GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 24, 2023

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

RE: License #: AS820014640
Investigation #: 2023A0116038
Crystal's Care

Dear Mr. 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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014640
Investigation #:	2023A0116038
Complaint Receipt Date:	06/29/2023
Investigation Initiation Date:	06/29/2023
Report Due Date:	08/28/2023
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:	Crystal's Care
Facility Address:	19640 Middlebelt New Boston, MI 48174
Facility Telephone #:	(734) 783-2509
Original Issuance Date:	02/07/1992
License Status:	REGULAR
Effective Date:	04/09/2022
Expiration Date:	04/08/2024
Capacity:	6
Program Type:	MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the hospital on 06/23/23 and was ready for discharge on 06/24/23. When the hospital staff contacted the home, staff told them that they would not be able to pick Resident A up until Monday 06/26/23 as they did not have enough staff.	Yes

III. METHODOLOGY

06/29/2023	Special Investigation Intake 2023A0116038
06/29/2023	APS Referral Received
06/29/2023	Referral - Recipient Rights Made.
06/29/2023	Special Investigation Initiated - Telephone Spoke with Beaumont Hospital receptionist.
07/05/2023	Inspection Completed On-site Interviewed staff, Labiba Smiley and Resident A.
07/05/2023	Inspection Completed-BCAL Sub. Compliance
07/11/2023	Contact - Telephone call made Interviewed staff, Chuwudi Okaro.
07/11/2023	Exit Conference With licensee designee, Nicholas Hargress.

ALLEGATION:

Resident A was taken to the hospital on 06/23/23 and was ready for discharge on 06/24/23. When the hospital staff contacted the home, staff told them that they would not be able to pick Resident A up until Monday 06/26/23 as they did not have enough staff.

INVESTIGATION:

On 06/29/23, I spoke with the emergency room receptionist who confirmed that Resident A was no longer in the hospital.

On 07/05/23, I conducted an unscheduled onsite inspection and interviewed staff, Labiba Smiley and Resident A. Ms. Smiley reported that she was not at work when the incident occurred but reported receiving a phone call from the hospital on Sunday morning 06/25/23. Ms. Smiley reported that she was on her way home from out of town and went directly to the hospital to pick Resident A up. Ms. Smiley reported that she made it to the hospital at about 12:15 p.m. Ms. Smiley reported that the hospital staff did share with her that Resident A was ready for discharge on Saturday 06/24/23, and informed her that the male staff who they spoke with on 06/24/23, told them that no one would be available to pick Resident A up until Monday 06/26/23, because they did not have the staffing to do so. Ms. Smiley reported that the staff person on shift at the time, Chuwudi Okaro, should have loaded the residents that were home in the van and went to the hospital to pick Resident A up. Ms. Smiley further reported that Mr. Okaro also could have contacted licensee designee, Nicholas Hargress who would have ensured that Resident A was picked and brought back home.

I interviewed Resident A and he reported that he was feeling good and glad to be home. Resident A was not aware of why he was in the hospital an additional night. Resident A confirmed that Ms. Smiley picked him up from the hospital.

On 07/11/23, I interviewed staff, Chuwudi Okaro, and he reported that he was the staff person on shift on 06/24/23, when the hospital staff called and informed him that Resident A was ready for discharge. Mr. Okaro reported that he was the only staff on duty at the time and admitted that he told the hospital staff that they did not have any staff available to pick Resident A up. I asked Mr. Okaro, if he had access to the homes van, and he reported that he didn't have the van key. I asked Mr. Okaro if he attempted to contact his manager or the licensee designee, Mr. Hargress. Mr. Okaro reported that he did not. Mr. Okaro reported that he made a mistake, and he is fully aware of his responsibilities to the residents. Mr. Okaro reported that this would not happen again.

On 07/11/23, I conducted the exit conference with licensee designee, Nicholas Hargress. Mr. Hargress reported being aware of the incident. Mr. Hargress reported that Mr. Okaro knows he could have called him, and he would have made sure that

Resident A was picked up on 06/24/23 and taken to the home. I informed Mr. Hargress of the rule violation, and he reported an understanding.

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 on the findings of the investigation, which included interviews of Ms. Smiley and Mr. Okaro, I am able to corroborate the allegation. Ms. Smiley confirmed that Resident A was medically ready for discharge on 06/24/23, and when the hospital staff called for him to be picked up, Mr. Okaro informed them that they did not have the staffing available to pick him up. Ms. Smiley reported she was contacted on the morning of 06/25/23 and she picked Resident A up. Mr. Okaro confirmed that he spoke with the hospital staff on 06/24/23, when they called to inform him, that Resident A was ready for discharge. Mr. Okaro reported that he was the only staff at the home and that they did not have any available staff to pick Resident A up until 06/26/23. This violation is established as the home did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/18/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:

07/24/23

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Ardra Hunter
Area Manager

Date