



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 21, 2024

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

RE: License #: AS250413361
Investigation #: 2024A0576039
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,

A handwritten signature in cursive script that reads "C. Garza".

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 #:	2024A0576039
Complaint Receipt Date:	05/31/2024
Investigation Initiation Date:	06/07/2024
Report Due Date:	07/30/2024
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?
Staff, Kamira Biggs spoke to Resident A disrespectfully when he asked for pain medication.	Yes

III. METHODOLOGY

05/31/2024	Special Investigation Intake 2024A0576039
06/07/2024	Special Investigation Initiated - Letter Sent email to Matt Potts, Genesee County Office of Recipient Rights (ORR)
06/10/2024	Contact - Document Received Email received from Matt Potts
06/10/2024	Inspection Completed On-site Interviewed Home Manager, Dana Thompson, Staff Makiah Moore, Resident A, and Resident B
06/21/2024	APS Referral
06/21/2024	Contact - Telephone call made Interviewed Staff, Kamira Biggs
06/21/2024	Exit Conference

ALLEGATION:

Staff, Kamira Biggs spoke to Resident A disrespectfully when he asked for pain medication.

INVESTIGATION:

On June 7, 2024, I sent an email to Matthew Potts, Genesee County Office of Recipient Rights (ORR) Investigator regarding if he is investigating this matter. On June 10, 2024, Investigator Potts confirmed he has this investigation and advised he will be substantiating a rights violation. Resident A reported Staff Biggs spoke to him in an inappropriate tone to which Staff Biggs denied. Resident B was interviewed and confirmed there was a dispute between Resident A and Staff Biggs over pain

medication. Staff Biggs raised her voice with Resident A to the point Resident B felt she was speaking to Resident A disrespectfully.

On June 10, 2024, I conducted an unannounced on-site inspection at ResCare Premier Neff Rd and interviewed Home Manager, Dana Thomspson regarding the allegations. Manager Thompson reported that Resident A asked for pain medication and Staff, Kamira Biggs said “no” and spoke to Resident A in a “disrespectful” manner. According to Manager Thompson, Resident A can have Tylenol for pain as needed and he requests pain medication for knee pain. Resident A felt Staff Biggs spoke to him disrespectfully however Staff Biggs denied doing so. The company conducted an internal investigation, which confirmed the allegations and Staff Biggs was terminated.

On June 10, 2024, I interviewed Staff, Makiah Moore. Staff Moore stated that she knows nothing of the allegation as she and Staff Biggs work on different shifts. Staff Moore explained Resident A is to request pain medication if he wants/needs it. Resident A can receive Tylenol as needed for knee pain every 6 hours. Staff Moore stated she heard that Staff Biggs was administering Resident A his medications. Resident A said to Staff Biggs that she forgot his pain medication and Staff Biggs said “no, you have to ask for it.” Staff Moore reported that Resident B told her that Staff Biggs got irritated with Resident A and “she did get a little upset”.

On June 10, 2024, I interviewed Resident A regarding the allegations. Resident A reported the allegations are true and Staff Biggs spoke to him “in a snotty way” because he asked her about his pain medication. Resident A has to ask for his pain medication (Tylenol) which he takes for arthritis in his knees. When Resident A wants or needs the Tylenol, he is to ask for it. The incident occurred a couple weeks ago, and Staff Biggs said, “you don’t have to ask me for that.” Resident A did not think it was nice how Staff Biggs spoke to him.

On June 10, 2024, I interviewed Resident B regarding the allegations. Resident B reported Resident A sometimes forgets to ask for his medication. Staff Biggs was agitated and “was short” with Resident A. Resident B reported Staff Biggs needed to be more patient with Resident A.

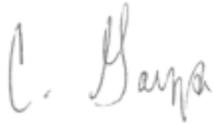
On June 21, 2024, I interviewed Kamira Biggs regarding the allegations. Staff Biggs advised she no longer works at the facility. Staff Biggs explained she was administering resident medications. Resident A was given his medication and Staff Biggs asked him if his medications looked correct. Resident A confirmed his medications were correct. Staff Biggs started doing paperwork and Resident A told Staff Biggs she forgot his pain medication. Staff Biggs said “no, you have to ask for pain medication”. Staff Biggs was trying to explain to Resident A that he receives his pain medication on an as needed basis and he said, “are you yelling at me?” Staff Biggs told Resident A she was not yelling at him. Staff Biggs denied she raised her voice when speaking to Resident A and did not think she was speaking to Resident A disrespectfully. Staff Biggs said she was just trying to explain to Resident A that she cannot give him an as needed medication without him asking for it.

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:	<p>It was alleged that Staff, Kamira Biggs spoke to Resident A disrespectfully after Resident A asked for pain medication. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation.</p> <p>Resident A was interviewed and stated the allegations were true. According to Resident A, when he asked for his pain medication, Staff Biggs spoke to him “in a snotty way.” Resident B was present and stated Staff Biggs “was short” with Resident A and needed to be more patient with him. Recipient Rights Officer Matt Potts said he was substantiating his investigation involving Resident A and Staff Biggs. The facility conducted an internal investigation and concluded Staff Biggs behaved inappropriately toward Resident A resulting in her termination.</p> <p>There is a preponderance of evidence to conclude Resident A was not treated with dignity.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

On June 21, 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.



6/21/2024

Christina Garza
Licensing Consultant

Date

Approved By:



6/21/2024

Mary E. Holton
Area Manager

Date