GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 10, 2025

Princess Kennedy
Asanpee Care
PO Box 871665
Canton, MI 48187

RE: License #: AS820286497
Investigation #: 2025A0901054
Princess Home

Dear Princess Kennedy:

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,

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 #:	AS820286497
Investigation #:	2025A0901054
Complaint Receipt Date:	09/09/2025
Investigation Initiation Date:	09/10/2025
Report Due Date:	11/08/2025
Licensee Name:	Asanpee Care
LicenseeAddress:	37664 Ford Rd. Westland, MI 48186
Licensee Telephone #:	(313) 522-9587
Administrator:	Princess Kennedy
Licensee Designee:	Princess Kennedy
Name of Facility:	Princess Home
Facility Address:	29605 Glenwood Inkster, MI 48141
Facility Telephone #:	(734) 326-1316
Original Issuance Date:	12/27/2006
License Status:	REGULAR
Effective Date:	11/17/2024
Expiration Date:	11/16/2026
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was punched in the face by Resident B.	No
Staff do not take Resident A to his doctor's appointments.	No
Resident A went on a leave of absence with his guardian, and the guardian was not given all his medication.	No
Resident A had items stolen by another resident.	No
The guardian is not allowed to give Resident A money.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2025	Special Investigation Intake 2025A0901054
09/10/2025	Special Investigation Initiated - Telephone Guardian A1
09/11/2025	Referral - Recipient Rights
09/15/2025	Inspection Completed On-site
09/15/2025	Contact - Document Received Email from GuardianA1
09/16/2025	Adult Protective Services Referral
09/16/2025	Contact - Telephone call made Licensee designee, Princess Kennedy
09/17/2025	Inspection Completed On-site

09/18/2025	Contact - Telephone call made Staff, Abel Emma
09/18/2025	Contact - Telephone call made Resident C
09/19/2025	Contact - Telephone call made Staff, Hope Udeh
09/19/2025	Contact - Telephone call made Resident A's Case Manager
09/22/2025	Contact - Telephone call made Resident A's therapist
11/04/2025	Exit Conference Licensee designee, Princess Kennedy
11/04/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was punched in the face by Resident B.

INVESTIGATION:

On 09/10/2025, I made a telephone call to Resident A's guardian, Guardian A1. She stated on 09/07/2025 Resident A was punched in the face by Resident B and staff did not do anything about it. She indicated staff sent Resident B to Resident A's room to tell him it was time to take his medication and the two of them had an exchange of words. Resident B punched Resident A twice in the face and staff broke it up. She said Resident A did not have any injuries and did not require medical care.

On 09/15/2025, I conducted an onsite inspection at the facility. The home manager, Nicholine Abongyum, was present and was interviewed. She confirmed that Resident A and B had a confrontation, but said there were no injuries. Nicholine stated Resident B went in Resident A's room to tell him and Resident C, who are roommates, that it was medication time and Resident A did not want him in there. She showed me the incident report, which was completed by staff, Abel Emma, and dated 09/07/2025 at 8:00 p.m. It indicated that Abel heard voices and ran to the

room. Upon getting there, Resident A and B were exchanging words. He separated them and had Resident A to come with him.

During the onsite inspection on 09/15/2025, I interviewed Resident B. He stated After taking his medication, he stopped by Resident A's room to tell him it was medication time. Resident A was on the phone and was made that he interrupted him. Resident A punched him in the face, so he punched him back in his face. He said staff broke them up and separated them. He further said Resident A is his friend and that they normally get along.

Resident A was not interviewed on 09/15/2025 due to not being home.

On 09/16/2025, I made a telephone call to the licensee designee, Princess Kenndey. She stated Guardian A1 sent her a text message regarding the incident. She said based on her internal investigation, after taking his medication, Resident B stopped by Resident A and C's room on his way to his room. He went to their room to tell them it was medication time. Resident A jumped from his bed and hit Resident B on the head and Resident B hit him back. Abel was present and heard them and intervened.

On 09/17/2025, I conducted another onsite inspection at the facility and interviewed Resident A. He explained that Resident B came to his room to tell him it was medication time and he hit him and pushed him in the chest because he did not want Resident B in his room. Resident B hit him back and staff came and broke them up. Resident A said he felt safe at the facility, and he normally gets along with Resident B.

On 09/18/2025, I made a telephone call to Abel. He confirmed he was working during the time of the incident. He made an announcement that it was time for the Residents to take their medication. Resident B was in the living room and took his first. As he was walking to his room, he stopped by Resident B and C's room, which is next to his, to let them know it was medication time. Resident A told Resident B to leave his room and pushed him. He stated he did not see anyone get punched and that it must have happened before he got back there. He immediately separated the two of them and there were no more issues the rest of the night.

On 09/18/2025, I made a telephone call to the facility and interviewed Resident C. He stated Resident A hit Resident B and Resident B hit him back. They started swinging at each other but were missing and hitting the air instead. He said staff broke them up and separated them.

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 I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A's protection and safety was not attended to. Everyone interviewed, including Resident A, indicated Resident A hit Resident B first and that staff intervened and separated them. Resident A also reported feeling safe at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff do not take Resident A to his doctor's appointments.

INVESTIGATION:

On 09/10/2025, I made a telephone call to Resident A's guardian, Guardian A1. She stated Resident A missed some appointments because staff do not always take him. According to Guardian A1, he missed a therapy appointment and a medical appointment in Ann Arbor that had to be rescheduled. She said when Resident A was placed at the facility, she told the licensee designee, Princess Kennedy, that he had a lot of medical appointments and that she would assist staff with taking him because she likes to stay on top of his medical care. She indicated Resident A was now caught up on all his appointments.

On 09/15/2025, I conducted an onsite inspection at the facility. The home manager, Nicholine Abongyum, was present and I interviewed her. She denied the allegations. She stated they do not have a problem taking Resident A to his appointments and showed me a calendar, which documented his appointments. She said Guardian A1 is very involved and prefers to take him to his appointments herself. She normally lets staff know in advance if she is taking him or needs them to do it. Nicholine indicated they do their best to keep all appointments but when there is a conflict, they occasionally must reschedule. She showed me that the appointment at the

cancer center in Ann Arbor was rescheduled for 09/12/20025 which was documented on the calendar.

On 09/16/2025, I made a telephone call to the licensee designee, Princess Kenndey. She stated she was not aware of Resident A missing any appointments and said when staff cannot make an appointment, they reschedule it. She also said they do not have a problem with taking Resident A where he needs to go but Guardian A1 often prefers to do it.

On 09/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. He was not aware of any missed appointments. He said Guardian A1, Princess, and staff make sure he goes to all his appointments.

On 09/19/2025, I made a telephone call to Resident A's case manager, Aleah Smith, from Hegira. She stated Guardian A1 complained to her before about Resident A missing appointments but Guardian A1 could not give any specific details regarding the appointments she was referring to. Aleah said she was not aware of Resident A missing any psychiatric and therapy appointments and, to her knowledge, he was up to date with his medical appointments. She also said Guardian A1 agreed to take him to some of his appointments. Aleah indicated that Guardian A1 complains a lot about the facility. She felt the placement was not a good fit for Resident A and Guardian A1. Aleah said Guardian A1 is very hands-on, likes to stay informed of every detail pertaining to Resident A, and is at the facility often. She said staff and Guardian A1 do not seem to work well together and felt it was in part due to miscommunication and understanding related to the language barriers.

On 09/22/2025, I made a telephone call to Resident A's therapist, Stephany Little, from Hegira. She said she was recently assigned to Resident A in May 2025 and that Guardian A1 usually brings him to his appointments. She said today was the only day staff brought him. Stephanie stated Guardian A1 likes to be involved and prefers to take Resident A to his appointments because she does not feel she can trust staff with that task. She further said that their system showed Resident A had a missed psychiatric appointment on 04/09/2025 but was seen on 05/12/2025. Their system did not show who cancelled the appointment.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions**

	and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that staff are not meeting Resident A's health care needs by not taking him to his appointments. Guardian A1 indicated that Resident A is up to date with all of his appointments and that she volunteered to assist with taking Resident A to his appointments. The psychiatric appointment and cancer center appointments that were cancelled were rescheduled and attended by Resident A. Resident A was not aware of any missed appointments, staff reported he was up to date on his appointments, as well as his therapist and case manager.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A went on a leave of absence with his guardian, and the guardian was not given all his medication.

INVESTIGATION:

On 09/15/2025, I received an email from Resident A's guardian, Guardian A1. It indicated that she picked Resident A up on 09/14/2025 for an overnight stay and was only given two pills for that night when it should have been three. I followed up with a telephone call. Guardian A1 said she did not have any verification regarding what medication she was given or how many pills she was given because she did not sign anything when given the medication and she did not check what she was given until she got home.

On 09/17/2025, I conducted an onsite inspection at the facility and reviewed Resident A's September 2025 medication log. The medications for 09/14/2025 were initialed by staff, Abel Emma. Based on the log, he takes three pills at night.

On 09/18/2025, I made a telephone call to Abel. He stated when he arrived at work on 09/14/2025, Resident A was leaving with Guardian A1 for his overnight visit. Staff, Hope Udeh, had already given Guardian A1 his medications.

On 09/19/2025, I made a telephone call to Hope. She explained that she gave Resident A his afternoon medication before he left on 09/14/2025. She gave Guardian A1 all his night medications for 09/14/2025 and all his morning

medications for 09/15/2025, because he was not coming back until the afternoon of 09/15/2025. Hope also reported she did not have Guardian A1 sign anything verifying what she was given.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is insufficient evidence to corroborate that staff did not provide Guardian A1 with all Resident A's medications while on leave of absence. Guardian A1 reported she did not receive all his medications and Hope reported she gave Guardian A1 all the medications. Additionally, Guardian A1 and Hope did not sign any documentation during the medication exchange to verify what was given.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had items stolen by another resident.

INVESTIGATION:

On 09/10/2025, I made a telephone call to Resident A's guardian, Guardian A1. She said Resident B stole money and other items from Resident A's fanny pack. She was unable to specify what those other items were. She also said he had clothes stolen by another resident but could not give a name. According to Guardian A1, staff did nothing about the stolen items.

On 09/15/2025, I conducted an onsite inspection at the facility. The home manager, Nicholine Abongyum, was present and was interviewed. She stated Guardian A1 once complained she saw Resident D, who is no longer there, with Resident A's shirt on. When questioned, both residents argued that the shirt belonged to them. Since she could not determine who it belonged to and since Guardian A1 has complained before about items being stolen, she suggested that Guardian A1 starts

labeling Resident A's belongings. Nicholine also said she was not aware of any money being stolen.

During the onsite inspection on 09/15/2025, I interviewed Resident B. He denied ever stealing anything from Resident A.

On 09/16/2025, I made a telephone call to the licensee designee, Princess Kennedy. She stated Resident A complains all the time about people stealing from him but never have any proof.

On 09/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. He reported having items stolen, like body spray and clothes, but denied having money stolen. He did not know who stole his items and said he had not seen anyone at the facility with his stuff. Resident A was not certain if they were stolen or if he misplaced the items. He also indicated that Resident D, who is not there anymore, once had a shirt of his but he let him have it.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(1) Upon a request from a resident or the resident's designated representative, a licensee may accept a resident's funds and valuables to be held in trust with the licensee.
ANALYSIS:	Based on the information I obtained during this investigation, there is lack of evidence to confirm the allegations. There is no indication that Resident A's belongings are not being treated as a trust obligation. Although Guardian A1 reported Resident A had items stolen by Resident B and D, Resident A denied this. He reported having items missing but was not sure if they were stolen or misplaced. He also admitted to giving Resident A the shirt that Guardian A1 claimed was stolen.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The guardian is not allowed to give Resident A money.

INVESTIGATION:

On 09/10/2025, I made a telephone call to Resident A's guardian, Guardian A1. She stated the licensee designee, Princess Kennedy, does not want her to give Resident

A allowance money because he buys marijuana, but she said she gives it to him anyway.

On 09/16/2025, I made a telephone call to Princess. She denied saying Resident A could not have allowance money. She stated Guardian A1 controls his money and gives him monthly allowance.

On 09/17/2025, I conducted an onsite inspection at the facility and interviewed Resident A. He stated Guardian A1 gives him allowance money every month.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A does not have access to his funds in reasonable amounts. Princess denied the allegations and everyone, including Guardian A1, reported resident A gets his allowance monthly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection I conducted on 09/17/2025, I reviewed Resident A's September medication log. The medications for 09/14/2025 were initialed by staff, Abel Emma.

On 09/18/2025, I made a telephone call to Abel. He stated when he arrived at work on 09/14/2025, Resident A was leaving and staff, Hope Udeh, had already given him his afternoon medication and sent the night medication with Guardian A1. I asked Abel why he initialed the log verifying he administered Resident A's 09/14/2025

nighttime medications when he was on leave of absence and not at the facility. He stated that it was their procedure to initial the log when they give medication to the guardian or responsible person. He said even though he did not give Guardian A1 the medication, he initialed it on behalf of Hope.

On 11/04/2025, I made a telephone call to the licensee designee, Princess Kennedy, for an exit conference. I informed her of my investigative findings which she conveyed she understood.

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 information I obtained during this investigation, Resident A's medication log sheet was not completed correctly. The above rule requires that staff only initial the log when they supervise the taking of medication by a resident. On 09/14/2025, Resident A's nighttime medication was given to Guardian A1 to administer while Resident A was on leave of absence with her. Although he did not administer the medication, Abel initialed the log as if he did.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/04/2025

Regina Buchanan — Date
Licensing Consultant

Approved By:

11/10/2025

Ardra Hunter — Date
Area Manager