GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27, 2025

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

RE: License #: AS820415985
Investigation #: 2025A0101011
Triple J's Bettercare Inc. #2

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415985
Investigation #:	2025A0101011
Complaint Receipt Date:	01/10/2025
Investigation Initiation Date:	01/14/2025
Report Due Date:	02/09/2025
Licensee Name:	Triple J's Bettercare Inc.
Licensee Address:	P.O. Box 13710 Detroit, MI 48213
Licensee Telephone #:	(313) 522-1421
Administrator:	Mercy Igiogbe, Designee
Licensee Designee:	Mercy Igiogbe
Name of Facility:	Triple J's Bettercare Inc. #2
Facility Address:	19977 Kingsville Harper Woods, MI 48225
Facility Telephone #:	(313) 469-7522
Original Issuance Date:	06/20/2023
License **Status:**	REGULAR
Effective Date:	12/20/2023
Expiration Date:	12/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/10/2025, complainant reported Resident B assaulted Resident A and knocked her out. Emergency medical services was called, and Resident A was currently on the way to Henry Ford Saint John Hospital. Resident A woke up talking on the way to the hospital.	Yes
On 01/11/2025, complainant reported Resident A reported her eye was red because direct care staff Latonya Gillette slapped her.	No
Additional Findings	Yes

III. METHODOLOGY

01/10/2025	Special Investigation Intake 2025A0101011
01/10/2025	APS Referral
01/14/2025	Special Investigation Initiated - Telephone Adult Protective Services, Charmaine Parks
01/14/2025	Contact - Telephone call made Zion Guardianship Services, Tamesha Scott
01/14/2025	Contact - Telephone call received Licensee designe, Mercy Igiogbe
01/14/2025	Contact - Telephone call received Michelle Livous, Office of Recipient Rights
01/14/2025	Contact – Telephone call received Licensee designee, Mercy Igiogbe
01/16/2025	Inspection Completed On-site Interviewed Home manager, LaTonya Gillette Direct care staf,f Kimberly Loyd Residents C, D, and E. Obtained copies of Resident A's medication logs, medication refusal charts & 27 incidents report on Resident A

01/16/2025	Contact - Document Received Resident A's and B's treatment plans and psychiatric evaluations.
02/26/2025	Contact - Document Received Resident A's discharge notice
02/27/2025	Contact - Telephone call made Direct care staff, Akai Gillon
02/28/2025	Contact - Telephone call received Ms. Gillion
02/28/2025	Contact - Telephone call made Licensee designee, Mercy Igiogbe
03/05/2025	Contact - Telephone call made Ms. Gillon, left message
03/05/2025	Contact - Telephone call made Ms. Igiogbe
03/05/2025	Contact - Telephone call made Adult Well Being Case manager, Tameshia Jones
03/07/2025	Contact – Documents received Additional medication logs and medication refusal charts
03/11/2025	Contact - Telephone call made Ms. Igiogbe Ms. Gillette
03/12/2025	Contact – Documents received Ms. Gillon's training
03/13/2025	Contact – Telephone call made Ms. Livous, Office of Recipient Rights
03/13/2025	Exit conference with Ms. Igiogbe

ALLEGATION: On 01/10/2025, complainant reported Resident B assaulted Resident A and knocked her out. Emergency medical services was called, and Resident A was currently on the way to Henry Ford Saint John Hospital. Resident A woke up talking on the way to the hospital.

INVESTIGATION: On 01/14/2025, I spoke with the adult protective services worker Charmaine Parks. Ms. Parks stated that Resident A died on 01/10/2025, at Henry Ford Saint John Hospital. Ms. Parks further stated Resident B was arrested on 01/09/2025, for physically assaulting Resident A and he was subsequently charged with homicide-murder-second degree. Ms. Parks stated Resident B is currently in the Wayne County Jail. Ms. Parks further stated this incident is so unfair because Resident A was the aggressor.

On 01/14/2025, I spoke with Resident A's guardian Tamesha Scott. Ms. Scott stated on 01/09/2025, Resident A was physically assaulted by another resident living in the home and on 01/10/2025, she died. Ms. Scott stated she was aware that Resident A was the aggressor.

On 01/14/2025, I received a telephone call from the licensee designee, Mercy Igiogbe. Ms. Igiogbe wanted to know if there was anything she needed to do regarding Resident A's death. Ms. Igiogbe stated on 01/09/2025, Resident A was "terrorizing" the other residents. Ms. Igiogbe stated Resident A would not leave Resident B alone. Ms. Igiogbe stated Resident A followed Resident B outside and they were the only ones in the backyard. Ms. Igiogbe stated Resident A came in the house and his fists were bleeding. According to Ms. Igiogbe Resident A stated, "She wouldn't leave me alone." Ms. Igiogbe stated the only staff on duty, Akia Gillon, went outside and found Resident A laying on the ground non-responsive. Ms. Igiogbe further stated Resident A would not take her medications. Ms. Igiogbe stated no one in the home has one on one staffing, therefore, her staffing ratio was one staff to six residents. Ms. Igiogbe further stated on 01/09/2025, she did not bring in additional staff when Resident A was "terrorizing" the other residents.

On 01/16/2025, I interviewed the home manager, LaTonya Gillette and direct care staff, Kimberly Loyd. They both stated that Resident A was aggressive, and she would not take her medications. Ms. Gillette and Ms. Loyd both stated that they were not working when Resident B assaulted Resident A.

On 01/16/2025, I interviewed Residents C, D, and E. Resident F refused to be interviewed. Residents C, D, and E stated they feel safe in their home. No one expressed that they were fearful of Resident A. They stated they felt bad for Resident A because she was "really sick." Residents C, D, and E stated they could not provide any information regarding Resident B assaulting Resident A because they were the only two people outside in the backyard.

On 01/16/2025, I reviewed several documents from Resident A's resident record, assessment plans, psychiatric evaluation, incident reports and medication logs. According to the psychiatric evaluation and the assessment plan Resident A's diagnosis was "Schizoaffective Disorder Bipolar type with Psychosis. Resident A [was] non-compliant with medications, delusional, psychotic, verbally and physically

aggressive, no behavioral control, violent, property destruction and nonsensical with poor insight."

According to Resident A's assessment plan she was on court ordered "Assisted Outpatient Treatment," however, the assessment plan did not give a staff to resident ratio to address her behavioral needs. Resident A's assessment plan stated she was to receive an injection every four weeks. The resident register stated Resident A's date of placement was 06/09/2024. On 01/16/2025, I reviewed Resident A's medication logs, and they did not indicate that she received an injection while in this home. On 03/05/2025, I asked Ms. Igiogbe if Resident A was receiving her injection. Ms. Igiogbe stated she did not know. On 03/05/2025, I spoke with Resident A's case manager, Tameshia Jones. Ms. Jones stated Resident A refused the injections. Ms. Jones did not provide written documentation of Resident A's refusal to accept the injections. Furthermore, Resident A's assessment plan stated Resident A will take her medication as prescribed. According to the medication logs Resident A often would not take her medications. Resident A's assessment plan also stated adult foster care staff will alert the psychiatrist of any side effect and changes in Resident A's mental stability. Ms. Igiogbe has no documentation indicating that the psychiatrist was contacted. However, Ms. Igiogbe stated she submitted 27 incidents reports regarding Resident A's behavior and refusing to take her medications to the case manager. On 03/05/2025, I spoke with Resident A's case manager. Ms. Jones stated she only received two incident reports from Ms. Igiogbe regarding Resident A's behavior. On 03/05/2025, I asked Ms. Igiogbe for the confirmations from her fax machine showing that she did send the incident reports to the case manager. Ms. Igiogbe stated that her fax machine does not give confirmation of documents being sent. Resident A's assessment plan further stated that Resident A will receive behavioral interventions and redirecting to address paranoia, psychosis, delusional behavior, elopement, wandering, verbal and physical aggression, violence toward others/property, smoking in the home and medication compliance. I spoke with Ms. Igiogbe regarding what behavioral interventions were being utilized to address Resident A's behaviors. Ms. Igiogbe could not tell me what behavior interventions were being utilized, and they were not identified in the assessment plan. Ms. Igiogbe stated if you don't take a client, you will be "blacklisted."

On 03/05/2025, I spoke with Ms. Gillon. Ms. Gillon expressed an unwillingness to discuss what happened on 01/09/2025, when Resident B assaulted Resident A. Ms. Gillon stated that day was very traumatizing, and she had to take two weeks off from work to regroup from it. Eventually she agreed to discuss the incident. Ms. Gillon stated Resident A had to be redirected the entire day. Ms. Gillon stated the day became increasingly "unbearable" and she kept calling the home manager. Ms. Gillon also stated she called Ms. Igiogbe. Ms. Gillon stated Resident A had a "rude encounter" with everyone in the house. Ms. Gillon's stated early in the day Resident A had an argument with Resident C and later that evening she kept bothering Resident B. According to Ms. Gillon, Resident B asked Resident A to stop but she did not. Ms. Gillon stated she told the residents to stay away from Resident A, but Resident A kept following Resident B. Ms. Gillon stated when Resident B went

outside Resident A would follow him and when Resident B came in the house Resident A would follow him. Ms. Gillon stated this went on throughout the day. Ms. Gillon stated she was passing medications, and Resident B came in the house. According to Ms. Gillon, Resident B's fists were bloody, and he said, "I messed her up, she is laid out on the ground." Ms. Gillon stated she found Resident A laying on the ground unconscious with a bloody face in the backyard. Ms. Gillon stated she called 911. Ms. Gillon stated emergency medical services transported Resident A to Henry Ford Saint John Hospital and Resident B was arrested.

On 03/12/2025, I conducted an exit conference with Ms. Igiogbe. Initially Ms. Igiogbe disagreed with my finding. Ms. Igiogbe stated that the case manager was in receipt of the incident reports. Ms. Igiogbe stated Ms. Jones is the case manager for ten of her residents and Ms. Jones was given incident reports when she came to the home weekly. We had a lengthy discussion regarding her responsibility to assess the residents referred for residential placement into the home and if no longer able to meet a resident needs, that resident should be discharged. The responsible agency cannot make you take a resident or tell you when to discharge them. We also discussed her responsibility for implementing the goals in a resident's assessment plan. If a goal is unrealistic, she should be addressing it in writing to the case manager. Ms. Igiogbe also stated the guardian gave little or no assistance to meet Resident A's needs. After our discussion Ms. Igiogbe acknowledged an understanding of how she violated the rule.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	The licensee did not provide the protection and supervision as specified in Resident A's assessment plan. According to Resident A's assessment plan, she was to receive an injection every four weeks. On 03/05/2025, I spoke with Resident A's case manager Tameshia Jones. Ms. Jones stated Resident A refused the injections. Resident A's assessment plan stated Resident A will take her medication as prescribed. According to the medication logs Resident A often would not take her medications. Resident A's assessment plan stated staff will alert the psychiatrist of any side effect and changes in Resident A's mental stability. Ms. Igiogbe has no documentation indicating that the psychiatrist was contacted. However, Ms. Igiogbe stated she submitted 27 incidents reports regarding Resident A's behavior and refusing to take her medications to the case manager. On 03/05/2025, I spoke with Resident A's case manager. Ms. Jones stated she only received two incident reports from Ms. Igiogbe regarding Resident A's behavior. On 03/05/2025, I asked Ms. Igiogbe for the confirmations from her fax machine showing that she sent the incident reports to the case manager. Ms. Igiogbe stated that her fax machine does not give confirmation of documents being sent. Resident A's assessment plan stated that Resident A will receive behavioral interventions. Ms. Igiogbe could not tell me what behavior interventions were being utilized, and they were not identified in the assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: 01/11/2025, complainant reported Resident A reported her eye was red because direct care staff, Latonya Gillette slapped her.

INVESTIGATION: On 01/16/2025, I interviewed the home manager, LaTonya Gillette. Ms. Gillette denied the allegation that she slapped Resident A. Ms. Gillette stated the red eye was likely from the assault she sustained from Resident B or when she jumped on Resident C on 01/01/2025. Ms. Gillette further stated Resident A would often make false allegations.

On 01/16/2025, I interviewed direct care staff, Kimberly Loyd. Ms. Loyd stated she has never observed Ms. Gillette mistreat a resident.

On 01/16/2025, I interviewed Residents C, D, and E. Resident F refused to be interviewed. They all stated that they have never observed a staff slap a resident and they have never been hit or slapped by a staff.

On 01/16/2025, I reviewed Resident A's assessment plan. According to Resident A's assessment plan Resident A was nonsensical. On 01/09/2025, Resident A reported that her eye was red because Ms. Gillette slapped her. Resident A made this statement even though, earlier on that same date Resident B physically assaulted Resident A and knocked her unconscious.

On 03/05/2025, I conducted an exit conference with Ms. Igiogbe. Ms. Igiogbe agreed with my finding.

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 upon the preponderance of evidence Ms. Gillette did not slap Resident A. Ms. Gillette denied the allegation. There were no witnesses, and on the same date Resident A was physically assaulted by Resident B. There is sufficient evidence to support that Resident A's eye was likely red because of the physical altercation that occurred on the same day with Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 01/09/2025, Ms. Gillon completed three incident reports regarding Resident A verbally, provoking everyone in the home. One report indicates that "staff kept calling the home manager to inform her of what was going on throughout the day leading up to the altercation between [Resident A and B]" and another report indicated the "home provider" was contacted. On 03/11/2025, I spoke with Ms. Igiogbe and Ms. Gillette. I asked them what action was taken when Ms. Gillon apprised them of Resident A's escalating behavior leading up to Resident B assaulting Resident A. They both stated they told Ms. Gillon to give Resident A a cigarette every hour.

On 01/14/2025, I spoke with Ms. Igiogbe. Ms. Igiogbe stated that Resident A was "terrorizing" the other residents in the home. Ms. Igiogbe stated Resident A did not

have one on one staffing. She further stated that on 01/01/2025, Resident A assaulted her roommate, and she [Resident A] was sent to the hospital. Ms. Igiogbe also stated on the same date she allowed Resident A to return to the home. Ms. Igiogbe acknowledged that she did not implement an emergency discharge or add additional staffing. Ms. Igiogbe stated on 01/07/2025, she gave Resident A a 30-day discharge notice.

On 01/16/2025, I reviewed 27 incident reports which documented Resident A was not taking her medications, and she was harming and provoking others.

On 01/16/2025, I reviewed Resident A's psychiatric evaluation and assessment plan. According to the psychiatric evaluation and the assessment plan Resident A's diagnosis was "Schizoaffective Disorder Bipolar type with Psychosis. Resident A [was] non-compliant with medications, delusional, psychotic, verbally and physically aggressive, no behavioral control, violent, property destruction and nonsensical with poor insight."

On 01/16/2025, I reviewed Resident B's psychiatric evaluation and assessment plan. Resident B's diagnoses are Schizophrenia and Bipolar I Disorder. Resident B was working on learning coping skills to deal with stress and controlling his anger in a non-aggressive manor. On 03/5/2025, Ms. Gillon stated on 01/09/2025, Resident A would not leave Resident B alone and consequently was assaulted.

On 03/05/2025, I conducted an exit conference with Ms. Igiogbe. Ms. Igiogbe agreed with my finding.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: (b) Be capable of appropriately handling emergency situations.

ANALYSIS:	Based upon the preponderance of evidence the licensee did not appropriately handle an emergency situation. On 01/09/2025, Ms. Gillon wrote three incident reports. One incident report stated she kept calling the home manager to inform her of what was going on throughout the day leading up to the altercation between [Resident A and B]" and another report indicated the "home provider" was contacted. On 01/14/2025, I spoke with Ms. Igiogbe. Ms. Igiogbe stated that Resident A was "terrorizing" the other residents in the home. Ms. Igiogbe stated Resident A had not been taking her medication. She further stated that on 01/01/2025, Resident A assaulted her roommate, and she was sent to the hospital. Ms. Igiogbe also stated on the same date she allowed Resident A to return to the home. Ms. Igiogbe acknowledged that she did not implement an emergency discharge or add additional staffing. Ms. Igiogbe stated on 01/07/2025, she gave Resident A a 30-day discharge notice. A 30-day notice was not appropriate because a 30-day discharge notice would have only prolonged a volatile situation. On 03/05/2025, I spoke with Ms. Gillon. Ms. Gillon stated Resident A had to be redirected the entire day. Ms. Gillon stated the day became increasingly "unbearable" and it was conveyed to Ms. Igiogbe and Ms. Gillette
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Residents A-F were not treated with dignity and his or her personal needs, including protection and safety being attended to at all times. On 01/09/2025, Ms. Gillon informed Ms. Igiogbe and Ms. Gillette of Resident A's escalating behavior throughout the day. They both stated they told Ms. Gillon to give Resident A a cigarette every hour.

	According to the psychiatric evaluation and the assessment plan Resident A's diagnosis was "Schizoaffective Disorder Bipolar type with Psychosis. Resident A [was] non-compliant with medications, delusional, psychotic, verbally and physically aggressive, no behavioral control, violent, property destruction and nonsensical with poor insight." According to Resident B's psychiatric evaluation Resident B is aggressive and he is unable to cope with stress. However, on 01/09/2025, he was left in a situation where Resident A was bothering him the entire day. Resident A's verbally provoking and aggressive behaviors were not addressed, leading to her being assaulted by Resident B. Residents B-F were being subjected to Resident A's verbally provoking and aggressive behaviors and Ms. Igiogbe did not protect them.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/16/2025, I reviewed Resident A's refusal of medication behavioral chart. During the month of December 2024 Resident A refused her medication 20 times. On 03/05/2024, I spoke with Ms. Igiogbe. Ms. Igiogbe stated a health care professional was not contacted when Resident A refused, her medications.

On 03/05/2025, I conducted an exit conference with Ms. Igiogbe. Ms. Igiogbe agreed with my finding.

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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

ANALYSIS:	On 03/05/2025, Ms. Igiogbe admitted that a health care professional was not contacted when Resident A refused her medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Edith Richardson
Licensing Consultant

03/27/2025
Date

Approved By:

03/27/2025

_____

Ardra Hunter
Area Manager

Date