GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 9, 2022

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

RE: License #: AS250284763
Investigation #: 2022A0779048
ResCare Premier Riverview

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.
- 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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250284763
Investigation #:	2022A0779048
Complaint Receipt Date:	07/22/2022
Investigation Initiation Date:	07/25/2022
Report Due Date:	09/20/2022
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 Riverview
Facility Address:	1467 Flushing Rd., Flushing, MI 48433
Facility Telephone #:	(810) 659-6444
Original Issuance Date:	11/13/2006
License **Status:**	REGULAR
Effective Date:	04/17/2021
Expiration Date:	04/16/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has missed multiple medical appointments over the last month.	Yes

III. METHODOLOGY

07/22/2022	Special Investigation Intake 2022A0779048
07/25/2022	Special Investigation Initiated - Telephone Voicemail message for complainant.
07/25/2022	APS Referral Complaint was refereed to APS centralized intake.
07/28/2022	Contact - Telephone call made Spoke to complainant.
08/01/2022	Inspection Completed On-site
09/08/2022	Exit Conference Conducted with licensee designee, Laura Hatfield-Smith.

ALLEGATION:

Resident A has missed multiple medical appointments over the last month.

INVESTIGATION:

On 7/28/22, a phone conversation took place with Complainant, who stated that this home has failed to get Resident A to three (3) separate medical appointments. She stated that Resident A's appointment with her psychiatrist on 7/1/22 was canceled by the home and she is not sure why. Complainant reported that appointment was rescheduled for the morning of 7/15/22, which was not kept and had to be scheduled for later that same day. She stated that appointment was via video conference. Complainant stated that Resident A had a scheduled appointment with a urologist on 7/20/22, due to her having reoccurring urinary tract infections, and staff failed to take her. Complainant reported that she was told that the staff working on 7/20/22 did not check the calendar of medical appointments and did not know to take Resident A. She

stated that she is not aware of Resident A having any known complications due to having to rescheduling these appointments.

On 8/1/22, an on-site inspection was conducted and Resident A was interviewed. Resident A confirmed that she did miss a few medical appointments that she was not aware of. She stated that she has asked to be informed of any future appointments that are made for her, so she knows when they are beforehand. Resident A stated that she likes it at this home and that staff are nice to her.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan indicates that Resident A utilizes a walker and is a stand-by assist from staff for toileting, bathing, and walking. Resident A received minimal assistance as needed for the rest of her activities of daily living. The home provided a copy of Resident A's completed and signed *AFC Resident Care Agreement form*. On this agreement, it states that the home will provide transportation to scheduled medical appointments for Resident A.

During the on-site inspection on 8/1/22, home manager, Shmarile Smith, was interviewed, who confirmed that Resident A was not taken to her psychiatrist appointment on 7/1/22 or her urologist appointment on 7/20/22. She stated that staff person, Talisha Boose-Herd, was the staff working on both those days and the one responsible for transporting Resident A to any appointments. Ms. Smith reported that they have a large calendar that lists all resident appointments and that it is policy that staff refer to the calendar at the beginning of each shift and plan the shift accordingly. Ms. Smith stated that Ms. Boose-Herd simply did not look at the calendar on either 7/1/22 or 7/20/22 and did not take Resident A to her appointments. She stated that Resident A's urology appointment was rescheduled for 7/29/22, which was kept, and that Resident A has not had any complications due to missing the original appointment. When asked about the Resident A's psychiatric appointment on 7/15/22, Ms. Smith stated that was a telehealth appointment via video conference. She reported that she handled that appointment and that there was a mix up and confusion regarding which email address was going to be used. Ms. Smith stated that she spoke to the psychiatrist's office, cleared up the mix up and had Resident A complete the appointment later that same day via facetime on her phone.

On 8/1/22, staff person, Talisha Boose-Herd, was interviewed. She confirmed that the home's policy is for staff to check the appointment calendar at the beginning of each shift. Ms. Boose-Herd claims that she does not remember what happened on 7/1/22 since it was too long ago. She stated that she thinks that the home's van was gone doing other resident's appointments on 7/20/22 and was not available for her to transport Resident A to her appointment.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**
ANALYSIS:	It was confirmed that Resident A missed scheduled medical appointments on 7/1/22 and 7/20/22. The explanation given by the home was that staff simply did not review the appointment calendar for those days and did not take Resident A to her appointments. Resident A's *AFC Resident Care Agreement,* which was completed and signed by all applicable parties, was viewed to state that the home will provide transportation to scheduled medical appointments for Resident A. Failure to provide such transportation on two separate occasions warrants the citing of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/7/22, an exit conference was conducted with licensee designee, Laura Hatfield-Smith. She was informed of the licensing rule violation and that a written corrective action plan is required to address the violation.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

9/9/2022

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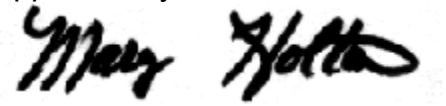
Christopher Holvey Date
Licensing Consultant

Approved By:



9/9/2022

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Mary E. Holton Date
Area Manager