GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 8, 2023

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

RE: License #: AS780389700
Investigation #: 2023A0584026
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 (517) 284-9727.

Sincerely,

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 #:	2023A0584026
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/29/2023
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 2/26/2023, a facility staff member left a room unlocked enabling Resident A to access items her Community Mental Health Personal Plan of Care prohibited.	Yes
Additional Finding	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake - 2023A0584026 Special Investigation Initiated – Letter to Andrea Andrykovich, Shiawassee Health and Wellness Recipient Rights.
03/02/2023	Contact - Face to Face interviews with Resident A, B, C, direct care staff Jason Threlkeld, Danielle Riley and Christian Begg.
03/06/2023	Contact – Face to face interviews with Jennifer O'Dell and Shelby Morse.
04/04/2023	Exit Conference via email to Laura Hatfield Smith, Licensee Designee.

ALLEGATION:

On 2/26/2023, a facility staff member left a room unlocked enabling Resident A to access items her Community Mental Health Personal Plan of Care prohibited.

INVESTIGATION:

On 02/28/2023, the Bureau of Community and Health Systems (BCHS) received the above complaint via the BCHS on-line complaint system.

On 3/2/2023, I conducted an unannounced onsite investigation and interviewed Resident A. Resident A stated during the facility's third shift on 2/26/2023, sometime around midnight, she was able to access the medication room that is always kept locked. Resident A stated she was able to secure items that were indicated on her Community Mental Health Person Centered Plan (PCP) that were prohibited. Resident A stated that the third shift staff member Jason Threlkeld was not aware

she obtained the items. However, Resident A also stated she did see Mr. Threlkeld conduct his routine checks of her while she was awake.

I reviewed documentation on Resident A's PCP, which 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. According to Resident A's PCP, Resident A is not to have in her possession any sharp items.

I interviewed Mr. Threlkeld, and direct care staff members Danielle Riley and Christian Begg, who all stated they worked the facility's second and third shift on 2/26/2023, prior to Resident A obtaining prohibited items from the unsecured medication room. Mr. Threlkeld, Ms. Riley, and Ms. Begg all stated they recall locking the medication room when not in use. Mr. Threlkeld stated he did not observe Resident A enter the medication room and confirmed conducting room checks of residents as required. Ms. Riley stated she noticed a superficial scratch on Resident A's arm and asked how that happened. Ms. Riley stated Resident A told her on 02/26/2023 she was able to enter the medication room during the overnight shift and obtain objects to scratch her skin. Ms. Riley stated that all scratches observed during a check of Resident A's body were superficial and did not require first aid. Ms. Riley stated Resident A gave her the items she obtained from the unsecured medication room.

According to SIR #2023A0584015, dated 2/15/2023, the facility was in violation of certification of specialized programs rule 330.1806(1) when it has been established Resident A was to receive 24/7 monitoring and 30-minute room checks from direct care workers at the facility, due to self-harming behaviors. There was 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. The facility's approved corrective active plan (CAP) dated 02/23/2023 indicated staff Angelica Bittner was terminated on 1/11/2023 for sleeping on the job.

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 interviews with Resident A and multiple facility staff members, as well as a review of Resident A's Community Mental Health PCP, 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 significant enough evidence to substantiate the allegation that on 2/26/2023, a facility staff member left the medication room unlocked, enabling

	Resident A to access items that were prohibited to her, per her Community Mental Health PCP.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2023A0584015 DATED 2/15/2023 AND CAP DATED 2/23/2023]**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/2/2023, I conducted an interview with Resident A where she disclosed facility staff member Shelby Morse recently engaged in "horseplay behavior" by sitting on part of her body on the couch and called her "dumb" for scratching her body with sharp items. Resident A stated this behavior occurred after facility staff members were told to not engage in horseplay activity with residents.

On 3/6/2023, I interviewed Residents B and C at the facility. Both Resident B and C stated they have witnessed Ms. Morse engage in physical horseplay with Resident A when Resident A asked Ms. Morse not to. Both Resident B and C stated they witnessed Ms. Morse try to sit on Resident A on the couch and sat on Resident A's legs. Resident C witnessed Ms. Morse poke Resident A on her behind or "butt" area.

I interviewed Ms. Morse who admitted telling Resident A she was "dumb" for scratching her skin as well as admitted to sitting on Resident A's legs on the couch on purpose. However, Ms. Morse denied poking Resident A in the buttocks area.
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According to SIR #2022A0584009, dated 3/10/2022, the facility was in violation of Adult Foster Care Administrative Licensing rule R 400.14305 (3) again when it was established that staff member Shelby Morse participated in horseplay with Resident A, even though it is prohibited by facility policy. The facility's approved CAP, dated 2/8/2022, indicated staff Shelby Morse was disciplined on 12/19/2022 with review of the facility's policy #6.20 F1 (Horseplay).

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:	Based upon my investigation, which consisted of an interview with Residents A, B, and C and facility staff member Shelby Morse, it has been established Ms. Morse engaged in disrespectful horseplay with Resident A. The facility has a policy against facility staff members engaging in "horseplay" with residents.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2022A0584009 DATED 3/10/2022 AND CAP DATED 2/8 2022]**

On 4/4/2023, I conducted an exit conference with licensee designee Laura Hatfield-Smith via email and shared with her the findings of this investigation.

IV. RECOMMENDATION

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

4/19/2023

Candace Coburn Date
Licensing Consultant

Approved By:

4/21/2023

Michele Streeter Date
Area Manager