GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2025

Raemicon Asugui
Trinity Elderly Services LLC
11631 Canterbury Dr
Warren, MI 48093

RE: License #: AS500413074
Investigation #: 2026A0990003
Trinity Elderly Care

Dear Mr. Asugui:

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) 972-9136.

Sincerely,



LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500413074
Investigation #:	2026A0990003
Complaint Receipt Date:	11/04/2025
Investigation Initiation Date:	11/05/2025
Report Due Date:	01/03/2026
LicenseeName:	Trinity Elderly Services LLC
Licensee Address:	11631 Canterbury Dr Warren, MI 48093
Licensee Telephone #:	(586) 202-9205
Administrator:	Raemicon Asugui
Licensee Designee:	Raemicon Asugui
Name of Facility:	Trinity Elderly Care
Facility Address:	11631 Canterbury Dr Warren, MI 48093
Facility Telephone #:	(586) 202-9205
Original Issuance Date:	10/04/2022
License Status:	REGULAR
Effective Date:	04/03/2025
Expiration Date:	04/02/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has worsening untreated wounds and soiled briefs, raising serious concerns that her basic care needs are not being met by staff.	No
Additional Findings	Yes

III. METHODOLOGY

11/04/2025	Special Investigation Intake 2026A0990003
11/04/2025	APS Referral Adult Protective Services (APS) received at intake.
11/05/2025	Special Investigation Initiated - Letter I emailed Heather Horan, APS Worker.
11/10/2025	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed Raemicon Asugui, licensee designee. I observed Resident A. I interviewed Logan Forsy, RN Case Manger from Brighton Hospice.
12/05/2025	Contact - Document Received I reviewed Resident A's resident record.
12/05/2025	Contact - Telephone call made I conducted a phone interview with Relative A.
12/05/2025	Contact - Telephone call made I left detailed message with Courtney, Brighton Hospice nurse. Courtney returned call on 12/8/2025 and I returned text and calls on 12/8/2025 and 12/15/2025.
12/15/2025	Contact - Document Sent I emailed Heather Horan, APS Workr. Ms. Horan's investigation was unsubstantiated.
12/22/2025	Exit Conference I conducted an exit conference with Raemicon Asugui.

ALLEGATION:

Resident A has worsening untreated wounds and soiled briefs, raising serious concerns that her basic care needs are not being met by staff.

INVESTIGATION:

On 11/04/2025, I received the complaint via email. In addition to the above allegation, it was reported that Resident A is aged 77 and is on hospice and the home is not able to meet her needs. On 10/28/2025, Resident A has wounds on her buttocks, bilateral calves and on the left heel of her foot. The wounds were leaking fluids through the bandages. Rico who works at the group home is in charge of Resident A's care on Mondays and Tuesdays. There are concerns because Resident A's wounds have declined in the last 3 weeks. Resident A's pain is under control, and she does not need emergency medical attention.

On 11/10/2025, I conducted an unannounced onsite investigation. I interviewed Raemicon Asugui, licensee designee. Mr. Asugui was aware of the allegation as he had been contacted by APS. Mr. Asugui said that Resident A is receiving hospice services from Brighton Hospice, and she has a nurse out frequently to treat her wounds. Resident A has stage five sacral wounds. Resident A previously was a patient at a skilled nursing facility and the family reached out to him because they could no longer afford to have her stay at the skilled nursing facility. Prior to being in nursing facility, Resident A was being taken care of by family members for one year. Resident A was admitted to the home on 01/23/2025. Mr. Asugui said that Resident A entered the home with sacral wounds that progressed. Mr. Asugui said that he changed Resident A's diapers that covered her wounds twice a day, once in the morning and once at night. Mr. Asugui changed Resident A's wound bandages if soiled 1-2 times a day prior to hospice services coming in more frequently. Mr. Asugui described Resident A's wounds as follows" right heal (decaying) and sacral sounds. Resident A is bedridden and has protein calorie malnutrition which contributes to the wounds not being able to heal, Resident A is given Ensure protein shakes. Resident A was diagnosed with this prior to being admitted to the home. Resident A was already receiving hospice services prior to admission. The hospice nurse came once a week and certified nursing assistance came to do ADL's (bed baths) on Monday, Wednesday and Friday. The nurse does wound care. Resident A has not had any hospitalizations since being admitted to the home. Mr. Asugui said that prior to admission he met with Resident A at the skilled nursing facility to complete the assessment plan. Mr. Asugui had mixed feelings about admission due to her wounds. The family said that it was $400 per day for Resident A to live at the skilled nursing facility. Resident A's hospice nurse is Courtney and her phone number was provided.

During the onsite, I observed Resident A in her bed. Resident A was awake but not able to be interviewed. There was a nurse present treating Resident A during the visit.

On 11/10/2025, I interviewed Logan Forsy, RN Case Manger from Brighton Hospice. Mr. Forsy said that he was standing in for Courtney today. He is an RN case manager. Mr. Forsy said that Resident A's wounds ae no healing but are improving. There was an odor, and she was prescribed Flagyl to treat the odor. Resident A is on pain care regiment which consists of Flagyl for wound care (daily, oxycodone every six hours for pain, Morphine every three hours as needed and/or before/after wound care, scheduled Morphine for comfort. Mr. Forsy said that this regiment began last week.

On 12/05/2025, I reviewed Resident A's resident record. I reviewed Resident A's *Resident Care Agreement*, *Health Care Appraisal, Resident Weight Record* and *Assessment Plan*. Resident A pays $3500 monthly. Resident A is diagnosed with pressure ulcer of sacral stage four, spinal stenosis cardiomyogenic and confusion. Resident A is prescribed a regular soft diet. Resident A is bed bound, a two person assist, full assist with ADLs. Resident A is prescribed a hospital bed with rails wedge foam and is to be turned from left to right every two hours. Resident A receives wound care dressings. Resident A is being weighed using arthrometric measurement (arm circumference). Resident measurement at admission was 35.5 cm and on 10/15/2025 measured 24cm.

On 12/05/2025, I conducted a phone interview with Relative A. Relative A said Resident A passed away on 11/24/2025 at the group home. Relative A said that Resident A had wounds prior to moving to the adult foster home. The wounds never improved due to her lack of nutrition and dehydration which was not due to neglect but because she refused to eat and drink most of the time. Relative A felt the group home was a better fit than a nursing home because there are less residents and they can be more attentive. Relative A became aware that Resident A's wounds were leaking from hospice staff, and at that time hospice staff took over all wound care. Prior to that, the group home was doing the care. Relative A expressed the home provided care to their satisfaction and that Resident A is resting and no longer in pain.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the allegations, there is insufficient evidence to support the claim that Resident A was not provided with care by her Assessment Plan. Resident A was admitted to the home in January 2025 with stage four sacral wounds and hospice services. Resident A's bandages and diapers were changed regularly, but due to her declining health and malnutrition, the

	wounds were not healing. According to Mr. Forsy, RN, case manager, the wounds could not heal but improved in terms of the odor. Resident A was prescribed a pain management medication schedule as well as wound care by hospice. Relative A feels that the home treated Resident A properly. Resident A passed away at the group home on 11/24/2025.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/10/2025, I interviewed Mr. Asugui. Mr. Asugui met with Resident A and her family at skilled nursing facility. Mr. Asugui decided to accept admission for care for Resident A because the family stated that they could not afford the skilled nursing facility. Resident A was diagnosed with stage four sacral wounds and malnutrition prior to admission to the home. Resident A was already receiving hospice services prior to admission.

On 12/22/2025, I conducted an exit conference with Mr. Asugui. We discussed the findings and Mr. Asugui agreed to submit a corrective action plan once the report has been received. I provided some technical assistance regarding admitting residents receiving skilled nursing services.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(1) A licensee shall not accept or care for a resident who requires continuous nursing care. Continuous nursing care does not include a resident who becomes temporarily ill while in the facility or a resident that is receiving care from a licensed hospice program.
ANALYSIS:	Based upon the investigation, there is evidence to support that Resident A required continuous nursing care prior to admission to the home in January 2025. Resident A was receiving hospice services prior to admission and was diagnosed with sacral wounds that required skilled nursing services to treat with bandages and cleaning.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

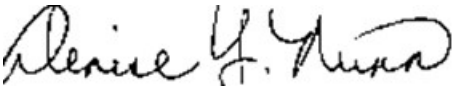
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



12/22/2025

LaShonda Reed — Date
Licensing Consultant

Approved By:



12/23/2025

Denise Y. Nunn — Date
Area Manager