GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 20, 2025

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

RE: License #:	AS250300908
Investigation #:	2025A0872024
	ResCare Premier Holly

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.
- 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 (517) 643-7960.

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 #:	2025A0872024
Complaint Receipt Date:	02/03/2025
Investigation Initiation Date:	02/04/2025
Report Due Date:	04/04/2025
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:	02/03/2024
Expiration Date:	02/02/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
In December 2024, staff Danisha Williams stayed in the movie theater while Resident A and Resident B went outside to smoke. Both residents require staff supervision while in the community.	Yes

III. METHODOLOGY

02/03/2025	Special Investigation Intake 2025A0872024
02/03/2025	Referral - Recipient Rights This complaint was referred by RRO. Kim Nguyen-Forbes is the RRO.
02/04/2025	Special Investigation Initiated - Letter I exchanged emails with RRO Nguyen-Forbes
02/04/2025	APS Referral I made an APS complaint via email
02/12/2025	Inspection Completed On-site Unannounced
02/14/2025	Contact - Document Sent I emailed the home manager requesting information related to this complaint
02/17/2025	Contact - Document Received AFC documentation received regarding this complaint
03/20/2025	Contact - Telephone call made I interviewed staff Danisha Williams
03/20/2025	Exit Conference I conducted an exit conference with the licensee designee, Laura Smith
03/20/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: In December 2024, staff Danisha Williams stayed in the movie theater while Resident A and Resident B went outside to smoke. Both residents require staff supervision while in the community.

INVESTIGATION: On 02/12/2025, I conducted an unannounced onsite inspection of ResCare Premier Holly Adult Foster Care facility. I interviewed Resident A, Resident B, and the home manager (HM), Brittany Hamilton.

I interviewed Resident A and Resident B at the kitchen table in the facility. I reviewed the allegations with them, and they admitted that they obtained marijuana while at the movies with staff. Resident A and Resident B told me that while at the movie theater, they told staff Danisha Williams that they were going to the bathroom. Resident B said that while they were in the bathroom, someone came up to him and gave him some marijuana. After leaving the bathroom, they went outside and smoked a cigarette as well as smoking some of the weed they were given. Resident B said that approximately one week later, HM Hamilton found the pipe with the marijuana in it and found out what they had done.

Resident A confirmed that he requires staff supervision while in the community and said that staff is supposed to always have him in their sight.

Resident B said that he is allowed to move independently in the community if he tells staff when and where he is going and when he will be back.

HM Hamilton said that Resident A requires line of sight while in the community and although Resident B requires staff supervision, he is allowed to check in and out with staff while in the community. HM Hamilton confirmed that during a community outing on 12/17/24, staff Danisha Williams and another staff took the residents to a movie. During the movie, Resident A and Resident B told Staff Williams that they were going outside to smoke a cigarette. After they were gone for several minutes, Staff Williams went to check on them. Staff Williams found them and noted that they were acting different. When they all returned to the AFC facility, Resident A and Resident B kept trying to go around the side of the house. Approximately one week later, HM Hamilton found a pipe with marijuana in it. Resident B eventually admitted that while at the movie theater, he and Resident B got the marijuana from someone they knew who was also at the movie theater.

On 03/20/25, I reviewed AFC paperwork related to this complaint. According to Resident A's Health Care Appraisal and diagnosis. I reviewed Resident A's Genesee Health System's (GHS) Individualized Plan of Service (IPOS) dated 06/20/24. According to this document, "AFC staff and (Resident A) are together while in the community at all times."

According to Resident B's Health Care Appraisal, and diagnosis. I reviewed Resident B's GH's IPOS dated 08/25/24. According to this document, "AFC staff should know where (Resident B) is at all times. If at any time they are unsure of his location while in

the community, they should conduct a check. Once located, AFC staff needs to assess his mental state and mood. If there is anything that he needs and to ensure he is safe in the community. If not found, AFC staff needs to call 911 immediately, then inform guardian and case manager within 24 hours. Along with following the AFC community policy."

On 03/20/2025, I interviewed staff Danisha Williams via telephone. According to Staff Williams, in December 2024 she took Resident A and Resident B on an outing to the movie theater. Staff Williams had to go to the bathroom so she told both residents to stay in their seats and she would be right back. Staff Williams told me that when she got back to the theater, both residents were gone. Staff Williams began looking for them and found them outside. Resident A was in the facility van and Resident B was walking toward the van. Staff Williams stated that she got in the van with them, and they returned to the facility. Staff Williams told me that she later found out that Resident A and Resident B somehow obtained marijuana while they were at the movie theater.

I asked Staff Williams what the supervision requirements for Resident A and Resident B. Staff Williams said that Resident A is required to be in line-of-sight of staff and staff is supposed to know the whereabouts of Resident B. I asked Staff Williams if she received any disciplinary action from this incident and Staff Williams stated that she received a written warning. Staff Williams told me that she has not left any of the residents unattended since that time.

On 03/20/2025, I conducted an exit conference with the licensee designee (LD), Laura Smith via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Smith agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	According to the home manager, Brittany Hamilton, Resident A, Resident B, staff Danisha Williams, Resident A's GHS IPOS, and Resident B's GHS IPOS, Resident A and Resident B require staff supervision while in the community. Staff Danisha Williams said that in December 2024, she left Resident A and Resident B in the movie theater unattended while she went to the bathroom. When Staff Williams returned, both residents were gone. Staff Williams found both residents outside, in the facility van.

	I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

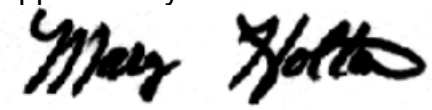
IV. RECOMMENDATION

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

March 20, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



March 20, 2025

Mary E. Holton Area Manager	Date