Initiated - Telephone Call to Guardian 1A
06/07/2022	Contact - Telephone call made Call to Angela Agodu to schedule onsite inspection
06/08/2022	Inspection Completed On-site Interviewed Angela Agodu, Home Manager, and Resident A-B
06/27/2022	Contact - Telephone call made Sarah Sides with Lincoln Behavior Services
06/27/2022	Contact - Telephone call made Follow up call to Guardian 1A
06/28/2022	Referral - Recipient Rights Intake assigned to Ann Alexander

07/01/2022	Contact - Telephone call made Call with Witness 1
07/18/2022	APS Referral Case not assigned for investigation
07/28/2022	Contact - Document Sent Email to Office of Recipient Rights
07/29/2022	Contact - Telephone call received Call from Ann Alexander with Recipient Rights
08/10/2022	Inspection Completed On-site (unannounced) Interviewed Resident B, C, and D
08/10/2022	Contact - Telephone call received Text message from Angela Agodu regarding silverware
08/10/2022	Contact - Telephone call made Follow up call to Ann Alexander
08/10/2022	Contact - Telephone call made Phone interviews with Witness 2 and 3
08/30/2022	Contact – Telephone call made Follow up call to Guardian 1A
08/30/2022	Contact – Telephone call made Follow up call to Angela Agodu
09/07/2022	Exit Conference Angela Agodu

ALLEGATION: The owner did not take resident to the dentist or eye doctor even at the insistence of the guardian.

INVESTIGATION: I reviewed Resident A's records, including his most recent Health Care Appraisals dated 1/19/22 and 5/4/22. There are no special instructions written by the physician regarding the need for dental or vision exams. However, Guardian 1A reported she requested that Resident A be taken to the dentist in 2018 and 2019 because "his teeth were breaking off when he ate, and he was missing many teeth." Guardian 1A indicated the home would not take Resident A to the dentist in 2019 due to the Covid-19 pandemic. I attempted to clarify the date of the pandemic, but Guardian 1A argued, the onset of this global health crisis started March 2019.

Guardian 1A also stated she started asking Mrs. Agodu to get Resident A's eyes examined sometime this year. According to Guardian 1A, she purchased reading glasses for Resident A, but she decided it was time for him to get his eyes evaluated by a specialist.

On 6/8/22, I interviewed Resident A in-person. Resident A reported he sees the doctor regularly. Resident A said he has no medical concerns to report.

On 8/10/22, I conducted an unannounced onsite inspection at the facility. It should be noted Resident A was gone on a doctor appointment.

On 8/30/22, I received a phone call from Mrs Agodu stating, "We don't play with their appointments." Per Mrs. Agodu there was a delay in getting Resident A seen by a dentist because they had a problem finding a provider that would accept his insurance. In addition, Mrs. Agodu indicated Resident A was placed on a waiting list to see the dentist due to the Covid-19 pandemic when many service providers would not see patients in-person. Since that time, Mrs. Agodu reported Resident A was seen by a dentist multiple times to get his teeth examined and extracted as needed. Although Mrs. Agodu could not locate the dates of any dental exams prior to 2022 (previous home manager purged those records), she was able to report Resident A was taken to the dentist on the following dates: 4/18/22, 5/9/22, 5/19/22, 6/14/22, 7/19/22, and 8/10/22. Resident A's next appointment with the dentist is scheduled for 9/2/22. Also, Mrs. Agodu reported Resident A had an eye exam completed on 6/7/22.

Based on these findings, it does not appear Mrs. Agodu refused Resident A's guardian request for medical treatment. On 9/7/22, I completed an exit conference with Mrs. Agodu. Mrs. Agodu agrees with the department's findings and recommendation.

APPLICABLE RULE	
R 400.14201	Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.

ANALYSIS:	<ul style="list-style-type: none"> • Resident A was placed in the home on 7/24/19. He was not placed there in 2018 as indicated by Guardian 1A. • Guardian 1A did not present an accurate history of facts as evidenced by her insistence that the Covid-19 pandemic first occurred in March of 2019. • Mrs. Agodu reasoned many health screenings and services were postponed due to the Covid-19 pandemic. Mrs. Agodu explained she did not deliberately forsake necessary medical care for residents. • Resident A was taken to the dentist and optometrist once Covid restrictions were lifted. • Therefore, based on these findings, I determined the licensee displayed a willingness to cooperate with the guardian.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The food provided by the home is not healthy. The residents are too often given Ramen noodles and hotdogs to eat. The meal portions are not adequate for grown men.

INVESTIGATION: There are 6 male residents placed at the home. I interviewed 4 out of 6 residents. Resident A reported the food is “good” and he receives 3 meals per day. I asked Resident A what type of foods are served at the home, Resident A responded, “Hamburger, hot dogs, salami sandwiches with mayo, and chicken strips.” According to Resident A, they never eat ramen noodles. Resident A also indicated the food portions are “nice.” Resident B reported they eat hot dogs at least twice a week with fries and pop. Resident B also denied residents are served ramen noodles. In fact, Resident B said he has never been served ramen noodles since being placed in the home. Resident B reported they eat pancakes and waffles at least 3 times weekly. Resident B expressed concern that the waffles are often burnt. Overall, Resident B stated he is satisfied with the food. Resident B agreed the portion sizes are good and he is allowed second helpings, if desired. Resident C is not satisfied with the food service. According to Resident C, the portion sizes are small and there is little to no variety in food served. Resident C reported he goes to bed hungry sometimes. Resident C is concerned the “food is not made with love.” Resident D complained there is no variety in food. According to Resident D, residents are fed the same menu items for lunch and dinner (mostly chicken and pork chops). Resident D said breakfast is the only meal that varies; he is satisfied with their breakfast options. Resident D reported the portion sizes are adequate since he normally gets full after each meal.

On 6/8/22, I requested to see a copy of their daily menus. Mrs. Agodu provided me 4 menus that are rotated on a weekly basis. I observed these menus are not specific as they do not include dates. Witness 1 agreed residents are not provided sufficient meal portions. Witness 1 expressed concern residents are fed canned goods rather than fresh fruits and veggies. Witness 2 and 3 indicated the residents are fed well at the home. Witness 2 and 3 reported the portion sizes are good. Witness 3 explained residents at the home are not restricted to specific meal or snack times, so they constantly eat causing the home to run out of certain food or snacks quickly.

I observed the home’s food supply in the kitchen. I observed hot dogs being prepared to serve for lunch on 6/8/22. I observed a total of 8 hot dogs cooking in a pot. I also observed a freezer full of bagged meats. The refrigerator had many items, such as, a gallon of milk (half used), fresh veggies (peppers and tomatoes), lots of condiments, breakfast sausage, and a pitcher of what looked to be water. I looked at the dry goods, this included canned vegetables, boxed macaroni and cheese, beans, instant oatmeal, grits, syrup, pasta, and several different seasonings. There is an extra storage freezer in the basement. This freezer was packed to capacity with such items as, frozen waffles, bagels, salami, cheese, and more bagged meat. On 8/10/22, I observed the food supply was sufficient. I observed additional fresh vegetables in the refrigerator, including carrots, onions, and lettuce. I do not recall seeing any fresh fruits during either visit to the home. According to Resident D, they get “apples and bananas”, but the residents “eat it up real fast”, so these items normally do not stay in the home for long.

Mrs. Agodu denies the home is ever without enough food to feed residents. Mrs. Agodu stated she does the grocery shopping for the home. When asked to provide receipts for groceries, Mrs. Agodu indicated she “throws them away”, citing she had no reason to keep them. In addition, Mrs. Agodu reported she never buys ramen noodles which is consistent with what was reported by Resident A and B.

On 9/7/22, I completed an exit conference with Mrs. Agodu. Mrs. Agodu agrees with the department’s findings and recommendation. Mrs. Agodu indicated all residents are satisfied with the food service except one who is diabetic. Mrs. Agodu said she thinks this single resident is unhappy because he is discouraged from over-eating and eating unhealthy foods. Mrs. Agodu also expressed concern that the Home Manager tends to cook meals in excessive amounts, like “14 eggs” for breakfast. Mrs. Agodu reported her plans to in-service the Staff on menu planning and meal preparation. Mrs. Agodu insists the residents are fed a variety of meals, including hamburgers and fish. She denies they eat the same meals every day. Mrs. Agodu reported she has even brought meals to the home from various restaurants to accommodate the residents’ tastes.

APPLICABLE RULE	
R 400.14313	Resident nutrition.
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	<ul style="list-style-type: none"> • Resident A-D acknowledged receiving 3 meals per day. • I observed the home had an adequate supply of food on both 6/8/22 and 8/10/22. • Resident D indicated fresh fruit is made available for residents, but they eat it all very quickly which possibly explains why I did not observe fresh fruit at the home. • Overall, there is insufficient evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is concern the dishes and what little silverware they have is not clean. The dishwashing liquid is watered down, in an effort, to stretch it.

INVESTIGATION: I completed an onsite inspection at the facility on 6/8/22. I did not disclose the nature of this allegation to Mrs. Agodu until I was onsite. I observed Ajax liquid dish soap placed by the sink. I observed the dish soap had about ¼ remaining. The dish soap was gold in color. It did not look “watered” down or altered in any way as indicated by the complainant. Mrs. Agodu denied they add water to the soap dispenser to make it last longer.

I also observed the utensil drawer when I went out to the home on 6/8/22 and 8/10/22. On 6/8/22, I observed a sufficient supply of silverware at the home. On 8/10/22, I observed a shortage of forks when I opened the same utensil drawer. Mrs. Agodu contacted me to report she maintains a reserve of silverware at the home. Mrs. Agodu explained residents often take forks to their bedrooms or accidentally throw them away while clearing their plates. Mrs. Agodu forwarded a photo via text of the home’s fork supply soon after I left. Mrs. Agodu reported she instructed her Staff to do a room search for silverware. The photo sent to me included an adequate supply of silverware with special emphasis on forks. I observed all silverware to be in clean condition.

On 9/7/22, I completed an exit conference with Mrs. Agodu. She agreed with the department’s findings and recommendation. Mrs. Agodu denied the dish soap is watered down.

APPLICABLE RULE	
R 400.14402	Food service.
	(4) All food service equipment and utensils shall be constructed of material and that is nontoxic, easily cleaned and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.
ANALYSIS:	<ul style="list-style-type: none"> • I observed adequate dish soap available at the home. • I observed a sufficient supply of eating utensils available at the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is a lack of bedding and most times no sheets are on the beds.

INVESTIGATION: On 8/10/22, I conducted an unannounced onsite inspection at the facility. I inspected each resident bedroom. I observed 3 bedrooms upstairs without adequate bedding. Specifically, some beds were missing sheets. Resident C indicated his sheets were being washed. I asked the Staff on duty to show me

where linen is stored. I observed additional bedding stored in the linen closet upstairs. Resident B was able to obtain a fitted sheet for his bed upon request. After a closer look, Staff demonstrated the third bed had sheets on it that were hidden underneath a comforter. Therefore, the home achieved compliance with the rule requirement prior to me leaving the premises.

On 9/7/22, I completed an exit conference with Mrs. Agodu. Mrs. Agodu reported she hired an exterminator to come to the home the morning of my visit. Per Mrs. Agodu, the Staff were “too lazy” to make up the beds, so that is why I saw some beds without proper linen. Mrs. Agodu was pleased to learn that I searched the linen closet for extra bedding. Mrs. Agodu stated she always has more than enough linen for each resident.

APPLICABLE RULE	
R 400.14411	Linens.
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	On 8/10/22, I observed all resident beds had proper bedding in accordance to the Rule requirements.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: I conducted an unannounced onsite inspection at the facility on 8/10/22. I observed the handrail leading to the upper level of the home is broken. The handrail has become partially detached from the wall.

On 9/7/22, I completed an exit conference with Mrs. Agodu. Mrs. Agodu acknowledged the handrail was broken. She did not say how long the handrail had been broken, however, Mrs. Agodu reported the handrail has since been repaired. She does not dispute the violation.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 8/10/22, I observed the handrail leading to the upstairs bedrooms was in disrepair.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 8/10/22, I completed an onsite inspection at the facility. I observed 2 smoke detectors on the main floor of the home chirping. On 8/30/22, I contacted Mrs. Agodu by phone. Mrs. Agodu indicated she was at the facility upon taking my call. I could hear a smoke detector chirping in the background.

On 9/7/22, I completed an exit conference with Mrs. Agodu. Mrs. Agodu explained a resident (name unknown) removed the smoke detector to secretly smoke inside of the house. Mrs. Agodu stated she informed this resident smoking is not allowed inside of the home. She does not dispute the violation.

APPLICABLE RULE	
R 400.14505	Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions and changes of category.
	(4) Detectors shall be tested, examined, and maintained as recommended by the manufacturer.
ANALYSIS:	<ul style="list-style-type: none"> • On 8/10/22, I heard 2 separate smoke detectors chirping on the main floor of the home. • On 8/30/22, I could overhear at least one smoke detector chirping at the home.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



9/7/22

Kara Robinson
Licensing Consultant

Date

Approved By:



9/12/22

Ardra Hunter
Area Manager

Date