



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2026

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

RE: License #: AS780389700
Investigation #: 2026A0466012
Res-Care Premier Raymond

Dear Ms. Hatfield-Smith:

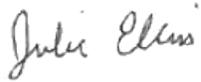
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Julie Elkins".

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780389700
Investigation #:	2026A0466012
Complaint Receipt Date:	01/06/2026
Investigation Initiation Date:	01/06/2026
Report Due Date:	03/07/2026
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:	Res-Care Premier Raymond
Facility Address:	715 Raymond Road Owosso, MI 48867
Facility Telephone #:	(989) 472-3829
Original Issuance Date:	11/29/2017
License Status:	REGULAR
Effective Date:	05/29/2024
Expiration Date:	05/28/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Direct care worker (DCW) Lillian Supal (legal name) but known as Landon Supal left scissors in a sink even though Resident A has self-harm history requiring all sharps to be locked up.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/06/2026	Special Investigation Intake 2026A0466012.
01/06/2026	APS Referral denied.
01/06/2026	Referral - Recipient Rights Andrea Andrykovich assigned.
01/06/2026	Special Investigation Initiated – Letter Complainant.
01/06/2026	Contact - Document Received ORR Andrea Andrykovich.
01/12/2026	Inspection Completed On-site with ORR Andrea Andrykovich.
01/12/2026	Contact - Telephone call made DCW Landon Supal, message left asking for a return call.
02/17/2026	Contact – Second telephone call made DCW Landon Supal voicemail and text message both left asking for a return call.
02/17/2026	Contact- Document sent to/from ORR Andrea Andrykovich.
02/17/2026	Contact- Document sent to/from licensee designee/administrator Laura Hatfield-Smith.
02/18/2026	Contact- Document sent to/from ORR Andrea Andrykovich.
02/18/2026	Exit Conference with licensee designee/administrator Laura Hatfield-Smith.

ALLEGATION: Direct care worker (DCW) Lillian Supal (legal name) but known as Landon Supal left scissors in a sink even though Resident A has self-harm history requiring all sharps to be locked up.

INVESTIGATION:

On 01/06/2026, Complainant stated that Resident A reported that direct care worker (DCW) Lillian Supal (legal name) but known as Landon Supal left a pair of scissors in the sink on 3rd shift while DCW Supal went downstairs for something. DCW Supal was the only DCW working that evening. Complainant reported that during this time, Resident A saw the scissors in the sink, took a picture of them, and reported that although she had thoughts of using them for self-harm, she left them there. Complainant reported that Resident A's *Individual Plan of Service* (IPOS) states that all sharps must be kept locked due to her history of self-harm.

On 01/06/2025, office of recipient rights (ORR) officer Andrea Andrykovich reported that she had not talked with Resident A yet but that she did talk with DCW Christian Beggs and DCW Krista Ostrander. ORR Andrykovich stated Resident A reported the scissors being in the sink to these two DCWs and Resident A showed them both a picture of the scissors in the kitchen sink. ORR Andrykovich reported that DCW Beggs and DCW Ostrander both stated that they informed DCW Linda Podolan, house manager, about this incident. ORR Andrykovich reported that DCW Beggs reported that when she arrived on shift, DCW Supal gave her a pair of scissors to lock up. DCW Beggs reported that it didn't make sense to her at the time, but because she already had the keys to the sharps, she didn't question it.

On 01/12/2026, ORR Andrykovich and I conducted a joint investigation and we interviewed Resident A who reported that she woke up in the middle of the night on 01/01/2026 and she went to the kitchen to get a drink and saw scissors/cutting sheers in the kitchen sink. Resident A reported that she thought about using the scissors to harm herself, but she didn't. Resident A reported that she took a picture of the scissors in the sink with her cell phone. Resident A reported that she believed that DCW Supal was in the bathroom or the basement because she did not see him. Resident A reported that DCWs go to the basement to do laundry or get supplies.

ORR Andrykovich and I observed the picture that Resident A had of the scissors. The picture was dated 01/01/2026 at 2:17am. The kitchen scissors had black handles with silver blades. The scissors were the only item in the kitchen sink in the picture.

ORR Andrykovich and I interviewed DCW Beggs who reported that she worked first shift on 01/01/2026 and when second shift came in, Resident A told them about the scissors being left in the kitchen sink in the middle of the night. DCW Beggs reported that Resident A showed DCW Beggs and DCW Ostrander a picture of the scissors in the sink. DCW Beggs reported that Resident A stated that DCW Supal was in the basement while the scissors were left in the sink. DCW Beggs reported that Resident A is a reliable reporter and she is not sure why she was up in the middle of the night. DCW Beggs reported all DCWs are trained that all sharps have to be locked up. DCW Beggs reported that when she arrived on shift at 7am, DCW Supal handed her the scissors to lock up after he had previously handed her the sharps

key. DCW Beggs reported that she did not understand it at the time and she was not sure why the scissors were out but that she did not question it.

ORR Andrykovich and I interviewed DCW Podolan who reported that third shift does not do meal preparation so she does not know why the kitchen scissors were left in the sink or even out of the area where they are locked up. DCW Podolan reported that all DCWs are trained that all sharps must be locked up so that they can follow Resident A's IPOS. DCW Podolan reported that she was told that DCW Supal was in the basement when the scissors were left in the sink. DCW Podolan reported that Resident A reported the incident to her and provided the picture. DCW Podolan reported that DCW Supal at first denied leaving the scissors in the sink and after he realized that Resident A took a picture the story changed. DCW Podolan showed me a text message thread between her and DCW Supal where DCW Supal reported that he "left the scissors in the sink when I took the keys" to DCW Beggs. DCW Supal texted that when "he went back to the kitchen to clean them then asked DCW Beggs to put them away because she had the keys." DCW Supal reported that Resident A was awake and could have seen the scissors in the sink. DCW Supal denied that he went to the basement and reported that he was away from the sink for "like two seconds and she was leaving the bathroom going back into her room while I was still in the kitchen."

I reviewed Resident A's record which documented that she was admitted to the facility on 02/14/2019. Resident A's record contained a *Health Care Appraisal* dated 08/26/2025, in the diagnosis section it documented, "deep vein thrombosis (DVT), pulmonary embolism, insomnia, AR, sleep apnea, hyperthyroidism and vitamin D deficiency. In the "general appearance" section of the report it stated, "alert, competent." I reviewed Resident A's written assessment plan that was dated 01/10/2025. In the "exhibits self-injurious behavior" section of the report it stated, "staff prompt as needed and document, history/current self-harmer."

I reviewed Resident A's IPOS which was dated 7/18/2025 and stated on page 2:

"All sharp objects must be kept in a locked area where [Resident A] cannot access. [Resident A] cannot possess any ropes, wires or charging cords without staff visual supervision. If [Resident A] watches videos about suicide, discusses harming herself or makes any gestures towards accessing items for self-harm within 24 hours of the scheduled outing she is not able to attend. Staff must complete visual supervision every 15 minutes during waking hours and every 30 minutes during sleeping hours to ensure her health and safety. Staff must search [Resident A] and her possessions when she returns from the community for any sharp objects and cords. These objects shall be stored in a locked area."

On 02/17/2025, I interviewed ORR Andrykovich who reported that she spoke with DCW Supal on 1/23/2026 and admitted that there was a brief period of time on 01/01/2026 that morning when he entered the dining room to give DCW Beggs the

keys to the secured sharps that Resident A must have seen the scissors unsecured during this time. DCW Supal reported that Resident A had been in the bathroom but when passing back by it, the door was open and assumed that Resident A had gone back to bed. DCW Supal didn't realize leaving the scissors in the sink at that time and that Resident A had access to them. DCW Supal reported that this was around 6:00am, it happened very fast and it was a very short period of time that the scissors were left unattended in the sink. DCW Supal stated Resident A must have seen the scissors in the sink and taken a picture.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	<p>Resident A's <i>Individual Plan of Service</i> dated 7/18/2025 states that all sharps are required to be locked up.</p> <p>Resident A reported that on 01/01/2026 around 2:00am she got up to get a drink of water and found the scissors in the kitchen sink. Resident A reported that she took a picture of the scissors in the sink with her cell phone. ORR Andrykovich and I observed the picture that Resident A had of the scissors in the kitchen sink that was dated 01/01/2026 at 2:17am.</p> <p>ORR Andrykovich reported that she interviewed DCW Supal on 1/23/2026 and DCW Supal admitted that there was a brief period of time on 01/01/2026 when the scissors were unsecured. DCW Supal reported not realizing leaving the scissors in the sink at that time and reported that this was around 6:00am, that the scissors were left unattended in the sink therefore a violation has been established.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/12/2026, I conducted an unannounced investigation and I reviewed Resident A's written *Assessment Plan for AFC Residents* dated 12/15/2025 and completed by DCW Podolan. I noted this document was signed by Resident A's on 01/06/2026, 22 days later but the space labeled "signature of licensee" was signed on 01/05/2026 by "Holly" and "P" last name but the other letters were not decipherable. The licensee designee that is documented in the facility file in the Bureau Information Tracking System (BITS) is Laura Hatfield-Smith therefore this document was not signed by the licensee designee. According to Resident A's *Resident Face Sheet*

that was located in Resident A's record, her admission date to the facility was 02/14/2019 so this an updated annual *Assessment Plan for AFC Residents*.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to two years after discharge.
ANALYSIS:	Resident A's written <i>Assessment Plan for AFC Residents</i> documented a completed date of "12/15/2025" where it stated, "date assessment plan was completed." Resident A's signed the assessment plan 22 days later on 01/06/2026. Someone else signed in the licensee designee portion of the report on 01/05/2026 therefore there is no documentation that the assessment plan was completed with the resident, responsible agency, if applicable, and the licensee for this annual assessment. The signature for the licensee designee is not Laura Hatfield-Smith meaning this document was not signed by the licensee designee therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 01/12/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained an amended IPOS dated 7/18/2025, however Resident A's record did not contain any documentation that training had been conducted on Resident A's IPOS by all direct care workers working with Resident A.

On 02/18/2026, ORR Andrykovich reported that her files documented that the home manager DCW Podolan was trained on the amended IPOS dated 7/18/2025 as a "train the trainer." At the time of the unannounced investigation there was no documentation in Resident A's record to verify that DCWs including DCW Supal had been trained in Resident A's amended IPOS dated 7/18/2025.

APPLICABLE RULE	
R 400.707	Staff training.

	<p>(1) Staff who work with residents shall have successfully completed training that provides basic concepts required in providing specialized dependent care before working independently. Staff shall show the ability to comprehend and be competent to deliver each resident's individual plan of service as written. Training must include all of the following before working independently:</p> <p>(b) Understanding and carrying out individual plans of service for residents.</p> <p>(3) Documentation of training must be maintained in the staff records to demonstrate that training has been completed and is current.</p>
ANALYSIS:	At the time of the unannounced investigation there was no documentation to verify that all DCWs including DCW Supal had been trained in Resident A's amended IPOS dated 7/18/2025 therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Julie Elkins

02/18/2026

Julie Elkins
Licensing Consultant

Date

Approved By:

Dawn Timm

02/18/2026

Dawn N. Timm
Area Manager

Date