GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2022

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

License # : AS780389700
Investigation #: 2022A0584025
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 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and 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 #:	2022A0584025
Complaint Receipt Date:	06/22/2022
Investigation Initiation Date:	06/23/2022
Report Due Date:	08/21/2022
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:	05/29/2022
Expiration Date:	05/28/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A found facility staff member Shawn “Jessie” Stinde asleep during his work shift at the facility. Documentation on Resident A’s Community Mental Health Person Centered Plan indicates Resident A requires 30-minute bed checks and 24/7 monitoring by facility staff members.	Yes

III. METHODOLOGY

06/22/2022	Special Investigation Intake 2022A0584025
06/23/2022	Special Investigation Initiated - Email to Ardis Bates, Shiawassee Health and Wellness Recipient Rights Specialist.
08/02/2022	Inspection Completed On-site Contact – Face to face interview with Resident A and Tiffany Baroski-Carsten, home manager.
08/02/2022	Contact - Telephone interview with Shawn "Jessie" Stinde, direct care staff.
08/11/2022	Exit Conference via email with Laura Hatfield-Smith

ALLEGATION:

Resident A found facility staff member Shawn “Jessie” Stinde asleep during his work shift at the facility. Documentation on Resident A’s Community Mental Health Person Centered Plan indicates Resident A requires 30-minute bed checks and 24/7 monitoring by facility staff members.

INVESTIGATION:

On 6/22/2022, the Bureau of Community and Health Services (BCHS) received the above allegation via the BCHS online complaint system.

On 06/23/2022, via email, I informed Shiawassee Health and Wellness Recipient Right’s Specialist I was assigned to investigate this allegation.

On 8/2/2022, I conducted an unannounced investigation onsite and reviewed Resident A's Community Mental Health Person Centered Plan (PCP). Documentation on Resident A's PCP confirmed Resident A is to receive 24/7 monitoring and 30-minute room checks at the facility due to self-harming behaviors.

I conducted separate in person interviews with Resident A and Tiffany Baroski-Carsten, home manager. Resident A stated she left her bedroom around midnight on 8/5/2022 to talk to Jessie Stinde, the facility staff member working the overnight shift, because she felt like she was going to harm herself. Resident A stated she had not seen Mr. Stinde check on her that evening, as he was supposed to. Resident A stated she walked around the home looking for Mr. Stinde and found him asleep on the floor in the activity room, between the long table and the wall, with a blanket pulled up over his head. Resident A stated she tried to wake Mr. Stinde and he did not wake up. Resident A stated she took a picture of Mr. Stinde sleeping with her cellular telephone and texted Ms. Baroski-Carsten the picture. Resident A stated there was no one else awake in the home during this incident and Mr. Stinde was the only scheduled staff working that night.

Ms. Baroski-Carsten confirmed that at approximately midnight on 08/05/2022, she received a photograph of Mr. Stinde sleeping, via text message, from Resident A. Via this text exchange, Resident A informed Ms. Baroski-Carsten she was unable to wake Mr. Stinde up. Ms. Baroski-Carsten showed me the photograph on her cellular telephone. I viewed the photograph and observed an individual lying on the floor with a pillow under their head and a blanket pulled up to their ears. Ms. Baroski-Carsten confirmed the person in the photograph was Mr. Stinde. According to Ms. Baroski-Carsten, she immediately drove to the facility and observed Mr. Stinde to be awake. Ms. Baroski-Carsten stated Mr. Stinde was the only staff person working that shift.

I conducted a telephone interview with Mr. Stinde. Mr. Stinde stated that during his shift on 08/05/2022, he did lay on the floor to "stretch out his back" because it was hurting. Mr. Stinde stated he put himself in a difficult situation by laying on the floor, covering up with a blanket, and using a pillow to rest his head. Mr. Stinde stated he was not asleep and was aware Resident A came into the activity room where he was laying. Mr. Stinde stated he did get up off the floor when he knew Resident A had come into the room. Mr. Stinde was not able to determine how long he was laying on the floor.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon my investigation, which consisted of an interview with Resident A, home manager Tiffany Baroski-Carsten and direct care staff member Shawn Stinde, a review of Resident A's community mental health PCP, and an observation of a photograph provided to me by Ms. Baroski-Carsten, it has been established Resident A is to receive 24/7 monitoring and 30-minute room checks at the facility due to self-harming behaviors. There is enough evidence to substantiate the allegation that on 08/05/2022, Mr. Stinde did not provide Resident A with supervision as indicated in her PCP.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/11/2022, I conducted an exit conference with licensee designee Laura Hatfield-Smith via an email and shared with her the findings of this investigation.

IV. RECOMMENDATION

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

8/19/2022

Candace Coburn — Date
Licensing Consultant

Approved By:

8/19/2022

Section Manager — Date