GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

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

RE: License #: AS780389700
Investigation #: 2026A1029027
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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS780389700
Investigation #:	2026A1029027
Complaint Receipt Date:	02/24/2026
Investigation Initiation Date:	02/25/2026
Report Due Date:	04/25/2026
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(S)

	Violation Established?
On 02/18/2026 direct care staff member Shannon Bocek left the medication room open as she walked away and Resident A entered the medication room and took two pin tacks off the board which she uses to self-harm.	Yes

III. METHODOLOGY

02/24/2026	Special Investigation Intake 2026A1029027
02/25/2026	Special Investigation Initiated – Letter ORR Ardis Bates
02/26/2026	Contact - Document Received-Email response from Ardis Bates
03/11/2026	Contact - Telephone call made to direct care staff members Christa Ostrander, Tricia Hollers, Linda Podolan (left message)
03/12/2026	Inspection Completed On-site- Face to Face with direct care staff members Christian Begg and Danielle Spencer, Resident A, Resident B at Res-Care Premier Raymond
03/13/2026	Contact - Document Sent to direct care staff member / home manager Linda Podolan
04/02/2026	Contact – Telephone call to direct care staff member Krista Ostrander, Ms. Bocek, Linda Podolan, Resident A (not available)
04/03/2026	APS referral made to Centralized Intake.
04/03/2026	Contact – Telephone call to licensee designee Laura Smith and direct care staff member Mercedes Hart (Left message)
04/03/2026	Exit conference with licensee designee Laura Smith

ALLEGATION: On 02/18/2026 direct care staff member Shannon Bocek left the medication room open as she walked away and Resident A entered the medication room and took two pin tacks off the board which she uses to self-harm.

INVESTIGATION:

On 02/24/2026, a complaint was received via Bureau of Community and Health Systems online complaint system alleging that on 02/18/2026 direct care staff member Shannon Bocek left the medication room open as she walked away and Resident A entered the medication room and took two pin tacks off the board which she used to self-harm. Office of Recipient Rights advisor, Ardis Bates was also assigned to investigate these allegations.

On 03/11/2026 I interviewed direct care staff member Tricia Hollers. Ms. Hollers stated she was told by Resident A that during second shift direct care staff member Ms. Bocek left the medication room open, so she went in and took a tack off the wall. Ms. Hollers stated Resident A uses pin tacks to self-harm. Ms. Hollers stated Resident A did not tell her how long the door was open but it was long enough for Resident A to go in and take a tack off the wall. Ms. Hollers stated she didn't see any fresh cuts on her at that time so she does not believe Resident A used this to self-harm. Ms. Hollers stated the medication room door is supposed to be closed at all times and this is covered regularly and in the medication training. Ms. Hollers stated she and Ms. Bocek were hired together in June 2026 and completed training together.

On 03/12/2026 I completed an unannounced on-site investigation and interviewed Resident A who stated she was able to access the medication room because a direct care staff member left the door open long enough for her to grab a tack from the bulletin board. Resident A states she uses these tacks to harm herself. Resident A stated she does not know how long the room was open because she just went in, grabbed the tack, and left. Resident A stated this is not the first time she went into the medication room because the door was left open. Resident A stated she has done this twice in the last two months. Resident A stated she went into the medication room because she wanted to find something to hurt herself with so she took the thumb tacks because she cuts herself with them. Resident A stated she did not cut herself with them this time like she did the last time she went into the medication room for tacks. Resident A stated she was caught this time because she was cheeking her medications instead of swallowing them so the direct care staff members searched her room and that's how they found the tacks. Resident A stated she told direct care staff how she was able to get into the room. Resident A stated she feels safe living at this AFC.

I interviewed direct care staff members Christian Begg and Danielle Spencer. Ms. Begg stated she was unaware of the time when the medication room door was left open because it's always shut when leaving the room. Ms. Begg stated sometimes the door sticks and she has to pull it hard to make sure it latches but if Resident A wants to find something to harm herself with, then she will find something, because in the past she

has gone outside for sticks and taken the pop tabs off the cans to cut herself with it. Ms. Begg stated Resident A will self-harm and cut herself more after she gets uses her vape pen in her room. Ms. Begg stated after using her vape pen, Resident A's voices get worse often ending in Resident A self-harming. Ms. Begg stated Resident A vapes in her room and she did not know if there was a policy against her doing this. I explained to Ms. Begg that she cannot vape in her resident bedroom at any time and must do so outside.

Ms. Spencer stated she heard about this incident but was not working when it occured and did not know the specific details. Ms. Spencer showed me the double door on the medication room and the bulletin boards with the tacks which are on the left side wall. I observed that the tacks could be easily reached even without stepping into the medication room and only standing by the doorway and reaching over to the wall on the left.

I interviewed Resident B who stated he is unaware of any residents going into the medication room because the door to the room is typically closed but he has observed it opened. Resident B stated he didn't know when this occurred or if anyone was able to get inside the room. Resident B stated residents typically go to the door to get their medications or they are administered while they are sitting at the table.

I reviewed the following documents in Resident A's record:

- *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."
- Resident A's written *Assessment Plan for AFC Residents* 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."
- 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."

Licensee designee Ms. Smith sent verification that Ms. Bocek completed all required licensing training.

I reviewed the *Medication Related Policies and Procedures* for Res-Care Premier Raymond which states "all medications will be stored in locked containers or secured in locked areas accessible only to authorized staff and designated for medication storage."

On 04/02/2026 I interviewed direct care staff member Krista Ostrander. Ms. Ostrander stated she did not observe the medication room door left open but heard about it a few days later. Ms. Ostrander stated she was not a witness or she definitely would have reported it. Ms. Ostrander stated she does not know how the tacks were found or if Resident A admitted she took them. Ms. Ostrander stated she was working that day but she did not know the door was open that day or that Resident A had managed to get into the room.

Ms. Ostrander stated Resident A vapes in her room and she has noticed Resident A doing this in the past but it's been a long time and she does not recall the date or timeframe this occurred. Ms. Ostrander stated if this occurs again, Resident A will be redirected to go outside. Ms. Ostrander stated there is a policy there is no vaping in the house and when they see her trying to do this then they will tell her that it's not allowed and she has to go outside.

On 04/02/2026 I interviewed direct care staff member Shannon Bocek. Ms. Bocek stated she does not recall leaving the medication room door open during her shift while she was working. Ms. Bocek stated she knows that the procedure for the medication room is to keep it closed and locked at all times. Ms. Bocek stated she did not know that Resident A was able to get into the room and take tacks off the wall. Ms. Bocek stated she does not know of any time Resident A has self-harmed herself with tacks. Ms. Bocek stated she has never observed Resident A using her vape pen in her bedroom and has always observed her using this outside.

On 04/02/2026 I interviewed direct care staff member, whose role is home manager, Linda Podolan. Ms. Podolan stated she wasn't there when this occurred and it was reported to her by Resident A and other direct care staff members Ms. Begg and Ms. Hollers because Resident A told them she found the door open. Ms. Podolan stated Resident A went into the medication room and she took some push pins off the wall but direct care staff were able to get them back from Resident A after searching her room. Ms. Podolan stated Resident A has not been able to access the medication room in the past. Ms. Podolan stated it was reviewed again with all the direct care staff members to keep sharp items locked up. Ms. Podolan stated this was discussed during a recent direct care staff member meeting and it was also put in their group chat when this initially happened. Ms. Podolan stated she is unaware of any harm that Resident A did

with the pins but there is a chance because the pins are so small and she can be sneaky.

Ms. Podolan stated she has not noticed Resident A vaping in her bedroom but she does keep them in her room. Ms. Podolan stated she was not aware Resident A couldn't vape in her room but she would share this information with the direct care staff members

On 04/03/2026 I interviewed licensee designee Laura Smith. Ms. Smith stated she was aware Ms. Bocek left the door open to the medication room instead of closing and locking it. Ms. Smith stated when issues like this occur, direct care staff members are disciplined immediately. Ms. Smith stated this had been an issue previously as Resident A accessed scissors that were left in the sink and that direct care staff member was terminated. Ms. Smith stated if Ms. Bocek read the *Individual Plan of Service* for Resident A then she should understand the plan and she would acknowledge what Resident A is capable of when she has access to sharp items.

Although it was inconclusive if Resident A was using her vape in her resident bedroom, I did address these concerns with Ms. Smith so she would be aware if there were future concerns. Ms. Smith stated she will immediately send a notice to remind all direct care staff members about the no-vaping policy and address this with Resident A in case she is vaping in her bedroom.

On 04/03/2026 I completed an exit conference with licensee designee Ms. Smith. Ms. Smith stated she will submit a plan of correction and implement a self-closing door for the medication door so it can never be left open in the future to eliminate Resident A from getting into the medication room. Ms. Smith stated she would also move or remove the bulletin board with the tacks so they are not accessible while someone is standing outside the room.

This is a repeat violation because on 02/18/2026 Special Investigation Report (SIR) 2026A0466012 substantiated concerns after direct care staff member Lillian Supal (who goes by Landon Supal) left scissors in a sink even though Resident A has a self-harm history requiring all sharps to be locked up. A corrective action plan was submitted after this investigation stating that *"Landon Supal was terminated on 01/21/2026 for repeated issues with the agency and recipient rights. File has been marked ineligible for rehire. All review will be done with all staff to ensure that all sharps are kept locked and immediately put away after use."* Corrective Action Plan compliance was received on 03/17/2026 with a memo that was going to be placed in the staff communication log as a reminder of locking up all sharps so Resident A could not access them.

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:	Resident A's *Individual Plan of Service* dated 7/18/2025 states that all sharps are required to be locked up. During this incident, the medication room door was left open and Resident A was able to enter the room and take a tack off the bulletin board. Resident A uses these tacks to self-harm and although she stated she did not self-harm during this incident, she was hiding the tack in her room and could have done so in the future.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2026A0466012 DATED 02/18/2026. CAP COMPLETED.]**

IV. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend no change in the license status.

Jennifer Browning _____04/08/2026_____
Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 04/09/2026
_____
Dawn N. Timm Date
Area Manager