GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 15, 2024

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

RE: License #: AS250413361
Investigation #: 2024A0576019
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.
- Indicate 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 #:** | 2024A0576019 |
| | |
| **Complaint Receipt Date:** | 01/22/2024 |
| | |
| **Investigation Initiation Date:** | 01/26/2024 |
| | |
| **Report Due Date:** | 03/22/2024 |
| | |
| **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 #:** | (810) 687-6820 |
| | |
| **Original Issuance Date:** | 01/31/2023 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/31/2023 |
| | |
| **Expiration Date:** | 07/30/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On January 22, 2024, Staff Tyron Boose left the facility around 3am. Resident A called the police to report there was no staff on duty. | Yes |
| Resident A was hit in the back of the head by another resident. | No |

## III. METHODOLOGY

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|---|---|
| 01/22/2024 | Special Investigation Intake<br>2024A0576019 |
| 01/22/2024 | APS Referral |
| 01/26/2024 | Special Investigation Initiated - Telephone<br>Interviewed Licensee Designee, Laura Hatfield-Smith |
| 01/30/2024 | Contact - Telephone call made<br>Interviewed Staff, Tyron Boose |
| 02/09/2024 | Contact - Telephone call made<br>Interviewed Resident A |
| 03/12/2024 | Inspection Completed On-site<br>Interviewed Home Manager, Dana Thompson, Resident A, Resident B, and Resident D |
| 03/14/2024 | Contact - Telephone call made<br>Interviewed Lamicia Reed, Genesee Health System Case Manager |
| 03/14/2024 | Contact - Telephone call made<br>Interviewed Christina Richardson, Genesee Health System Case Manager |
| 03/14/2024 | Contact - Telephone call made<br>Interviewed Licensee Designee, Laura Hatfield-Smith |
| 03/14/2024 | Exit Conference |

**ALLEGATION:**

On January 22, 2024, Staff Tyron Boose left the facility around 3am. Resident A called the police to report there was no staff on duty.

**INVESTIGATION:**

On January 26, 2024, I interviewed Licensee Designee, Laura Hatfield Smith regarding the allegations. Licensee Designee Smith confirmed the allegations were true and Staff Tyron Boose was terminated for leaving the residents home alone and without staff supervision. Staff Boose left the home about 3am and the police came to the home after Resident A called 911.

On January 30, 2024, I interviewed Staff Tyron Boose regarding the allegations. Staff Boose explained that he was working on January 22, 2024, on the midnight shift. Staff Boose received a call that his grandmother was unresponsive, so he left the facility to go to his grandmother's home. He left the home about 3am and returned around 5am. Staff Boose confirmed no other staff was on duty when he left the facility, and there were 5 residents left at the home without any staff supervision. Staff Boose advised he did attempt to call his supervisor to apprise her of the situation prior to leaving the home.

On February 9, 2024, I interviewed Resident A regarding the allegations. Resident A reported he woke up about 2am-3am to get a bowl of cereal. There was no staff at his home and there was no car in the driveway. Resident A called 911 and the home manager, Dana Thompson came to the home by 5am.

On March 12, 2024, I conducted an on-site inspection at the home and interviewed Home Manager, Dana Thompson. Home Manager Thompson confirmed Staff Tyron Boose was automatically terminated due to leaving the home during his shift.

| **APPLICABLE RULE** | |
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| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | It was alleged that Staff, Tyron Boose left his shift on January 22, 2024, leaving residents without staff supervision. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. |

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| | Staff Boose was interviewed and confirmed he left duty due to receiving a phone call that his grandmother fell ill. No other staff were on duty and 5 residents were at home alone without staff supervision. Resident A reported he woke up to get a bowl of cereal and found no staff at the home. Resident A called the police and the home manager arrived to the home a couple hours later.<br><br>There is a preponderance of evidence to conclude the licensee did not have sufficient direct care staff on duty for the care and supervision of the residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

Resident A was hit in the back of the head by another resident.

**INVESTIGATION:**

On February 9, 2024, I interviewed Resident A regarding the allegations. Resident A reported he does not feel safe living with Resident B. Resident B accuses Resident A of doing things he does not do. Resident B accused Resident A of urinating on Resident B's bed and bedroom floor, and this is not true. Resident B keeps his bedroom locked and Resident A does not go into Resident B's bedroom. Resident B hit Resident A a few months ago. Resident B is delusional and Resident A keeps his distance from him. Resident B is supposed to move from the home according to Resident A.

On March 12, 2024, I conducted an unannounced on-site inspection at ResCare Premier Neff Rd and interviewed Home Manager, Dana Thompson. Home Manager Thompson reported she believes Resident B has hit Resident A in the past however she has never witnessed this. Due to Resident B's behaviors, he has been provided a 30-day discharge from the home however his case manager has not been able to secure Resident B a new placement. Home Manager Thompson reported that Licensee Designee, Laura Hatfield Smith came to the home today and advised Resident B that he will be moving to a new home soon. Resident B will be transferred to another ResCare home by the end of the week. According to Home Manager Thomspon, Resident B has never hit any other residents and Resident B is ill and delusional. Resident B accuses Resident A of conspiring with another resident (Resident C) that used to live with Resident B at a different home in the past. Resident B believes Resident C calls Resident A and tells him to do things to Resident B to upset him. According to Home Manager Thompson, Resident B has a history of targeting one

resident at each home he lives in. Resident A does not feed into Resident B's accusations and behaviors and does not retaliate.

On March 12, 2024, I interviewed Resident B regarding the allegations. Resident B reported Resident A will break his belongings such as headphones and DVD's. Resident A puts powder on Resident B's belongings in his bedroom and Resident A wrecked Resident B's table as it is wobbly. Resident A will put smudges on Resident B's glasses. Resident B showed me his glasses and there appeared to be smudges on the lenses, which Resident B said was done by Resident A. Resident B took me to his bedroom, which was locked, and Resident B unlocked with a key he carries in his pocket. Resident B showed me the powder on a table in his room and the powder appeared to be dust however Resident B said it was not dust and it was powder. Resident B explained that Resident C calls other people and "pays them off to wreck my stuff". Resident B stated he has hit Resident A in the face before however he will not do that again because he does not want to go to jail. Resident B stated there is a conspiracy to get him to Flatrock.

On March 12, 2024, I interviewed Resident D regarding the allegations. Resident D reported he has lived at the home since November 2023. Resident D has never witnessed Resident B hit Resident A. Resident B accused Resident A of things Resident B does himself. Resident A does not go into Resident B's room and Resident B thinks things are happening that are not. Resident A tells Resident B not to talk to him and Resident A stays away from Resident B.

On March 12, 2024, I interviewed Resident A regarding the allegations. Resident A reported Resident B has hit him in the head once because "he's crazy". Resident A could not recall when Resident B hit him and stated he was not hit hard. Resident A stated the hit was a "love tap" and Resident B is not very strong. Resident A explained that Resident B accuses him every day of things that he does not do.

On March 12, 2024, I reviewed Resident A's Individual Plan of Service (IPOS), which revealed Resident A is 50 years old and diagnosed with Schizoaffective Disorder; Bipolar Type and Antisocial Personality Disorder. In 2000 Resident A was adjudicated Not Guilty by Reason of Insanity for charges stemming from an incident in October 1999 when he attempted to harm himself. Resident A's charges included assault, arson, and firearm misuse.

On March 12, 2024, I reviewed Resident B's IPOS, which revealed Resident B is 62 years old. Resident B exhibits "illogical thoughts and verbalizations". Resident B experiences delusions and hears voices that tell him to do things.

On March 14, 2024, I interviewed Lamicia Reed, Resident A's Case Manager from Genesee Health System. Case Manager Reed reported she is aware of the incident between Resident A and Resident B, and it happened sometime last year. Case Manager Reed did not recall the details of the incident and she did not believe them to be serious. AFC Staff try to keep Resident A and Resident B separated as the two do

not get along. Resident A and Resident B do not cross paths and there have been no recent incidents between the two residents. According to Case Manager Reed, Resident A is doing well and is “a laid-back person”.

On March 14, 2024, I interviewed Christina Richardson, Resident B’s Case Manager from Genesee Health System (GHS). Case Manager Richardson reported she has been Resident B’s Case Manager for around 9 months. Case Manager Richardson reported she is not familiar with the allegations and the incident was likely not a huge problem. Resident B reports Resident A is tampering with his belongings however Resident A is not doing anything to Resident B. The home reported that it would be hard for Resident A to do anything to Resident B or his belongings as staff monitor the residents. According to Case Manager Richardson, Resident B is diagnosed with Schizophrenia and Obsessive-Compulsive Disorder (OCD) and that Resident B has insight to his diagnosis but little insight as to the symptoms they present.

On March 14, 2024, I interviewed Licensee Designee, Laura Hatfield-Smith regarding the allegations. Licensee Designee Smith reported there have been issues with Resident B accusing Resident A of doing things to upset him that are not true. Resident B will be touring another ResCare facility, and the plan is to move him within the week. According to Licensee Designee Smith, Resident B was given a 30 day notice to vacate the home 6 months ago however the county has been unable to secure another placement for him.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |
| **ANALYSIS:** | It was alleged that Resident A was hit in the head by another resident. Upon conclusion of investigative interviews and a review of documentation, there is not a preponderance of evidence to conclude a rule violation.<br><br>Resident A was interviewed and stated Resident B hit him in the head because “he is crazy”. Resident A reported Resident B often accuses him of things that he does not do. Resident A could not recall when Resident B hit him and stated he was not hurt or injured as a result of Resident B hitting him. Resident B |

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|---|---|
| | confirmed he hit Resident A and stated he would not hit him again as he does not want to go to jail. The home manager, Resident B's case manager, and licensee designee all report that Resident B accuses Resident A of doing things that he does not do, and it is likely the result of mental illness. Due to Resident B's difficult behaviors, he was given a 30-day discharge notice several months ago however his placing agency has been unsuccessful in locating him another placement.<br><br>There is not a preponderance of evidence to conclude that the licensee is permitting another resident of the home to mistreat Resident A. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On March 14, 2024, I conducted an Exit Conference with Licensee Designee, Laura Hatfield-Smith. I advised Licensee Designee Smith I would be requesting a corrective action plan for the cited rule violation.

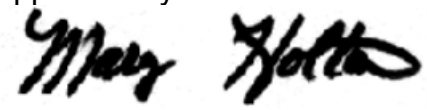
## IV. RECOMMENDATION

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

3/15/24

Christina Garza Date
Licensing Consultant

Approved By:



3/15/24

Mary E. Holton Date
Area Manager