GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2025

Princess Kennedy
Asanpee Care
PO Box 871665
Canton, MI 48187

RE: License #: AS820286497
Investigation #: 2026A0901005
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 #:	2026A0901005
Complaint Receipt Date:	11/04/2025
Investigation Initiation Date:	11/05/2025
Report Due Date:	01/03/2026
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 out of three of his prescriptions.	Yes
Guardian A1 was banned from visiting Resident A.	No
All allegations reported were not investigated because they were previously investigated (SIR #2025A0901054 and SIR # 2025A0119036).	

III. METHODOLOGY

11/04/2025	Special Investigation Intake 2026A0901005
11/04/2025	Adult Protective Services (APS) Referral
11/05/2025	Special Investigation Initiated - Telephone APS
11/06/2025	Referral - Recipient Rights
11/07/2025	Contact - Telephone call made Guardian A1
11/10/2025	Inspection Completed On-site
11/13/2025	Inspection Completed On-site
11/14/2025	Exit Conference Licensee designee, Princess Kennedy

ALLEGATION:

Resident A was out of three of his medications.

INVESTIGATION:

On 11/05/2025, I made a telephone call to Deante Brown, from APS, and left a voice message for additional information. I also followed up with an email.

On 11/07/2025, I made a telephone call to Guardian A1. She stated while at the facility earlier this week, she checked Resident A's medications and noticed he was out of his Ativan, Simvastatin, and Mirabegron medications and staff never contacted her or attempted to get refills from the doctors. She also stated she contacted his doctors herself since staff did not.

On 11/08/2025, I received a text message from Guardian A1 that indicated that Resident A was also out of his Sertraline medication.

On 11/10/2025, I conducted an onsite inspection at the facility and reviewed Resident A's medications and log sheets. The Ativan and Mirabegron were not on his November medication log sheet and not available in the facility. He last received the Mirabegron on 08/31/2025 and it was not refilled since then. The Ativan was last received on 10/31/2025. The Simvastatin and Sertraline were available in the facility with his other medications and based on the prescription labels, were filled on 10/07/2025. His November 2025 medication log sheet was also correctly filled out to verify he had been receiving them. During this onsite inspection the program manager, Candace G'Long, arrived. She said the home manager, Nicholine Abongyume, Resident A, and Guardian A1 were at Hegira to meet with the psychiatrist to get Resident A's Ativan refilled. Candace indicated that the pharmacy never received a new prescription for the Ativan, which is why it was not filled and sent to the facility with his other medications. She explained that the prescriptions for psychotropic medications go straight to the pharmacy, but no one contacted the psychiatrist regarding Resident A being out of the medication and needing a new prescription. Candace was not sure why staff never contacted the urologist for a refill of the Mirabegron when Resident A ran out. She said she explained to staff that even though Guardian A1 is very involved when it comes to managing his care and takes him to 90% of his appointments, they are still responsible for Resident A and ensuring he has all his medications. Candace stated she was in the process of putting a plan in place to prevent this from happening again.

On 11/13/2025, I conducted another onsite inspection at the facility and observed Resident A's Ativan and Mirabegron to be available in the facility and documented on his medication log sheets. He began receiving both medications 11/10/2025. Nicholine was present during this onsite visit. She stated no one contacted the psychiatrist regarding Resident A being out of his Ativan because they thought the doctor was just late sending the prescription to the pharmacy. Regarding the

Mirabegron, she stated when he ran out no one contacted the prescribing doctor or notified Guardian A1 and she had no explanation why. She said since the pharmacy stopped sending it, she assumed he was taken off it.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the information I obtained during this investigation, Resident A's medication was not given as ordered. His Ativan was prescribed to be taken three times daily and he did not receive it 11/01/2025-11/09/2025. The Mirabegron was prescribed to be taken once a day, and he did not receive it 09/01/2025-11/09/2025. The home manager and program manager confirmed staff did not contact the prescribing doctors for refills.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Guardian A1 was banned from visiting Resident A.

INVESTIGATION:

On 11/07/2025, I made a telephone call to Guardian A1. She stated the licensee designee, Princess Kennedy, told her she was banned from coming to the facility because she accused Guardian A1 of harassing staff and the other residents. Guardian A1 said despite this, she continues to visit, and no one has interfered with her visits or tried to put her out.

On 11/10/2025, I conducted an onsite inspection at the facility. The program manger and staff, Thelma Ebooh, was present. They denied Guardian A1 ever

being banned from coming to the facility. They showed me the sign in log, which verified that Guardian A1 visits almost daily and multiple times a day.

On 11/13/2025, I conducted another onsite inspection at the facility and interviewed Resident A. He stated he sees Guardian A1 a lot because she always comes to visit him and takes him to appointments and other places.

On 11/14/2025, I made a telephone call to Princess. She denied the allegation. She reported having an issue with Guardian A1 harassing staff and other residents but said she never banned her from visiting. I also conducted an exit conference with Princess at this time. I informed her of my investigative findings, which she conveyed she understood and the need for a better system in place to prevent future medication errors.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(l) Receive visitors at a reasonable time. Exceptions or visitor restrictions must be covered in the resident's assessment plan. Special consideration must be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. Resident A was not denied the right to have visits from Guardian A1. Princess denied the allegation and Guardian A1 reported she was never stopped from visiting. The visitors log also verified that she visits frequently.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

_____11/19/2025

Regina Buchanan — Date
Licensing Consultant

Approved By:

11/20/2025

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Ardra Hunter — Date
Area Manager