



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

November 15, 2024

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

RE: License #: AS250413361  
Investigation #: 2025A0576006  
ResCare Premier Neff Rd

Dear Laura 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.
- 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,

A handwritten signature in cursive script, appearing to read "C. Garza".

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**

<b>License #:</b>	AS250413361
<b>Investigation #:</b>	2025A0576006
<b>Complaint Receipt Date:</b>	10/29/2024
<b>Investigation Initiation Date:</b>	10/31/2024
<b>Report Due Date:</b>	12/28/2024
<b>Licensee Name:</b>	ResCare Premier, Inc.
<b>Licensee Address:</b>	9901 Linn Station Road, Louisville, KY 40223
<b>Licensee Telephone #:</b>	(989) 791-7174
<b>Administrator:</b>	Laura Hatfield-Smith
<b>Licensee Designee:</b>	Laura Hatfield-Smith
<b>Name of Facility:</b>	ResCare Premier Neff Rd
<b>Facility Address:</b>	8358 Neff Rd, Mt. Morris, MI 48458
<b>Facility Telephone #:</b>	(810) 687-6820
<b>Original Issuance Date:</b>	01/31/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/31/2023
<b>Expiration Date:</b>	07/30/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	Violation Established?
For 2 consecutive days, Staff Tamara Players failed to take Resident A's blood pressure (BP) before administering Resident A's blood pressure medication. The medication is given depending on BP results.	Yes

## III. METHODOLOGY

10/29/2024	Special Investigation Intake 2025A0576006
10/31/2024	Special Investigation Initiated - Letter Sent email to Michelle Salem, Genesee County Office of Recipient Rights (ORR)
10/31/2024	Contact - Document Received Received email from Michelle Salem
11/08/2024	Inspection Completed On-site Interviewed Resident A and Staff Jorell Moore
11/14/2024	Contact - Document Received Viewed Resident A's vital record
11/15/2024	Contact - Telephone call made Interviewed Staff Tamara Players
11/15/2024	APS Referral
11/15/2024	Exit Conference

### ALLEGATION:

For 2 consecutive days, Staff Tamara Players failed to take Resident A's blood pressure (BP) before administering Resident A's blood pressure medication. The medication is given depending on BP results.

## INVESTIGATION:

On October 31, 2024, I sent an email to Michelle Salem, Genesee County Office of Recipient Rights (ORR) Investigator regarding who the staff person was that made the alleged error and any updates she can provide. Investigator Salem advised Staff Tamara Players did not take Resident A's blood pressure prior to administering his blood pressure medication. It is ordered that Resident A is to have his blood pressure taken prior to his blood pressure medication being administered as the administering of the medication is dependent on what Resident A's blood pressure is.

On November 8, 2024, I conducted an unannounced on-site inspection at ResCare Premier Neff Rd and interviewed Resident A regarding the allegations. Resident A reported that staff forgot to take his blood pressure. Resident A could not recall who the staff person was that forgot to take his blood pressure. Resident A reported he is to have his blood pressure taken before he is given his blood pressure medication. Resident A reported he was okay after taking his blood pressure medication even though his blood pressure was not taken.

On November 8, 2024, I interviewed Staff Jorell Moore regarding the allegations. Staff Moore reported there was a new staff person filling in at the home and she missed taking Resident A's blood pressure before giving him his blood pressure medication. Resident A takes his blood pressure medication, Metoprol Tar 25mg twice per day and staff are to take his blood pressure prior to administering this medication.

On November 8, 2024, I reviewed Resident A's medication administration record (MAR) which revealed Resident A is prescribed Metoprol Tar 25mg twice per day at 8am and 8pm. The MAR indicates the medication is to be held if Resident A's systolic blood pressure is less than 110 or heart rate less than 60.

On November 8, 2024, I viewed an order for Resident A signed by Dr. Lisa Lindsay. The order indicates that Resident A's blood pressure medication is to be held if blood pressure is less than 110/60 or heart rate less than 60.

On November 14, 2024, I viewed Resident A's *vital record* for October 2024. The document did not have a blood pressure or pulse recorded on October 26, 2024, and October 27, 2024, at 8pm.

On November 15, 2024, I interviewed Staff Tamara Players regarding the allegations. Staff Players reported that she was filling in at ResCare Premier Neff Rd. Staff Players reported that she read the MAR wrong and thought she was supposed to check Resident A's blood pressure after Resident A took his blood pressure medication. Resident A was okay, and no harm came to Resident A after Resident A took his blood pressure medication. Staff Players reported that as a result of her error she is in the process of retraining with respect to resident medication administration.

On November 15, 2024, I conducted an Exit Conference with Licensee Designee, Laura Hatfield-Smith. I advised Licensee Smith I would be requesting a corrective action plan for the cited rule violation. Licensee Designee advised that the staff member involved has been disciplined and will be retrained.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<p><b>(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:</b></p> <p><b>(a) Medications.</b></p>
<b>ANALYSIS:</b>	<p>It was alleged that Resident A is required to have his blood pressure checked prior to receiving his blood pressure medication and staff failed to take his blood pressure before administering the medication. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation.</p> <p>Staff Tamara Players was interviewed and confirmed that she failed to take Resident A's blood pressure prior to administering his blood pressure medication. Staff Players reported she read Resident A's MAR incorrectly and thought she was supposed to take Resident A's blood pressure after administering the BP medication. I viewed Resident A's doctor order from Lisa Lindsay which indicates Resident A's blood pressure medication is to be held if blood pressure is less than 110/60 or heart rate less than 60. I viewed Resident A's <i>vital record</i> for October 2024. The document did not have a blood pressure or pulse recorded on October 26, 2024, and October 27, 2024, at 8pm.</p> <p>There is a preponderance of evidence to conclude Resident A's health care instructions with respect to medications was not followed.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



11/15/2024

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Christina Garza  
Licensing Consultant

Date

Approved By:



11/15/2024

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Mary E Holton  
Area Manager

Date