GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20, 2022

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

RE: License #:	AS250294097
Investigation #:	2022A0872013
	ResCare Premier Clinton

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 (906) 226-4171.

Sincerely,

Susan Hutchinson

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 #:	AS250294097
Investigation #:	2022A0872013
Complaint Receipt Date:	12/13/2021
Investigation Initiation Date:	12/15/2021
Report Due Date:	02/11/2022
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 Clinton
Facility Address:	16020 Jennings Road Fenton, MI 48430
Facility Telephone #:	(810) 750-1370
Original Issuance Date:	02/28/2008
License Status:	REGULAR
Effective Date:	08/19/2020
Expiration Date:	08/18/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 12/10/21, Resident A was found alone ½ mile from the facility. Police transported her back to the facility. Staff did not know she was missing.	Yes

III. METHODOLOGY

12/13/2021	Special Investigation Intake 2022A0872013
12/15/2021	Special Investigation Initiated - On Site Unannounced
12/16/2021	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
01/02/2022	Contact - Document Received AFC documentation received regarding Resident A
01/03/2022	APS Referral I made an APS complaint via email
01/04/2022	Contact - Document Received I exchanged emails with APS Worker, Kizzie Baker
01/20/2022	Contact - Telephone call made I interviewed staff Lateisha Davis via telephone
01/20/2022	Contact - Telephone call made I've left messages for staff Kyah Grimsley
01/20/2022	Exit Conference I conducted an exit conference with the licensee designee, Laura Hatfield-Smith, via email
01/20/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 12/10/21, Resident A was found alone ½ mile from the facility. Police transported her back to the facility. Staff did not know she was missing.

INVESTIGATION: On 12/15/21, I conducted an unannounced onsite inspection of ResCare Premier-Clinton Adult Foster Care facility. I interviewed Resident A and staff Kaniah Deloach.

When I entered the facility, Resident A was on one of the couches, and she appeared to be dozing. She had on a t-shirt, a winter coat, pants, and shoes. Her appearance was disheveled.

Resident A agreed to speak with me, but she was difficult to understand. She would mumble at times and some of the things she talked about did not make any sense. She was somewhat agitated and would go off on a tangent, talking about things that were unrelated to what we were discussing.

Resident A said that she has lived at this facility for 10-11 years. She said that she is not actually a resident, but staff treats her that way. She told me that she does not have a guardian, or a case manager and she said she does not take any medications. She said that staff tries to make her do things like showers and eat but she does not do it if she does not feel like it. I asked her about the incident that took place a few days ago when the police picked her up and brought her back to the facility. At first, she became angry with me and told me that the police never brought her anywhere. She eventually acknowledged that the police brought her back home but then said that “My kids brought me back or some imposter brought me back here.”

I asked Resident A why she left the facility and she said that she was going to get some clothes. She said that she did not tell staff she was leaving because if she told them, they would not let her go. According to Resident A, she is not allowed to leave the facility, but she wants to go and see her kids and her sisters. She told me staff has not let her leave the facility for the past 8-9 years. She told me that it is a secret where her clothes are, and staff won’t tell her when they buy her clothes or where they put her clothes. On the day of the incident, she said that she left and “one of these people here called the police.” I asked her what she was wearing when she left, and she said she does not know. I asked her if she was cold and she said that she was not cold, she had a coat on, and it was daytime. I asked Resident A if she crossed a busy street and she said that she crossed at the light “but someone honked at me.” She told me that she knows how to cross the street and she does not know why someone honked at her and does not know why the police picked her up. Resident A seemed incoherent at times and her mental acuity was questionable.

Staff Kaniah Deloach said that she has worked at this facility since July 2021. She said that she was working on 12/10/21 along with staff Kyah Grimsley and the home manager, Lateisha Davis. According to Ms. Deloach, Resident is not allowed unsupervised community access. She is currently non-compliant with medications, eating, bathing, and hygiene. Ms. Deloach confirmed that Resident A does not have a

guardian and said that her case manager is aware of Resident A's issues. Resident A is allowed to go outside to smoke cigarettes and she is allowed to walk to the end of the driveway, but she is not allowed to leave the property. Staff is not required to be outside with her but when she is outside, staff is required to check on her every 20 minutes.

Ms. Deloach told me that on 12/10/21, staff Kyah Grimsley was cleaning Resident A's bathroom and Resident A was lying in bed. At one point, the police showed up at the facility with Resident A. Ms. Deloach said that she and the other staff did not know that Resident A had left the property and assumed that she was still in her bedroom laying down. Ms. Deloach said that she does not know how long Resident A was gone and she does not know how she left.

According to Ms. Deloach, she, and other staff constantly prompt Resident A to eat and wear appropriate clothing but Resident A is very non-compliant. If staff is too persistent, Resident A will become angry and will try to attack them. She said that staff will try to assist Resident A with bathing, eating, and daily living activities but Resident A will not cooperate.

On 01/04/22, I exchanged emails with Adult Protective Services (APS) Worker, Kizzie Baker. Ms. Baker said that Resident A's health had deteriorated, and she is currently in the hospital.

On 1/20/22, I interviewed the home manager, Lateisha Davis, via telephone. Ms. Davis said that on 12/10/21, she was working with staff Kaniah Deloach and Kyah Grimsley. At approximately 12:00pm, Ms. Davis went into her office for a meeting and remembers seeing Resident A standing outside of her office, talking to herself. She said that at 3:00pm, she, Ms. Deloach, and Ms. Grimsley were walking out of the facility because their shift was over, and they saw the police pull up with Resident A. Ms. Davis said that she did not know that Resident A had left the facility. Since Ms. Grimsley was the staff doing 20-minute checks on Resident A, Ms. Davis asked Ms. Grimsley how Resident A got out of the house without anyone knowing. Ms. Grimsley said, "I don't know."

According to Ms. Davis, staff is required to conduct 20-minute visuals on Resident A, with the last check being at 2:40pm before their shift ends. Ms. Davis examined the 20-minute visual log and noted that Ms. Grimsley had written that Resident A was in her bed, sleeping, at each one of the 20-minute checks. However, Ms. Grimsley could not explain how Resident A left the facility without seeing her leave. I asked Ms. Davis if she has any idea how long Resident A was gone before police brought her back to the facility, and she said "no."

According to Ms. Davis, Ms. Grimsley is no longer employed by ResCare Premier-Clinton. She said that Ms. Grimsley put her 2-week notice in and her last day was sometime last month.

I've left messages for Ms. Grimsley but as of this date, she has not returned my calls.

On 1/20/22, I reviewed AFC paperwork related to Resident A. I reviewed an Incident/Accident Report (IR) dated 12/10/21 related to her elopement. According to the IR, “(Resident A) walked off property without anyone knowing. Police brought her back. They said she was crossing the street when (they) found her.” The corrective measures taken were, “Home manager report incident to case manager and RR. Staff will follow protocol and completed 20-minute visual checks. Home manager will check all documentation is being completed. Disciplinary action requested. Staff will be in-serviced on visuals.”

According to Resident A’s Community Mental Health Individualized Plan of Service (IPOS) dated 3/20/20, she has a history of non-compliance and substance abuse. She is diagnosed with schizoaffective disorder, unspecified and she requires “much human assistance” with shopping for food and other necessities of daily living. It also states, “AFC staff agrees to ensure home is properly supervised so elopement will not be possible for (Resident A.) Staff will ensure (Resident A) is within hearing/vision range in the home and community during the next year.”

According to Resident A’s Assessment Plan dated 8/18/21, she requires “24-hour supervision and 20 minute visuals during waking, visuals during sleep.”

On 01/20/22, I conducted an exit conference with the licensee designee, Laura Hatfield-Smith via email. I told Ms. Hatfield-Smith that I have concluded my investigation and explained which rule violation I am substantiating. I suggested to Ms. Hatfield-Smith that in light of the fact that Resident A has a history of eloping from the facility and a history of non-compliance with treatment, she should consider enforcing the 30-day notices that Resident A has been given.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS	On 12/10/21, police brought Resident A back to the facility after finding her alone, approximately ½ mile away. Staff Kaniah Deloach and Lateisha Davis said that they did not know that Resident A had left the facility and they do not know how long she was gone. Ms. Davis said that staff Kyah Grimsley documented conducting 20-minute visuals on Resident A throughout their shift and wrote that Resident A was in bed. Ms. Grimsley told Ms. Davis that she does not know how or when Resident A left the facility.

ANALYSIS:	Resident A's IPOS states that staff is to "ensure home is properly supervised so elopement will not be possible for (Resident A.) Staff will ensure (Resident A) is within hearing/vision range in the home and community during the next year." Resident A's Assessment Plan states she requires "24-hour supervision and 20-minute visuals during waking, visuals during sleep." I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

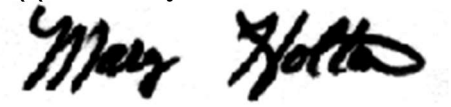
IV. RECOMMENDATION

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

January 20, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



January 20, 2022

Mary E. Holton Area Manager	Date