GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2026

Princess Kennedy
Triple C's Care Inc.
PO Box 871204
Canton, MI 48187

RE: License #: AS820418776
Investigation #: 2026A0121020
Triple C Home

Dear Ms. 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) 456-0380.
Sincerely,

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820418776
Investigation #:	2026A0121020
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/26/2026
Report Due Date:	07/24/2026
Licensee Name:	Triple C's Care Inc.
Licensee Address:	37664 Ford Rd, Suite. B Westland, MI 48185
Licensee Telephone #:	(313) 522-9587
Administrator:	Princess Kennedy
Licensee Designee:	Princess Kennedy
Name of Facility:	Triple C Home
Facility Address:	33545 Bock Street, Garden City, MI 48135
Facility Telephone #:	(313) 772-3307
Original Issuance Date:	12/05/2024
License **Status:**	REGULAR
Effective Date:	12/05/2025
Expiration Date:	12/04/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The home lacks adequate supervision of residents.	Yes

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A0121020
06/26/2026	Special Investigation Initiated - Telephone Call to Witness 1
07/01/2026	Inspection Completed On-site Interviewed direct care staff, Thelma Eboh and Resident A and B.
07/01/2026	Contact - Telephone call made Candace Gee-Long, Program Manager
07/01/2026	Contact - Telephone call made Tiffany Jennings, Home manager
07/02/2026	Contact - Telephone call received Mrs. Gee-Long
07/09/2026	Contact - Document Sent Letter to Witness 1
07/09/2026	Referral - Recipient Rights
07/10/2026	Contact - Telephone call received Michelle Livous, Recipient Rights Investigator (RRI)
07/10/2026	Contact - Telephone call made Sarah Brookins, Supervisor with Lincoln Behavioral Services
07/10/2026	Contact - Document Received Received Resident B's treatment plan
07/10/2026	Exit Conference Princess Kennedy

ALLEGATION: The home lacks adequate supervision of residents.

INVESTIGATION: On 6/26/26, I initiated the complaint with a phone call to Witness 1 who expressed concern that the staff do not provide adequate supervision of the residents. Per Witness 1, there is a "violent" individual that resides at the facility who screams and makes threatening statements as he walks the neighborhood. Witness 1 described the individual as the tallest, black male in the home with dreadlocks.

On 7/1/26, I conducted an unannounced onsite inspection at the facility, arriving at approximately 10:45 AM. Direct care staff, Thelma Eboh was the sole staff on duty. Resident A, B, and C were present as well. Ms. Eboh indicated that Resident D and E were away on medical appointments with home manager, Tiffany Jennings. Ms. Eboh identified Resident A and C as the only 2 black males in the home with dreadlocks. In comparison, Resident A is much taller (approximately 3-4 inches) than Resident C, so I determined Resident A matched the description in the complaint. Resident A acknowledged he did recently go outside on the porch and had an argument with his girlfriend on the phone. Resident A accused the next door neighbor of being "racist" because the neighbor called the police on him. Resident A reported that pursuant to contact with the police, he no longer yells when outside. According to Ms. Eboh, Resident A does not have a 1:1 staffing assignment, so he is permitted to go in the community unsupervised. Ms. Jennings acknowledged Resident A does hallucinate and talks to the voices in his head. Ms. Jennings admitted that these conversations are sometimes aggressive because Resident A will use profanity to curse at the voices he hears. But in general, Ms. Jennings indicated that Resident A is harmless. In fact, Ms. Jennings reported Resident A is the "best" resident in the home; he is respectful, medication compliant, and follows staff directions.

According to Ms. Eboh, Resident B is the only resident in the home with a 1:1 staffing assignment. However, on the day of inspection, Ms. Eboh was the only staff present during the full hour I was on site. When asked Ms. Eboh, Ms. Jennings, and Program Manager, Candace Gee-Long were not familiar with the details of Resident B's staffing assignment. So, I contacted Sarah Brookins with Lincoln Behavioral Services on 7/10/26. Ms. Brookins verified Resident B is approved for 1:1 staffing 24 hours per day; this authorization expires on 9/7/26.

On 7/10/26, I completed an exit conference with licensee designee, Princess Kennedy. Ms. Kennedy confirmed Resident A is allowed to go in the community without staff supervision. Ms. Kennedy also acknowledged that Resident A talks loud on his phone and sometimes he repeats vulgar rap lyrics, but overall Resident A is not aggressive. With regard to Resident B's 1:1 staffing assignment, Ms. Kennedy explained Resident B was likely staying home on 7/1/26 because he didn't want to go on transport with Ms. Jennings. Ms. Kennedy is adamant that 2 staff are scheduled to work at the facility at all times.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	On 7/1/26, Ms. Kennedy failed to provide 1:1 supervision as specified in Resident B's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/28/26

Kara Robinson — Date
Licensing Consultant

Approved By:

07/28/26

Ardra Hunter — Date
Area Manager