GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2022

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

RE: License #:	AM440284750
Investigation #:	2022A0872041
	Rescare Premier Reamer Meadows

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 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 284-9700.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440284750
Investigation #:	2022A0872041
Complaint Receipt Date:	06/07/2022
Investigation Initiation Date:	06/07/2022
Report Due Date:	08/06/2022
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:	Rescare Premier Reamer Meadows
Facility Address:	3082 Reamer Lapeer, MI 48446
Facility Telephone #:	(810) 664-1371
Original Issuance Date:	01/23/2008
License Status:	REGULAR
Effective Date:	07/28/2020
Expiration Date:	07/27/2022
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 6/06/22, Resident A was taken to the hospital to have a ring cut off her left ring finger. Her finger was crusted, swollen, and lacerated.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/07/2022	Special Investigation Intake 2022A0872041
06/07/2022	APS Referral This complaint was referred by APS but was not assigned for investigation
06/07/2022	Special Investigation Initiated - Letter I emailed APS Supervisor, Kathryn Dennis
06/07/2022	Contact - Document Sent I exchanged emails with RRO, Lisa Jolly
06/14/2022	Inspection Completed On-site Unannounced
06/14/2022	Contact - Document Received AFC documentation received from the home manager, Andrea Bunker
06/30/2022	Contact - Telephone call made I interviewed Resident A's public guardian, Violet Coutour
06/30/2022	Exit Conference I conducted an exit conference with the licensee designee, Laura Smith
07/01/2022	Contact – Document received I received additional documentation about this complaint from the home manager
07/01/2022	Exit Conference I conducted another exit conference with Ms. Hatfield-Smith

ALLEGATION: On 6/06/22, Resident A was taken to the hospital to have a ring cut off her left ring finger. Her finger was crusted, swollen, and lacerated. She had been having trouble for two weeks but declined treatment.

INVESTIGATION: On 6/07/22, I exchanged emails with Lapeer County Recipient Rights Officer, Lisa Jolly. Ms. Jolly said that she is aware of the allegations regarding Resident A. Ms. Jolly stated that Resident A refused to get her finger looked at. Staff continued to encourage her and eventually, Resident A agreed.

On 6/14/22, I conducted an unannounced onsite inspection of ResCare Premier-Reamer Meadows Adult Foster Care facility. I interviewed Resident A and the home manager, Andrea Bunker.

I looked at Resident A's left ring finger and did not see any evidence of an injury. Resident A told me that a while ago, her fiancée gave her an engagement ring. She said that she put the ring on her left ring finger even though it was tight. Resident A told me, "I felt like I needed to wear it whether I liked it or not since it was an engagement ring." Resident A said that staff noticed that the ring looked tight, and they offered to help her get it off and/or take her to the doctor. Resident A said that she told staff that she did not want the ring removed and would not allow staff to look at her finger anymore. Resident A told me that eventually, her finger got swollen and had puss on it, but it was not bleeding. She said that she finally told staff that she would go to the doctor to have her finger looked at, but she refused to go to urgent care or ER (emergency room). According to Resident A, her doctor was not able to get her in for a few days. When staff took her to the doctor, her doctor told her that she needed to go to the emergency room to have the ring cut off. Resident A said that she did not want to go to ER, but she agreed. She said that ER staff cut the ring off and gave her oral antibiotics and an antibiotic cream.

Ms. Bunker confirmed that Resident A had a ring on her finger that was too tight. Ms. Bunker said that staff does not know how long the ring had been on Resident A's finger. Ms. Bunker said that Resident A refused to allow staff to treat her finger and she refused to go to the doctor. When Resident A eventually agreed to be seen by her own primary care physician (PCP), her PCP was not able to get her in for an appointment for a few days. By the time staff took her to her PCP, her PCP said that the ring would need to be cut off at the hospital. Ms. Bunker said that hospital staff cut the ring off and gave her oral antibiotics and an antibiotic cream and she is fine now. Ms. Bunker agreed to send me information related to this complaint.

On 6/21/22, I reviewed AFC paperwork related to Resident A. Resident A was admitted to ResCare Premier-Reamer Meadows on 3/10/14. According to her Assessment Plan, she requires prompts for bathing, grooming, dressing, and personal hygiene. According to her Health Care Appraisal, she is diagnosed with schizophrenia, bipolar, type 2 diabetes, constipation, and obesity.

Resident A's Lapeer County Individualized Plan of Service (IPOS) dated 6/23/21 states that she has a legal guardian and payee. She takes psychotropic medications to assist with delusions and hallucinations. Resident A requires "reminders" and transportation for medical appointments and requires 24-hour supervision.

On 6/30/22, I interviewed Resident A's public guardian, Violet Coutour, via telephone. Ms. Coutour confirmed that Resident A had a ring on her finger that was too tight and eventually, she had to have it cut off at the hospital. According to Ms. Coutour, staff notified her that they were concerned that the ring may be too tight, so she spoke to Resident A, encouraging her to go to the doctor. Ms. Coutour said that staff and Resident A's case manager also continued to encourage Resident A to have her finger looked at, but she refused for over a week. Ms. Coutour stated she feels staff did everything they could to try and treat Resident A, but she continually refused. Ms. Coutour told me that Resident A has resided at ResCare Premier-Reamer Meadows for several years and she does not have any concerns about her care.

On 07/05/22, I reviewed an Incident/Accident Report (IR) dated 06/06/22. According to the IR, "Resident A had an appointment with Elaine Boyle today to look at a ring that had been stuck on resident's finger for an unknown amount of time. While at the appointment Elaine Boyle suggested we go to McLaren ER to have the ring removed/cut off as she did not have the tools to do so. Once examined at ER it was found that the ring had cut into her finger and needed treatment with bacitracin/zinc ointment and cephalexin."

According to the hospital discharge paperwork, Resident A was diagnosed with "constrictive jewelry of finger; wound, open, finger." She was given medications and wound care instructions.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A put a ring on her left ring finger that was too tight. She refused to allow staff to look at or treat her finger for over a week. Staff continued to encourage her, and they notified Resident A's case manager and guardian who also encouraged Resident A to be seen by a physician.

	Resident A finally agreed to be seen by her PCP. On 6/06/22, Resident A went to her PCP who then referred her to the hospital. While at the hospital, the ring was cut off her finger and she was given an antibiotic and an antibiotic cream for treatment. It is not known how long the ring was on Resident A's finger. The home failed to seek immediate medical care when they became aware Resident A's finger was swollen. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

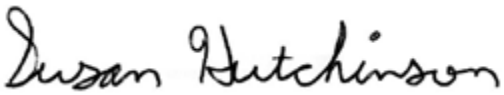
INVESTIGATION: During my investigation, I noted that the licensee designee did not send me the completed Incident/Accident Report regarding Resident A's ER visit as required by this rule.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	During my investigation, I noted that the licensee designee did not send me the completed Incident/Accident Report regarding Resident A's ER visit as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/01/22, I conducted an exit conference with the licensee designee. I explained which rule violations I am substantiating and told her I would send her my investigation report once it is approved.

IV. RECOMMENDATION

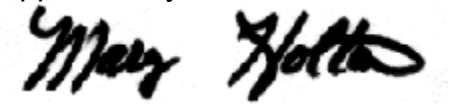
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



July 5, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



July 5, 2022

Mary E. Holton Area Manager	Date