GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2021

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

RE: License #: AS500407631
Investigation #: 2021A0990012
Forever Care IV (4)

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500407631
Investigation #:	2021A0990012
Complaint Receipt Date:	06/18/2021
Investigation Initiation Date:	06/18/2021
Report Due Date:	08/17/2021
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 IV (4)
Facility Address:	4673 Ashburton Sterling Heights, MI 48310
Facility Telephone #:	(248) 914-8951
Original Issuance Date:	06/07/2021
License Status:	TEMPORARY
Effective Date:	06/07/2021
Expiration Date:	12/06/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was dropped off at the at the emergency room (ER) with no paperwork or reason as to why he was there. Resident A was left there alone without staff.	Yes
Additional findings	Yes

III. METHODOLOGY

06/18/2021	Special Investigation Intake 2021A0990012
06/18/2021	Special Investigation Initiated - Letter Licensing Consultant, Eric Johnson initiated the complaint by emailing the licensee designee (LD) Ihsan (Allen) Asmar requesting documents.
06/18/2021	APS Referral Adult Protective Services (APS) referral initiated at intake.
06/29/2021	Contact - Document Sent I emailed Christina Gregory from APS to inquire about the APS investigation. Ms. Gregory responded via email.
07/01/2021	Contact - Document Sent I emailed Mr. Asmar, LD, requesting a call back to discuss the allegations.
07/02/2021	Inspection completed onsite I conducted an unannounced onsite investigation. I interviewed direct care staff Ahja Washington, Tremaine Nix and Resident A. I briefly spoke to manager Miranda Crider via phone. I observed Resident B, Resident C Resident D and Resident E.
07/02/2021	Contact - Document Sent I emailed Mr. Asmar, LD, and home manager Mirander Crider. I requested documents.
07/21/2021	Contact – Telephone call made I called direct care staff Shannon Stines. The phone number provided was disconnected.

08/03/2021	Contact - Document Received I reviewed documents received regarding Resident A on 07/02/2021.
08/03/2021	Contact - Telephone call made I conducted s phone interview with Relative A.
08/03/2021	Contact - Document Sent I contacted the Office of Recipient Rights (ORR) to inquire if there was a current investigation. I was informed there was an investigation but with different allegations.
08/03/2021	Contact - Document Sent I emailed Amber Sultes, Right Investigator. I requested a phone interview.
08/03/2021	Contact - Document Received I emailed Ms. Gregory to inquire as to the status of APS investigation. Ms. Gregory replied that her investigation was unsubstantiated and would send report when available.
08/03/2021	Contact - Document Sent I emailed Mr. Asmar to schedule an exit conference.
08/06/2021	Contact - Telephone call made I called Sheila Jackson Director of operations of Forever Care Home (Macomb division). Ms. Jackson was informed that an exit conference was needed with Mr. Asmar as the LD and administrator. Ms. Jackson said that she would contact and inform him to contact me.
08/06/2021	Contact - Telephone call made I conducted a phone interview with Ms. Stines.
08/06/2021	Exit conference I conducted the exit conference with Mr. Asmar.

ALLEGATION:

Resident A was dropped off at the at the emergency room (ER) with no paperwork or reason as to why he was there. Resident A was left there alone without staff.

INVESTIGATION:

NOTE: This incident on 05/31/2021, stems from the previous home, Roan AFC Home license # AS500366690. The Roan AFC license was closed on 6/15/2021. The Roan AFC Home license was under a management agreement with R & C Homes, Inc. until the new license was issued on 06/07/2021. The residents from Roan AFC Home were moved to Forever Care Homes IV located at 4673 Ashburton Place, Sterling Heights, MI 48310 on 06/15/2021.

On 06/29/2021, I emailed Christina Gregory from APS to inquire about the APS investigation. Ms. Gregory responded via email that Resident A was only left at Ascension Hospital Oakland-Macomb hospital for a few hours. Ms. Gregory said that a staff member eventually picked up Resident A from the hospital and according to Resident A, it was the home manager Shannon Stines that picked him up. Resident A was transported back the home. Resident A was moved to the new address at the beginning of June 2021.

On 07/02/2021, I conducted an unannounced onsite investigation. I interviewed direct care staff Ahja Washington, Tremaine Nix and Resident A. I briefly spoke to manager Miranda Crider via phone. I observed Resident B, Resident C Resident D and Resident E. Ms. Washington said that she has been employed with the company for about one year however, recently returned to work in June 2021 from being off for an extended medical leave of absence. Ms. Washington said that she did not work at Roan AFC Home from April 2021 through June 2021 due to being out. Ms. Washington said that she was not aware of the allegations.

Mr. Nix was interviewed and said that he worked at the Roan AFC Home. He recalled the incident in which, Resident A was hospitalized but does not recall who transported him to the hospital or who picked him up. I

I interviewed Resident A. Resident A said that he was in the hospital alone. Resident A said that he was transported to the hospital by ambulance. Resident A said that direct care staff Mirander picked him up from the hospital. Resident A said that he was at the hospital overnight.

I briefly spoke with Mirander Crider via speakerphone. Ms. Crider said that she is a manager however, Shannon Stines was the manager at Roan AFC Home.

On 07/02/2021, I emailed Mr. Asmar, LD, and home manager Mirander Crider. I requested documents. I requested that Resident A's *Resident Care Agreement*, Individual Plan of Service (IPOS)*, Assessment Plan*, *Health Care Appraisal* and the incident report for the hospitalization to be sent to me by 07/09/2021 5PM.

On 08/03/2021, I reviewed Resident A's documents. I observed that Resident A's Individual Plan of Service (IPOS) was completed on 05/12/2021 and it documents that

Resident A is to have 1:1 staffing for 12 hour per day. Resident A does not have the necessary skills to live independently in the community and requires 24-hour supervision, daily support, and monitoring to ensure his health and safety. Resident A requires staff to transport and accompany him while accessing the community. Resident A requires assistance by caregivers with sharing healthcare concerns. Caregivers are to accompany Resident A to all medical appointments.

I reviewed the incident report that was written by Shannon Stines on 05/31/2021. The incident report documented that Resident A was having suicidal ideations and was given agitation medication and transported to the hospital.

On 08/03/2021, I conducted a phone interview with Relative A. Relative A said that Resident A was transported Ascension Hospital Macomb because he was threatening his self and others in the home. Relative A said that this is a common behavior displayed and the staff sends Resident A to the ER each time. Relative A received a call from the hospital social worker (name unknown) the same day he was taken to the ER requesting that he is picked up. The social worker said that she called the Roan AFC home several times and there was no answer. Relative A said that the social worker said that Resident A was dropped off at the ER alone and no staff stayed with him. The hospital social worker told Relative A that she had to pick-up Resident A because she is the legal guardian. Relative A refused to pick-up Resident A because it was the staff's responsibility to do so. Relative A also called the home and there was no answer received. Relative A said that eventually someone from the home was reached and picked up Resident A. Relative A said that each time they send him to the hospital he is never with staff. Relative A said that Resident A is supposed to have 1:1 staffing however, the Roan AFC home or the current residence is never fully staffed. Relative A described that there was a time Resident A was admitted into the hospital and the hospital could not reach the home and she had to bring him clothing. Relative A said that she has expressed to Resident A's supports coordinator Angela Gholston many times that she would like a new provider.

On 08/06/2021, I conducted a phone interview with Ms. Stines. Ms. Stines said that she is no longer the manager for Forever Care Homes IV, and she resigned in July 2021. Ms. Stines recalled the incident in which Resident A had to be taken to the ER. Ms. Stines said that Resident A was threatening self and others. Ms. Stine said that he was transported to the ER via police. Ms. Stines said that the incident occurred on Memorial Day holiday. After Resident A left the home, she transported the other four residents to a picnic in Miland, MI to celebrate the holiday. Ms. Stines was working alone on this day because they were short staffed, and she could not be present at the ER with Resident A. Ms. Stines said this is the reason she left the company because she was working 24-hours per day as the manager.

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:	On 05/31/2021, Resident A was transported to the Ascension Hospital ER via ambulance due to agitation and threatening behavior. Resident A was left at the hospital alone. According to Resident A, he was alone in the ER and a staff person picked him up. Relative A was contacted by the ER social worker on 05/31/82021 due to the social worker not being able to reach any staff at the home because Resident A was ready for discharge. Relative A said that Resident A was left alone at the hospital. According to Resident A's IPOS he is to have 1:1 supervision for 12 hours per day with caretakers, he does not have the skills to navigate the community independently, and Resident A does not have the necessary skills to live independently in the community and caregivers are to accompany Resident A to all medical appointments because he requires assistance with relaying healthcare concerns. Ms. Stines admitted that Resident A was transported to the ER without staff on 05/31/2021, because she was the only staff present and had to stay with the other four residents which she took out on an outing for the holiday. Resident A was not protected due to being left alone at the ER without staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/03/2021, I reviewed Resident A's documents. I reviewed the incident report written by Shannon Stines on 05/31/2021. The incident report documented that Resident A was having suicidal ideations and was given agitation medication and transported to the hospital. The incident report was not on the licensing form and was not sent to the licensing division.

On 08/06/2021, I conducted an exit conference with Mr. Asmar. Mr. Asmar said that Resident A has threatening behaviors towards staff and has assaulted staff in the past. When this occurs, Resident A is transported to the hospital. Mr. Asmar admitted that there has been come staffing shortages and was not aware that residents per their IPOS are to be accompanied by staff to the ER. Mr. Asmar was informed of the violations and agreed to submit a corrective action plan.

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: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	On 05/31/2021, Resident A was transported to the Ascension Hospital ER. The incident report was not sent to the licensing division within 48 hours. The incident report was written on the incorrect form.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

L. Reed 08/06/2021

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 08/10/2021

Denise Y. Nunn Date
Area Manager