STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 11, 2022

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

RE: License #: AS730311060
Investigation #: 2022A0576015
ResCare Premier McCarty

Dear Ms. Hatfield-Smith:

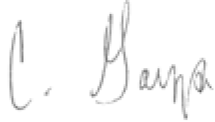
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



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 #:	AS730311060
Investigation #:	2022A0576015
Complaint Receipt Date:	12/17/2021
Investigation Initiation Date:	12/17/2021
Report Due Date:	02/15/2022
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 McCarty
Facility Address:	3475 Hospital Road, Saginaw, MI 48603
Facility Telephone #:	(989) 791-7883
Original Issuance Date:	03/30/2011
License Status:	REGULAR
Effective Date:	10/26/2021
Expiration Date:	10/25/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Home Manager, Danielle Lane did not ensure that Resident A was seen by a mental health professional in a timely manner resulting in Resident A not receiving a new script for his Seroquel XR 150mg tablets. Resident A has been out of Seroquel XR 150mg tablet since receiving his last dose on the evening of 11/30/2021 at 8:00pm.	Yes

III. METHODOLOGY

12/17/2021	Special Investigation Intake 2022A0576015
12/17/2021	Special Investigation Initiated - Letter Email sent to Ardis Bates, Shiawassee County Office of Recipient Rights (ORR)
12/20/2022	Contact - Document Received Email received from Ardis Bates
12/20/2022	Contact - Document Received Reviewed Incident Reports (IR)
01/25/2022	Inspection Completed On-site Interviewed Staff, Latoya Brooks, and Resident A
02/10/2022	Contact - Telephone call made Left message for Home Manager, Danielle Lane to return call
02/10/2022	Contact - Telephone call made Interviewed Davina McCaskey, Program Coordinator
02/10/2022	Exit Conference Exit Conference conducted with Licensee Designee, Laura Hatfield-Smith
02/11/2022	APS Made referral to Adult Protective Services (APS)

ALLEGATION:

Home Manager, Danielle Lane did not ensure that Resident A was seen by a mental health professional in a timely manner resulting in Resident A not receiving a new script for Seroquel XR 150mg tablets. Resident A has been out of Seroquel XR 150mg tablet for at least 2 weeks.

INVESTIGATION:

On December 17, 2022, I sent an email to Ardis Bates, Shiawassee County Office of Recipient Rights (ORR) regarding this investigation. On December 20, 2022, Ms. Bates reported Resident A missed 17 doses of 2 medications (Seroquel XR 150mg and Paxil 30mg).

On December 20, 2022, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated for December 15, 2022, and authored by Davina McCaskey. The IR documented that "MAR was reviewed and noticed Resident A has been out of Seroquel XR 150mg since 12/1/2022 and Paxil 30mg." Corrective measure include monitoring and manager will be disciplined for not ensuring the medications were in the home.

On January 25, 2022, I completed an unannounced on-site inspection at ResCare Premier McCarty and interviewed Staff, Latoya Brooks. Regarding the allegations, Ms. Brooks reported Resident A did not receive his needed medication for at least a week due to not having any refills of the medication. Ms. Brooks explained Resident A needed to see his doctor and had a couple appointments scheduled however the appointments were missed. For one appointment, Resident A was taking long to get ready and there was traffic, resulting in the appointment being missed. There was also a problem with the guardian not attending an appointment with Resident A, which was required. Resident A was out of the medication for at least a week and the Program Coordinator, Davina McCaskey was able to work things out.

On January 25, 2022, I interviewed Resident A who reported he has lived at is home since March 7, 2019. Resident A reported he is doing fine and his home fine. Resident A reported he has depression, and he needs medications. Resident A was not sure what medications he takes. Resident A reported staff treat him well and denied any current concerns.

On February 10, 2022, I called Home Manager, Danielle Lane. There was no answer, and I left a message requesting a return call.

On February 10, 2022, I interviewed Program Coordinator, Davina McCaskey regarding the allegations. Ms. McCaskey reported she was at the home on December 15, 2022, completing a routine monthly review of facility paperwork. The medication administration records (MAR) were reviewed and she discovered Resident A had not been receiving 2 medications, Seroquel XR 150mg and Paxil 30mg since December 1, 2022, due to not having refills. Ms. McCaskey explained Resident A was in the process

of being transferred over from Shiawassee County to Saginaw County for services and his previous doctor had written enough medication orders for him to be seen by Saginaw County. Resident A had an initial doctor appointment set for September 22, 2022, in Saginaw County however the guardian canceled. A second appointment was set for November 3, 2022, however the guardian missed this appointment. A third appointment was set for November 18, 2022, however Resident A and the home manager, Danielle Lane was 20 minutes late so Resident A was unable to been seen. No other appointment was made, and Resident A ultimately ran out of 2 medications on December 1, 2022. Ms. Lane nor any staff alerted Ms. McCaskey that Resident A had run out of his medications, and she did not discover the medication errors until she reviewed the MAR on December 15, 2022. No one completed IR's indicating medication errors, which would have alerted her that there was a problem, and no one contacted the doctor to advise Resident A was out of his needed medications. When Ms. McCaskey discovered the error, she contacted Resident A's doctor from Shiawassee County, and he wrote an order for Resident A to obtain his medications.

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.
	It was alleged that Resident A was not seen by his doctor for needed medication prescriptions resulting in him being without a medication for several days. Upon conclusion of investigative interviews and review of IR's, there is a preponderance of evidence to conclude a rule violation. Resident A did not receive 2 medications, Seroquel XR 150mg and Paxil 30mg from December 1, 2022, through December 15, 2022, due to facility staff not ensuring timely medical appointments with his doctor so medication orders could be obtained. Resident A had 3 doctor appointments set however he did not make any of these appointments. 2 appointments were missed due to the guardian and 1 appointment was missed due to facility staff not ensuring Resident A got to the appointment on time. No other appointment was made, and

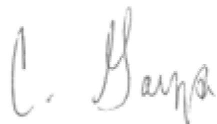
ANALYSIS:	staff did not communicate to anyone that there was a problem with Resident A not seeing the doctor, that he did not have any refill orders, or that he had run out of his medications. Staff did not attend to Resident A's personal needs and safety at all times as they did not ensure required medical appointments and current doctor orders for medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	It was alleged that Resident A was without needed medications, and no one had been in contact with his doctor to report the medication errors. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Resident A did not receive 2 medications, Seroquel XR 150mg and Paxil 30mg for over 2 weeks and staff did not contact Resident A's doctor to report the medication errors during this time. The medication errors were discovered due to a routine review of medication administration sheets (MARS) by the program coordinator, Davina McCaskey who was then able to secure new orders for the needed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 10, 2022, I conducted an Exit Conference with Licensee Designee, Laura Hatfield-Smith. I advised Mrs. Hatfield-Smith I would be requesting a corrective action plan with regards to the cited rule violations.

IV. RECOMMENDATION

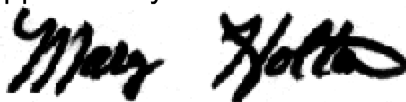
Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.



2/11/2022

Christina Garza — Date
Licensing Consultant

Approved By:



2/11/2022

Mary E Holton — Date
Area Manager