GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2024

Laura Hatfield-Smith
ResCare Premier, Inc.
805 N Whittington Pkwy
Louisville, KY 40222-5186

RE: License #: AS250413361
Investigation #: 2024A0576034
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 #:	2024A0576034
Complaint Receipt Date:	04/24/2024
Investigation Initiation Date:	04/25/2024
Report Due Date:	06/23/2024
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 DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/16/24, a medication error occurred where Resident A got/took Resident B's medication. One of the medications erroneously taken was Clozaril. The medication error placed Resident A at risk of harm (though no harm occurred).	Yes

III. METHODOLOGY

04/24/2024	Special Investigation Intake 2024A0576034
04/25/2024	APS Referral
04/25/2024	Special Investigation Initiated - Letter Sent email to Brandy Morris, Genesee County Adult Protective Services (APS)
04/26/2024	Contact - Document Received Email received from Brandy Morris
05/02/2024	Inspection Completed On-site Interviewed Home Manager, Dana Thompson, and Resident A
05/09/2024	Contact - Telephone call made Interviewed Staff, Tennacle Mullins
05/14/2024	Exit Conference

ALLEGATION:

On 4/16/24, a medication error occurred where Resident A got/took Resident B's medication. One of the medications erroneously taken was Clozaril. The medication error placed Resident A at risk of harm (though no harm occurred).

INVESTIGATION:

On April 25, 2024, I sent an email to Brandy Morris, Genesee County Adult Protective Service (APS) Investigator regarding the status of investigation involving Resident A. On April 26, 2024, Investigator Morris advised she substantiated her case due to lack of care from Staff, Tennacle Mullins toward Resident A. Investigator Morris advised

Resident A is diagnosed with schizoaffective disorder-bipolar type, borderline personality disorder, and a moderate intellectual disability. Resident A reported he made a mistake by grabbing the wrong medication and he thought the medications were his. Resident A was taken to Hurley Hospital the day of the incident, and the ER staff discharged him the same day. The doctor reported to Resident A and the AFC staff that he would be fine.

On May 2, 2024, I completed an unannounced on-site inspection at ResCare Premier Neff Rd and interviewed Home Manager, Dana Thompson regarding the allegations. Manager Thompson reported that on April 16, 2024, she received a call from second shift staff, Tennacle Mullins who reported Resident A took Resident B's 8pm medications. Manager Thompson asked Staff Mullins how this occurred, and the staff person could not explain. Manager Thompson asked Staff Mullins if she prepared more than one resident's medications at a time, and she said yes. After Resident A took the wrong medication poison control was contacted and they advised staff to monitor Resident A. Resident A threw up once, was "loopy" and otherwise okay. The following day, Resident A still did not feel well so he was taken to the hospital where he was evaluated and released. According to Manager Thompson, Staff Mullins is a newer staff person and after this medication error occurred, she was signed up for a refresher training on medication administration. Staff Thompson must also complete 10 medication passes while being monitored by Manager Thompson.

On May 2, 2024, I interviewed Resident A who reported he took the wrong medications by accident. His medications were right next to another resident's medications, and he grabbed the wrong medications and took them. There were 2 cups of medications available on the counter and staff did not hand Resident A his medications.

On May 2, 2024, I reviewed an Incident Report (IR) regarding Resident A. Resident A is 67 years old and on April 16, 2024, he came into the medication area and took another resident's medication. Staff, Tennacle Mullins called the home manager who instructed her to contact poison control. Poison control advised staff not to give Resident A his 8pm medications and increase visual checks to every 10 minutes. Corrective measures include staff will attend medication training again before passing medications, staff will follow medication protocol, complete one person's medications at a time, follow the 5 rights, and discipline was requested.

On May 9, 2024, I interviewed Staff, Tennacle Mullins regarding the allegations. Staff Mullins reported she was passing medications and Resident A was talking and not paying attention. Staff Mullins had all 6 resident medications set up and ready to be administered and she was going to call each resident one by one. Staff Mullins called Resident A and he grabbed the wrong medications and quickly took them. Staff Mullins realized right away that Resident A took the wrong medications and called her home manager. Poison control was also called and advised that if Resident A continued to throw up to take him to the emergency room. Staff continued to monitor Resident A throughout the shift, and he threw up one time after taking the wrong medications. Staff

Mullins reported she does not usually set up all medications at one time but that time she did. Staff Mullins re-did medication training as a result of the medication error.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that Resident A took the wrong medications and was placed at risk of harm. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. On April 16, 2024, Staff, Tennacle Mullins prepared 6 resident medications in the medication area. Resident A came and grabbed the wrong medications as they were unsecured. Staff Mullins reported she set up resident medications and Resident A grabbed the wrong medications. I reviewed an IR which documented the medication error. There is a preponderance of evidence to conclude Resident A took medication that was not prescribed to him.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 14, 2024, I conducted an Exit Conference with Licensee Designee, Laura Hatfield-Smith. I advised Licensee Designee Hatfield-Smith I would be citing a rule violation and requesting a corrective action plan.

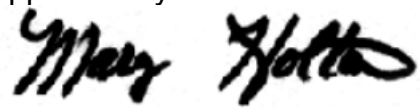
IV. RECOMMENDATION

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

5/14/2024

Christina Garza Date
Licensing Consultant

Approved By:



5/14/2024

Mary E. Holton Date
Area Manager