



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2025

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

RE: License #: AS820292158
Investigation #: 2025A0778035
Triple J's Bettercare Inc 3

Dear Ms Igiogbe:

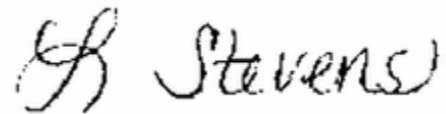
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 456-0439.

Sincerely,

A handwritten signature in black ink, reading "LaKeitha Stevens". The signature is written in a cursive, flowing style. The first name "LaKeitha" is written in a more compact, cursive script, while the last name "Stevens" is written in a slightly more legible, though still cursive, style.

LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820292158
Investigation #:	2025A0778035
Complaint Receipt Date:	06/18/2025
Investigation Initiation Date:	06/18/2025
Report Due Date:	08/17/2025
Licensee Name:	Triple J's Bettercare Inc.
Licensee Address:	P.O. Box 13710 Detroit, MI 48213
Licensee Telephone #:	(313) 522-1421
Administrator:	Mercy Igiogbe
Licensee Designee:	Mercy Igiogbe
Name of Facility:	Triple J's Bettercare Inc 3
Facility Address:	20427 Lennon Street Harper Woods, MI 48225
Facility Telephone #:	(313) 522-1421
Original Issuance Date:	09/25/2007
License Status:	REGULAR
Effective Date:	03/11/2024
Expiration Date:	03/10/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/12/25, Resident was taken to the hospital due to taking marijuana and alcohol brought into the home by staff.	Yes
Staff are not completing medication logs.	No
There is no hot water in the kitchen sink. The facility toilet seat is cracked.	Yes

III. METHODOLOGY

06/18/2025	Special Investigation Intake 2025A0778035
06/18/2025	APS Referral Referral received
06/18/2025	Referral - Recipient Rights Referred to ORR
06/18/2025	Special Investigation Initiated - Telephone Telephone interview with APS worker, Ashley Rasberry
07/03/2025	Inspection Completed On-site Face to face interviews with Residents A-D and staff, Aubrey Fletcher
07/15/2025	Contact - Telephone call made Telephone interview with licensee designee, Mercy Igiogbe
07/15/2025	Contact - Telephone call made Telephone call made to staff, Gloria Lloyd and case manager Keonie Thomas
07/23/2025	Contact - Telephone call made Telephone call to Guardian A1
07/23/2025	Contact - Telephone call made Telephone call made to staff, Gloria Lloyd
07/23/2025	Exit Conference

	Telephone exit conference with licensee designee, Mercy Igiogbe
07/23/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 5/12/25 Resident was taken to the hospital due to taking marijuana and alcohol brought into the home by staff.

INVESTIGATION: On 06/18/2025, I completed a telephone interview with an Adult Protective Services Worker, Ashley Raspberry. Ashley stated her complaint will be substantiated. Ashley stated she spoke with staff, Gloria Llyod, who confirmed bringing marijuana to the job and Resident A ate it.

On 07/03/2025, I completed a face-to-face interview with Resident A. Resident A stated he stole marijuana and alcohol from staff. He stated her bag was on the floor in the Livingroom. He stated he went in the bag, ate her marijuana and drank her alcohol. Resident A stated he could not remember the name of the staff.

While onsite I completed an interview with staff, Aubrey Fletcher. He stated all staff were made aware of the situation because the licensee designee called an all-staff meeting. Mr. Fletcher stated Resident A was taken to the hospital but discharged with no issues. Mr. Fletcher stated Gloria is the staff member who brought the items into the facility.

I attempted a telephone interview with staff, Gloria Llyod. I left messages requesting a return call. To date, my call has not been returned. According to licensee designee Mercy Igiogbe, Gloria Llyod was immediately terminated from the facility.

I attempted a telephone interview with Case Manager A1, Keonie Thomas. I left messages requesting a return call. To date, my call has not been returned.

On 07/23/2025, I completed a telephone interview with Guardian A1. She stated staff Gloria called her upset and told her Resident A took her liquor and marijuana. She stated Gloria told her she needed to be paid back and requested twenty dollars. Guardian A1 stated she never paid Gloria, and Gloria has not contacted her again. Guardian A1 stated Resident A suffered no issues because of eating marijuana and drinking alcohol.

On 07/23/2025, I completed a telephone exit conference with licensee designee, Mercy Igiogbe. I informed her this complaint will be substantiated. Mercy stated staff,

Gloria Llyod told her Resident A ate her marijuana. Mercy stated Gloria did not inform her of alcohol. However, Mercy stated Gloria was immediately terminated.

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:	Resident A consumed marijuana and alcohol that was brought into the facility by staff, Gloria Llyod. Resident A was transported to the hospital and later discharged with no issues or complications. Guardian A1 stated staff Gloria contacted her and requested twenty dollars due to Resident A eating her marijuana and drinking her alcohol.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff are not completing medication logs.

INVESTIGATION: While onsite I observed the medication logs and medication for all residents. I observed the logs to be completed in entirety with no errors.

I interviewed Residents A-D. Residents A-D indicated they receive their medication, and they've observed staff signing the log after administration.

APPLICABLE RULE	
R 400.14312	Resident medications.
	<p>(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:</p> <p>(b) Complete an individual medication log that contains all of the following information:</p> <ul style="list-style-type: none"> (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:	<p>There is no evidence of staff not complying with the completion of medication logs.</p> <p>I observed medication logs to be completed in entirety.</p> <p>Residents A-D indicated staff administer their medication and they observe staff signing the log.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is no hot water in the kitchen sink. The facility toilet seat is cracked.

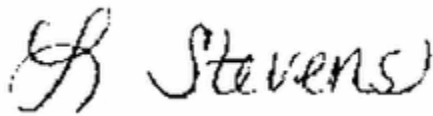
INVESTIGATION: While onsite for inspection I observed the toilet seat for the facility to be in good condition. It was not cracked. However, I observed the water from the kitchen sink to not dispense properly. The water came out in a small stream with little to no pressure. In addition, the water did not reach 90 degrees.

During my telephone exit conference with licensee designee, Mercy Igiogbe; she indicated she will contact maintenance regarding the water pressure and temperature. I informed her a corrective action plan will be required for this complaint.

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:	The water from the kitchen sink was not adequately dispensed. The water came out in a small stream with little to no pressure. In addition, the water temperature did not get greater than 90 degrees.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



08/14/2025

LaKeitha Stevens
Licensing Consultant

Date

Approved By:



08/19/2025

Ardra Hunter
Area Manager

Date