



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 7, 2023

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

RE: License #: AL820007594
Investigation #: 2023A0992032
Brush Street Residence

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,

A handwritten signature in black ink, appearing to read "Denasha Walker".

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 #:	AL820007594
Investigation #:	2023A0992032
Complaint Receipt Date:	07/06/2023
Investigation Initiation Date:	07/07/2023
Report Due Date:	09/04/2023
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:	Brush Street Residence
Facility Address:	35646 Brush Wayne, MI 48184
Facility Telephone #:	(734) 728-8920
Original Issuance Date:	02/17/1987
License Status:	REGULAR
Effective Date:	11/24/2022
Expiration Date:	11/23/2024
Capacity:	13

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL
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II. ALLEGATION(S)

	Violation Established?
Ebony Carson, direct care staff, passes medication and she is not trained to do so. She is often verbally abusive towards the residents.	No
Additional Findings	Yes

III. METHODOLOGY

07/06/2023	Special Investigation Intake 2023A0992032
07/07/2023	Special Investigation Initiated - On Site Sarah Street, Area Manager, Resident A-C.
07/20/2023	Contact - Face to Face Ms. Street
07/20/2023	Contact - Telephone call made Nicholas Hargress, licensee designee
07/24/2023	Contact - Face to Face Resident D
07/25/2023	APS Referral
07/25/2023	Contact - Telephone call made Teria Wiley, Resident D's guardian with Family Options
07/26/2023	Referral - Recipient Rights
07/26/2023	Contact - Telephone call made Ebony Carson, direct care staff.
08/03/2023	Exit Conference Mr. Hargress

ALLEGATION: Ebony Carson, direct care staff actively passes medication, and she is not trained to do so. She is often verbally abusive towards the residents.

INVESTIGATION: On 07/07/2023, I completed an unannounced onsite inspection and interviewed Sarah Street, Area Manager and Residents A-C regarding the allegations. Ms. Street denied the allegations, she said Ebony Carson, direct care staff is trained. She said she was hired approximately two or three months ago; she completed her training and was assigned to the Brush Street home. Ms. Street said Ms. Carson's complete employee file is not onsite, but she could get it for me to review. I reviewed the documents that were onsite. Based on the documentation, Ms. Carson's date of hire was 04/06/2023. I observed her direct care job description and staff orientation part 1, which was signed and dated 03/17/2023 by Ms. Carson. According to the staff orientation part 1, Ms. Carson completed all required training. However, she did not have certificates or training verification onsite. Ms. Street checked her email to see if she had a copy of Ms. Carson's training transcript, but she did not. She was able to locate a copy of Ms. Carson's fingerprints via email which was dated 04/07/2023. Ms. Street said she has a physical copy of Ms. Carson's training transcript, physical and TB at the office, she agreed to provide me with a copy. Ms. Street said although Ms. Carson is relatively new, she is trained, and she is always on shift with another fully trained staff. Ms. Street said the staff are trained with toolbox. I asked to see the toolbox binder and Ms. Street said it is at the office. I explained that when a licensee subscribes to toolbox and have multiple homes, they are required to have a subscription/binder for each home. Ms. Street called Nicholas Hargress, licensee designee and made him aware of the toolbox requirements. She made Mr. Hargress aware that I will be contacting him to discuss the allegations. I reviewed the medication administration record and observed "EC," Ms. Carson's initials dating back to 05/2023. I requested the following items from Ms. Street, Ms. Carson's training transcript, her physical/TB and the staff schedule, which Ms. Street agreed to provide.

I interviewed Residents A-C, all of which denied the allegation. Residents A-C were unable to identify the staff by name but stated all the staff treat them well. Residents A-C denied having any concerns.

On 07/20/2023, I completed a follow-up onsite inspection, Ms. Street provided me a copy of Ms. Carson's training transcript which was dated 03/18/2023 through Direct Care Training Resource Center. Ms. Carson's transcript contained medication training, and all required direct care worker training. Ms. Street said Mr. Hargress has a subscription through Direct Care Training Resource Center, not Toolbox. Ms. Street also provided me a copy of Ms. Carson's physical and TB. The physical was dated 11/14/2022 and her TB 03/17/2023. I made Ms. Street aware that Ms.

Carson's physical was not within 30 days of her employment and assumption of duties in the home.

On 07/20/2023, I contacted Mr. Hargress and discussed the allegations. Mr. Hargress said Ms. Carson is trained and he subscribes to Direct Care Training Resource Center, not Toolbox. I made him aware that I reviewed Ms. Carson's training transcript and verified her medication training. He said Direct Care Training Resource Center is very costly to have a subscription for each home. I explained the Toolbox program and further stated that when a licensee subscribes to Toolbox and have multiple homes, they are required to have a subscription/binder for each home. I provided him with Toolbox information and suggested he compare the two programs for future training resources. Mr. Hargress denied having any knowledge of Ms. Carson being rude and/or verbally abusive towards the residents. I made him aware based on my interviews with Residents A-C, the staff is not verbally abusive and treats them well.

On 07/24/2023, I made face-to-face contact with Resident D and interviewed her regarding the allegation, which she denied. Resident D said she does not know all the staff by name but said she is treated fair by all the staff. Resident D denied having any concerns.

On 07/25/2023, I contacted Teria Wiley, Resident D's guardian with Family Options and interviewed her regarding the allegation. Ms. Wiley denied having any concerns regarding the quality-of-care Resident D receive from the Brush Street Residence staff. She said Resident D has been at the home for over five years and they treat her well. She said although Resident D often ask to move, it is because she wants to be closer to her church but that is not an option at this time. Ms. Wiley said ultimately Resident D's placement suits her best.

On 07/26/2023, I contacted Ms. Carson, and interviewed her regarding the allegation. Ms. Carson denied the allegation and said she was trained by Advance Care, Incorporated prior to working in the home. Ms. Carson said upper management has a copy of her training transcript. Ms. Carson went on to say she believe the allegation was reported out of malice by her son. She said her son used to work for the company and was recently removed from the schedule. She said her son is upset and he chose to report the false information against her. Ms. Carson said due to her son's actions and threats, she had to get a personal protection order against him.

On 08/03/2023, I conducted an exit conference with Mr. Hargress. I made him aware that based on the investigative findings, there is insufficient evidence to support the allegations; the allegations are unsubstantiated. Mr. Hargress denied having any questions or concerns.

APPLICABLE RULE	
R 330.1806	Staffing levels and qualifications.
	<p>(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all of the following areas:</p> <p>(a) An introduction to community residential services and the role of direct care staff.</p> <p>(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.</p> <p>(c) Basic interventions for maintaining and caring for a client's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness.</p> <p>(d) Basic first aid and cardiopulmonary resuscitation</p> <p>(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications.</p> <p>(f) Preventing, preparing for, and responding to environmental emergencies, for example, power failures, fires, and tornados.</p> <p>(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the licensed facility.</p> <p>(h) Non-aversive techniques for the prevention and treatment of challenging behavior of clients.</p>

ANALYSIS:	<p>During this investigation, I interviewed Nicholas Hargress, licensee designee; Sarah Street, area manager; Ebony Carson, direct care staff, regarding the allegations, all of which denied the reported allegation.</p> <p>I reviewed Ms. Carson’s training transcript which was dated 03/18/2023 through Direct Care Training Resource Center, Ms. Carson’s transcript contained medication training, and all required direct care worker training. I also reviewed the medication administration record and observed “EC,” Ms. Carson’s initials dating back to 05/2023, no discrepancies noted.</p> <p>Based on the investigative findings, there is insufficient evidence that Ebony Carson, direct care staff failed to successfully complete a proper precautions and procedures for administering prescriptive and nonprescriptive medications training. The allegation is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>During this investigation, I interviewed Nicholas Hargress, licensee designee; Sarah Street, area manager; Ebony Carson, direct care staff, Teria Wile, Resident D’s guardian with Family Options, Residents A-D regarding the allegations, all of which denied the reported allegation.</p> <p>Based on the investigative findings, there is insufficient evidence that Ebony Carson, direct care staff failed to always treat the residents with dignity. The allegation is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/20/2023, I reviewed a Ms. Carson's employee file/training. Ms. Carson's file did not contain a physical within 30 days of her employment and assumption of duties in the home.

On 07/20/2023, I completed an exit conference with Mr. Hargress regarding the additional findings. I made him aware upon review of Ms. Carson's employee file, the file did not contain verification of her health within 30 days of her employment and assumption of duties in the home. Mr. Hargress denied having any questions. He agreed to review the report and submit the corrective action plan as required.

On 08/03/2023, I completed an exit conference with Mr. Hargress regarding the additional findings. I made Mr. Marable aware upon review of Ms. Carson's employee file, the file did not contain a physical within 30 days of her employment and assumption of duties in the home Mr. Hargress denied having any questions. He agreed to review the report and submit the corrective action plan as required.

APPLICABLE RULE	
R 400.15205	Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	At the time of inspection, Ebony Carson, dire care staff employee file did not contain a statement signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health within 30 days of her employment, and assumption of duties in the home.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



08/03/2023

Denasha Walker
Licensing Consultant

Date

Approved By:



08/07/2023

Ardra Hunter
Area Manager

Date