GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2022

Laura Hatfield-Smith
ResCare Premier, Inc.
Suite 1A
6185 Tittabawassee
Saginaw, MI 48603

RE: License #: AS780389700
Investigation #: 2022A0584009
Res-Care Premier Raymond

Dear Ms. Hatfield-Smith:

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 2/8/2022, an acceptable written corrective action plan was received and approved.

Please review the enclosed documentation for accuracy and contact me with any questions. If you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780389700
Investigation #:	2022A0584009
Complaint Receipt Date:	01/10/2022
Investigation Initiation Date:	01/10/2022
Report Due Date:	03/11/2022
Licensee Name:	ResCare Premier, Inc.
Licensee Address:	9901 Linn Station Road Louisville, KY 40223
Licensee Telephone #:	(989) 791-7174
Administrator:	Laura Hatfield-Smith
Licensee Designee:	Laura Hatfield-Smith
Name of Facility:	Res-Care Premier Raymond
Facility Address:	715 Raymond Road Owosso, MI 48867
Facility Telephone #:	(989) 472-3829
Original Issuance Date:	11/29/2017
License Status:	REGULAR
Effective Date:	05/29/2020
Expiration Date:	05/28/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not treated with dignity.	Yes

III. METHODOLOGY

01/10/2022	Special Investigation Intake 2022A0584009
01/10/2022	Special Investigation Initiated - Letter To Ardis Bates, Shiawassee Health and Wellness Recipient Rights
02/08/2022	Contact - Telephone call made To Tiffany Baroski-Carsten, home manager
02/08/2022	Contact - Telephone call received From Tiffany Baroski-Carsten, home manager
02/08/2022	Contact – Telephone call made To Makayla Brown
02/08/2022	Exit Conference with Laura Smith
03/09/2022	Contact – Face to Face Interview with Resident A

ALLEGATION:

Resident A was not treated with dignity.

INVESTIGATION:

On 1/10/22, I received email communication from recipient rights investigator Ardis Bates. She verified that she was involved with an investigation of staff who allegedly violated Resident A's rights by telling her she must go to bed when she was not ready to do so. Ms. Bates stated she has left a voicemail with Makayla Brown and Ms. Brown has not returned her call.

On 2/8/22, I interviewed home manager Tiffany Baroski-Carsten by telephone. Ms. Carsten stated that when she went in to work on 1/8, Resident A reported to her that staff Makayla Brown was forcing her to go to bed when she was not ready to go. Ms.

Carsten stated the information in an incident report submitted to Shiawassee County Health and Wellness was as follows:

> "On 1-8-2022, [Resident A] told staff that on 1-7-2022 on 3rd shift, Makayla (3rd shifter) told her it was past 12am and she needed to go to bed. When [Resident A] stated no I don't want to go to bed, Makayla tipped her out of the chair she was in and proceeded to tug on her jacket and make her go to her room even with [Resident A] stating "no I don't want to go to bed". [Resident A] told staff she got tired of arguing with Makayla and just went to bed but is really upset about how Makayla treated her and is afraid of her working 3rds alone and taking care of her"

Ms. Baroski-Carsten stated a corrective training was given to staff on 1/13 regarding resident rights and reminding the staff that this is the resident's home where there are no house rules or set bedtimes.

Acknowledgment of the training was signed by five staff members, including Makayla Brown.

On 2/8/22, I made a telephone call to the phone number of Makayla Brown. A message to call back was left.

On 2/8/22, licensee designee Laura Hatfield-Smith submitted a corrective action plan for the violation established. I reviewed and approved her plan.

On 3/9/22, I visited with Resident A at the facility. Resident A stated that the event where staff Makayla Brown was forcing her to go to bed was the first time that had occurred by any staff at the facility. Resident A said it did not happen after the incident and the staff at the facility have not forced her to go to bed when she was not ready.

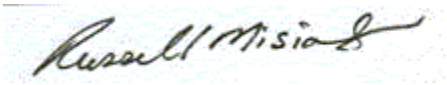
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff member Makayla Brown violated the resident rights by insisting Resident A go to bed and physically grabbed her to get up and go to bed. This violated Resident A's dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable correction plan has been received. I recommend no change in the status of this license.

3/10/2022

Candace Coburn — Date
Licensing Consultant
Approved By:



3/10/2022

Russell B. Misiak — Date
Area Manager