GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

Julianne Krissinger
ResCare Premier, Inc.
Suite 1A
6185 Tittabawassee
Saginaw, MI 48603

RE: License #: AS580264465
Investigation #: 2024A0116022
ResCare Premier Milan

Dear Ms. Krissinger:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580264465
Investigation #:	2024A0116022
Complaint Receipt Date:	02/08/2024
Investigation Initiation Date:	02/08/2024
Report Due Date:	04/08/2024
Licensee Name:	ResCare Premier, Inc.
Licensee Address:	9901 Linn Station Road Louisville, KY 40223
Licensee Telephone #:	(989) 791-7174
Administrator:	Julianne Krissinger, Board Member
Licensee Designee:	Julianne Krissinger, Board Member
Name of Facility:	ResCare Premier Milan
Facility Address:	288 Anderson Milan, MI 48160
Facility Telephone #:	(734) 439-8672
Original Issuance Date:	07/01/2004
License Status:	REGULAR
Effective Date:	01/01/2023
Expiration Date:	12/31/2024
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

I. ALLEGATION(S)

	Violation Established?
Program manager and licensee designee, Melissa Hasler is alleged to have verbally abused Resident A by yelling, using profanity, and antagonizing him. This occurred in front of three staff and a resident.	Yes
Medications are not being properly disposed.	Yes

II. METHODOLOGY

02/08/2024	Special Investigation Intake 2024A0116022
02/08/2024	Special Investigation Initiated - Telephone Left a message for Rita Doss, acting program manager.
02/09/2024	Contact - Telephone call made Interviewed staff, Beckie Urbance.
02/09/2024	Contact - Telephone call made Interviewed Executive Director, Rita Doss.
02/09/2024	Contact - Telephone call made Interviewed former licensee designee, Melissa Hassler.
02/09/2024	Contact - Telephone call made Interviewed staff, Samantha Libby.
02/14/2024	APS Referral Received.
02/15/2024	Inspection Completed On-site Interviewed Residential Manager and Resident A, spoke with Rita Doss and reviewed medication area/room.
02/15/2024	Inspection Completed-BCAL Sub. Compliance

02/29/2024	Exit Conference With Julianne Krissinger, Board Member.

ALLEGATION:

Program manager and licensee designee, Melissa Hasler is alleged to have verbally abused Resident A by yelling, using profanity, and antagonizing him. This occurred in front of three staff and a resident.

INVESTIGATION:

On 02/09/24, I interviewed staff, Beckie Urbance, and she reported that she was terminated yesterday 02/08/24, for an unrelated matter. Ms. Urbance reported that she was one of the staff on shift on 12/20/23 when the incident took place. Ms. Urbance reported that Resident A acts as if no rules apply to him and there has been an ongoing issue with him continuing to take food and beverages in his room which has caused a rodent issue. Ms. Urbance reported that on 12/20/23 she asked Resident A not to take his drink in his bedroom and he told her if anyone has an issue with it, they can speak with him directly. Ms. Urbance reported that she informed the licensee designee, Melissa Hasler, that Resident A was not following the house rules and asked if she could come upstairs and speak with him. Ms. Urbance reported that Ms. Hassler came upstairs and went to speak with Resident A in his bedroom. Ms. Urbance reported Ms. Hassler and Resident A came out of his bedroom and they were arguing back and forth. She reported that Resident A was screaming at the top of his lungs and Ms. Hassler was yelling back at him. Ms. Urbance reported that she does not recall if Ms. Hassler was using profanity or threatening language. She reported that it was intense, and her focus shifted to moving the knives, and hard objects out of the way as she was worried that Resident A may attack Ms. Hassler. Ms. Urbance reported that Ms. Hassler went back to the basement and on her way down Resident A picked up a chair and attempted to throw it down the stairs at her. Ms. Urbance reported things eventually calmed down and Ms. Hassler contacted management to inform them of the matter.

On 02/09/24, I interviewed executive director, Rita Doss, and she reported that she was not in the home when the incident occurred. Ms. Doss reported once aware of the incident, the company had an outside company's compliance and ethics department complete an investigation into the matter and that investigation confirmed that licensee designee, Ms. Hassler, verbally abused Resident A resulting in her termination on 02/08/24. Ms. Doss reported that staff Beckie Urbance was also terminated on 02/08/24 on an unrelated matter. Ms. Doss reported that she will serve as the new licensee designee and administrator and is preparing all of the required paperwork so that she can be credentialed for the positions.

On 02/09/24, I interviewed former licensee designee and administrator, Melissa Hassler. Ms. Hassler reported that on 12/20/23, she was asked by staff Beckie Urbance, to come upstairs to speak to Resident A as he was continuing to take food and beverages in his bedroom. Ms. Hassler reported that this is prohibited due to it causing a rodent issue. Ms. Hassler reported that she went in Resident A's bedroom to speak with him and asked him to bring the energy drink out of his room and to consume it in the kitchen. Ms. Hassler reported that Resident A was not listening so she took the can from the dresser and proceeded to walk out of the bedroom. She reported Resident A began yelling and screaming at her and then grabbed her arm. Ms. Hassler reported that she asked Resident A to take his hands off her and reported that he obliged. Ms. Hassler admitted that she raised her voice at Resident A after several attempts of re-direction were unsuccessful. Ms. Hassler denied using

profanity and threatening Resident A. Ms. Hassler reported that she then went downstairs to her office and reported that Resident A attempted to throw a kitchen chair at her. Ms. Hassler reported that a few minutes later Resident A came down to her office and apologized to her for his actions. Ms. Hassler reported that she was suspended pending further investigation and was terminated yesterday 02/08/24.

On 02/15/24, I conducted a scheduled onsite inspection and interviewed residential manager, Alyssa Olds, Resident A and spoke with Rita Doss. Ms. Olds reported that she was present in the home on 12/20/23, when the incident occurred and gave a similar account of the incident as provided by Ms. Urbance and Ms. Hassler. Ms. Olds added that Ms. Hassler was screaming and yelling and going back and forth with Resident A instead of not engaging him. Ms. Olds reported that she was trying to calm Ms. Hassler and Resident A down but was unsuccessful. She reported that Ms. Hassler told her, “I’m ok, it’s not like he intimidates me.” Ms. Olds reported that Ms. Hassler was antagonizing Resident A threatening to call his treatment team and get him kicked out of the house and out of the program. She reported that Ms. Hassler was using profanity at Resident A and was totally out of character. Ms. Olds reported that things finally calmed down after Resident A attempted to throw a chair at Ms. Hassler as she went back downstairs to her office. Ms. Olds reported that it was a stressful and tense interaction.

I interviewed Resident A and he reported that on 12/20/23, Ms. Hassler came in his room and grabbed his monster energy drink out of his hand after he refused to take it in the kitchen. Resident A reported that he grabbed it back from her, and Ms. Hassler begins to get louder and is in a screaming match with him. Resident A reported that Ms. Hassler yelled at him and said, “No fucking food or drink in your room.” He said he replied, “It’s a stupid fucking rule.” Resident A reported that it was a long drawn out back and forth between the two of them that got totally out of control. Resident A reported that he could have handled the situation better and admitted that the following day he went downstairs and apologized to Ms. Hassler, who also apologized to him. Resident A reported nothing like this had ever happened between he and Ms. Hassler he hates that she was terminated behind this.

I spoke briefly with Ms. Doss who reported they have terminated three employees, 2 were not directly related to this incident and reported they are getting things back in order in the facility. Ms. Doss reported they are hiring and hoping to fill the open positions with quality candidates.

On 02/29/24, I conducted the exit conference with Julianne Krissinger, board member, and informed her of the findings of the investigation and the rule violation. Ms. Krissinger reported an understanding and stated that the issues cited in the report have already been rectified.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Urbance, Ms. Hassler, Ms. Olds and Resident A, I am able to corroborate the allegations. Ms. Urbance and Ms. Olds both observed the incident and reported that Ms. Hassler was yelling at and arguing with Resident A because he refused to go into the kitchen to finish his drink. Ms. Olds added that Ms. Hassler was using profanity toward Resident A, was antagonizing him and threatening to have him kicked out of the home. Ms. Hassler admitted to raising her voice at Resident A but denied using profanity or threats to kick him out of the home and program. Resident A reported that Ms. Hassler was yelling at him, grabbed his drink from his hand and used profanity during the incident. This violation is established as Ms. Hassler, during her interaction with Resident A subjected him to verbal abuse and made threats to have him kicked out of the program and the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are not being properly disposed.

INVESTIGATION:

On 02/09/24, I interviewed staff, Beckie Urbance and she reported that she was asked by Ms. Hassler and Ms. Olds to be the medication coordinator for the home. Ms. Hassler reported it was unofficial as she did not receive the title or an increase in pay for the additional responsibilities of the job. Ms. Urbance reported that she did her best to help with organizing and keeping the medication cabinet together but admitted it was overwhelming as there were bags of expired medications that were over six years old. Ms. Urbance reported that she disposed of a lot of the expired medications but was never granted the time to focus solely on getting the medication room together. Ms. Urbance reported she was working the floor taking care of residents. Ms. Urbance reported that the expired medications still stored in the home was an issue before she was hired.

On 02/09/24, I interviewed executive director, Rita Doss, and she reported that during the ethics investigation, it was determined that Beckie Urbance, medication coordinator, had not properly disposed of expired medications, creams and other over the counter medications. Ms. Doss reported that was the only concern found as it related to residents' medications. Ms. Doss reported that all of the expired medications have since been properly disposed.

On 02/09/24, I interviewed licensee designee and administrator, Melissa Hassler, and she reported that Ms. Urbance was not and did not properly dispose of expired prescription medications, over the counter medications and topicals. Ms. Hassler reported that she is aware that those medications have now been properly disposed.

On 02/15/24, I conducted a scheduled onsite inspection and interviewed residential manager, Alyssa Olds. Ms. Olds confirmed that former staff, Beckie Urbance, was the medication coordinator and failed to properly dispose of the expired prescription medications, as well as the over-the-counter medications and topicals.

I visually observed the medication room where the residents' medications are stored and locked. All of the medications were neatly stored in bins labeled by resident and current. There were no expired medications observed.

On 02/29/24, I conducted the exit conference with Julianne Krissinger, board member, and informed her of the finding of the investigation and rule violation cited. Ms. Krissinger reported an understanding.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Urbance, Ms. Hassler and Ms. Olds I am able to corroborate the allegations. Ms. Urbance, Ms. Olds and Ms. Hassler all admitted there were expired medications that had not been properly disposed of that were being stored in the medication room. During the onsite inspection, I visually observed the medication room and did not observe any expired medication. The area was neat, clean and nicely organized. Ms. Olds confirmed that all of expired medications had recently been properly disposed.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

02/29/2024
Date

Approved By:

02/29/2024

Ardra Hunter
Area Manager

Date