GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 20, 2023

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

RE: License #: AS250284763
Investigation #: 2023A0779042
ResCare Premier Riverview

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250284763
Investigation #:	2023A0779042
Complaint Receipt Date:	05/10/2023
Investigation Initiation Date:	05/11/2023
Report Due Date:	07/09/2023
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:	ResCare Premier Riverview
Facility Address:	1467 Flushing Rd., Flushing, MI 48433
Facility Telephone #:	(810) 659-6444
Original Issuance Date:	11/13/2006
License **Status:**	REGULAR
Effective Date:	04/17/2023
Expiration Date:	04/16/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
AFC staff did not have someone present with resident in emergency room (ER).	Yes

III. METHODOLOGY

05/10/2023	Special Investigation Intake 2023A0779042
05/11/2023	Special Investigation Initiated - Letter Email sent to Resident A's case manager.
05/15/2023	APS Referral Complaint was referred to APS centralized intake.
05/17/2023	Contact - Telephone call made Spoke to Resident A's case manager.
05/22/2023	Inspection Completed On-site
06/16/2023	Exit Conference Held with licensee designee, Laura Hatfield-Smith

ALLEGATION:

AFC home did not have staff present with resident in ER.

INVESTIGATION:

On 5/17/23, a phone conversation took place with Resident A's CMH (Community Mental Health) case manager, Sara Anani, who confirmed that she was aware of this allegation. She stated that per Resident A's guardians request, staff of this home took Resident A to the CMH crisis clinic, where it was determined that Resident A needed to go to the local emergency room (ER). Ms. Anani reported that staff took Resident A to the ER, but that Resident A was never admitted into the hospital. Ms. Anani stated that Resident A was kept in a room in the ER until an appropriate psychiatric placement could be found elsewhere. She stated that this home's staff stayed at the ER until approximately 9:00pm, at which time they left Resident A in the ER unattended. She reported that the guardian was asked if she could go to the hospital but she could not

do it. Ms. Anani reported that hospital staff would occasionally check on Resident A but were not able to be in the room consistently. She stated that Resident A was left in the ER room from 9:00pm until 8:00am the next day, when she arrived at the ER, and this home's staff did come back to the ER until 12:00pm. Ms. Anani stated that, due to her mental health and mobility issues, Resident A is not allowed to be in the community unsupervised.

On 5/22/23, an on-site inspection was conducted and Resident A was interviewed. Resident A confirmed that staff took her to the ER but they had to leave, so she was alone at the ER overnight. Resident A could not remember the exact time the staff left or how many hours she was left alone. Resident A stated that she never left the room that night and that she was fine. She stated that she is now doing okay after an 8-night stay at a hospital in Pontiac, MI.

On 5/22/23, home manager, Taleisha Boose-Herd, stated that they had some staff call-ins the night that Resident A went to the ER and that they only had one staff available that 3rd shift. She stated that they did not have an extra staff person available to go sit with Resident A at the ER. Ms. Boose-Herd reported that she had just worked 16 hours straight, so she could not go the ER. She reported that Resident A's guardian was contacted, but she couldn't go the ER for some reason. Ms. Boose-Herd admitted that she originally told Resident A's guardian that they would have staff go the ER before knowing that staff had called-in and were not coming to work that 3rd shift.

On 5/22/23, staff person, Earline Jackson, stated that on 5/9/23, she observed Resident A walk out of the home, so she followed her outside. Ms. Jackson stated that she stepped in front Resident A before Resident A could walk out into the road. She stated that Resident A told her that she "was ready to die". Ms. Jackson reported that she was able to convince Resident A to go back into the home, that Resident A's guardian was contacted and that the decision was made to take Resident A to CMH and then the hospital.

The home provided a copy of an *AFC Licensing Division Incident/Accident Report* (IR), which documented the incident resulting in Resident A being taken to CMH and the hospital. The IR matched the information obtained during the interview with staff person, Ms. Jackson. The corrective measures listed on the IR were for the home to continue to monitor and provide Resident A with appropriate staffing, redirection, prompts and assistance as needed. The home would follow hospital discharge instructions.

On 5/22/23, staff person, Arshane Hairston, stated that she was the staff person who transported Resident A to CMH and the hospital on 5/9/23. She confirmed that Resident A was never actually admitted to the hospital and that the hospital was searching for an appropriate psychiatric placement for her. Ms. Hairston stated that she stayed at the ER with Resident A until 9:00pm and that she had to leave. She stated that it was her understanding that a 3rd shift staff would eventually go to the hospital and stay with Resident A. Ms. Hairston reported that Resident A's son had called her after

she left the hospital and said that he would go up there and stay until 3rd shift staff arrived, but she later learned that he never went there.

Resident A's licensing assessment plan was reviewed. The plan stated that Resident A utilizes a walker, requires stand-by assistance from staff to complete her activities of daily living, and that she is not allowed to be in the community unsupervised. Resident A's CMH individual plan of service (IPOS) was also reviewed. It stated that Resident A suffers from Bi-polar disorder and personality disorder and that staff are to provide Resident A with transportation and accompany her to all appointments.

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:	It was confirmed that Resident A is not allowed to be out in the community unsupervised. On 5/9/23, Resident A was having some issues with her mental health and staff had to take her to the local emergency room (ER), but Resident A was never actually admitted into the hospital. Resident A remained in the ER waiting for an appropriate psychiatric placement to be found. Staff person, Arshane Hairston, stayed with Resident A at the hospital until 9:00pm, at which time she left before another staff could arrive to relieve her. Resident A was left at the hospital ER unsupervised from 9:00pm until approximately 12:00pm the next day. Resident A was not provided the proper supervision or protection as specified in her written assessment plan and/or CMH IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/16/23, an exit conference was held with licensee designee, Laura Hatfield-Smith. She was informed of the outcome of this investigation and that a written corrective action plan is required.

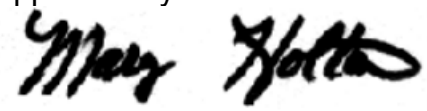
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

6/20/2023

Christopher Holvey — Date
Licensing Consultant

Approved By:



6/20/2023

Mary E. Holton — Date
Area Manager