GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

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

RE: License #: AL820007594
Investigation #: 2026A0121012
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 was required. On May 7, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007594
Investigation #:	2026A0121012
Complaint Receipt Date:	04/08/2026
Investigation Initiation Date:	04/08/2026
Report Due Date:	06/07/2026
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:	11/24/2024
Expiration Date:	11/23/2026
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/30/26, Resident A was admitted to the hospital for failure to thrive because he has not been eating. Resident A reported that direct care staff, Al, slams his head against the wall and sometimes against the bed. Management has been made aware of the abuse but accuses Resident A of lying.	No
Additional Findings	Yes

III. METHODOLOGY

04/08/2026	Special Investigation Intake 2026A0121012
04/08/2026	Special Investigation Initiated - Telephone Ashley Rasberry with Adult Protective Service (APS)
04/08/2026	Contact - Telephone call made Licensee designee, Nicholas Hargress
04/08/2026	Contact - Telephone call received Home manager, Tawana Martin
04/08/2026	Contact - Document Received Email from Ms. Rasberry with APS
04/08/2026	Contact - Document Received Emergency discharge report
04/09/2026	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A and staff, Devaughn Little
04/20/2026	Referral - Recipient Rights
04/20/2026	Contact - Telephone call made Nurse Melissa Alsobrooks
04/20/2026	Exit Conference Mr. Hargress

ALLEGATION: **On 3/30/26, Resident A was admitted to the hospital for failure to thrive because he has not been eating. Resident A reported that direct care staff, Al, slams his head against the wall and sometimes against the bed. Management has been made aware of the abuse but accuses Resident A of lying.**

INVESTIGATION: On 4/8/26, I spoke with adult protective services (APS) worker, Ashley Rasberry, licensee designee, Nicholas Hargress, and home manager, Tawana Martin. All reported that no one lives or works at the home named Al. The following day, I visited Resident A at his new placement. Resident A maintains that a direct care staff named Al "punched me in the face .. he beat the hell out of me … he beat me up real bad … threw me in the tub, made me wash up … he smashed my head all over with his fist as hard as he could … he did it for nothing." However, Resident A's new staff, Devaughn Little, described Resident A as "confused." For example, on the day of inspection, Resident A told Mr. Little that he didn't get lunch; however, I observed food and drink on a tray at his bedside that had been untouched. Resident A's hospice nurse, Melissa Alsobrooks, confirmed Resident A is confused, making his case difficult to manage. Nurse Alsobrooks indicated that Resident A's behavior is typical of "end of life patients." Nurse Alsobrooks also reported seeing a "decline" in Resident A's cognitive abilities.

On 4/20/26, I completed an exit conference with Mr. Hargress. Mr. Hargress stated all residents at Brush Street Residence are provided 3 healthy meals per day in accordance with the licensing requirements. Because Resident A's mental state declined, it is possible the resident skipped meals causing significant physical changes.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

ANALYSIS:	Because Resident A's statements are not reliable, there is insufficient evidence that a staff named Al committed any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 4/8/26, I reviewed Resident A's emergency discharge notice. The report is dated 3/30/26 and states the following, "Your actions/behaviors in the home are intolerable for other members in the home and staff members. We can no longer keep you in our care, for various safety reasons. At this time, you need a higher level of care." Mr. Hargress signed the report. On 4/8/26 and 4/20/26, I talked to Mr. Hargress by phone. Mr. Hargress acknowledged he failed to submit Resident A's discharge notice to the department. In addition, Mr. Hargress explained Resident A was not allowed back into the home because the resident "kept calling the police complaining about being sick." I informed Mr. Hargress that residents cannot be discharged to the hospital without consent. Therefore, Mr. Hargress failed to discharge Resident A until an appropriate placement had been secured.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(6) A licensee shall take all of the following steps before discharging a resident under subrule (5) of this rule: **(c) A resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	Mr. Hargress discharged Resident A from the home with less than 30- days' notice before an appropriate setting that met the resident's immediate needs was located.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.



06/05/26

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Kara Robinson — Date
Licensing Consultant

Approved By:



06/11/26

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Ardra Hunter — Date
Area Manager