GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2024

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

RE: License #: AS820393375
Investigation #: 2024A0992048
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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820393375
Investigation #:	2024A0992048
Complaint Receipt Date:	08/15/2024
Investigation Initiation Date:	08/16/2024
Report Due Date:	10/14/2024
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:	10/25/2023
Expiration Date:	10/24/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Tracee Martin is verbally abusive towards the residents. She swears at the residents and call them names.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/15/2024	Special Investigation Intake 2024A0992048
08/15/2024	Referral - Recipient Rights
08/16/2024	Special Investigation Initiated - Telephone Resident A's guardian, Damond Watkins with Faith Connection was not available. Message left.
08/16/2024	APS Referral
08/16/2024	Contact - Telephone call received Mr. Watkins
08/16/2024	Contact - Telephone call made Resident A's guardian, Paul Torony with Faith Connection
08/22/2024	Inspection Completed On-site Home manager, Tracee Martin; direct care staff, Monique French; Residents A, B and C.
08/22/2024	Contact - Telephone call made Resident A's supports coordinator, Candice Jones with Community Living Services (CLS).
08/22/2024	Contact - Document Received Resident A’s individual plan of services (IPOS)
08/30/2024	Inspection Completed On-site Direct care staff, James Talley and Desi Smith; Residents A and D.
09/05/2024	Contact - Telephone call made Licensee designee, Ihsan Asmar (also known as) Allen Asmar.
09/09/2024	Contact - Telephone call made

	Resident B's supports coordinator, Holly Adkins with Open Arms Inc/MORC was not available. Message left.
09/09/2024	Contact - Telephone call received Ms. Adkins
09/09/2024	Contact - Document Sent Email sent to Resident B's supports coordinator, Faith Redwine-Otieno with Open Arms Inc/MORC.
09/10/2024	Contact - Document Received Email received from Ms. Redwine-Otieno
09/17/2024	Contact - Telephone call made Resident A's clinician, Dr. Ann Liesen, with Easter Seals MORC.
09/17/2024	Exit Conference Mr. Asmar

ALLEGATION: Direct care staff, Tracee Martin is verbally abusive towards the residents. She swears at the residents and call them names.

INVESTIGATION: On 08/16/2024, I received a return call from Resident A's guardian, Damond Watkins with Faith Connection. Mr. Watkins made me aware that he is no longer Resident A’s guardian, and his case was transferred to Paul Torony with Faith Connections.

On 08/16/2024, I contacted Mr. Torony and interviewed him regarding the allegation. He confirmed he is familiar with the allegation. Mr. Torony stated when he spoke with Resident A regarding this matter, he changed his story and was unable to identify the staff. Mr. Torony stated Resident A has a history of embellishing stories and his credibility is questionable. Mr. Torony denied he has any concerns regarding Resident A’s placement or the level of care he is receiving.

On 08/22/2024, I completed an unannounced onsite inspection. I interviewed home manager, Tracee Martin; direct care staff, Monique French; Residents A and B. Ms. Martin denied the allegation. She stated on or about 08/14/2024 she administered Resident A’s medication at 5:00 p.m. She stated Resident A carried on with his day with no issues. She stated the next day when it was time for Resident A to take his medication, he refused. Ms. Martin stated Resident A was upset and stated the medication made him sick. Ms. Martin stated she tried to talk to him, but he was angry. She stated she believe his anger stemmed from him not having any more cigarettes; she stated he is a compulsive smoker. Ms. Martin denied swearing at Resident A or any of the residents. She stated Resident A is delusional, which is

why he requires 1:1 staffing. I asked which staff is assigned as his 1:1 staffing today, and Ms. Martin explained that James Talley is assigned as his 1:1 but he had to transport Resident D to the hospital. Ms. Martin explained Residents A and B require 1:1 staffing. I reviewed Resident B's individual plan of services (IPOS), which confirmed Resident B requires 1:1 staffing. There were two staff on shift.

Ms. French denied the allegation. She stated she was on vacation on or about 08/14/2024 and did not witness the reported incident. Ms. French stated she has never heard Ms. Martin swear at any of the residents.

Resident A stated Ms. Martin always swear at him and calling him a "bitch and/or fat motherfucker." I asked Resident A if any of the other staff or resident have witnessed Ms. Martin swear at him and he said yes, he stated Resident B was present. He stated Ms. Martin swears at all the residents. Resident A stated "P. Diddy" gave him 20 million dollars and it was announced on the radio. He went on to say everyone keeps stealing his money. He stated the "Russians gave Community Living Services (CLS) 15 million dollars for him." He stated he evented "Subway and Amazon." Resident A stated he is tired of the way he is being treated at the home. He stated Ms. Martin is very disrespectful. Resident A stated he did an album with Run DMC. He said when his mother died, she left him 60 million dollars and his sister has access to his money and refuses to care for him.

Resident B confirmed he has heard Ms. Martin call Resident A a "bitch." He stated she has called him a "bitch" too. He stated physically he is treated well but the staff does swear at the residents from time to time. When I asked Resident B if there are other staff that swears at him or any of the other residents, he said yes but was unable to provide the staff's name.

I attempted to interview Resident C, but he refused to be interviewed.

On 08/22/2024, I contact Resident A's supports coordinator, Candice Jones with Community Living Services (CLS). Ms. Jones stated she is aware of the allegation. She confirmed Resident A has delusional behaviors. Ms. Jones also confirmed Resident A requires 1:1 staffing.

On 08/28/2024, a new intake received, 202261. The allegation will be addressed in this investigation.

On 08/30/2024, I completed an unannounced onsite inspection. I interviewed direct care staff, James Talley and Desi Smith; Residents A and D. Mr. Talley stated he has never heard Ms. Martin or any of the other staff swear at the residents.

Ms. Smith stated she does not typically work with Ms. Martin. However, she denied denied having any knowledge of Ms. Martin or any of the other staff swearing at the residents.

Resident A confirmed the allegation. He stated he was telling Ms. Martin there is no bread and she said, “You do not know what the fuck you are talking about, fat motherfucker.” Resident A stated he is tired of being treated with no respect. He said Ms. Martin is always swearing at him and the other residents and nothing is being done about it. He stated Ms. French was present when Ms. Martin called him a “fat motherfucker.” Resident A stated he does not deserve such treatment.

Resident D confirmed the allegation. He stated he heard Ms. Martin swearing at Resident A. He stated he stays out of it because he doesn’t want any problems. Resident D stated he was recently hospitalized because the treatment he receives from the staff, makes him have an anxiety attack. He stated Ms. Martin always swears at him and the other residents. He stated she has called him an “asshole” in the past. He stated she always says “fuck you” to him. Resident D stated he has expressed his concerns to management, and the owner but nothing is being done. He stated the staff is rude and he does not deserve to be treated that way.

On 09/05/2024, contacted licensee designee, Ihsan Asmar (also known as) Allen Asmar regarding the allegation. Mr. Asmar was not aware of the reported treatment, he stated he would investigate it.

On 09/17/2024, I made follow-up contact with Mr. Asmar. He stated Ms. Martin is a longtime employee and he has never had any complaints or concerns regarding the way she treat the residents. He stated he recently terminated several staff and was concerned maybe a former staff reported the allegations in attempt to get Ms. Martin fired. I explained that although I am unable to reveal the reporting source, multiple residents stated Ms. Martin is verbally abusive and often swears at them. Mr. Asmar stated if there were multiple residents, actions need to be taken and he will handle it accordingly. I proceeded to conduct an exit conference and I made him aware that based on the investigative findings, there is sufficient evidence to support the allegation. As a result, a written corrective action plan is required, and due within 15 days of this report. Mr. Asmar agreed to review the report and submit the corrective action plan as required.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with licensee designee; direct care staff; Residents A's guardian; and Residents A, B, and D. Although Resident A presented with delusional thoughts, he was adamant that Ms. Martin often swears at him. Residents B and D also confirmed the allegation. Based upon my investigation, it has been determined that Residents A, B, and D are not being treated with dignity by home manager Tracee Martin.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/22/2024, I completed an unannounced onsite inspection. During the inspection, home manager, Tracee Martin stated Resident A is delusional, which is why he requires 1:1 staffing. I asked which staff is assigned as his 1:1 staffing today, and Ms. Martin explained that James Talley is assigned as his 1:1 but he had to transport Resident D to the hospital. Ms. Martin explained Residents A and B require 1:1 staffing. I reviewed Resident B's individual plan of services (IPOS), which confirmed Resident B requires 1:1 staffing. There were two staff on shift.

On 09/05/2024, contacted licensee designee, Ihsan Asmar (also known as) Allen Asmar. I made him aware that during two separate unannounced onsite inspections, there were only two staff on shift and according to the resident's needs, there should be three. Mr. Asmar stated the home is typically staffed with three direct care staff, but one staff transported Resident D to the hospital. I explained I realize isolated incidents occur, but I completed two separate unannounced onsite inspections and there were two staff on shift both times. Mr. Asmar stated he believe Resident B's IPOS was amended, and he no longer requires 1:1 staffing.

On 09/09/2024, I contacted Resident B's supports coordinator, Holly Adkins with Open Arms Inc/MORC. Ms. Adkins made me aware that she is no longer Resident B's supports coordinator, and his case was transferred to Faith Redwine-Otieno with Open Arms Inc/MORC.

On 09/10/2024, I received an email received from Ms. Redwine-Otieno. She confirmed Resident B is on her caseload, but she has not met with him. She stated she is unsure if Resident B requires 1:1 staffing. Ms. Redwine-Otieno provided contact information for Resident A's clinician, Dr. Ann Liesen, with Easter Seals MORC.

On 09/17/2024, I contacted Dr. Ann Liesen regarding Resident A's needs. Dr. Liesen confirmed Resident B requires 1:1 staffing.

On 09/17/2024, I completed an exit conference with Mr. Asmar. I explained that based on the investigative findings, I have determined that there was insufficient direct care staff on duty for the supervision, personal care, and protection of Residents A and B as specified in their assessment plan. Mr. Asmar stated that typically the home is staffed with three direct care staff but sometimes situations occur that is out of his control.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 08/22/2024 and 08/30/2024, there was insufficient direct care staff on duty for the supervision, personal care, and protection of Residents A and B as specified in their assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/17/2024

Denasha Walker — Date
Licensing Consultant

Approved By:

09/25/2024

Ardra Hunter — Date
Area Manager