GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

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

RE: License #:	AS250294097
Investigation #:	2022A0123056
	ResCare Premier Clinton

Dear Ms. Hatfield-Smith:

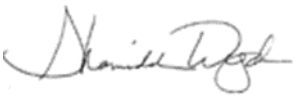
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

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 #:	AS250294097
Investigation #:	2022A0123056
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/08/2022
Report Due Date:	11/07/2022
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 Clinton
Facility Address:	16020 Jennings Road Fenton, MI 48430
Facility Telephone #:	(810) 750-1370
Original Issuance Date:	02/28/2008
License Status:	REGULAR
Effective Date:	08/19/2020
Expiration Date:	08/18/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was discharged from the hospital on 09/01/2022. At the time of discharge his previous medications had been discontinued, and two new medications were ordered. The facility passed Resident A's discontinued medication, Lybalvi 30 mg, for four days after the medication was discontinued.	Yes

III. METHODOLOGY

09/08/2022	Special Investigation Intake 2022A0123056
09/08/2022	Special Investigation Initiated - Letter
09/08/2022	APS Referral APS referral completed.
09/12/2022	Contact - Document Sent I sent an email to Complainant 1 requesting a call back.
09/12/2022	Contact - Telephone call received I spoke with Complainant 1 via phone.
09/20/2022	Inspection Completed On-site I conducted an unannounced on-site visit.
09/28/2022	Contact - Telephone call made I interviewed staff Waunice Gray via phone.
09/30/2022	Exit Conference I spoke with licensee designee Laura Hatfield-Smith via phone.
10/07/2022	Contact- Document Received I received a copy of Resident A's 30-day discharge notice.

ALLEGATION: Resident A was discharged from the hospital on 09/01/2022. At the time of discharge his previous medications had been discontinued, and two new medications were ordered. The facility passed Resident A's discontinued medication, Lybalvi 30 mg, for four days after the medication was discontinued.

INVESTIGATION: On 09/12/2022, I spoke with Complainant 1 via phone. Complainant 1 stated the following:

A staff person reported that Resident A refused to take his medications, and it was discovered that the refused med had been discontinued. The facility's home manager said that staff only retrieved a few pages of Resident A's discharge paperwork, so staff were not aware of the medication change, and staff passed the discontinued medication for four nights. Resident A refuses to share medical information sometimes, and he is his own guardian. Resident A was discharged with clear instructions, but he did not provide the information to staff.

On 09/20/2022, I conducted an unannounced on-site visit at the facility. I interviewed home manager Lateisha Davis, Resident A, and Resident A's Genesee Health System (GHS) psychologist Marcus McKee, LLP.

Staff Davis reported that Resident A had refused to give staff his discharge paperwork and scripts. When he did hand them over, she faxed the pharmacy the paperwork. She stated that Resident A can be uncooperative and does not like to pay his medication co-pays.

Mr. McKee stated that the home did not receive a copy of the discharge paperwork. Resident A does not have a guardian and was being difficult fighting about it with the home manager. He stated that Resident A only handed staff the first page of the discharge paperwork. He stated that Resident A was fighting with Staff Davis about handing over the scripts, the hospital and pharmacy had different script information, and no one was communicating with the facility or GHS. He stated that Resident A's resistance to communicating with providers is what led him to being hospitalized, as he was off his medication due to refusing to allow the medications from the pharmacy to be delivered. Mr. McKee stated that Resident A is court ordered to take his medication, and he was not stable when he was discharged from the hospital. He stated that Resident A was only compliant with his medication about three to four days before he was discharged and was not provided appropriate psychiatric treatment.

Resident A was interviewed stated that his diagnosis and medications changed. He stated that he returned back to the facility via Your Ride and gave his discharge paperwork to staff Waunice Gray. He stated that Staff Gray saw his new scripts the night he returned home. He denied that he took the discontinued medication at all after he returned home from the hospital. Resident A does not have a guardian.

On 09/20/2022, during the on-site visit, I received a copy of Resident A's *Assessment Plan for AFC Residents* dated 08/03/2022. The assessment plan under *Moves Independently in the Community* states "*not approved for LOA's; follow NGRI contract*." A copy of Resident A's LLP Treatment Plan dated 10/13/2021 states that he "*does not have any stipulations in his ALS contract against unsupervised access to the community during the day*". For medications it notes that "*staff will administer and monitor*." A copy of Resident A's medication administration records was reviewed. Per the documentation, it appears that Resident A was passed the Lybalvi

20-10 Mg tablet at bedtime September 1st, 3rd, 4th, and 5th. Staff initials are circled for 09/02/2022, which indicates the medication was not passed. D/C (discontinued) is written on the medication administration record after 09/05/2022. The Aripiprazole 10 mg (Abilify) script has staff initials circled for September 1st through September 3rd, 2022, which indicates the medication was not passed. The start date for the script is 09/01/2022.

On 09/28/2022, I interviewed staff Waunice Gray via phone. She reported that Resident A returned from the home via Your Ride, and only provided her with one page of the discharge paperwork. She stated she asked Resident A if any of his medications changed and if there was more paperwork, and he told her no. She stated that the facility usually gets a call from the hospital asking for pharmacy information, but the facility did not receive that call. She stated that Resident A changes his medications with the pharmacy directly and does not tell staff of the changes. Staff Gray also stated that Resident A will change his mind about a medication, says the med does not work, and will refuse to take it. She stated that Resident A has exhibited this behavior since 07/20/2021 when he moved into the facility. She stated that Resident A is currently refusing some of his medication.

On 10/07/2022, I received a faxed copy of Resident A's 30-day discharge notice from the facility due to the facility stating they can no longer meet his needs due to Resident A not cooperating/participating in the programming process.

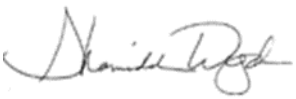
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	On 09/12/2022, Complainant 1 reported that Resident A was passed his discontinued Lybalvi 20-10 mg tablets for four days after the medication was discontinued after a hospital stay. Staff Lateisha Davis reported that Resident A refused to give staff his discharge paperwork and scripts the day he arrived back to the facility. Resident A's psychologist Marcus McKee, LLP reported that Resident A did not provide a copy of the paperwork regarding his medications to staff. Resident A denied the allegations.

	Staff Waunice Gray reported that Resident A did not provide her with all of his discharge paperwork and that Resident A denied that he had any medication changes. Resident A's medication administration records confirm he was passed his discontinued Lybalvi 30 mg tablets for four days post the discontinuation date. There is a preponderance of evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/30/2022, I conducted an exit conference with licensee designee Laura Hatfield-Smith. I informed her of the findings and conclusion.

IV. RECOMMENDATION

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

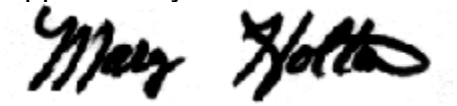


10/10/2022

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



10/10/2022

_____

Mary E. Holton Date
Area Manager