GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 19, 2023

Cajetan Kimfon
Special Care Homes L.L.C
1632 Ashby Street
Westland, MI 48186

RE: License #: AS820402241
Investigation #: 2023A0121038
Ashby A.F.C

Dear Mr. Kimfon:

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, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
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 #:	AS820402241
Investigation #:	2023A0121038
Complaint Receipt Date:	08/02/2023
Investigation Initiation Date:	08/02/2023
Report Due Date:	10/01/2023
Licensee Name:	Special Care Homes L.L.C
Licensee Address:	1632 Ashby Street Westland, MI 48186
Licensee Telephone #:	(313) 960-0934
Administrator:	Cajetan Kimfon, Designee
Licensee Designee:	Cajetan Kimfon, Designee
Name of Facility:	Ashby A.F.C
Facility Address:	1632 Ashby Street Westland, MI 48186
Facility Telephone #:	(734) 589-8891
Original Issuance Date:	04/08/2020
License **Status:**	REGULAR
Effective Date:	04/08/2023
Expiration Date:	04/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 7/5/23, the following was observed by a male contractor at the home. The shower in the home does not have a curtain for privacy. There was a female resident observed naked in the shower with the bathroom door open wide enough for everybody to see inside. That same female was later wheeled to her bedroom by Staff with no shirt on, exposing her breast. Men were present.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/02/2023	Special Investigation Intake 2023A0121038
08/02/2023	Special Investigation Initiated - Telephone Left message for APS worker, Tammy Coleman
08/03/2023	Contact - Telephone call received Return call from Tammy Coleman
08/03/2023	Contact - Telephone call made Cajetan Kimfon, licensee designee
08/11/2023	Contact - Telephone call made Attempted call to Witness 1.
08/11/2023	Contact - Telephone call made Follow up call to Tammy Coleman to verify Witness 2's phone number.
08/17/2023	Inspection Completed On-site Unannounced
08/19/2023	Contact - Telephone call received Text from Mr. Kimfon. Photos of the repairs made.
08/21/2023	Contact - Telephone call made

	Witness 1.
08/21/2023	Referral - Recipient Rights
08/24/2023	Contact - Telephone call made Witness 2.
08/24/2023	Contact - Telephone call made Tammy Coleman with APS
08/28/2023	Exit Conference Mr. Kimfon

ALLEGATION: On 7/5/23, the following was observed by a male contractor at the home. The shower in the home does not have a curtain for privacy. There was a female resident observed naked in the shower with the bathroom door open wide enough for everybody to see inside. That same female was later wheeled to her bedroom by Staff with no shirt on, exposing her breast. Men were present.

INVESTIGATION: On 8/2/23, I initiated the complaint with a phone call to Adult Protective Services Worker, Tammy Coleman. Mrs. Coleman returned my call the following day. Mrs. Coleman identified the naked female as Resident A. Resident A is non-verbal, but she can say small phrases per Mrs. Coleman. Mrs. Coleman indicated she will "absolutely" be substantiating the case. On 8/3/23, I contacted licensee designee, Cajetan Kimfon to notify him the department received a complaint. I did not disclose the allegation.

On 8/17/23, I completed an unannounced onsite inspection at the facility. I observed Resident A sleeping in bed fully clothed. I interviewed Resident D who shares a room with Resident A. Resident D reported it is common for Resident A to sleep with clothes on. Resident D stated Resident A is known to change clothes multiple times per day. Resident D stated she's also observed Resident A rush out the bathroom naked before Staff have a chance to dress her. Resident C denied having ever seen Resident A naked in the home. Resident A, B, and E could not participate in a fluid interview due to their low cognitive abilities.

There were 3 direct care workers on duty when I arrived. Their names were Godfrey Leghu, Comfort Epamba, and Linus Gemoh. Both Godfrey and Comfort denied Resident A has been seen naked in the home. Comfort reported she assists with showering Resident A. Comfort stated she uses a blanket or bed sheet to cover Resident A during transport to her room after bathing. Comfort indicated she has not encountered any problems with Resident A exposing her body during transport.

Comfort described the task of showering Resident A as seamless. I did not interview Linus since I had a difficult time understanding his speech with heavy accent.

On 8/21/23, I interviewed Witness 1 by phone. Witness 1 works for a wheelchair company named Nu Motion. Witness 1 explained he was at the home on 7/5/23 to assist Witness 2 with a custom wheelchair fitting for Resident B. While at the home, Witness 1 stated he observed "an African American woman with short hair" in the bathroom nude. Resident A fits the description. According to Witness 1, a female worker had been assisting Resident A in the shower, but each time the worker left the room, the door remained wide open. Witness 1 is adamant he saw Resident A's naked body in the shower area and there was no shower curtain available. Not only that, Witness 1, stated once the shower was complete, the female worker proceeded to wheel Resident A to the bedroom "in plain sight of me and my co-worker with no top and no bra." Witness 1 was not sure if Resident A had on briefs or covering below; he said, "I wasn't trying to stare" in an apparent uncomfortable environment. In addition, Witness 1 indicated he goes to many AFC homes in his profession, so he knows the Staff's conduct and treatment of Resident A was inappropriate. On 8/24/23, I contacted Witness 2 to obtain his witness statement. Witness 2 reported he was preoccupied with Resident B's mold fitting more than Witness 1, so he didn't see as much. However, Witness 2 confirmed the bathroom door was definitely open while Resident A was in the shower, exposing the resident's nude body. In fact, Witness 2's assessment is that Staff seemed fairly unattended to Resident A's needs.

On 8/28/23, I completed an exit conference with Mr. Kimfon. Mr. Kimfon indicated that he had spoken with his Staff, and they all deny Resident A is allowed to be in the common areas of the home naked. Mr. Kimfon repeatedly stated, "I do not believe my staff did that." However, Mr. Kimfon could not provide a logical explanation why a mandated reporter would say they saw the resident nude. It should also be noted the bathroom door was in disrepair when I went out to the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	- On 8/17/23, I observed the bathroom door was no longer attached to the door frame as the hinges were disassembled. It is reasonable to conclude, the door may have malfunctioned on or around, 7/5/23. - Both Witness 1 and 2 reported seeing Resident A in the shower area nude during their visit to the home. - On 7/5/23, there were male visitors, male staff, and a male resident in the home. - Witness 1 is a mandated reported; he has nothing to gain or lose by reporting the incident. The department has determined Witness 1 is a reliable witness. - Therefore, it is more likely than not, Resident A was not treated with consideration and respect, with due recognition of personal dignity and the need for privacy on the day of Witness 1's visit.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 8/17/23, I observed bedrooms #4 and #5 without proper window treatments. Specifically, bedroom #4 had torn/worn blinds and bedroom #5 had 1 of 2 windows with no window treatment. The untreated window is facing the neighbor's driveway, so persons on the outside can see clearly inside the home. The window's placement is right above Resident A's bed. Mr. Kimfon reported Resident A purposely pulled the blinds down in Room 5 causing them to break.

On 8/31/23, I received a text message from Mr. Kimfon with updated images of both rooms. Bedrooms #4 and #5 had newly installed blind.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Observed 2 out of 5 bedrooms did not provide adequate window treatments for residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 8/17/23, I observed the door to the full bathroom was disassembled and no longer attached to the hinges. A make-shift curtain had been installed at the door frame. Direct care worker, Godfrey reported the curtain was installed the morning of my visit. However, Resident D reported the curtain had been up for at least 3 days prior to my visit.

On Saturday, August 19, 2023, I received a text message from Mr. Kimfon with updated images of the bathroom door. Mr. Kimfon also sent a video demonstration of the door opening and closing to verify the repairs were complete. Based on this finding, the door appears to be in good, working condition. During the exit conference, Mr. Kimfon explained the door has been replaced “a couple times” because it gets damaged when the residents bump the door with their wheelchairs. There are currently 4 residents in care who require the regular use of a wheelchair.

APPLICABLE RULE	
R 400.14407	**Bathrooms.**
	(3) Bathrooms shall have doors. Only positive-latching, non-locking-against-egress hardware may be used. Hooks and eyes, bolts, bars, and other similar devices shall not be used on bathroom doors.
ANALYSIS:	On 8/17/23, I observed 1 of 2 bathroom doors in disrepair.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION: On 8/17/23, I observed a space heater in bedroom #3. The portable unit was placed on Resident C’s nightstand. Resident C confirmed the unit was indeed a space heater. Resident C indicated she uses a heater because the home is generally cold.

On 8/28/23, I completed an exit conference with Mr. Kimfon. Mr. Kimfon was surprised to learn about the space heater. Mr. Kimfon stated Resident C’s family likely brought the space heater inside the home. Mr. Kimfon is adamant that Staff know space heaters are not permitted.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.

ANALYSIS:	On 8/17/23, Resident C had a small space heater in her bedroom.
CONCLUSION:	VIOLATION ESTABLISHED

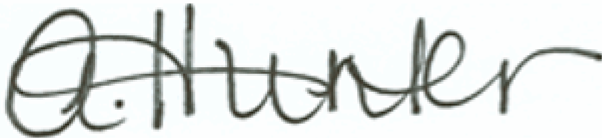
IV. RECOMMENDATION

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

9/18/23

Kara Robinson   Date
Licensing Consultant

Approved By:



9/19/23

Ardra Hunter   Date
Area Manager