GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2021

Donzell Dawkins
Premier Care Assisted Living, LLC
1109 16th Street
BAY CITY, MI 48708

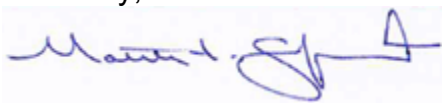
RE: License #: AS650380905
Investigation #: 2021A0360038
Premier Care Assisted Living 5 LLC

Dear Mr. Dawkins:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS650380905
Investigation #:	2021A0360038
Complaint Receipt Date:	09/09/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	10/09/2021
Licensee Name:	Premier Care Assisted Living, LLC
Licensee Address:	1109 16th Street BAY CITY, MI 48708
Licensee Telephone #:	(989) 295-7641
Administrator:	Donzell Dawkins
Licensee Designee:	Donzell Dawkins
Name of Facility:	Premier Care Assisted Living 5 LLC
Facility Address:	5189 M33 Alger, MI 48610
Facility Telephone #:	(989) 295-7641
Original Issuance Date:	12/21/2016
License Status:	REGULAR
Effective Date:	12/20/2019
Expiration Date:	12/19/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's behavioral medication was not filled, and he was subsequently hospitalized for behavioral issues.	No

III. METHODOLOGY

09/09/2021	Special Investigation Intake 2021A0360038
09/09/2021	Special Investigation Initiated - Telephone Val Sciotti APS
09/09/2021	APS Referral
09/14/2021	Inspection Completed On-site Resident A, Home manager Ericka Allen
10/04/2021	Contact - Telephone call made Guardian 1-A
10/05/2021	Exit Conference With licensee designee Donzell Dawkins

ALLEGATION: Resident A's behavioral medication was not filled, and he was subsequently hospitalized for behavioral issues.

INVESTIGATION: On 9/9/2021 I was assigned a complaint from the LARA online complaint system.

On 9/9/2021 I contacted adult protective services worker (APS) Val Sciotti. Ms. Sciotti stated she received a complaint alleging Resident A's Ativan was not filled and he was hospitalized after not receiving the medications. She stated she went to the home and found the medications had been filled and Resident A was administered the medication as prescribed. She stated she would not be substantiating the complaint and would be closing the APS investigation.

On 9/14/2021 I conducted an unannounced onsite inspection at the home. The home manager Ericka Allen provided me with Resident A's September 2021 medication administration record, medication list, and controlled drug disposition form. The documents showed that Resident A is prescribed Lorazepam 1mg PRN with directions to administer by mouth four times a day as needed. Ms. Allen stated if Resident A was administered more than 2 Lorazepam per day, he would become very drowsy and sedated. She stated they would administer the Lorazepam as needed due to agitation. I observed Resident A's Lorazepam 1mg which was filled on 6/10/21. There were still 7 tabs left in the bubble pack. The MAR documented that

Resident A had received 1-2 Lorazepam each day for the month of September. Ms. Allen stated on 9/8/2021 Resident A became combative and attacked a staff member which triggered him being sent to the hospital for evaluation. She stated he returned to the home but was issued a 30-day discharge notice for assaulting a staff member. She stated they are working closely with his guardian and medical providers and if he can stabilize his behaviors, they may not discharge him.

While at the home on 9/14/2021 I attempted an interview with Resident A however due to his diagnosed severe cognitive impairment and autism he was unable to be interviewed.

On 10/4/2021 I contacted Resident A's guardian; Guardian 1-A. Guardian 1-A stated prior to Resident A moving into Premier Care he was typically administered 2 Lorazepam per day for agitation. She stated when Resident A was hospitalized on 9/8/2021 the home was in contact with her right away. She stated Resident A had an emergency medication review just a couple days after his hospitalization and his behaviors have seemed to stabilize. She stated Resident A has been a big challenge to find the right medication balance. She stated she has no concerns with the home running out of medication. She stated she has worked very closely with them to monitor his behavior and get his medication on track. She stated they have taken very good care of him and go above and beyond to try to meet his needs.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complaint alleged Resident A's behavioral medication was not filled, and he was subsequently hospitalized for behavioral issues. APS did not substantiate the allegation. Resident A's Lorazepam was filled and administered. Resident A's guardian has no concerns with the home.

	There is not a preponderance of evidence that Resident A was not administered his medication as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 10/05/2021 I conducted an exit conference with the licensee designee Donzell Dawkins. Mr. Dawkins concurred with the findings of the investigation.

IV. RECOMMENDATION

I recommend no change in the status of the license

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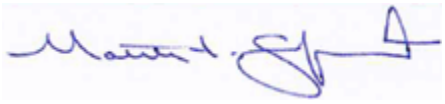

10/05/2021

Matthew Soderquist Date
Licensing Consultant

Approved By:

10/05/2021

Jerry Hendrick Date
Area Manager