

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

September 30, 2022

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

> RE: License #: | AS730389603 Investigation #: | 2022A0123049

> > Res-Care Premier Lawndale

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) 643-7960.

Sincerely,

Shamidah Wyden, Licensing Consultant Bureau of Community and Health Systems 411 Genesee P.O. Box 5070 Saginaw, MI 48607 989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730389603	
Investigation #:	2022A0123049	
Investigation #:	2022A0123049	
Complaint Receipt Date:	08/08/2022	
Investigation Initiation Date:	08/09/2022	
Report Due Date:	10/07/2022	
Report Due Date.	10/01/2022	
Licensee Name:	ResCare Premier, Inc.	
Licensee Address:	9901 Linn Station Road	
	Louisville, KY 40223	
Licensee Telephone #:	(989) 791-7174	
-		
Administrator:	Laura Hatfield-Smith	
Licenses Decimans	Laura Hatfield Coeith	
Licensee Designee:	Laura Hatfield-Smith	
Name of Facility:	Res-Care Premier Lawndale	
Facility Address:	3946 Lawndale Rd.	
	Saginaw, MI 48603	
Facility Telephone #:	(989) 401-6840	
Original Issuance Date:	10/06/2017	
License Status:	REGULAR	
License Status.	REGULAR	
Effective Date:	04/06/2022	
Expiration Date:	04/05/2024	
Capacity:	6	
Capacity.	0	
Program Type:	DEVELOPMENTALLY DISABLED	
	MENTALLY ILL	

II. ALLEGATION(S)

Violation Established?

On 08/05/2022, Resident A was hit by staff Charlene Pasionek. It	Yes
is alleged that Staff Pasionek smacked Resident A on her hand	
several times, then yelled at Resident A to not hit her. It is alleged	
that Resident A was hitting Staff Pasionek prior to Staff Pasionek	
smacking Resident A's hand.	

III. METHODOLOGY

08/08/2022	Special Investigation Intake 2022A0123049
08/08/2022	APS Referral Information received regarding APS referral.
08/09/2022	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
08/11/2022	Inspection Completed On-site I conducted an unannounced visit at the facility.
08/15/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Charlene Pasionek.
08/16/2022	Contact - Telephone call received I spoke with Staff Pasionek via phone.
09/13/2022	Contact - Telephone call made I left a message requesting a return call from staff Chase Ostrander.
09/13/2022	Contact - Telephone call received I spoke with Staff Ostrander via phone.
09/13/2022	Contact - Telephone call made I made an attempted call to staff Tangela Prior.
09/13/2022	Contact - Telephone call made I interviewed staff Mijaya Branch via phone.
09/13/2022	Contact - Telephone call made

	I left a voicemail requesting a return call from Guardian 1.
09/14/2022	Contact - Telephone call received I spoke with Guardian 2 via phone.
09/21/2022	Contact- Telephone call made I made a second unsuccessful attempt to reach Staff Pryor via phone.
09/27/2022	Contact- Telephone call made I left a voicemail requesting a return call from licensee designee Laura Hatfield-Smith regarding an exit conference.
09/30/2022	Exit Conference I spoke with Laura Hatfield-Smith via phone.

ALLEGATION: On 08/05/2022, Resident A was hit by staff Charlene Pasionek. It is alleged that Staff Pasionek smacked Resident A on her hand several times, then yelled at Resident A to not hit her. It is alleged that Resident A was hitting Staff Pasionek prior to Staff Pasionek smacking Resident A's hand.

INVESTIGATION: On 08/09/2022, I spoke with Complainant 1 via phone. Complainant 1 reported the following:

There were two other staff on shift the day of the alleged incident who were witnesses, staff Tangela Pryor and staff Mijaya Branch. This is the first incident that Complainant 1 is aware of. Resident A hitting others is out of her character but has been an ongoing behavior the last few weeks, and it may be due to her declining health. Staff Pasionek is a re-hired staff and has only been back to work a few weeks. Resident A hit Staff Pasionek, then Staff Pasionek popped Resident A on the hand and said, "You don't hit me!"

On 08/11/2022, I conducted an unannounced on-site at the facility. I spoke with home manger Angie Sovine. She stated that she was on vacation at the time of the incident, and staff Chase Ostrander filled in for her. She stated that she had never had any issues with Staff Pasionek prior to this alleged incident. During this on-site, I observed Resident A. Resident A was not interviewed due to limited of verbal skills. Staff Sovine reported that Resident A has dementia and Down Syndrome.

On 08/11/2022, I obtained copies of requested documents at the facility. A copy of an incident report dated for 08/05/2022 authored by staff Tangela Pryor states the following:

"[Resident A] was sitting at the dining room table & Mijaya & Charlene decided to get her up to take her to her room to change her brief. When Charlene approached [Resident A], [Resident A], became very agitated & got vulgar and combative.

[Resident A] swung at Charlene. Unaware if [Resident A] made contact or not with Charlene. [Resident A] was still being vulgar calling Charlene a "bitch" and telling her to "go home" and to "stop." Charlene then yelled in her face saying, "you do not hit me!" and Charlene hit [Resident A] on her hands three times. Charlene and Mijaya continued to change her after Mijaya got [Resident A] to calm down and redirect. "

On 08/16/2022, I interviewed staff Charlene Pasionek via phone. Staff Pasionek denied hitting Resident A. She stated that Resident A is combative and Resident A hit her in the breast that day. Staff Pasionek stated that Staff Branch and Staff Pryor were present that day. Staff Pasionek did state that she said to Resident A "do not hit me". Staff Pasionek stated that she "probably did" raise her voice, as she was upset, but denied hitting Resident A.

On 09/13/2022, I spoke with home manager Chase Ostrander via phone. He stated that he was not present at the home the day of the incident, so he did not witness it. He stated that he only knows he said/she said and what the incident reports say. He stated that he was told Staff Pasionek hit Resident A's hand while she was sitting at the table, and again in her bedroom.

On 09/13/2022, I interviewed staff Mijaya Branch via phone. Staff Branch stated that she worked second shift with Staff Pasionek the day of the incident. She stated that Resident A had wet herself, she was fussy, cussing, and hitting staff. Resident A hit Staff Pasionek. Staff Pasionek then hit Resident A back and told her she could not do that. She stated that Staff Pasionek popped Resident A's hand, and then again at the kitchen table. She stated that after being popped, Resident A's hands were red, and Resident A was upset and fussy after it happened. She stated that she had never seen Staff Pasionek do this before.

On 09/13/2021, and 09/21/2022, I made attempts to reach staff Tangella Prior via phone. The contact numbers provided for her appeared to be out of service.

On 09/14/2022, I spoke with Guardian 2, Resident A's co-guardian via phone. Guardian 2 stated the following:

They are in the process of finding Resident A a new placement due to her declining health. Staff at this facility are not trained to meet her needs as she keeps yelling and pushing staff away. He stated that he was told that a staff person slapped Resident A's hand. He stated that the family has no concerns regarding Resident A's care, as the facility is doing the best they can. He stated that he has no knowledge of the staff doing anything like this prior to this alleged incident, but that he is more worried about Resident A harming herself as she is unstable on her feet.

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:	Complainant 1 stated that it was reported that Staff Pasionek hit Resident A's hand and told Resident A "you don't hit me!"	
	An incident report written by staff Tangella Prior details that on 08/05/2022, Staff Pasionek was observed hitting and yelling at Resident A.	
	Staff Mijaya Branch was interviewed and reported that Resident A hit staff Pasionek, and Staff Pasionek hit Resident A back and told Resident A that she could not hit her. Staff Branch stated that Resident A's hands were red after the incident.	
	Staff Pasionek denied hitting Resident A but stated that she probably did raise her voice at Resident A because she was upset.	
	Guardian 2 stated that he was informed that a staff person had hit Resident A.	
	There is a preponderance of evidence to substantiate a rule violation.	
CONCLUSION:	VIOLATION ESTABLISHED	

On 09/30/2022, I conducted an exit conference with Laura Hatfield-Smith via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).

Maile Wood	09/30/2022
Shamidah Wyden Licensing Consultant	Date

Approved By:

09/30/2022

Mary E. Holton Date
Area Manager