



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Marion Justice
Tri County Care Provider Inc
P.O. BOX 14488
DETROIT, MI 48214

RE: License #: AM820009976
Investigation #: 2026A0101032
Tri County Care Provider

Dear Ms. Justice:

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,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, 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 #:	AM820009976
Investigation #:	2026A0101032
Complaint Receipt Date:	04/23/2026
Investigation Initiation Date:	05/01/2026
Report Due Date:	06/22/2026
Licensee Name:	Tri County Care Provider Inc
Licensee Address:	101 Winona D Highland Park, MI 48203
Licensee Telephone #:	(313) 410-9028
Administrator:	Marion Justice
Licensee Designee:	Marion Justice
Name of Facility:	Tri County Care Provider
Facility Address:	3041 Bewick Detroit, MI 48214
Facility Telephone #:	(313) 822-2110
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	01/31/2025
Expiration Date:	01/30/2027
Capacity:	10
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established
On 04/16/2026, a staff forcibly grabbed Resident A and made him clean the bathtub.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/23/2026	Special Investigation Intake 2026A0101032
04/23/2026	Referral received from APS
05/01/2026	Special Investigation Initiated - On Site Interviewed home manager Yolanda Irvin, Resident A, Resident B, volunteer Sandra Little and the designated person Kiley Justice
05/01/2026	Inspection Completed-BCAL Sub. Compliance
06/04/2026	Contact-Document received from the licensee designee Resident A's assessment Resident A's ID sheet Ms. Little's training
06/04/2026	Contact- Telephone call made Resident A's case worker Daysha Walker, MiSide
06/04/2026	Exit conference with the licensee designee Marion Justice and the designated person.

ALLEGATION: On 04/16/2026, a staff forcibly grabbed Resident A and made him clean the bathtub.

INVESTIGATION: On 05/01/2026, I interviewed the home manager, Yolanda Irvin. Ms. Irvin stated that she was not present when the incident happened, however, "It did happen." Ms. Irvin stated she was transporting the other residents and Ms. Little

was at the group home with Residents A and B. Ms. Irvin stated Resident B witnessed the incident.

On 05/01/2026, I interviewed Resident A. Resident A stated that nothing happened.

On 05/01/2026, I interviewed Resident B. Resident B stated Resident A came out of the bathroom and went upstairs. She stated that staff, Sandra, ran up the stairs, grabbed Resident A's arm and put it behind his back. Resident B further stated that Sandra escorted Resident A with his arm still behind his back, down the stairs, back into the bathroom and told him to clean the tub. Resident B stated she does not believe Sandra was trying to hurt Resident A, she was "redirecting" him. Resident B stated, "She should have never put her hands on him."

On 05/01/2026, I interviewed volunteer, Sandra Little. Ms. Little stated that she did run upstairs behind Resident A, grabbed him by his shirt, escorted him down the stairs, back into the bathroom and told him to clean the tub. Ms. Little stated she would never harm Resident A. Ms. Little stated she did not know that she could not physically redirect a resident. Ms. Little stated that she was trained.

On 05/01/2026, I interviewed the designated person, Kiley Justice. Mr. Justice stated that Ms. Little is trained.

On 06/04/2026, I spoke with Resident A's and Resident B's case worker, Daysha Walker. Ms. Walker stated due to Resident A's limited cognitive ability he is unable to convey what happened. Ms. Walker stated Resident A also might be experiencing dementia but has not been diagnosed. Ms. Walker stated Resident B, who is credible, informed her about the incident.

On 06/04/2026, I conducted an exit conference, with the licensee designee Marion Justice and Mr. Justice, they agreed with my findings.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (b) Use any form of restraint without an order from an appropriately licensed health care professional or physical force, other than physical restraint for crisis intervention.

ANALYSIS:	<p>Based upon the preponderance of evidence, volunteer, Sandra Little, used physical force with Resident A.</p> <p>According to Resident B, Resident A came out of the bathroom and went upstairs. She stated that staff Sandra ran up the stairs, grabbed Resident A's arm and put it behind his back. Resident B further stated that Sandra escorted Resident A with his arm still behind his back, down the stairs, back into the bathroom and told him to clean the tub.</p> <p>Ms. Little admitted that she did run upstairs behind Resident A, grabbed him by his shirt, escorted him down the stairs, back into the bathroom and told him to clean the tub.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 05/01/2026, I interviewed the home manager, Yolanda Irvin. Ms. Irvin stated she was not present when the incident occurred. Ms. Irvin stated she was transporting the other residents and Ms. Little was at the group home with Residents A and B.

On 05/01/2026, I interviewed Ms. Little and Mr. Justice. They both stated that she was trained.

On 06/04/2026, Ms. Justice's daughter in law, Courtney Justice, emailed me a copy of Ms. Little's training certificate. The only certificate forwarded to me was for CPR and First Aid.

On 06/04/2026, I spoke with Mr. Justice. Mr. Justice stated Ms. Little does not have the direct care training.

On 06/04/2026, I conducted an exit conference with Mr. and Ms. Justice. I informed them that since Ms. Little was not trained and was providing care this was an additional violation.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(3) An individual, including a volunteer, cook, or private duty staff shall not be considered in determining the ratio of direct care staff-to-residents unless the individual meets the

	qualifications of a direct care staff member and is providing direct care to residents on behalf of the licensee.
ANALYSIS:	<p>Based upon the preponderance of evidence, Ms. Little was considered in determining the ratio of direct care staff-to-residents and she did not meet the qualifications of direct care staff.</p> <p>According to Ms. Irvin this incident occurred when she was transporting other residents and Ms. Little was at the group home with Residents A and B.</p> <p>On 06/04/2026, Ms. Justice's, daughter-in-law, Courtney Justice emailed me a copy of Ms. Little's training certificate. The only certificate forwarded to me was for CPR and First Aid.</p> <p>On 06/04/2026, I spoke with Mr. Justice. Mr. Justice stated Ms. Little does not have the direct care training.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Edith Richardson
Licensing Consultant

06/09/2026
Date

Approved By:



06/11/2026

Ardra Hunter
Area Manager

Date