GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 22, 2021

Adam Hamilla
Allcare United LLC
1030 Lucharles Ave
Mt Morris, MI 48458

RE: License #: AS250359799
Investigation #: 2021A0779043
Allcare United

Dear Mr. Hamilla:

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 (906) 226-4171.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250359799
Investigation #:	2021A0779043
Complaint Receipt Date:	09/14/2021
Investigation Initiation Date:	09/14/2021
Report Due Date:	11/13/2021
Licensee Name:	Allcare United LLC
Licensee Address:	1030 Lucharles Ave Mt Morris, MI 48458
Licensee Telephone #:	(810) 640-7699
Administrator:	Adam Hamilla
Licensee Designee:	Adam Hamilla
Name of Facility:	Allcare United
Facility Address:	1030 Lucharles Ave, Mt Morris, MI 48458
Facility Telephone #:	(810) 640-7699
Original Issuance Date:	12/17/2014
License **Status:**	REGULAR
Effective Date:	06/17/2021
Expiration Date:	06/16/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/13/2021, this home had to do an emergency discharge of all the residents due to staffing shortages and the residents only had 24 hours to find a new home.	Yes

III. METHODOLOGY

09/14/2021	Special Investigation Intake 2021A0779043
09/14/2021	APS Referral Complaint was referred to AFC licensing by APS.
09/14/2021	Special Investigation Initiated - Telephone Interview conducted with licensee, Adam Hamilla.
09/14/2021	Contact - Telephone call made Spoke to representative from Valley Area on Aging.
09/14/2021	Contact - Telephone call made Spoke to Resident A's POA.
09/15/2021	Contact - Telephone call made Spoke to Resident B and Resident C's Guardian.
09/15/2021	Contact - Telephone call made Spoke to Resident D's and Resident E's guardian.
10/21/2021	Exit Conference Conducted with licensee designee, Adam Hamilla.
10/22/2021	Inspection Completed On-site

ALLEGATION:

On 9/13/2021 this home had to do an emergency discharge of all the residents due to staffing shortages and the residents only had 24 hours to find a new home.

INVESTIGATION:

On 9/14/21, a phone interview was conducted with licensee designee, Adam Hamilla, who confirmed that a 24-hour discharge notice was sent out to all residents' guardians and/or Power of Attorney (POA). He stated that it was a difficult decision to make, but that he does not have enough staff in order to provide quality care to the residents. Mr. Hamilla stated that as part of the discharge notice, guardians were told that care of the residents would continue until new and appropriate settings that can meet their needs were found. He stated that three of the residents were placed there through Valley Area on Aging (VAA) and that they have already found new placements for them. He reported that all five residents have actually found new homes to go to. Mr. Hamilla claims that no guardians/POA expressed any concerns when provided the discharge notice and appeared to be understanding of the situation. He stated that as of today, he has no staff and that he and his wife have been covering all the shifts on their own. Mr. Hamilla reported that he cannot find anyone to hire or even show up for an interview.

On 9/14/21, a phone conversation took place with Jackie Maliszewski from Valley Area on Aging (VAA). She confirmed that Mr. Hamilla had provided them with the 24-hour discharge notice for the three residents they have placed there. Ms. Maliszewski stated that their impression was that finding new homes for those residents was an emergency situation, so they started looking immediately and found all three new homes to go to already.

On 9/14/21, a phone conversation took place with Resident A's POA. She confirmed that she was aware of the situation and that VAA had found a new home for Resident A. POA reported that on 9/13/21, this home contacted her by phone to say that they had to do an emergency closure because they had no staff and that she received the discharge notice via email later that day. She stated that she knew that this home was having problems regarding staff and were looking to hire new staff. She stated that she realizes that they were in a very tough situation. POA reported that Resident A's transition to his new home went smoothly and that Resident A handled the situation fine. POA stated that this home was great with Resident A and that she has no complaints.

On 9/15/21, the guardian of Resident B and Resident C, Guardian B1, confirmed that she received a phone call first and then the 24-hour discharge notice later the same day on 9/13/21. She stated that she was given the impression that new placements for Resident B and Resident C had to be found as soon as possible. Guardian B1 reported that she was a little shocked by the short notice but stated that she is sympathetic to the staff shortage issue. She stated that she is confident that this home would have continued to provide care past the 24-hour deadline and actually did by one day.

Guardian B1 stated that Resident B and Resident C seem to be handling this situation okay and are doing fine at their new home.

On 9/15/21, the guardian of Resident D and Resident E, Guardian D1, stated that she knew this home was having staffing issues and that she is sympathetic to this issue. She reported that she received a phone call on 9/13/21, followed by the actual 24-hour discharge notice in writing. Guardian D1 stated that the notice mentioned that the home would continue care until an appropriate placement could be found and that she is confident that they would have lived up to that if necessary. She stated that the care that Resident D and Resident E received at this home was good, that she has no complaints and that she is sorry to see them close.

On 10/21/21, an exit conference was conducted with licensee designee, Adam Hamilla. He stated that his struggles continue with not being able to find and/or employ any qualified staff at this home. Mr. Hamilla stated that there are plans to try and sell both the LLC, which is the licensee, and the property together. If a purchaser cannot be found in the near future, Mr. Hamilla will close this AFC license.

On 10/22/21, an on-site inspection was conducted. It was verified that all the residents have moved out of this home.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

ANALYSIS:	There was sufficient evidence found to prove that licensee designee, Adam Hamilla, sent all five resident's guardians/POA a 24-hour discharge notice and not the required 30-day notice. While a 30-day written discharge notice was not given, care was provided to a few of the residents past the 24-hour deadline given. Mr. Hamilla took proper precautions and steps to work with the residents' guardians and placing agency to relocate the residents, due to no staffing caused by a statewide staffing shortage.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved written plan of correction, it is recommended that the status of this home's license remain unchanged.

10/22/2021

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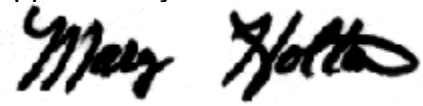
Christopher Holvey Date
Licensing Consultant

Approved By:



10/22/2021

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Mary E Holton Date
Area Manager