GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 4, 2021

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

RE: License #: AS500407631
Investigation #: 2021A0990019
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 #:	2021A0990019
Complaint Receipt Date:	08/03/2021
Investigation Initiation Date:	08/03/2021
Report Due Date:	10/02/2021
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 Hts, 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?
On an unknown date late July 2021, Resident B was observed on the front porch alone. There was an unknown resident observed in the communal living area, naked from the waist down and had urinated on the floor. A direct care staff name unknown was found sitting in the backyard talking on his phone.	No
The residents are being taken to another adult foster home called Highlite AFC twice a week due to short staffing.	No
Resident A requires 1:1 staffing and there is concern that this is not being provided.	Yes
Late July 2021, Resident A reported that he had not eaten all day. Resident A said that there were no staff present. The unknown staff said that he was not able to feed the residents because the pantry was locked.	No
On 08/09/2021, it was reported that no staff trainings have been provided for staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/03/2021	Special Investigation Intake 2021A0990019
08/03/2021	Special Investigation Initiated - Telephone I conducted a phone interview with Relative A.
08/06/2021	Contact - Telephone call made I contacted Sheila Jackson-Regional Director to request that Ihsan (Allen) Asma licensee designee (LD) contact to discuss complaints.
08/06/2021	APS Referral I made a referral to Adult Protective Services (APS).
08/06/2021	Contact - Document Sent I requested documents related to the investigation.

08/06/2021	Contact - Telephone call made I conducted a phone interview with Mr. Asmar, LD.
08/09/2021	Contact - Telephone call made I conducted a phone interview with Amber Sultes, Office of Recipient Rights investigator (ORR).
08/24/2021	Inspection Completed On-site I conducted an unannounced onsite investigation. I interviewed Miranda Crider, home manger. I interviewed Resident A. I observed Resident B and Resident C.
09/01/2021	Contact - Telephone call made I conducted a virtual meeting with Amber Sultes, Rebecca Walny, and Erisa Naco from ORR.
09/03/2021	Contact - Telephone call made I conducted a virtual exit conference with Mr. Asmar, Sheila Jackson-Regional Director and Charles Mack-Home Manager.
09/16/2021	Contact - Telephone call made I conducted a phone interview with the former manager of Highlite Alana Doris.
09/16/2021	Contact - Telephone call made I conducted a phone interview with direct care staff Keith Hicks.
09/20/2021	Contact - Document Received I received an email from Ms. Sultes regarding Resident A's 1:1 ratio requirement.
09/21/2021	Contact - Document Received I received a photo via email from Ms. Jackson. A screen was applied to the front door.
09/24/2021	Contact - Document Received I received an email from Mark Mishal, Director of the Office of Recipient Rights regarding staff training records.
09/24/2021	Contact - Document Received I emailed Ms. Jackson and requested the staff training records. Ms. Jackson emailed several staff training records back.
10/06/2021	Contact - Telephone call made I attempted a phone interview with former direct care staff Shelly Austin. Phone number disconnected.

10/06/2021	Contact - Document Received I reviewed documents related to the investigation.
10/14/2021	Exit conference I conducted an exit conference with Mr. Asmar.
10/27/2021	Contact - Telephone call made I called the facility to speak to Resident A. There was no answer. I left a brief message.
11/03/2021	Contact - Telephone call made I conducted a phone interview with Resident A.

ALLEGATION:

- **On an unknown date late July 2021, Resident B was observed on the front porch alone. There was an unknown resident observed in the communal living area, naked from the waist down and had urinated on the floor. A direct care staff name unknown was found sitting in the backyard talking on his phone.**
- **The residents are being taken to another adult foster home called Highlite twice a week due to short staffing.**
- **Resident A requires 1:1 staffing and there is concern that this is not being provided.**

INVESTIGATION:

In addition to the above allegations, it was reported that the staff are taking the six residents to Highlite AFC home twice a week because they are short staffed. They are not staying overnight but are there most of the day. The concern is insufficient staff at Forever Care Homes IV and if there is enough staff at Highlite to supervise a total of ten residents. Highlite's capacity is four and Forever Care Homes IV capacity is six.

On 08/03/2021, I conducted a phone interview with Relative A. Relative A said that she received a phone call from Resident A expressing concerns that he could not find a staff person in the home, and he was hungry. Relative A made several phone calls to the home and received no answer or call back. Relative A said that she arrived at the home around 4PM (actual date not provided) and observed Resident B standing on the porch alone. Relative A said that when she entered the home, there was a male resident standing in the living room naked from the waist down standing in urine. Relative A walked throughout the home and could not find staff. Relative A said that she went to the backyard and observed an African American male staff person sitting with his back turned from the home talking on his cell phone. Relative A said that there was only one staff person working and Resident A is to have 1:1 supervision in the home. Relative A said that due to the lack of staffing the residents are taken to another adult foster home called Highlite AFC for meals. Resident A has called a few times from Highlite AFC,

and he would tell her that they are there because there was no staff at their home. Relative A said that this is occurring 2-3 per week. Relative A said that she is working with Resident A's case manager on getting him moved to a different home.

On 08/06/2021, I conducted a phone interview with Allen Asmar, licensee designee (LD). Mr. Asmar said that his company employs 35 staff and for about 32 residents. Mr. Asmar said that some of his staff at times rotate homes when there is a staffing need. Mr. Asmar was unsure of the staff person's name that was observed sitting in the backyard as alleged however, he said he would investigate this. Mr. Asmar said that the residents go to Highlite AFC for barbeques and activities. Mr. Asmar denied that the residents are taken to Highlite AFC due to the lack of staffing.

On 08/09/2021, I conducted a phone interview with Amber Sultes, Office of Recipient Rights investigator (ORR). I informed Ms. Sultes of the allegations. Ms. Sultes said there is concern that there is not adequate staffing because Resident A is to have 1:1 staffing in which, would require two staff on shift. Ms. Sultes said that the manager Miranda Crider was in-serviced regarding this requirement by Resident A's behaviorist some time ago.

On 08/24/2021, I conducted an unannounced onsite investigation. I observed Resident B standing on the front porch. I interviewed Miranda Crider, home manager. I interviewed Resident A. I observed Resident B and Resident C. Ms. Crider was working alone. Ms. Crider was aware of the incident regarding the Resident A saying that he had not eaten all day and said that the staff person's name is Keith (last name not provided at this time). Ms. Crider said that Keith works at a different home and was filling in that day. Ms. Crider said that there was another staff person present today working but was away to pick-up a resident. Ms. Crider was informed that there are to be at least two staff per Resident A's Individual Plan of Service (IPOS), this information was obtained from a recent investigation dated 08/10/2021. Ms. Crider said that the 1:1 was not approved at this time, nor have they received funding for Resident A to receive 1:1 staffing.

I interviewed Resident A. Resident A said that he always sleeps at his home but visits other homes. I observed Resident B and Resident C, but they were not interviewed because they are non-verbal.

On 09/01/2021, I conducted a virtual meeting with Amber Sultes, Rebecca Walny, and Erisa Naco from ORR. Ms. Sultes said that Resident A is to have 1:1 staffing, and Mr. Crider was in-serviced on this in June by Resident A's behaviorist. Ms. Shultz said the 1:1 funding is approved.

On 09/03/2021, I conducted a virtual exit conference with Mr. Asmar, Sheila Jackson-Regional Director and Charles Mack-Home Manager. Ms. Jackson provided the staff person's name that was on schedule as Keith Hicks. Mr. Asmar, Ms. Jackson, and Mr. Mack all indicated that the two homes combine (Highlite and Forever Care Homes IV) outings and recreation with each other. They denied that the residents are taken there

due to lack of staffing. Ms. Asmar was informed that the 1:1 staffing is approved and that there should be two staff on staff at the home.

On 09/16/2021, I conducted a phone interview with the former manager of Highlite Alana Doris. Ms. Doris said that she has transferred as manager to Forever Care Homes V and is no longer at Highlite. Ms. Doris denied that the residents were brought to Highlite due to lack of staffing. Ms. Doris said that they do monthly birthday parties for the residents at Forever Care Homes IV and Highlite together. Ms. Doris said that they have events on the Saturdays and the homes combine for these events only. Ms. Doris denied that the residents from Forever Care Homes IV were sleeping at Highlite.

On 09/16/2021, I conducted a phone interview with direct care staff Keith Hicks. Mr. Hicks denied that he was sitting in the backyard with his back turned when Relative A was present. Mr. Hicks said that he was sitting at the desk in the living room when she walked inside. Mr. Hicks said that Relative A was there because Resident A wanted fast food. Mr. Hicks said that Resident E walked into the living room without his pants on because he was in the bathroom prior to Relative A arriving. Resident E does this sometimes and denied that he was standing in urine but walked out of the bathroom with his pants still down. Mr. Hicks immediately took Resident E back inside the bathroom to help him dress. Mr. Hicks said that there was a resident standing on the porch in eyesight view. Mr. Hicks said that one of the residents likes to sit on the porch most of the day. Mr. Hicks said that was his first time working at the home and works for the company at a different adult foster care home in Wayne County. Mr. Hicks admitted to working alone this day.

On 09/20/2021, I received an email from Ms. Sultes. Ms. Sultes stated that on 07/21/2021 she conducted a phone interview with the Home Manager, Miranda Crider. Ms. Sultes said that Ms. Crider said that she was not aware Resident A was 1:1 because she had just returned from medical leave. Ms. Sultes stated that on 07/29/2021, she conducted a phone interview with MORC Behaviorist, Nikki Schluentz, who informed her that Ms. Crider was made aware on 06/29/2021 that Resident A was a 1:1. Ms. Sultes said that prior to these conversations, Ms. Schluentz had conversations with Ms. Crider about the 1:1 staffing for Resident A. Ms. Crider had mentioned before that there is no funding to provide staff for his 1:1 ratio. Ms. Sultes reviewed Resident A's review form and he was officially approved for 1:1 funding on 05/12/2021.

On 10/06/2021, I reviewed the staff August schedule and observed that there was only one staff working the day shift on 8/23/2021 and 8/30/2021. I reviewed Highlite's resident register and there are four residents. I reviewed Resident E's IPOS, and it documents that he is able to use the restroom independently but may need reminders, staff should be within hearing distance for reminders of thoroughness, wiping and handwashing.

On 11/03/2021, conducted a phone interview with Resident A. Resident A recalled visiting the other group home but does not remember why, when, or how often.

Resident A said that he liked going to the other home for visits and would like to go back there. Resident A said that he likes being outside of the home. Resident A denied that there was ever a time that he did not want to visit the other home. Resident A said that the visits to the other home were “half of an hour”. Resident A denied ever sleeping in the home. Resident A did not provide any further information about the other group home.

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 08/24/2021, I observed only one direct care staff at the home. There is sufficient evidence that there is not adequate staffing per Resident A’s IPOS which requires 1:1 ratio. On the August staff schedule, there was only one staff on schedule on 08/23/2021 and 08/30/2021. Furthermore, Ms. Sultes from ORR confirmed that Resident A is to have 1:1 staffing which requires two staff on shift and the home manager was in-serviced on this requirement 05/12/2021 and 06/29/2021. Direct care staff Keith Hicks also confirmed that he worked alone in the home late July.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (p) The right of access to his or her room at his or her own discretion.

ANALYSIS:	Per interviews, the residents visit Highlite AFC home for recreation activities and do not have overnight visits. I interviewed Resident A on 11/03/2021 and Resident A stated that he liked visiting the other group home. Resident A did not remember, why, when and how often they visited the home. Resident A said that he would visit the home for half an hour and did not sleep at the other group home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident B enjoys being on the front porch. I observed him standing on the porch on 08/24/2021 however, staff was within hearing and eyesight. Mr. Hicks was sitting at the desk in the living room and in view of Resident B on the porch. Mr. Hicks denies being in the backyard with his back turned to the home. There is not enough information to support that this occurred. There is insufficient evidence to support that Resident E was standing in urine. According to Mr. Hicks, Resident E was using the restroom when Relative A arrived, and he came out undressed. Resident E's IPOS documents that he uses the restroom independently, however, needs reminders for thoroughness, wiping and handwashing.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

In late July 2021, Resident A reported that he had not eaten all day. Resident A said that there were no staff present. The unknown staff said that he was not able to feed the residents because the pantry was locked.

INVESTIGATION:

On 08/03/2021, I conducted a phone interview with Relative A. Relative A said that she received a phone call from Resident A expressing concerns that he was hungry and that he had not eaten all day. Relative A said that she arrived at the home (date not

provided) at 4PM and was told by the staff person present that he (name unknown at the time) was unable to provide meals because the food was locked away and that the staff person on the previous shift had taken the keys home with her by mistake. Relative A said that she went out and bought subways sandwiches for the residents.

On 08/06/2021, I conducted a phone interview with Mr. Asmar, LD. Mr. Asmar denied that the residents went a full day without a meal. Mr. Asmar said that the pantry is not locked at the home, but the storage area is where the extra food and supplies are stored.

On 08/09/2021, I conducted a phone interview with Amber Sultes, Office of Recipient Rights investigator (ORR). Ms. Sultes was informed of the allegations. Ms. Sultes said that there should be no locks on the pantry because there are no residents in the home that require this.

On 08/24/2021, I conducted an unannounced onsite investigation. I interviewed Miranda Crider, home manager. I interviewed Resident A. Ms. Crider was aware of the incident and said that the staff person's name is Keith (last name not provided at this time). Ms. Crider said that Keith works at a different home and was filling in that day. Keith told Ms. Crider that Resident A called Relative A because he did not like the food that was served that day. Ms. Crider said that when Resident A does not get his way, he calls Relative A. Ms. Crider said that the residents were given meals that day. Keith was going to give Resident A an alternate meal but the pantry where the over-supply of food is kept was locked. Ms. Crider said that the person that worked the midnight shift accidentally took the key.

During the onsite, I observed an adequate food supply. I did not observe locks on the kitchen cabinets or refrigerator and there was an adequate food supply.

I interviewed Resident A. Resident A recalled the incident and said that the staff person made meals for him, but he did not like what was made. Resident A said that he is always fed three meals per day. I observed that Resident A is a husky build. I observed Resident B and Resident C, but they were not interviewed because they are non-verbal.

On 09/01/2021, I conducted a virtual meeting with Amber Sultes, Rebecca Walny, and Erisa Naco from ORR. Ms. Sultes said that no residents are approved for pantry locks in the home. Ms. Sultes said that Resident A is always hungry. Ms. Sultes reiterated that the home must be approved for pantry locks per a resident's behavior plan. Ms. Sultes said that there are no residents in the home with a plan for pantry locks.

On 09/03/2021, I conducted a virtual exit conference with Mr. Asmar, Sheila Jackson-Regional Director and Charles Mack-Home Manager. Ms. Jackson said that a former staff person took the supply room key whose name is Shelly Austin. However, Mr. Hicks had access to food. Mr. Mack said that Ms. Auston works at a different home as a manager, and he went and retrieved the key from her later that day in late July. Mr.

Mack said that the key was returned to the home after rush hour. Mr. Mack said that the residents in the home eat a lot. Resident C does roam the home and gets into the food a lot. The extra food is locked, and food is easily accessible in the pantry, cabinets, fridge, and deep freezer. Mr. Mack said he does the grocery shopping for most of the homes every two weeks and there is always an adequate food supply.

On 09/16/2021, I conducted a phone interview with direct care staff Keith Hicks. Mr. Hicks denied that the pantry was locked in the kitchen. Mr. Hicks said that there is emergency and extra food in the back of the home that is locked. Mr. Hicks said the day he worked (could not recall specific date in July 2021), he cooked beef stroganoff and mixed veggies for dinner around 4:30PM. Mr. Hicks said that Resident A did not want what was made. Mr. Hicks suggested alternate meals for Resident A in which he denied wanting and said that he wanted fast-food. Mr. Hicks told Resident A that there was extra food, but it was locked away. Mr. Hicks said he made sandwiches, chips, and fruit cups for lunch that Resident A and all the other residents ate that day as well. Mr. Hicks said that Resident A calls Relative A every time he does not get his way. Relative A arrived at the home unannounced and brought Resident A what he requested. Mr. Hicks said that Relative A did not bring subway sandwiches for the other residents. Mr. Hicks said that he has worked at the home twice.

On 09/20/2021, I received an email from Ms. Sultes. Ms. Sultes stated that on 07/21/2021, she conducted a phone interview with Home Manager, Miranda Crider. Ms. Sultes said that Ms. Crider told her that the reason the cabinets are locked-up is because Resident C gets into the cupboards.

On 10/06/2021, I observed menus and they were adequate for three meals per day. In review of the menus, I observed on the menu on Wednesday 07/28/2021, for dinner was the following: Goulash, mixed vegetables, salad, and rye bread. I observed that the lunch menu was chicken salad wrap with lettuce, tortilla, garden salad and pineapple tidbits. I reviewed Residence A's IPOS and it is documented that in the Mental Health Safeguards section that the following are triggers for Resident A related to the allegations: Having to wait/delay gratification and not giving him control over his life for example "What to eat".

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(**1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.**
ANALYSIS:	In late July 2021, former direct care staff Shelly Austin worked the midnight shift and accidentally took home the extra food storage keys according to Ms. Crider, Mr. Mack, and Mr. Hicks. Mr. Hicks worked the day shift and did not have access to the

	overflow of food in storage. Mr. Hicks had access to food but was looking for alternate meals for Resident A because Resident A did not want what was cooked for dinner which was beef stroganoff and mixed veggies. Resident A admitted to eating meals this day and reported that he wanted something different to eat other than what was provided. Furthermore, in review of the menus there was a similar meal as described by Mr. Hicks listed on 07/28/2021 which is, consistent with the time frames reported and the meal that was provided.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL ALLEGATIONS:

On 08/09/2021, it was reported that no staff trainings have been provided for staff.

INVESTIGATION:

On 08/09/2021, I conducted a phone interview with Amber Sultes, Office of Recipient Rights investigator (ORR). Ms. Sultes said that she has requested training records from Ms. Asmar for staff working in their homes July and August. Ms. Sultes said that this has not been provided. Ms. Sultes said that it is believed that the staff are working untrained.

On 09/01/2021, I conducted a virtual meeting with Amber Sultes, Rebecca Walny, and Erisa Naco from ORR. Ms. Walny said that she has had a challenging time obtaining staff training records for all their homes. Ms. Walny said that three direct care records (Shannon Stines, Ahja Washington and James Carter) staff records were not found. Ms. Walny said that there is a major communication issue with Mr. Asmar and his staff.

On 09/03/2021, I conducted a virtual exit conference with Mr. Asmar, Sheila Jackson-Regional Director and Charles Mack-Home Manager. Ms. Jackson said that there are staff training records available and have been provided to ORR. I informed Ms. Jackson that ORR did not have the staff training records two days ago. Ms. Jackson said that she would double check her emails. Ms. Jackon said that there are some staff records that cannot be located at the office. Ms. Jackson said that the files for Shannon Stines, Ahja Washington and James Carter are missing. Mr. Asmar said that the employee records were kept onsite, and it is believed that one of the staff files that is missing, someone took them from the home. Ms. Asmar said that they are reorganizing their system. I recommended that the staff trainings records/personnel records hard copies should be kept at a centralized location and copies onsite. Ms. Jackson said that she would email the staff training records that she has. I received the training records on 09/24/2021.

On 09/24/2021, I received an email from Mark Mishal, Director of the Office of Recipient Rights. Mr. Mishal stated that they have not able verify that staff have completed the

direct care worker training, which includes medication administration. Mr. Mishal said that their Quality Department found this in an audit last October and that he has requested that they provide the training records for all staff, both current and former. Mr. Mishal said that they are unable to produce any evidence that their staff have received the direct care worker training and medication administration. This means that untrained staff have been administering medications. Mr. Mishal said that there is at least one individual is on insulin. Mr. Mishal had a string of very frustrating emails that he would share if needed. I emailed Mr. Mishal the staff training records received. I informed Mr. Mishal to discuss the other missing training records with the appropriate licensing consultant.

On 10/06/2021, I reviewed the following direct care staff records for Sheila Jackson, Barbara Conrad, Charles Jackson, Tari Masa, Willie Jackson, Sehar Saeed, Lalisha Hutchins and Farwoz Saeed. There were no training records for Miranda Crider, Shannon Stines, Ahja Washington and James Carter.

The following trainings were expired:

- Sheila Jackson - CPR and First Aid record dated 2001.
- Barbara Conrad - CPR and First Aid expired on 08/14/2021.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all of the following areas: **(d) Basic first aid and cardiopulmonary resuscitation**
ANALYSIS:	On 10/26/2021, I observed that direct care staff Sheila Jackson CPR and First Aid record was dated in 2001. Barabra Conrad's CPR and First Aid expired on 08/14/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e)Verification of experience, education, and training.**
ANALYSIS:	I requested training records on 09/04/2021 and received on 09/24/2021. The following direct care staff Miranda Crider, Shannon Stines, Ahja Washington and James Carter did not have training records.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/24/2021, I conducted an unannounced onsite investigation. I interviewed Miranda Crider, home manager and Resident A. I observed Resident B and Resident C. Resident B was on the front porch. I observed that the front door was wide open with no screen. Ms. Crider was in the living room area. Ms. Crider said that the screen door was removed because the residents like to sit on the porch, and it is easier to keep the front door open.

On 09/21/2021, I received an email from Ms. Jackson. There was a photo of a screen applied to the front door.

On 10/14/2021, I conducted an exit conference with Mr. Asmar. I informed Mr. Asmar of the allegations and findings. Mr. Asmar agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	On 08/24/2021, I observed that the front door did not have a screen. A screen was applied to the front door on 09/21/2021.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

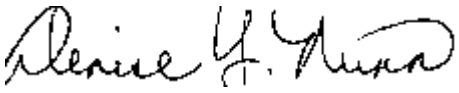
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, there is no change to the license status.

11/03/2021

LaShonda Reed — Date
Licensing Consultant

Approved By:



11/04/2021

Denise Y. Nunn — Date
Area Manager