GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 22, 2023

James Wilson
Jwilson4144 Holdings Inc
8345 Jaclyn Ann Drive
Flushing, MI 48433

RE: License #: AM250339356
Investigation #: 2023A0569035
B.R.A.G.

Dear Mr. Wilson:

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 (517) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250339356
Investigation #:	2023A0569035
Complaint Receipt Date:	03/30/2023
Investigation Initiation Date:	03/30/2023
Report Due Date:	05/29/2023
Licensee Name:	Jwilson4144 Holdings Inc
Licensee Address:	8345 Jaclyn Ann Drive Flushing, MI 48433
Licensee Telephone #:	(810) 391-6008
Administrator:	James Wilson
Licensee Designee:	James Wilson
Name of Facility:	B.R.A.G.
Facility Address:	1376 E Hurd Road Clio, MI 48420
Facility Telephone #:	(810) 670-0408
Original Issuance Date:	11/01/2013
License Status:	REGULAR
Effective Date:	04/25/2022
Expiration Date:	04/24/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with fecal matter under his fingernails on 3/26/23.	Yes

III. METHODOLOGY

03/30/2023	Special Investigation Intake 2023A0569035
03/30/2023	Special Investigation Initiated - Letter Email to ORR.
05/17/2023	Contact - Telephone call made. Contact with Pat Shepard, RRO.
05/17/2023	Contact - Document Received Photos received from Pat Shepard.
05/17/2023	Contact - Telephone call made. Attempted contact with Guardian. Left voicemail and email address. Requested return phone call.
05/17/2023	Contact - Telephone call made. Contact with Asia Buggs, staff person.
05/17/2023	Inspection Completed On-site
05/17/2023	Contact - Telephone call made. Contact with Guardian.
05/17/2023	Inspection Completed-BCAL Sub. Compliance
05/17/2023	Exit Conference Exit conference with James Wilson, licensee designee.

ALLEGATION:

Resident A was observed with fecal matter under his fingernails on 3/26/23.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A went to the bathroom just prior to being served lunch on 3/26/23. The complainant reported that Resident A then returned to the dining room table and was observed to have fecal matter under and around his fingernails. The complainant reported that Resident A's plan of service requires staff to assist Resident A following toileting when washing his hands. The complainant reported that staff did not assist Resident A on 3/26/23.

An unannounced inspection of this facility was conducted on 5/17/23. Resident A was discharged from this facility by his guardian (Guardian) following this incident. All of the residents in this facility were observed during the inspection. All of the residents were observed to be appropriately dressed and groomed with no visible injuries. Resident A's plan of service was reviewed during the inspection. Resident A's plan of service documents on page 9, that "staff will assist [Resident A] washing his hands at the end of toileting to insure thoroughness of cleaning". Resident A's written assessment also documents that Resident A requires staff assistance with washing his hands following toileting. Resident A's file contains documentation that all of the staff working in this facility were in-serviced regarding Resident A's plan of service on 10/4/22.

Pat Shepard, recipient rights officer, stated on 5/17/23 that she investigated this complaint, and determined that there was sufficient evidence to substantiate a violation of Resident A's recipient rights. Ms. Shepard stated that she had two photos of Resident A's hands, taken on 3/26/23, which show that Resident A did have what appears to be fecal matter under and around his fingernails. Ms. Shepard submitted the photos to the department on 5/17/23. The photos were reviewed and confirm the allegation and statement given by Ms. Shepard.

Guardian stated on 5/17/23 that he was visiting Resident A at this facility on 3/26/23 during the noon meal. Guardian stated that prior to staff serving Resident A, they instructed Resident A to go to the bathroom and wash his hands. Guardian stated that staff are supposed to go to the bathroom with Resident A to ensure that he washes his hands correctly due to his history of getting fecal matter on his hands and not properly washing his hands. Guardian stated that staff did not go with Resident A to the bathroom, and when he returned to the table, Guardian observed Resident A to have fecal matter under and around his fingernails. Guardian stated that staff did not check Resident A's hands when he returned to the table and proceeded to serve Resident A his meal.

Asia Buggs, staff person, stated on 5/17/23 that she was working on 3/26/23 when this incident occurred. Ms. Buggs stated that it was time for lunch, and Resident A was instructed to go to the bathroom and wash his hands. Ms. Buggs stated that no staff went with Resident A to the bathroom to assist Resident A with washing his hands. Ms. Buggs stated that she did not notice any fecal matter on Resident A's hands when Resident A returned to the table. Ms. Buggs stated that she is not sure if Resident A had fecal matter on his hands or not, but that she did not remember seeing any on Resident A's hands.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's plan of service and written assessment document that staff are to assist Resident A with washing his hands following toileting due to Resident A's history of getting fecal matter on his hands while toileting. Guardian stated that staff sent Resident A to the bathroom on 3/26/23 while Guardian was visiting Resident A, and staff did not go with Resident A to the bathroom or assist Resident A following toileting. Guardian stated that he observed Resident A to have fecal matter under and around his fingernails when he returned to the dining room table, and staff did not check Resident A's hands prior to serving Resident A his meal. Ms. Shepard stated that she had photos of Resident A's hands, taken on 3/26/23, confirming that Resident A did have fecal matter under and around his fingernails. Ms. Shepard has cited a violation of Resident A's recipient rights due to staff not following Resident A's plan of service. The photos of Resident A's hands were reviewed and confirm the allegation. Resident A's written assessment and plan of service both document that staff are to assist Resident A with washing his hands following toileting. Based on the statements given, documentation reviewed, and observations made, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with James Wilson, licensee designee, on 5/17/23. The findings in this report were reviewed.

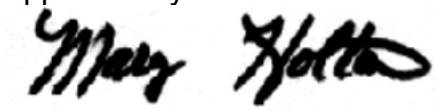
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

5/22/23

Kent W. Gieselman — Date
Licensing Consultant

Approved By:



5/22/23

Mary E. Holton — Date
Area Manager