STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

November 18, 2021

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

RE: License #:	AS250300908
Investigation #:	2022A0872003
	ResCare Premier Holly

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 (906) 226-4171.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250300908
Investigation #:	2022A0872003
Complaint Receipt Date:	10/19/2021
Investigation Initiation Date:	10/19/2021
Report Due Date:	12/18/2021
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 Holly
Facility Address:	4242 W Baldwin Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 655-0354
Original Issuance Date:	05/27/2009
License Status:	REGULAR
Effective Date:	02/03/2020
Expiration Date:	02/02/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was recently prescribed oxygen. He has been caught smoking cigarettes in his bedroom. Staff is not following his plan of service regarding his oxygen and smoking materials.	Yes

III. METHODOLOGY

10/19/2021	Special Investigation Intake 2022A0872003
10/19/2021	Special Investigation Initiated - Telephone I contacted the licensee designee, Laura Hatfield-Smith about this complaint
10/19/2021	Contact - Telephone call received Ms. Hatfield-Smith provided me with an update on this case
10/19/2021	Contact - Telephone call made I interviewed Guardian A1
10/21/2021	Contact - Document Received I exchanged emails with Guardian A1
10/26/2021	Contact - Telephone call received I received a phone call from Ms. Hatfield-Smith updating me on this situation
10/26/2021	Contact - Document Sent I emailed the program manager, Davina McCaskey requesting information about this complaint
10/26/2021	APS Referral I made an APS complaint via email
10/28/2021	Inspection Completed On-site Unannounced
10/28/2021	Contact - Document Received AFC documents received regarding this complaint

11/18/2021	Contact - Telephone call made I interviewed the home manager, Ellen Porter
11/18/2021	Exit Conference I conducted an exit conference with Holly Yates via telephone
11/18/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was recently prescribed oxygen. He has been caught smoking cigarettes in his bedroom. Staff is not following his plan of service regarding his oxygen and smoking materials.

INVESTIGATION: On 10/19/21, I interviewed Guardian A1 via telephone. According to Guardian A1, Resident A is diagnosed with schizophrenia with religious delusions which he takes injections for every 4 weeks. She said that he has been a client of Genesee County Health System (GHS) for approximately 50 years. Guardian A1 said that Resident A was recently prescribed oxygen. She is concerned because he has been caught smoking in the Adult Foster Care (AFC) facility. Guardian A1 said that according to staff, Resident A has been caught smoking in the home on 10/15, 10/16, 10/18, and 10/19. She said that Resident A has a roommate, and she is concerned that since Resident A now has oxygen in his room, he is putting himself and others in danger by smoking around his oxygen tank.

On 10/19/21, I interviewed the licensee designee, Laura Hatfield-Smith via telephone. Ms. Hatfield-Smith confirmed that Resident A has been caught smoking in the AFC home and this situation has been addressed with his GHS case manager. She said that GHS is reluctant to restrict Resident A's ability to have cigarettes and/or a lighter on his person. According to Ms. Hatfield-Smith, his GHS Individualized Plan of Service (IPOS) states that if staff sees Resident A's lighter out in the open, they are allowed to take it, but they are not allowed to search his person or his belongings. The IPOS also states that if Resident A tries to light something, staff are not allowed to take the lighter out of his hand—instead they are to call Guardian A1 and ask her to come over and get it from him. I spoke with Ms. Hatfield-Smith about my concerns regarding Resident A smoking in the facility and she acknowledged this is a problem that she has been trying to address but GHS has been unwilling to be restrictive. She said that she will contact GHS and tell them that if they do not put it in Resident A's IPOS that his smoking materials must be confiscated, she will tell them that she is going to have to issue an emergency discharge notice for his safety and the safety of the others in the home.

On 10/21/21, I received a voicemail message from Guardian A1. She said that she was able to retrieve Resident A's lighter and cigarettes from him and she does not believe he has smoked in his room since the last time staff caught him.

On 10/21/21, I received another voicemail message from Guardian A1. She said that she was just at the facility and saw Resident A's oxygen tank in his room, plugged in. She said that Resident A is not supposed to have the oxygen tank in his room during the day and said that she is concerned because staff did not seem to know about his restrictions.

On 10/26/21, I spoke to Ms. Hatfield-Smith via telephone. She told me that she did speak to Resident A's GHS case manager and asked that it be put in his IPOS that Resident A is not allowed to have cigarettes or a lighter on his person. She said that the AFC is going to remove Resident A's oxygen tank from his room during waking hours and will offer it to him at night. Thus far, he has been non-complaint regarding using his oxygen. Ms. Hatfield-Smith stated that because of Resident A's non-compliance regarding using cigarettes in the home, not taking his medications, not eating, etc. she will be issuing him a 30-day discharge notice tomorrow.

On 10/28/21, I conducted an unannounced onsite inspection of ResCare Premier-Holly AFC. I interviewed Resident A and the home manager, Ellen Porter. I also conducted a visual inspection of some areas of the facility.

Upon arriving at the facility, I observed a "No smoking, oxygen in use" sign posted on the front door. I also noted an oxygen warning sign in the kitchen and two in Resident A's bedroom. I interviewed Resident A in his bedroom. I did not see an oxygen tank and asked him if he uses oxygen. He said that staff does not leave it in his room during the day and will bring it to him at night. I asked Resident A if he smokes cigarettes in the home and he said, "I used to." He said that he last smoked in his room approximately one week ago and he used one of his empty ensure bottles as an ashtray. He told me that staff caught him smoking in his room and told him he can't do that. I talked to him about the dangers of smoking around oxygen and he acknowledged that the oxygen could cause an explosion. He said that he only smoked in his room on two separate occasions and said that he will not smoke in the home again. I asked him if he has any cigarettes of lighters on him right now and he said that staff has them.

The home manager, Ellen Porter confirmed that Resident A has been caught smoking in his room. She said that he went through a period in August 2021 where he was caught smoking in his room but then stopped until he started up again in October 2021. She said that she personally caught him smoking in his room on two occasions and believes other staff caught him smoking in his room an additional five times or so. According to Ms. Porter, Resident A was last caught smoking in the facility on 10/16/21. She said that on 10/26/21, Resident A had a lighter and cigarettes on him but when staff asked for them, he gave them up.

Ms. Porter confirmed that Resident A was recently given a restriction in his IPOS which states that he is not to have smoking materials on his person, so staff keeps Resident A's smoking materials in staff areas only. However, Resident A still goes on community outings, and he has been known to purchase smoking items without staff knowledge. Therefore, if staff sees smoking paraphernalia on him and he refuses to give it to them,

staff must call his guardian and ask her to come over and take the items from him. Ms. Porter also confirmed that Resident A was given a 30-day notice on 10/26/21. Ms. Porter stated that Resident A is prescribed oxygen at nighttime, but he is usually non-compliant.

On 10/28/21, I received AFC documentation from the facility regarding Resident A. I reviewed Resident A's IPOS dated 6/01/21. The plan did not have any statements or recommendations about Resident A smoking at the facility or having cigarette paraphernalia on him.

I reviewed a prescription from the Visiting Physicians Association dated 10/12/21. According to the order completed by Barbara Ciesliga, MD Resident A is prescribed "oxygen via nasal cannula at night while sleeping at 2liter/min setting on his oxygen concentrator."

I reviewed his IPOS Safeguard Plan dated 10/12/21. According to the plan, "(Resident A) requires oxygen at night to treat his COPD and maintain his physical health stability. Due to safety concerns regarding the use of oxygen and fire (Resident A's cigarette lighter) his oxygen concentrator will be kept in a safe, designated area until required to use at night. Staff will obtain (his) lighter when he goes to his room for the night. Staff will maintain lighter on their person to access for (him) when he wants to smoke. Staff will then bring oxygen concentrator to (his) room, assist him in using oxygen and monitor him throughout the night. When (he) awakes in the morning, staff will remove (his) oxygen concentrator from his room and place it in designated safe area. Staff will then give (him) his lighter back for the day."

According to Resident A's Assessment Plan dated 10/20/21, "Staff are to hold all smoking materials and to give a cigarette and light for him per his request."

I reviewed staff progress notes from 8/22/21 through 8/28/21 and from 10/15/21 through 10/26/21. According to the notes, staff caught Resident A smoking in his bedroom on 8/27/21 twice on 8/28/21, 10/15/21 and 10/18/21. Staff also found cigarettes and a lighter in his room on 10/21/21 and 10/26/21.

I reviewed his LLP treatment plan dated 10/21/21 with an implementation date of 10/26/21 and a target date of 11/03/21. According to this document, "(Resident A) will maintain safe smoking practices. He will engage in zero incidences of unsafe smoking for 12 consecutive months. Unsafe smoking is defined as smoking in unauthorized areas. The restriction includes denying access to cigarettes and lighters/lighting materials; requiring all cigarettes to be lit by staff when (he) is in an approved smoking area; staff maintaining possession of all cigarettes."

On 11/18/21, I interviewed home manager, Ellen Porter via telephone. I asked her if Resident A's oxygen tank was in his room during daytime hours on 10/12/21. She said that she did not receive Resident A's Safeguard Plan regarding his oxygen use until 10/18/21. On 10/20/21, Resident A went to the hospital. He returned on 10/21/21 at

approximately 3:00am. EMS staff settled Resident A in his room and hooked him up to his oxygen. When 1st shift staff came on duty on 10/21/21 they did leave the oxygen tank in Resident A's room. 2nd shift staff left the oxygen tank in his room as well. Ms. Porter said that this is the only time that Resident A used his oxygen and staff was not familiar with the new restrictive plan. She said that she has since trained staff about the restrictive plan and Resident A's oxygen tank is removed from his room during daytime hours.

On 11/18/21, I conducted an exit conference with Holly Yates who is filling in for Laura Hatfield-Smith while she is on leave. I discussed the results of my investigation and explained which rule violation I am substantiating. Ms. Yates agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(3) A licensee and direct care staff who are responsible for implementing the resident's written assessment plan shall be trained in the applicable behavior intervention techniques.
ANALYSIS	According to staff notes, Guardian A1, home manager Ellen Porter, licensee designee Laura Hatfield-Smith, and Resident A, Resident A was caught smoking in his bedroom on more than one occasion. Resident A's original IPOS dated 6/01/21 did not address unsafe smoking behaviors. His Safeguard Plan dated 10/12/21 states that staff are to take his lighter at nighttime Resident A's LLP Treatment Plan dated 10/21/21 states that staff is to keep all smoking materials away from Resident A. On 10/12/21, Resident A was prescribed 2liters of oxygen to be administered at nighttime. Resident A's IPOS Safeguard Plan dated 10/12/21 states that his oxygen tank should be kept in a safe place during the daytime and only brought into his room at night.

	Guardian A1 said that on 10/21/21, she found Resident A's oxygen tank in his room even though it was during the day and staff did not seem aware of the restrictions. Home manager, Ellen Porter said that Resident A's oxygen tank was in his room during daytime hours on 10/12/21 because EMS staff hooked him up when returning from the hospital and 1st and 2nd shift staff did not remove it. During my unannounced inspection on 10/28/21, I did not see Resident A's oxygen tank in his room. On 10/28/21, Resident A told me that staff does not keep his oxygen tank in his room during the day and will bring it in to his room at nighttime. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Susan Hutchinson   November 18, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton   November 18, 2021

Mary E Holton Area Manager	Date