GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 21, 2022

Jennifer Hescott
Provision Living at East Lansing
6300 Abbot Road
East Lansing, MI 48823

RE: License #:	AH330403275
Investigation #:	2023A1021004
	Provision Living at East Lansing

Dear Ms. Hescott:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330403275
Investigation #:	2023A1021004
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/12/2022
Report Due Date:	12/10/2022
Licensee Name:	AEG East Lansing Opco, LLC
Licensee Address:	1610 Des Peres Rd. St. Louis, MO 63131
Licensee Telephone #:	(314) 272-4980
Administrator:	Wendy Mehan
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at East Lansing
Facility Address:	6300 Abbot Road East Lansing, MI 48823
Facility Telephone #:	(517) 275-9916
Original Issuance Date:	07/08/2022
License Status:	TEMPORARY
Effective Date:	07/08/2022
Expiration Date:	01/07/2023
Capacity:	126
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility failed to inform Resident A's family of fall.	Yes
Facility is not ensuring Resident A is eating.	No
Additional Findings	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A1021004
10/12/2022	Special Investigation Initiated - Letter referral sent to APS
10/12/2022	Contact - Telephone call made interviewed complainant by telephone
10/13/2022	Inspection Completed On-site
10/14/2022	Contact-Telephone call made Interviewed Careline Hospice nurse Katie Haviland
10/14/2022	Contact-Document received Received documents from the facility
11/21/2022	Exit Conference Exit conference with authorized representative Jennifer Hescott

ALLEGATION:

Facility failed to inform Resident A's family of fall.

INVESTIGATION:

On 10/11/22, the licensing department received a complaint with allegations the facility failed to inform Resident A's family and hospice company of falls.

On 10/12/22, I interviewed the complainant by telephone. The complainant alleged Resident A's hospice company came to the facility on 10/5 and Resident A had a black eye. The complainant alleged the staff members working that day had no

report of a fall or knowledge of how the Resident got a black eye. The complainant alleged Resident A had a fall on 9/25/22 and the hospice company was not notified. The complainant alleged Resident A's family was also not notified of these falls.

On 10/12/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 10/13/22, I interviewed facility administrator Wendy Mehan at the facility. Ms. Mehan reported Resident A is in the memory care unit and has a diagnosis of dementia. Ms. Mehan reported Resident A had a fall on 10/4/22 and she was not notified of the fall. Ms. Mehan reported Resident A was found on the floor in her bedroom with no injuries. Ms. Mehan reported the director of nursing (DON) emailed Careline Hospice. Ms. Mehan reported the medication technician working the floor attempted to call Careline Hospice, but the telephone number was incorrect. Ms. Mehan reported the medication technician reported she did call and left a message with Resident A's family. Ms. Mehan reported the DON did not follow facility protocol by appropriately notifying family, hospice, and facility administrator. Ms. Mehan reported the DON has been terminated. Ms. Mehan reported the facility provided education to the medication technician on informing the administrator if there is an issue with contacting appropriate parties on incidents. Ms. Mehan reported Resident A's family and hospice company reported Resident A had a fall on 9/25/22, but staff members did not report that she had a fall. Ms. Mehan reported the facility has no documentation or knowledge of a fall on 9/25/22. Ms. Mehan reported the facility has re-educated staff on incident reporting and there is a medication technician meeting for next week on notifying appropriate people.

On 10/13/22, I interviewed regional nurse Katie Johnson at the facility. Ms. Johnson reported when a resident falls, the caregiver is to check for injuries and check vitals. Ms. Johnson reported if the resident hits their head, emergency medical services (EMS) is to be contacted. Ms. Johnson reported the caregiver is to contact the resident's authorized representative, administrator, and hospice, if applicable. Ms. Johnson reported the facility has Forsite monitoring system that monitors residents' activity in their room. Ms. Johnson reported the facility will review the system to implement appropriate interventions to prevent future falls.

On 10/13/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported she was working on 10/4/22 when Resident A fell. SP1 reported she was in the medication room with the DON, and they heard a bump. SP1 reported they found Resident A on the floor in the common area. SP1 reported she completed the observation form. SP1 reported she attempted to contact Careline Hospice, but the company said they did not have the resident on service and hung up on her. SP1 reported Resident A's face sheet did not have the authorized representative telephone number on it. SP1 reported the DON reported she would contact the appropriate parties. SP1 reported a few weeks prior to this, Resident A was on the floor in her apartment and rolled over and hit her head on the nightstand. SP1 reported she was provided this information during shift change.

On 10/13/22, I observed Resident A at the facility. Resident A had a significant black eye.

On 10/14/22, I interviewed Careline Hospice nurse Katie Haviland by telephone. Ms. Haviland reported on 9/25/22, the DON emailed her reporting Resident A had a fall, hit her head, neuro checks were normal, and the resident had a laceration. Ms. Haviland reported she emailed the DON back reporting to call the office for a nurse assessment and provided the telephone number for the branch. Ms. Haviland reported she also provided education to the DON that emailing her is not appropriate notification. Ms. Haviland reported the DON emailed back questioning if a nurse did need to come out. Ms. Haviland reported she emailed back and reported that a nurse needed to be contacted because Resident A had a fall and did have an injury. Ms. Haviland reported she sent this correspondence to her shift supervisor. Ms. Haviland reported on 10/3/22, she received an email from the DON reporting the telephone number was incorrect. Ms. Haviland reported on 10/4/22, she visited Resident A at the facility and Resident A had a large bump and bruising around her eye. Ms. Haviland reported she interviewed all caregivers working and no staff member was aware of a fall or injury. Ms. Haviland reported she spoke with Ms. Mehan and Ms. Mehan had no knowledge of a fall. Ms. Haviland reported she contacted Resident A's family to inform her of the visit and Resident A's family had no knowledge of a fall or injury.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Interviews conducted revealed Resident A had at least two falls at the facility and the facility failed to contact the resident's authorized representative and physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility is not ensuring Resident A is eating.

INVESTIGATION:

The complainant alleged Resident A is not woken up for meals and has weight loss.

Ms. Mehan reported the facility offers three meals a day and snacks are available. Ms. Mehan reported if a resident is sleeping during a meal, caregivers will provide the meal when they wake up. Ms. Mehan reported Resident A wakes up late and does not eat a big breakfast. Ms. Mehan reported Resident A does come out for lunch and dinner. Ms. Mehan reported Resident A loves sandwiches and tends to eat finger foods. Ms. Mehan reported residents are weighed monthly and there has not been a weight decrease.

SP1 reported Resident A will sleep through breakfast but caregivers will provide cereal once she wakes up. SP1 reported she will eat lunch with the other residents. SP1 reported Resident A likes sandwiches and finger foods. SP1 reported the facility does ensure Resident A is eating.

On 10/13/22, I interviewed SP2 at the facility. SP2 reported Resident A's appetite has increased and she is eating more than she used to. SP2 reported Resident A typically does not eat breakfast but the facility will ensure that she eats some cereal. SP2 reported Resident A tends to eat sandwiches and other finger foods.

Ms. Haviland reported Resident A is provided meals at the facility. Ms. Haviland reported Resident A does not eat breakfast but will eat lunch and dinner with the other residents. Ms. Haviland reported she has observed Resident A during mealtimes at the facility and Resident A eats most of the food provided to her.

I reviewed Resident A's weight records. On 7/22/22, Resident A weighed 107 pounds. On 10/13/22, Resident A weighed 115 pounds.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Interviews conducted and document review revealed lack of evidence to support the allegation facility does not provide Resident A meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

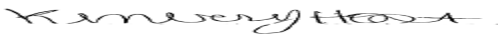
The facility could not provide any incident reports for Resident A's falls.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional. (d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
For Reference: R.325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Resident A sustained injuries due to the falls at the facility. The facility failed to complete an incident report on the falls.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/21/22, I conducted an exit conference with authorized representative Jennifer Hescott by telephone.

IV. RECOMMENDATION

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



10/14/22

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Kimberly Horst — Date
Licensing Staff

Approved By:

11/15/2022

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Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section