GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AS250413361
Investigation #: 2023A0576050
ResCare Premier Neff Rd

Dear Laura 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.
- Be signed and dated.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250413361
Investigation #:	2023A0576050
Complaint Receipt Date:	06/14/2023
Investigation Initiation Date:	06/15/2023
Report Due Date:	08/13/2023
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 Neff Rd
Facility Address:	8358 Neff Rd., Mt. Morris, MI 48458
Facility Telephone #:	(989) 791-7174
Original Issuance Date:	01/31/2023
License Status:	TEMPORARY
Effective Date:	01/31/2023
Expiration Date:	07/30/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped on June 12, 2023, and staff were to complete routine checks. Staff were unaware Resident A eloped from the home.	Yes

III. METHODOLOGY

06/14/2023	Special Investigation Intake 2023A0576050
06/15/2023	Special Investigation Initiated - Letter Sent email to Matt Potts, Genesee County Office of Recipient Rights (ORR)
06/30/2023	Inspection Completed On-site Interviewed Staff, Jessena Neely
07/14/2023	Contact - Face to Face Interviewed Program Coordinator, Cheryl Broach, and Resident A
07/17/2023	Contact - Document Received Reviewed Incident Report (IR)
07/31/2023	Exit Conference Exit Conference conducted with Licensee Designee, Laura Hatfield-Smith
07/31/2023	APS Referral Referral made to APS.

ALLEGATION:

Resident A eloped on June 12, 2023, and staff were to complete routine checks. Staff were unaware Resident A eloped from the home.

INVESTIGATION:

On June 15, 2023, I sent an email to Matt Potts, Genesee County Office of Recipient Rights Officer (ORR) regarding this matter. Officer Potts advised he is investigating the allegations involving Resident A. According to Officer Potts, staff on 2nd shift claimed to

have seen Resident A around 10:50pm, ten minutes before the shift ending. 3rd shift staff advised when they completed room checks, Resident A and his roommate's door was locked. The staff knocked and heard the roommate say "yeah" and did nothing further. The manager reported staff should have done hourly checks including opening the door and viewing the residents however staff admitted this was not done. According to Officer Potts, Resident A has not been located.

On June 30, 2023, I completed an unannounced on-site at ResCare Premier Neff Road and interviewed Staff, Jessena Neely. Staff Neely reported that on June 12, 2023, Resident A left the home around 11pm during shift change. The following day, first shift Staff, Alexander Rutherford noticed Resident A was missing. Resident A was gone from the home for 2-3 days and he went to his brother's home. Resident A is not on 1 on 1 or line of sight supervision. Per ResCare policy, the facility is to complete 20-minute checks, which were done by staff however they were inaccurate as staff did not document Resident A was out of the home. Staff Neely was not sure if an incident report was written and advised Resident A was not home as he had an outside appointment.

On June 30, 2023, I viewed a form entitled "ResCare Residential Program Visuals". The form documented that visual checks for Resident A were completed on June 12, 2023, at 7am through June 13, 2023, at 6am at 20-minute intervals or 1-hour intervals on 3rd shift. From June 12, 2023, at 11pm through June 13, 2023, at 6am 1-hour checks were completed on Resident A and all the hourly checks indicated Resident A as in his room.

On July 14, 2023, I interviewed Program Coordinator, Cheryl Broach who reported when Resident A left the home 2nd and 3rd shift staff were unaware and documented that he was in the home. It was not until 1st shift staff came on duty the following day and realized Resident A was not in the home. Resident A's brother was called and initially denied knowing where Resident A was, however, he called back and advised Resident A was with him. Resident A's brother advised he would bring Resident A home and Resident A returned 3 days later. When Resident A returned, he was fine and reported he left during 2nd shift. According to Coordinator Broach, Resident A can go with family and any outings in the community must be approved. Residents are to sign out when they leave the home and Resident A did not sign out when he left. Resident A is his own guardian, and an IR was written regarding this matter.

On July 14, 2023, I interviewed Resident A regarding the allegations, and he reported his brother was having problems so Resident A "went to give him a hand". Resident A did not tell staff he was leaving, and he left the home at about 11pm on June 12, 2023. Resident A went out the front door and he walked away from the home until his brother picked him up. Staff called Resident A's brother looking for Resident A and Resident A's brother called staff back to inform them that Resident A was fine and would be coming back home. Resident A's brother lives in Flint and he went to his brother's home for a couple days then returned home. Resident A denied any concerns about his

home and likes it. Staff are helpful and next time he will tell staff if he is leaving the home.

On July 14, 2023, I reviewed Resident A's records. Resident A's AFC Assessment Plan reveals Resident A does not move independently within the community and he is to "follow Individual Plan of Service (IPOS) and NGRI (Not Guilty by Reason of Insanity) contract. Resident A's Genesee Health System treatment plan documented that staff are to be aware of Resident A's whereabouts at all times. Staff should check on Resident A at least every 30 minutes. While in the community, Resident A should be provided with staff supervision at all times unless attending a closed NA/AA meeting or otherwise on an NGRI approved unsupervised leave from the group home.

On July 17, 2023, I reviewed an AFC Licensing Division Incident / Accident Report (IR) dated for June 13, 2023, and authored by Alexandira Rutherford. The IR documented that on June 13, 2023, staff was getting breakfast and medications ready for the residents. Staff knocked on Resident A's door and his roommate came out. Staff told the roommate to have Resident A come get his breakfast and medications and the roommate advised Resident A was not in the bedroom. The manager was notified, and Resident A was reported missing to the police and Resident A's case manager. Corrective measures include staff will be trained on completing 20-minute visual checks of residents and documenting. Resident A was noted to be found at his brother's home.

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 alleged that Resident A eloped from his home on June 12, 2023, and staff were unaware he left. Upon conclusion of investigative interviews and a review of Resident A documentation, there is a preponderance of evidence to conclude a rule violation. Resident A eloped from his home on June 12, 2023, at approximately 11pm. Per Resident A's treatment plan, staff are to be aware of Resident A's whereabouts at all times and staff are to check on Resident A every 30 minutes. Resident A was gone from the home for at least an entire 8-hour shift before 1st shift staff on June 13, 2023, discovered he was absent from the home. The home provided documentation that Resident A was viewed in his room by staff from 11pm on June 12, 2023, through June 13, 2023, at 6am however he was gone from the home at this time.

	There is a preponderance of evidence to conclude Resident A was not provided the protection and supervision as defined in his written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 31, 2023, I conducted an Exit Conference with Licensee Designee, Laura Hatfield-Smith. I advised Licensee Designee Hatfield-Smith I would be requesting a corrective action plan for the cited rule violation.

IV. RECOMMENDATION

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

7/31/2023

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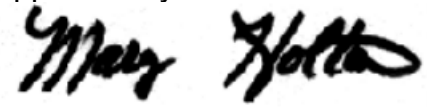
Christina Garza Date
Licensing Consultant

Approved By:



7/31/2023

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Mary E. Holton Date
Area Manager