GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 13, 2021

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

RE: License #:	AS250284763
Investigation #:	2021A0123037
	ResCare Premier Riverview

Dear Ms. Hatfield-Smith:

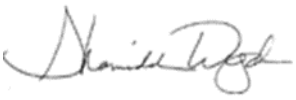
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250284763
Investigation #:	2021A0123037
Complaint Receipt Date:	07/15/2021
Investigation Initiation Date:	07/15/2021
Report Due Date:	09/13/2021
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 Riverview
Facility Address:	1467 Flushing Rd. Flushing, MI 48433
Facility Telephone #:	(810) 659-6444
Original Issuance Date:	11/13/2006
License Status:	REGULAR
Effective Date:	04/17/2021
Expiration Date:	04/16/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 06/18/2021, Resident A eloped. She got into a stranger's car and did not want to return to the AFC home. 911 was called and Resident A was taken to the Hurley Medical Center emergency room for evaluation.	Yes
Resident A has been eloping for the last two to three weeks from the AFC home. A 30-day notice was issued on 06/22/2021 due to Resident A eloping. Resident A's guardian was not notified of Resident A eloping until 06/18/2021, when she eloped again.	No

III. METHODOLOGY

07/15/2021	Special Investigation Intake 2021A0123037
07/15/2021	Special Investigation Initiated - Telephone I spoke with APS investigator Samantha Belanger via phone.
07/15/2021	APS Referral Information received regarding APS referral.
07/19/2021	Contact - Telephone call made I spoke with Resident A's public guardian via phone.
07/19/2021	Contact - Telephone call made I spoke with Resident A's public guardian via phone.
07/20/2021	Inspection Completed On-site I conducted an unannounced visit to the facility.
07/20/2021	Contact - Document Sent A letter was faxed to the City of Flushing police department requesting a police report.
07/20/2021	Contact- Telephone call received I received a voicemail from the City of Flushing Police Department.
07/20/2021	Contact- Telephone call made I made a return call to the City of Flushing Police Department.
07/20/2021	Contact - Document Received Documentation was received from the City of Flushing Police Department.
07/27/2021	Contact - Telephone call made

	I left a voicemail requesting a return call from staff Mercedes Turner.
07/27/2021	Contact - Telephone call received I interviewed Staff Turner via phone.
08/13/2021	Exit Conference I spoke with licensee designee Laura Hatfield-Smith via phone.

ALLEGATION:

- **On 06/18/2021, Resident A eloped. She got into a stranger's car and did not want to return to the AFC home. 911 was called and Resident A was taken to the Hurley Medical Center emergency room for evaluation.**

- **Resident A has been eloping for the last two to three weeks from the AFC home. A 30-day notice was issued on 06/22/2021 due to Resident A eloping. Resident A's guardian was not notified of Resident A eloping until 06/18/2021, when she eloped again.**

INVESTIGATION: On 07/15/2021, I spoke with APS investigator Sam Belanger via phone. She stated the following: She is not substantiating the APS allegations. Resident A did not walk off of the premises and did not get into the driver's vehicle, so Resident A did not technically elope. Staff at the facility said that Resident A never actually eloped from the facility until 06/18/2021, and the guardian was notified. She stated that Resident A denied the allegations, and staff that were interviewed denied that Resident A got into the vehicle. The driver of the vehicle contacted the police. Resident A was sent to the hospital on 06/18/2021. The facility gave a 30 day notice to Resident A due to not being able to accommodate Resident A's behaviors, and they are looking for alternative placement.

An incident report received by AFC Licensing on 06/21/2021, with an incident date of 06/18/2021, states the following in the explain what happened/describe injury section: *"[Resident A] eloped from home while staff was doing client care on another consumer. [Resident A] tried to hitch a ride with someone and they called the police on her. Was transported to hospital, because she was refusing to let police escort her back into house.* Under corrective measures taken to remedy and or prevent recurrence it states: *"Staff wrote IR, documented, notified guardian. Once at hospital consumer complained of back pain, prescribed Cephalexin 500 mg 3x's daily, nystatin ointment BID Will monitor as much as we can. Document follow discharge instructions."* In the physician's diagnosis of injury, illness, or cause of death, if known section it states: *"Yeast infection of skin (apron area) under belly." The incident report was signed* by staff Davina McCaskey. The report was also completed and signed by staff Shmarile Smith.

It is documented on the incident report that Guardian 1 was notified on 06/18/2021. This incident report also included a copy of the 30-day notice provided to Summit Pointe and Guardian Finance on behalf of Resident A. The incident report states that ResCare Premier River program *"can no longer tolerate her actions (elopements) nor meet her needs. She is not cooperating/participating in the programming process and is upsetting the success of the program and her peers."*

On 07/19/2021, I interviewed Resident A's public guardian via phone. Guardian 1 stated that Resident A is not able to be in the community on her own. Resident A is 84 years of age and is diagnosed with major depressive disorder, arthritis, restless leg syndrome, anxiety, borderline personality disorder, schizophrenia, and memory issues. She stated that Resident A is not able to leave the premises, and that she was not aware that Resident A had been attempting to elope, until she actually eloped. Guardian 1 stated that she was informed that Resident A went out onto the main road, and that she was taken by a stranger to McDonald's, and police were called because Resident A did not want to return to the facility. She stated that she was informed that Resident A flagged down a car that picked her up. She stated that she does not think the facility is a safe environment, and questions why the facility does not have appropriate staffing that they are not able to make sure Resident A's needs are met. She stated that Resident A does not require a one to one staff, only when using the phone, because Resident A has a history of inappropriate phone use.

On 07/19/2021, I conducted an unannounced visit to the facility. I interviewed home manager Shmairle Smith. Staff Smith stated that Resident A only made attempts to elope the first two times. The third time, Resident A eloped off of the property. Staff Smith stated that she thinks Resident A went down the street but did not make it far. She stated that Resident A eloped on 06/18/2021. She stated that a stranger brought Resident A back to the home. She denied that Resident A was taken to McDonald's. She stated that the driver of the vehicle said that Resident A tried to get into her car, so she brought Resident A back to the home. The driver called the police. Staff Smith stated that she was present on 06/18/2021 during the incident, and so was staff Mercedes Turner. She stated that there are six residents in the facility, and there are usually two staff on shift. She stated that from 9:00 pm to 11:00 pm there is one staff on shift. Staff Smith stated that it was told by the police that Resident A reported staff were trying to kill and suffocate her. Resident A was sent to Hurley Medical Center. She stated that the police tried to prompt Resident A to go back into the house. Staff and police could not get Resident A back inside, so an ambulance was called. She stated that Resident A was at the hospital for a couple of hours and came back. Staff Smith stated that she and Staff Turner were in a resident's room providing care for not more than five minutes. She stated that she is not sure of the direction Resident A went walking, and that the police responded immediately. She stated that she saw there was police outside after tending to the other resident. She stated that she overheard the driver saying Resident A had got into her car. She denied that Resident A has a one to one staff.

On 07/19/2021, I interviewed Resident A at the facility. Resident A stated that she wanted to go for a walk and did not think to ask staff. She stated that she was walking on the sidewalk. She denied getting into the driver's car. She stated that she spoke with a lady who called the police and hospital. She stated that she was taken to the hospital. She stated that she does not remember if she refused to go back into the facility. She stated that the hospital says she had to be seen because she went out into the road. She stated that she does not remember making any comments about anyone trying to suffocate or kill her. She stated that this was the first time she has walked away from the facility.

Copies of Resident A's *Health Care Appraisal*, *Behavior Treatment Plan*, and *Assessment Plan for AFC Residents* were obtained during the onsite on 07/19/2021. The *Health Care Appraisal*, dated for 07/07/2021, states that Resident A is diagnosed with borderline personality disorder, and uses a walker. On Page 8 of the *Behavior Treatment Plan*, it states *"Restriction #1: Freedom of Movement: At this time [Resident A] will not be permitted to leave the AFC home unless accompanied by a staff member and should not be left alone with a telephone or allowed to talk on the telephone anywhere other than the dining area of the home."* Resident A's *Assessment plan for AFC Residents* indicates that Resident A cannot move independently in the community, and that she uses the assistance of a walker, and requires 24-hour supervision.

On 07/19/2021, I also obtained a copy of the staff schedule for June 12th through June 25th. This schedule confirms that Staff Smith and Staff Turner were the only two staff on schedule during the time of the incident that occurred on 06/18/2021 where Resident A eloped.

On 07/20/2021, I spoke with an individual named Katie from the City of Flushing Police Department. She stated that the documentation they have for 06/18/2021 is not an actual police report, but an event chronology of the 911 call. She stated that a City of Flushing deputy responded. Resident A was sent to Hurley Medical Center for a mental/psych transport due to paranoia/confusion. The location of the caller was Flushing Road and Resident A was in the roadway and confused. At the end of the driveway, the driver stopped and put Resident A in the car. Resident A said that she thinks people are going to killer her. Three officers responded within a few minutes.

On 07/20/2021, I received a copy of the *Event Chronology* report from the City of Flushing Police Department. The report notes that a call was made at 3:12 pm on 06/18/2021, from a driver who came across an elderly female who appeared very confused and paranoid, who thinks that EMS is going to come and kill her. At 3:13 pm, the notes indicate that Resident A will not get out of the roadway, and the caller is trying to get her into the driveway. At 3:14 pm the caller reported that Resident A is trying to get into her vehicle, and then has let Resident A sit in her vehicle until the police arrives. At 3:15 pm, a police officer arrives. EMS was contacted at 3:20 pm.

On 07/27/2021, I interviewed staff Mercedes Turner via phone. She stated that she and Staff Smith got up to go and check on a resident. She stated that she walked past Resident A and made eye contact with Resident A. Resident A was watching television at the time. She stated that to her understanding, while she and Staff Smith were providing personal care in a resident's room, Resident A got out of the driveway into the street and flagged a driver down. She stated that she saw them in front of the house. She stated that to her understanding, Resident A made attempts to elope, but that is the first time she got towards the end of the driveway. She stated that she does not think Resident A got into the driver's car. She stated that Staff Smith responded outside, and she (Staff Turner) stayed in the home with the other residents. She stated that Resident A was sent to the hospital, and that there have been no issues since 06/18/2021.

On 08/13/2021, I conducted an exit conference with licensee designee Laura Hatfield-Smith. She stated that they have installed door alarms and had it addressed in Resident A's plan. She stated that staff also do 20 minute visuals during waking hours, and hourly checks at night. She stated that Resident A does not have a history of walking away. I informed her of the findings and conclusion.

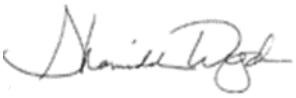
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Guardian 1, Resident A, and Staff Smith reported that Resident A left the premises of the home. Resident A stated that she was walking on the sidewalk, and that the hospital told her that she was being seen by them because she walked into the road. Guardian 1 stated that she was informed that Resident A went out onto the main road, and that she was taken by a stranger to McDonald's, and police were called because Resident A did not want to return to the facility. Staff Smith reported that Resident A eloped off of the property. Staff Smith stated that she thinks Resident A went down the street but did not make it far. She stated that she overheard the driver saying Resident A had got into her car. A City of Flushing *Event Chronology* report from the City of Flushing Police Department was reviewed. The report notes that Resident A was in the roadway, and also got into the driver's vehicle.

	Resident A's *Assessment plan for AFC Residents* indicates that Resident A cannot move independently in the community, and that she uses the assistance of a walker, and requires 24-hour supervision. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.**
ANALYSIS:	Adult Protective Services worker Sam Belanger reported that the guardian was notified on the date of the incident. An incident reported dated for 06/18/2021 notes that Guardian 1 was notified of the elopement. Guardian 1 stated that stated Resident A is not able to leave the premises, and that she was not aware that Resident A had been attempting to elope, until she actually eloped. Staff Smith and Staff Turner reported that Resident A had only made attempts to elope prior to her actually doing so on 06/18/2021. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

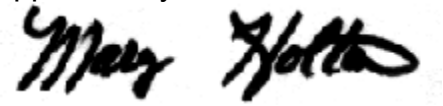
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the license for this AFC small group home (capacity 6).



08/13/2021

Shamidah Wyden Date
Licensing Consultant

Approved By:



08/13/2021

Mary E Holton Date
Area Manager