GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2021

Ihsan Asmar
R & C Homes, Inc.
4004 Lovett Ct.
Inkster, MI 48141

RE: License #: AS820393375
Investigation #: 2021A0992021
Forever Care Homes III

Dear Mr. Asmar:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820393375
Investigation #:	2021A0992021
Complaint Receipt Date:	06/08/2021
Investigation Initiation Date:	06/08/2021
Report Due Date:	08/07/2021
Licensee Name:	R & C Homes, Inc.
Licensee Address:	4004 Lovett Ct. Inkster, MI 48141
Licensee Telephone #:	(248) 881-7543
Administrator:	Ihsan Asmar
Licensee Designee:	Ihsan Asmar
Name of Facility:	Forever Care Homes III
Facility Address:	14465 Buck St. Taylor, MI 48180
Facility Telephone #:	(734) 442-7063
Original Issuance Date:	10/25/2018
License **Status:**	REGULAR
Effective Date:	10/25/2019
Expiration Date:	10/24/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents A and B were assigned as roommates and currently share a room. Resident B attacked Resident A, leaving injuries.	Yes
Resident B ran out of her medications and was without medications for at least one week.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/08/2021	Special Investigation Intake 2021A0992021
06/08/2021	Special Investigation Initiated - Telephone Pamela Traskos, Adult Protective Services (APS)
06/09/2021	Inspection Completed On-site Keith Hicks, home manager, Annie Charleston and Mary Mosley direct care staff (DCS)
06/10/2021	Contact - Telephone call made Myla, Resident B's guardian with Guardian & Associates
06/10/2021	Contact - Telephone call made Joe Jenkins, Resident B's Support Coordinator with Community Care Services
06/10/2021	Contact - Telephone call made Allen Asmar, licensee designee
06/10/2021	Contact - Telephone call made Charles Jackson, home manager
06/10/2021	Contact - Document Received Incident reports involving Residents A and B.
07/09/2021	Exit Conference Mr. Asmar.

ALLEGATION: Residents A and B were assigned as roommates and currently share a room. Resident B attacked Resident A, leaving injuries.

INVESTIGATION: It should be noted that an additional intake was received on 6/10/2021, with similar allegations which will be addressed within this investigation.

On 6/08/2021, I contacted Pamela Traskos, adult protective services (APS) regarding the allegations. Ms. Traskos explained while visiting Resident A she noticed he had scratches all over him and when she asked him about the scratches, he said Resident B attacked him. Ms. Traskos said she interviewed Resident B to get a better understanding of what happened, and she said Resident A tried to rape her and she was defending herself. During the course of the interview, Resident B recanted and said she scratched Resident A because he was getting smart with her. Ms. Traskos said she suggested Residents A and B stay away from each other and that's when Resident A made her aware that they are roommates. Ms. Traskos said she asked Charles Jackson, home manager about them being roommates and he said he wasn't aware that they couldn't share a bedroom.

On 6/9/2021, I completed an unannounced onsite inspection and interviewed Keith Hicks, home manager; at the time I arrived Mr. Hicks and Resident C were the only people present. I proceeded to interview Mr. Hicks regarding the allegations. He explained that Resident B has a single room, but stated she previously shared a bedroom with Resident A; he said now Resident A shares a bedroom with Resident C. I observed Resident A's bedroom that he currently shares with Resident C which was adequately furnished. Resident B's bedroom was also adequately furnished. I asked about the whereabouts of Residents A and B, Mr. Hicks explained that Resident A was demonstrating violent and aggressive behaviors prior to my arrival, so he was transported to the hospital and Resident B is in the community with another resident. I asked Mr. Hicks if he has any knowledge of an altercation between Resident A and B and he said no. I asked if he observed Resident B scratch Resident A and he said no. He said any injuries Resident A has, it's likely he did it to himself. He said Resident A doesn't like women for some reason and has a tendency to blame others. I requested to review Resident A and B's assessment plan and/or individual plan of services (IPOS) to determine any behaviors (if any) level of care and/ or needs outlined in their assessments. Resident A's resident file didn't contain an assessment plan or IPOS; Mr. Hicks explained that Resident A was picked up from Henry Ford Hospital as an emergency admittance on 5/21/2021, and his file is not complete. Resident B's file contained an IPOS. Per her IPOS she "will utilize increased staffing and 1:1 care over a 16-hour period to manage strong emotions and increase self-reliance as evidenced by problem solving, a reduction of verbal outbursts, willingness to be redirected to shower, take medication and be a

cooperative team player in her recovery." Mr. Hicks said he's aware Resident B requires supervision due to her behaviors, but stated Joseph Jenkins, case manager visited with her earlier and said she could go for a walk in the community.

While interviewing Mr. Hicks, Annie Charleston and Mary Mosely, direct care staff arrived at the home; I proceeded to interview Ms. Charleston and Ms. Mosley regarding the allegations.

Ms. Charleston confirmed Resident A was observed with scratches on him but was uncertain how he sustained the injuries. Ms. Charleston said she believes he did them himself. She said Resident A has extreme behaviors. She said today he broke the screen door, was hitting himself with whatever he could pick up and he went across the street to the neighbors and started banging on their door. Ms. Charleston was unable to attest to the sleeping arrangements for Residents A and B.

Ms. Mosely confirmed she observed the scratches on Resident A, she said she believe he self-inflicted the injuries; she denied seeing any physical altercation between Residents A and B. Ms. Mosley said Resident A has extreme behaviors which lead to him being hospitalized today. Ms. Mosley confirmed Resident A and B were sharing a room prior to him going to the hospital.

On 6/10/2021, I contacted Allen Asmar, licensee designee and interviewed him regarding the allegations. Mr. Asmar explained that Resident B is verbally and physically aggressive and she could've possibly attacked Resident A but Resident A has behaviors as well. Mr. Asmar further stated that he has had to make numerous repairs to the home due to Resident B destroying property. As far as making sure all involved agencies were notified, Mr. Asmar agreed to follow up with Charles Jackson, home manager to see if there are incident reports involving Resident B that were sent to the various agencies. As far as Residents A and B sharing a room, Mr. Asmar said they shared a room for a very short period of time (a day) when Resident A was first admitted into the home. I referenced rule 400.14408 (8) "residents of the opposite sex shall not occupy the same bedroom for sleeping purposes unless they are husband and wife," and explained to Mr. Asmar that regardless of how long Resident A and B shared a room, it's a violation.

On 6/10/2021, I received a call from Mr. Jackson; we proceeded to discuss the allegations. Mr. Jackson stated that there was an argument between Residents A and B, he said Resident A attacked Resident B and then later that day, Resident B attacked Resident A. He said incident reports (IR) were completed at the time of the incident but it's uncertain if the IRs were faxed to licensing or the other required departments; Mr. Jackson agreed to review the IRs and provide me with copies. Mr. Jackson confirmed Residents A and B were roommates but stated they have since been separated. He said Resident A shares a room with Resident C and Resident B currently has her own room.

On 6/10/2021, I received six incident reports from dated between 5/28/2021 through 6/10/2021, from Mr. Jackson. Five of the incident reports outlined Resident B displaying serious hostility and attempts at self-inflicted harm or harm to others.

On 6/10/2021, I contacted Myla Williams, Resident B's case manager with Guardian and Associates. I made her aware of the allegations and asked about her knowledge of the reported allegations. Ms. Williams explained that she previously received a call from Ms. Traskos regarding Resident B's behaviors. She said from her understanding Residents A and B attacked each other; Ms. Williams said she was not notified by the Mr. Asmar or any of the staff about Resident B's behaviors. She said Resident A is known for being delusional, physically, and verbally aggressive. As for the sleeping arrangements, Ms. Williams said she's not sure if Resident A and B shared a room. She said Joseph Jenkins, Resident B's supports coordinator visited with her and he might have more information.

On 6/10/2021, I contacted Mr. Jenkins and interviewed him regarding the allegations. Mr. Jenkins said Resident B has a very low baseline, she is delusional and can be verbally and physically aggressive. He said he was concerned because she stated that her roommate was trying to kill her and when he visited the home, he discovered her roommate was Resident A, a male. Ms. Jenkins said the fact that Resident A and B are roommates was very concerning and he is in the process of having her replaced. He said Resident B stated Resident A is violently delusional and has attacked her multiple times. Mr. Jenkins said Mr. Asmar and/or staff failed to notify him and/or Ms. Williams. He also said Resident B on an unknown date ran out of her medications due to pharmacy error and was without medications for at least one week, which possibly resulted in her aggressive behaviors, and he was not notified in a timely manner, nor was Ms. Williams.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(8) Residents of the opposite sex shall not occupy the same bedroom for sleeping purposes, unless they are husband and wife.

ANALYSIS:	During this investigation, I interviewed Allen Asmar, licensee designee, Pamela Traskos, adult protective services; Myla Williams, Resident B's case manager with Guardian and Associates; Joseph Jenkins, Resident B's supports coordinator; Keith Hicks and Charles Jackson, home managers; Annie Charleston and Mary Mosley, direct care staff regarding the allegations. All of which confirmed Residents A and B did share a bedroom. Resident A was hospitalized and was not interviewed regarding the allegations. Resident B was not interviewed as she no longer resides at the home and her whereabouts are unknown. Based on the investigative findings, there is sufficient evidence that Residents A and B occupied the same bedroom for sleeping purposes. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**

ANALYSIS:	During this investigation, I interviewed Allen Asmar, licensee designee; Myla Williams, Resident B's case manager with Guardian and Associates; Joseph Jenkins, Resident B's supports coordinator; and Charles Jackson, home manager regarding the allegations. Ms. Williams and Mr. Jenkins stated they did not receive any form of notification regarding Resident B's behavior prior to this investigation. Adult foster care licensing did not receive a copy of the incident reports prior to this investigation. Based on the investigative findings, there is sufficient evidence that Allen Asmar failed to provide a written report to the Resident B's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of her displaying serious hostility and/or attempts at self-inflicted harm or harm to others.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: **Resident B ran out of her medications and was without medications for at least one week.**

INVESTIGATION: On 6/10/2021, I contacted Allen Asmar, licensee designee and interviewed him regarding the allegations. Mr. Asmar explained it wasn't an error on the home behalf, but that the pharmacy was not filling the medications due to a funding issue, an issue that was out of his control. I explained that although I understand it was a pharmacy issue, Resident B can't go without her medications for several days. I suggested if this situation occurs in the future to contact the guardian/supports coordinator sooner and/or take the resident to the hospital.

On 6/10/2021, I contacted Ms. Williams, Resident B's case manager with Guardian and Associates and proceeded to ask her about the allegations. Ms. Williams confirmed she received a telephone call from the staff because Resident B was out of her medication, and she had been out for a week. Ms. Williams said the staff was not proactive regarding Resident B's medication and she should have been notified immediately.

On 6/10/2021, I contacted Mr. Jenkins and interviewed him regarding the allegations. Mr. Jenkins confirmed he received a call from the staff regarding Resident B being out of her medication for at least a week, he said it was a pharmacy error. He said it was easily fixed by contacting the pharmacy, however, he said he should've been contacted sooner.

On 7/9/2021, I reviewed Resident B's medication administration record (MARs). The MARs didn't contain label instructions for use, The initials of the person who administers the medication, which shall be entered at the time the medication is given. There were several medications listed including: Carbamzetine 200mg, Haloperidol 10mg Tablets, Benztropine MES 1mg Tablet, Pantoprazole SOD DR 40mg, Vitamin B Complex Tablet and Trazodone 100mg Tablet.

- Carbamzetine 200mg was not initialed on the 14th through the 16th, 19th and the 23rd through the 31st at 8:00 a.m.
- Carbamzetine 200mg was not initialed on the 14th through the 31st at 4:00 p.m. Although there was an 8:00 p.m. dosage documented for Carbamzetine 200mg, there were no initials for the entire month.
- Haloperidol 10mg Tablets was not initialed on the 14th through the 20th and the 22nd through the 31st at 8:00 a.m. Although there was an 8:00 p.m. dosage documented for Haloperidol 10mg, there were no initials for the entire month.
- Benztropine MES 1mg Tablet was not initialed on the 14th through the 21st and the 22nd through the 31st at 8:00 a.m.
- Benztropine MES 1mg Tablet was not initialed on the 13th through the 31st at 8:00 p.m. The 20th was circled without initials.
- Pantoprazole SOD DR 40mg was not initialed at all.
- Vitamin B Complex Tablet was not initialed at all.
- Trazodone 100mg Tablet was not initialed 1st through the 6th and the 9th through the 31st. The 20th was circled without initials.

On 7/9/2021, I conducted an exit conference with Mr. Asmar and individually addressed the allegations. I explained that upon completion of the investigation, there is sufficient evidence to support the allegation that Residents A and B were sharing a bedroom, rather it was for a short period of time or not, they cannot share a room. I further explained that any time a resident displays serious hostility such as attacking staff, other residents or causing harm to themselves, such behaviors should be reported to the residents designated representative (if applicable), responsible agency (if applicable), and the adult foster care licensing division within 48 hours of the behaviors. I also explained that the medications were not properly documented, and Resident A didn't receive her medications as prescribed and/or staff didn't initial the MARs when they administered the medications. I further explained that based on the violation cited, a corrective action plan is required, in which Mr. Asmar agreed. Mr. Asmar denied having any questions and agreed to review the report once received.

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:

	(b) Complete an individual medication log that contains all of the following information: **(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.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	During this investigation, I interviewed Allen Asmar, licensee designee; Myla Williams, Resident B's case manager with Guardian and Associates; and Joseph Jenkins regarding the allegations. Ms. Williams and Mr. Jenkins stated they did not receive any form of notification regarding Resident B's behavior prior to this investigation. Adult foster care licensing did not receive a copy of the incident reports prior to this investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident B requires 1:1 staffing and was in the community unsupervised.

On 6/9/2021, I completed an unannounced onsite inspection and interviewed Keith Hicks, home manager. At the time I arrived Mr. Hicks and Resident C were the only people present. I asked about the whereabouts of Resident B and Mr. Hicks stated she is in the community with another resident. I requested to review Resident B's assessment plan and/or individual plan of services (IPOS) to determine her level of care, behaviors and needs, Resident B's file contained an IPOS. Per her IPOS she "will utilize increased staffing and 1:1 care over a 16-hour period to manage strong emotions and increase self-reliance as evidenced by problem solving, a reduction of verbal outbursts, willingness to be redirected to shower, take medication and be a cooperative team player in her recovery." Mr. Hicks said he is aware Resident B requires supervision due to her behaviors, but not necessarily 1:1 staffing. He said Joseph Jenkins, Resident A's supports coordinator visited with her earlier today and said she could go for a walk in the community.

While interviewing Mr. Hicks, Annie Charleston and Mary Mosely, direct care staff arrived at the home; I proceeded to interview them both regarding the allegations. Ms. Charleston and Ms. Mosely said they were aware Resident B required supervision but not 1:1 staffing.

On 6/10/2021, I contacted Ms. Williams, Resident B's case manager with Guardian and Associates. I proceeded to ask about Resident B's behaviors/needs. She said Resident B is known for being delusional, physically, and verbally aggressive. As for her 16 hours of 1:1 staffing, she said she is sure that those are wake hours. Ms. Williams suggested I contact Mr. Jenkins for more specifics regarding her IPOS.

On 6/10/2021, I contacted Mr. Jenkins and interviewed him regarding Resident B. Mr. Jenkins said Resident B has a very low baseline, she is delusional and can be verbally and physically aggressive. As far as her 1:1 staffing requirements, Mr. Jenkins said Resident B should receive 16 hours of 1:1 staffing during wake hours and the remaining 8 hours are sleep hours and doesn't require 1:1 staffing. I further explained that while visiting the home, Resident B was in the community with another resident without staff. I asked if he authorized her to be in the community without staffing and he said no.

On 6/10/2021, I contacted Mr. Asmar and made him aware while I was visiting the home, Resident B was in the community with another resident, unsupervised. Mr. Asmar said he was unaware Resident B was in the community unsupervised. He said there were three staff on shift and Resident B shouldn't have been in the community with another resident unsupervised.

On 6/10/2021, I received a call from Mr. Jackson, and made him aware while I was visiting the home, Resident B was in the community with another resident, unsupervised. I asked Mr. Jackson if he was aware of Resident B's 1:1 staffing needs and he said yes. However, he said Resident B will takeoff without staff knowing. He said staff has been in the bathroom before and Resident B will leave the home. I explained that based on Resident B's 1:1 staffing requirements, there should be two staff on shift unless it's during sleep hours. He said Resident B has also disarmed the alarms on the doors to sneak out the house. I informed Mr. Jackson that there were three staff on shift and no efforts were made to locate Resident B; all three staff were aware Resident B was in the community with another resident, unsupervised.

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:	During this investigation, I completed an unannounced onsite inspection and interviewed Keith Hicks; Annie Charleston and Mary Mosley, direct care staff; all of which stated Resident B was in the community with another resident, unsupervised. I reviewed Resident B's IPOS, which states she requires 16-hours of 1:1 staffing. Mr. Jenkins said Resident B should receive 16 hours of 1:1 staffing during wake hours and the remaining 8 hours are sleep hours and doesn't require 1:1 staffing. Based on the investigative findings, there is sufficient evidence that Allen Asmar failed to provide supervision and protection as defined in the act and as specified in the resident's written individual plan of service. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

7/9/2021

Denasha Walker Date
Licensing Consultant

Approved By:

7/15/2021

Ardra Hunter Date
Area Manager