GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2024

Nicholas Hargress
Advance Care, Incorporated
P.O. Box 74484
Romulus, MI 48174

RE: License #: AS820251656
Investigation #: 2024A0992044
Avalon

Dear Nicholas Hargress:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820251656
Investigation #:	2024A0992044
Complaint Receipt Date:	07/09/2024
Investigation Initiation Date:	07/10/2024
Report Due Date:	09/07/2024
Licensee Name:	Advance Care, Incorporated
Licensee Address:	P.O. Box 74484 Romulus, MI 48174
Licensee Telephone #:	(248) 738-4986
Administrator:	Nicholas Hargress
Licensee Designee:	Nicholas Hargress
Name of Facility:	Avalon
Facility Address:	6007 Carnegie Romulus, MI 48174
Facility Telephone #:	(737) 728-1410
Original Issuance Date:	10/01/2003
License Status:	REGULAR
Effective Date:	04/21/2024
Expiration Date:	04/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
On 7/1/2024, the residents were left in the home unattended.	Yes

III. METHODOLOGY

07/09/2024	Special Investigation Intake 2024A0992044
07/10/2024	Special Investigation Initiated - On Site Home manager, Gregory Gilmer, Residents A and B.
07/11/2024	Contact - Telephone call made Licensee designee, Nicholas Hargress
07/11/2024	Contact - Document Received Direct care staff termination notice
07/12/2024	Contact - Document Sent Records request submitted to Romulus Police Department
07/12/2024	Contact - Telephone call made Direct care staff, Fatima Kirby was not available. Message left.
07/19/2024	Contact - Document Received Police report
07/25/2024	Contact - Telephone call made Ms. Kirby was not available. Message left.
07/25/2024	Contact - Telephone call made Resident A's guardian, Kathlyn Brown with Family Options.
08/02/2024	Contact - Telephone call made Adult protective services, Kya Lockett.
08/02/2024	Exit Conference Mr. Hargress

ALLEGATION: On 7/1/224, the residents were left in the home unattended.

INVESTIGATION: On 07/10/2024, I completed an unannounced onsite inspection and interviewed home manager, Gregory Gilmer, Residents A and B regarding the allegation. Mr. Gilmer stated he was on vacation when the incident occurred, and he stated he was made aware of the situation once he returned. He stated direct care staff, Emillion Cross was terminated.

Resident A stated Mr. Cross was on shift, and he administered medication between 9:30 p.m. and 10:00 p.m. Resident A stated he went to bed after receiving his medication and woke up around 1:15 a.m. to use the restroom. He stated he went back to sleep and woke up sometime after 2:00 a.m. to go to the restroom. He stated he noticed the front door was cracked and Mr. Cross was not in the home. Resident A stated he woke up Resident B and he looked for Mr. Cross too, but he was not in the home. Resident A stated he called the police. He stated when the police arrived, they remained in the home until direct care staff, Fatima Kirby arrived.

I attempted to interview Resident B, but difficulty understanding him, I was unable to interview him.

On 07/11/2024, I contacted licensee designee, Nicholas Hargress and interviewed him regarding the allegation, which he confirmed. Mr. Hargress stated he was made aware of the incident when it occurred and as a result Mr. Cross was terminated. Mr. Hargress agreed to provide me with a copy of the termination notice.

On 07/11/2024, I received a copy of the termination notice for Mr. Cross. The termination notice stated the following "This letter is to confirm that your employment at Advance Care is terminated effective immediately. Due to the seriousness of the allegations at the Avalon Residence, you are no longer eligible to be on the schedule. Please refrain from returning to any of the Advance Care/Clearer Vision locations. Once all investigations are complete, you ma/may not be contacted for an exit interview."

On 07/19/2024, I received a copy of the Romulus Police Department police report, 240011964. According to the report the police were dispatched to Avalon residence due to reports of a group home with no staff in the home. Police arrived to find Resident A present. Attempts were made to contact Mr. Cross, to no avail. Contact was made with Ms. Kirby and the officers remained onsite until Ms. Kirby arrived.

On 07/25/2024, I contacted Resident A's guardian, Kathlyn Brown with Family Options regarding the allegation, which Ms. Kirby stated she was not made aware. She denied having any concerns regarding the placement but stated she would follow-up with Resident A.

On 08/02/2024, I contacted adult protective services, Kya Lockett regarding the allegation. Ms. Lockett confirmed she investigated the allegation and substantiated. Ms. Lockett stated the allegations were reported to the office of recipient rights.

On 08/02/2024, I completed an exit conference with Mr. Hargress. I made him aware that based on the investigative findings, there is sufficient evidence to support the allegation that the residents were left unattended and there was not sufficient direct care staff on duty for the supervision, personal care, and protection of the residents. Due to the violation identified in the report, I made Mr. Hargress aware that a written corrective action plan is required, which he agreed. Mr. Hargress denied having any questions at this time.

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:	Based upon interviews with the licensee designee, Resident A and review of the police report, it has been established that the residents were left unattended and there was not sufficient direct care staff on duty for the supervision, personal care, and protection of residents. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

08/02/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

08/06/2024

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Ardra Hunter Date
Area Manager