GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

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

RE: License #: AS250411497
Investigation #: 2022A0580054
Res-Care Premier Lake Rd.

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250411497
Investigation #:	2022A0580054
Complaint Receipt Date:	08/30/2022
Investigation Initiation Date:	08/30/2022
Report Due Date:	10/29/2022
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 Lake Rd.
Facility Address:	1220 W. Lake Rd. Clio, MI 48420
Facility Telephone #:	(989) 791-7174
Original Issuance Date:	04/29/2022
License Status:	TEMPORARY
Effective Date:	04/29/2022
Expiration Date:	10/28/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents left unattended by 3rd shift staff, Ms. Keyanna Tims.	Yes
Staff, Mr. Anthony Lawler refused to give Resident A his PRN medication when requested.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/30/2022	Special Investigation Intake 2022A0580054
08/30/2022	Special Investigation Initiated - Telephone A call was made to the home manager.
09/14/2022	Inspection Completed On-site An onsite inspection was conducted. Contact was made with Ms. Cheryl Broach, Program Director and Ms. Dana Vallee, HRS Liaison.
09/14/2022	Contact - Face to Face An interview was conducted with Resident A.
09/14/2022	Contact - Face to Face An interview was conducted with Resident B.
09/14/2022	Contact - Face to Face An interview was conducted with Resident C.
09/14/2022	Contact - Document Received An additional complaint was received and combined with this investigation.
09/14/2022	Contact - Telephone call made A call was made to Ms. Michelle Salem of Recipient Rights in Genesee County.
09/19/2022	Contact - Telephone call made A call was made to Mr. Anthony Lawler, direct staff.
09/23/2022	Contact - Telephone call made A call was made to Ms. Cheryl Broach, Program Director.

09/26/2022	Contact - Telephone call made A call was made to Ms. Kim Nguyen-Forbes, Recipient Rights Investigator in Genesee County.
09/26/2022	Contact - Telephone call made A call was made to Ms. Keyanna Tims, staff.
09/30/2022	Contact - Telephone call made A call was made to Ms. Keyanna Tims, staff.
10/05/2022	Contact - Document Received A copy of the documents requested was received.
10/10/2022	Contact - Telephone call made A call was made to Ms. Christina Richardson, assigned Genesee Health Systems (GHS), case manager for Resident A.
10/10/2022	Contact - Telephone call made A call was made to Ms. Lenora Cooper, assigned GHS Case Manager for Resident B.
10/11/2022	APS Referral A referral sharing the allegations for both complaints was made to APS.
10/11/2022	Contact - Telephone call received A call was received from Mr. Stasko, assigned GHS case manager for Resident C.
10/12/2022	Contact - Telephone call received An interview was conducted with Resident A.
10/12/2022	Exit Conference An exit conference was held with the licensee designee, Ms. Laura Hatfield-Smith.

ALLEGATION:

Residents left unattended by 3rd shift staff Ms. Keyanna Tims.

INVESTIGATION:

On 08/30/2022, I received a complaint via BCAL Online complaints.

On 08/30/2022, I spoke with Ms. Emily Conant home manager. She shared that staff, Ms. Keyanna Tims was working 3rd shift, which is scheduled from 11pm-7am. At 7:10am, staff texted her in a group chat, asking her who is scheduled to come in. Staff, Mr. Anthony Lawler is the staff that was scheduled to be there at 7am. At 7:33am, Ms. Tims texted again indicating that "this is ridiculous" and she was leaving. Ms. Conant stated that she attempted to contact Ms. Tims to let her know that she was on the way to relieve her, however, she did not respond. By the time she arrived at the home, Ms. Tims had left, and Mr. Lawler was present. Mr. Lawler indicated to management that Ms. Tims was still present when he arrived at work, sitting in her car in the driveway. However, according to the timecards, Ms. Tims clocked out at 7:22am. Mr. Lawler's timecard indicated that he arrived to work at 8:06am, which would have left a window of 44 minutes that the residents were left alone. Ms. Tims was terminated and placed on the do not hire list, while Mr. Lawler was given a written reprimand. There are currently 4 residents in the home.

On 09/14/2022, I conducted an onsite inspection at Res Care. Contact was made with Ms. Dana Vallee, HRS Liaison for the corporation and Ms. Cheryl Broach, Program Coordinator. A staff meeting/training was being conducted with new staff. Ms. Valle shared that the manager, Ms. Emily Conant is no longer employed at the home. She also shared that staff, Ms. Keyanna Tims has been fired and no longer works for the corporation. Ms. Broach can be contacted for any information needed directly related to the home.

While onsite, an interview was conducted with Resident A while outside on the porch. Resident A started that he has been in the home an estimated 4-5 months. To his knowledge, the residents have not been left alone. Resident A was appropriately dressed and appeared to be receiving adequate care.

An interview with Resident B was also while outside on the porch. Resident B indicated he has resided in the home for 1 ½ months. He said it's cool living there and he likes living there a lot. He does not recall ever being left alone by staff. Resident B was appropriately dressed and appeared to be receiving adequate care.

During the interview with Resident C, while outside on the porch, he indicated that he has been in the home an estimated 4-weeks and likes living there. He does not recall being left alone.

On 09/19/2022, I spoke with direct staff, Mr. Anthony Lawler. He admitted that on the date of the allegations, he was late coming to work. He stated that Ms. Simms was sitting in her car in the driveway. She had not left the premises. He does not recall what time he arrived.

On 09/26/2022, I spoke with Ms. Kim Nguyen-Forbes, Recipient Rights Investigator in Genesee County. She shared that in her interview with staff, Ms. Tims, she indicated that she did clock out that morning, however, she claims that she sat in her car until 1st shift staff, Mr. Lawler arrived. In her interview with staff, Mr. Lawler, he stated that Ms. Tims had not left, but was in her car when he arrived at work. Based on their interviews and other gathered information, she will be substantiating based on risk of harm to the residents, due to staff not actively being present in the home.

On 09/26/2022, I made a call to Ms. Keyanna Tims. A voice mail message was left requesting a return call. On 09/30/2022, I made a call to Ms. Keyanna Tims. A voice mail message was left requesting a return call.

On 10/10/2022, I spoke with Ms. Christina Richardson, assigned Genesee Health Systems (GHS), case manager for Resident A. She shared that she had not been made aware of the allegations involving Resident A. She indicated that she visits with Resident A at least weekly at the home and he has not said anything. She had no concerns with the home or the staff prior to this incident.

On 10/10/2022, I made a call to Ms. Lenora Cooper, GHS assigned case manager for Resident B. She stated that she was aware of the allegations that the residents were left alone. She indicated that Resident B has a public guardian, Ms. Denise Ketchmark. Ms. Cooper indicated that she is aware of the fact that the home has only been opened a few months, however, there continues to be a high turnover in staff. No other concerns with the home were expressed.

On 10/11/2022, I spoke with Mr. David Stasko, assigned GHS case manager for Resident C. He shared that he had been made aware of the allegations. He shared that he was surprised an appalled that staff would intentionally leave the residents alone. Prior to this, he'd had no prior concerns. Staff always seemed polite and professional when he visits the home.

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 on interviews conducted with the residents and case managers, former home manager, Ms. Conant, Recipient Rights Investigator, Ms. Kim Nguyen-Forbes, and staff members, Ms. Dana Valle, Ms. Cheryl Broach and Mr. Anthony Lawler, there is evidence to substantiate the allegation that the residents were left alone by 3rd shift staff, Ms. Keyanna Tims.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff, Mr. Anthony Lawler refused Resident A's PRN medication when asked.

INVESTIGATION:

On 09/14/2022, I received an additional complaint alleging that staff, Mr. Anthony Lawler refused Resident A medication when asked.

On 09/14/2022, I spoke with Ms. Michelle Salem of Recipient Rights in Genesee County. She shared that in her investigation, it was determined that on 09/08/2022, Resident A requested a PRN medication, Tums, around 4pm. Staff, Mr. Anthony Lawler asked him to wait due to assisting other residents. Mr. Lawler estimates that he gave it to him at 8pm. Mr. Lawler did not record that gave Resident A the medication on the medication log. Furthermore, Resident A does not have a prescription or standing medical order for Tums. Resident A should have been given Mylanta.

On 09/19/2022, I spoke with direct staff, Mr. Anthony Lawler. Mr. Lawler stated that stated when Resident A came and asked for his medication, he asked that he wait because he needed to call a manager to confirm that it could be given. Mr. Lawler stated that he ended up giving Resident A the medication later that day. He does not recall what the medication was. He did not record the information on Resident A's medication log.

On 09/23/2022, I spoke with Ms. Broach regarding the allegations. She shared to her knowledge, when Resident A requested his Tums medication, staff was busy at that moment and asked Resident A to wait until he was done. Resident A then got upset indicating that it is his right to have his medication and walked off. Documents to complete the investigation were requested. To her knowledge, Resident A was provided with his medication at a later time.

On 10/05/2022, I received a copy of the AFC Assessment plan for Resident A, along with his September 2022 medication log and standing medical orders. The standing orders medication orders for Resident A indicate that Resident A can be given the over the courter medication Mylanta, 2tsp by moth every 4 hours as needed. This

medication is prescribed for Gas Heartburn and Indigestion. Resident A does not have a prescription or standing medication order for the use of Tums. The September 2022 medication log for Resident A does not indicate that Resident A was given a PRN medication on 09/08/2022.

10/11/2022, I made a referral sharing the allegations for both complaints to APS.

On 10/12/2022, I conducted a follow-up phone interview with Resident A. He recalled that on the day in question, he was having problems with his acid reflux and requested his PRN medication of Mylanta. Staff, Mr. Anthony Lawler told him he'd have to wait. Resident A indicated that Mr. Lawler did not give him any Mylanta or Tums for his reflux.

On 10/12/2022, I conducted an exit conference with the licensee designee, and shared with her the findings of this investigation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on interviews conducted with Resident A, Recipient Rights Investigator, Ms. Michelle Salem, and staff members, Ms. Cheryl Broach and Mr. Anthony Lawler, there is evidence to substantiate the allegation that Resident A was not given his PRN medication when asked.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Staff, Mr. Anthony Lawler stated that he gave Resident A his PRN medication on 09/08/2022. Mr. Lawler did not record the PRN medication administered to Resident A.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	Based on the interview conducted with staff, Mr. Anthony Lawler, there is evidence to substantiate the licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

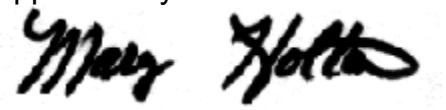
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

October 12, 2022

Sabrina McGowan — Date
Licensing Consultant

Approved By:



October 12, 2022

Mary E. Holton — Date
Area Manager