GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2023

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

RE: License #: AS820277913
Investigation #: 2023A0901027
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

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820277913
Investigation #:	2023A0901027
Complaint Receipt Date:	05/04/2023
Investigation Initiation Date:	05/04/2023
Report Due Date:	07/03/2023
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
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:	05/16/2022
Expiration Date:	05/15/2024
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff drink and smoke weed all day.	No
Resident A was thin and appeared psychiatrically decompensated and it seems this condition had gone on for a while.	No
Staff gave Resident A 2 doses of his medication.	No
Staff cooks at the facility for their families and do not give the residents any.	No
Resident A was unkempt and smelling.	No
Additional Findings	Yes

III. METHODOLOGY

05/04/2023	Special Investigation Intake 2023A0901027
05/04/2023	Special Investigation Initiated - Telephone Dawn Massad, St. John Hospital
05/04/2023	Referral - Recipient Rights
05/04/2023	APS Referral
05/09/2023	Inspection Completed On-site Staff Residents B and C
05/09/2023	Contact - Telephone call made Resident D
05/11/2023	Contact - Telephone call made Resident E

05/16/2023	Contact - Telephone call made Suzie Inez, Case Manager
05/19/2023	Contact - Telephone call made Resident A
05/19/2023	Inspection Completed-BCAL Sub. Compliance
06/26/2023	Exit Conference Mercy Igiogbe, Licensee Designee

ALLEGATION:

Staff drink and smoke weed all day.

INVESTIGATION:

On 05/09/2023, I conducted an unannounced onsite inspection at the above facility. The home was clean, and I did not detect a marijuana odor. The home manager, Tainay Waters, was present as well as staff, Gloria Loyd and Osayande Ediagbonya. I did not smell marijuana on either of them during my conversations with them, and they each denied smoking marijuana or drinking alcohol while on duty or observing others do it. Furthermore, neither of them appeared to be under the influence of drugs or alcohol.

During the onsite inspection on 05/09/2023, I attempted to interview Resident A, but he refused to talk to me.

On 05/09/2023, I interviewed Residents B and C separately. They were aware of what marijuana was and denied ever seeing staff use it while on duty or smell it in the home. They also denied observing staff drink alcohol while on duty.

I later made a telephone call to the facility on 05/09/2023, and interviewed Resident D. He was aware of what marijuana was and denied ever seeing staff use it while on duty or smell it in the home. He also denied observing staff drink alcohol while on duty.

On 05/11/2023, I made a telephone call to the facility and interviewed Resident E. She was aware of what marijuana was and denied ever seeing staff use it while on duty or smell it in the home. She also denied observing staff drink alcohol while on duty.

On 05/16/2023, I made a telephone call to Resident A's case manager from CNS Health Care. She stated she is at the facility often and has never smelled marijuana or suspected staff of being under the influence of drugs or alcohol.

On 05/19/2023, I made a telephone call to the facility and interviewed Resident A. Initially, he denied any knowledge of staff drinking alcohol or smoking marijuana while on duty. He later said he think so but was unable to provide names or other specific information.

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.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the information obtained during this investigation there is a lack of evidence to confirm the allegations. There is no indication that staff are not able to meet the needs of the residents. Everyone interviewed, except for Resident A, denied ever observing staff to be under the influence of drugs or alcohol while on duty. In addition to this, Resident A gave inconsistent statements regarding the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was thin and appeared psychiatrically decompensated and it seems this condition had gone on for a while.

INVESTIGATION:

On 05/04/2023, I made a telephone call to Dawn Massad, social worker from St. John Hospital. She stated when Resident A came to the hospital on 04/02/203. He was very thin and seemed very decompensated, as if he had not taken his medications in a while.

On 05/09/2023, I conducted an unannounced onsite inspection at the above facility. The home manager, Tainay Waters, was present as well as staff, Gloria Loyd and Osayande Ediagbonya. They stated Resident A has always been thin and does not

eat much. His 03/23/2022 health care appraisal documented his weight as 129.4 lbs and his 02/09/2023 health care appraisal documented his weight as 136 lbs. I reviewed weight records from the years 2021 until 2023, which showed fluctuation in his weight with the smallest being 115 lbs and highest being 140 lbs. Staff also indicated that Resident A was mentally decompensating due to being noncompliant with taking his medications. They stated this has been an ongoing problem, which they keep his case manager informed off. Sometimes he does well with taking his medications and sometimes he refuses. This also contributes to why he was sent to the hospital on 04/02/2023. He had not been taking his medications consistently and his behavior was becoming problematic.

On 05/16/2023, I made a telephone call to Resident A's case manager from CNS Health Care. She confirmed what was reported by staff. She stated she has known Resident A for 20 years and he has always been very thin. He also has a history refusing his medications. Staff had been keeping her informed and she was in agreement with them that he needed to go to the hospital. She stated his most recent hospitalization was definitely warranted.

On 05/19/2023, I made a telephone call to the facility and interviewed Resident A. He admitted to sometimes refusing to take his medications, but stated lately he has been taking it.

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 obtained during this investigation, there is a lack of evidence to confirm the allegations. It was confirmed that Resident A has always been very thin, which is why staff did not see his weight as an issue. Due to observing a change in his behavior and Resident A not consistently taking his medications, staff notified his case manager of the concerns and also had him hospitalized, which his case manager was in agreement with.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff gave Resident A 2 doses of his medication.

INVESTIGATION:

On 05/04/2023, I made a telephone call to Dawn Massad, social worker from St. John Hospital. She stated when Resident A was brought to the hospital, he complained about being given 2 doses of his medication. He reported telling staff he had already took his medication, but she made him take it again anyway. This allegedly happened on 04/02/2023. Ms. Massad stated they were unable to confirm that he was overdosed.

On 05/09/2023, I conducted an unannounced onsite inspection at the above facility. The home manager, Tainay Waters, was present as well as staff, Gloria Loyd and Osayande Ediagbonya. Ms. Loyd stated she was present on 04/02/2023 and denied giving Resident A 2 doses of his medication. All 3 staff indicated that prior to being hospitalized Resident A was not compliant with taking his medications and was very picky about when he took it and who he allowed to give it to him. Ms. Loyd further indicated that it was difficult enough getting him to take his prescribed dosage of medications. He is not the type that would let you give it to him twice.

On 05/09/2023, I attempted to interview Resident A, but he refused to talk to me.

On 05/16/2023, I made a telephone call to Resident A's case manager from CNS Health Care. She stated she doubted very seriously if staff overdosed Resident A. She indicated they have been very good with his care and keeping her informed. Ms. Inez also reported she has a lot of history with Resident A and he tends to be delusional and say things that are not true. She also stated he can be very defiant and if staff tried to give him a 2nd does, it was unlikely he would take it.

On 05/19/2023, I made a telephone call to the facility and interviewed Resident A. he was unsure if he was given 2 doses of his medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on information obtained during this investigation, there is a lack of evidence to confirm that Resident A's medications were not given as prescribed. The hospital was not able to confirm that he was given an overdose of medications, Resident A was unsure if he was given 2 doses, and Ms. Loyd denied giving him 2 doses.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff cooks at the facility for their families and do not give the residents any.

INVESTIGATION:

On 05/09/2023, I conducted an unannounced onsite inspection at the above facility. The home manager, Tainay Waters, was present as well as staff, Gloria Loyd and Osayande Ediagbonya. They each denied the allegations and stated they are not aware of any of the staff doing this. I observed an ample supply of food in the refrigerator, freezer, and cabinets.

On 05/09/2023, I interviewed Residents B and C separately. They each reported getting 3 meals a day and stated they get plenty to eat.

On 05/09/2023, I made a telephone call to the facility and interviewed Resident D. He reported receiving 3 meals a day and being able to have as much as he wants.

On 05/11/2023, I made a telephone call to the facility and interviewed Resident E. She stated they get 3 meals a day and there is always plenty to eat.

On 05/19/2023, I made a telephone call to the facility and interviewed Resident A. He stated staff always cook food for the residents and that they get 3 meals a day. He stated he does not always want to eat because he is not always hungry.

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:	Based on the information observed during this investigation, there is a lack of evidence to confirm the allegations. The residents reported receiving 3 meals a day and getting enough to eat. I also observed a sufficient food supply.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was unkempt and smelling.

INVESTIGATION:

On 05/04/2023, I made a telephone call to Dawn Massad, social worker from St. John Hospital. She sated when Resident A came to the hospital, his hygiene was poor and he had an odor.

On 05/09/2023, I conducted an unannounced onsite inspection at the above facility. The home manager, Tainay Waters, was present as well as staff, Gloria Loyd and Osayande Ediagbonya. They stated Resident A practice poor hygiene. Although they encourage him daily, he does not like to bathe and does not always change his clothes.

On 05/16/2023, I made a telephone call to Resident A's case manager from CNS Health Care. She confirmed what was reported by staff. She stated Resident A does not like to take showers and baths and that staff cannot force him. She also reported that he likes to dumpster dive, which contributes to odor.

On 05/19/2023, I made a telephone call to the facility and interviewed Resident A. He stated staff tells him to bathe but he only does it when he wants to.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. Staff encourages and affords Resident A the opportunity to bathe daily but he refuses, which he admitted. This was also confirmed by his case manager.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite inspection on 05/09/2023, I requested to see Resident A's medication logs for the last few months. I observed a lot of blank spaces and there was no documentation to explain the blanks. Staff, Gloria Loyd, stated she was still working on them and was not done filling them in. She was attempting to fill the blank spaces in during this onsite inspection. I explained to her that the medication log is supposed to be initialed as soon as the medications are administered. I also explained that there should never be blank spaces that are unaccounted for. There should always be documentation to indicate if the resident refused, was in the hospital, or on a leave of absence.

On 06/26/2023, I conducted an exit conference with the licensee designee, Mercy Igiogbe. I informed her of my investigative findings, which she agreed with and stated she would do another medication training with each staff.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Based on the blank spaces that were observed on Resident A's medication log sheets, the logs are not being initialed at the time the medication is administered. When questioned about the logs, Ms. Loyd stated she was not done working on them.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/27/2023

Regina Buchanan — Date
Licensing Consultant

Approved By:

06/28/2023

Ardra Hunter — Date
Area Manager