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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

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

RE: License #: AS780389700
Investigation #: 2023A0584015
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.
- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

A handwritten signature in cursive script that reads "Candace Coburn". The signature is written in a dark ink and has a fluid, connected style.

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780389700
Investigation #:	2023A0584015
Complaint Receipt Date:	12/19/2022
Investigation Initiation Date:	12/20/2022
Report Due Date:	02/17/2023
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?
On 12/17/2022, Resident A found staff Angelica Bittner sound asleep in the recliner in the living room when staff are not to be asleep during their shift.	Yes

III. METHODOLOGY

12/19/2022	Special Investigation Intake 2023A0584015
12/20/2022	Special Investigation Initiated – Email and telephone interview with Ardis Bates, Shiawassee Health and Wellness Recipient Rights Worker. Contact - Telephone call made- Davina McCaskey, Residential Coordinator.
01/27/2023	Onsite investigation conducted. Contact - Face to Face interview Resident A.
01/30/2023	Contact - Document Sent. Email to home manager, Tiffany Baroski-Carsten
02/13/2023	Exit Conference with Laura Hatfield Smith, Licensee Designee
02/15/2023	Contact – Telephone interview with Tiffany Baroski-Carsten

ALLEGATION:

On 12/17/2022, Resident A found staff Angelica Bittner sound asleep in the recliner in the living room when staff are not to be asleep during their shift.

INVESTIGATION:

On 12/19/2022, the Bureau of Community and Health Systems (BCHS) received the above allegation via the BCHS online complaint system.

On 12/20/2022, I conducted a telephone interview with Shiawassee Health and Wellness Recipient Rights officer Ardis Bates, who informed me she investigated the allegation. Ms. Bates stated, as part of her investigation, she conducted interviews and is substantiating “*neglect level three*”. According to Ms. Bates, Resident A

requires 30-minute checks and 24/7 supervision by direct care workers when she is out of her bedroom. Ms. Bates stated she was provided a photograph of direct care worker Angelica Bitter sleeping in the facility recliner, that was taken by Resident A on 12/17/2022.

On 1/27/2023, I conducted an unannounced onsite investigation and interviewed Resident A. Resident A stated that she woke up the morning of 12/17/2022 and found Ms. Bittner sound asleep in the facility’s living room. Resident A confirmed she took a photo of Ms. Bittner asleep with her cellphone and texted it to the facility’s home manager Tiffany Baroski-Carsten. Resident A showed me the photo she had taken of Ms. Bittner asleep. Resident A stated she had a difficult time waking Ms. Bittner. However, Ms. Bittner was awake when Ms. Baroski-Carsten arrived at the facility that morning.

I 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 by direct care workers at the facility, due to self-harming behaviors.

On 2/15/2023, I conducted a telephone interview with Ms. Baroski-Carsten, who stated that Ms. Bittner was the only person scheduled to work at the facility on 12/17/2022 when she was discovered asleep.

APPLICABLE RULE	
R 330.1806	Staffing levels and qualifications.
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, which consisted of an interview with Shiawassee Health and Wellness Recipient Rights Officer Ardis Bates and Resident A, a review of Resident A’s community mental health PCP, and an observation of a photograph provided to me by Resident A, it has been established Resident A is to receive 24/7 monitoring and 30-minute room checks from direct care workers at the facility, due to self-harming behaviors. There is enough evidence to substantiate the allegation that on 12/17/2022, Angela Bittner, the only direct care worker at the facility, did not provide Resident A with supervision as indicated in her PCP because she was sleeping.
CONCLUSION:	VIOLATION ESTABLISHED

On 2/13/2022, I conducted an exit interview with licensee designee Laura Hatfield Smith via telephone, who agreed with the findings of this investigation. Ms. Hatfield Smith stated they had terminated Ms. Bittner's employment on 1/11/2023, due to several personnel policy violations.

IV. RECOMMENDATION

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



2/15/2023

Candace Coburn
Licensing Consultant

Date

Approved By:



2/16/2023

Michele Streeter
Area Manager

Date