GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2022

Jennifer Hescott
Provision Living at Fenton
440 N. Fenway Drive
Fenton, MI 48430

RE: License #: AH250405635
Investigation #: 2023A1027016
Provision Living at Fenton

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250405635
Investigation #:	2023A1027016
Complaint Receipt Date:	11/17/2022
Investigation Initiation Date:	11/18/2022
Report Due Date:	01/17/2023
Licensee Name:	AEG Fenton Opco, LLC
Licensee Address:	Ste 385 1610 Des Peres Rd. St. Louis, MO 63131
Licensee Telephone #:	(517) 294-0534
Administrator:	Michael Scully
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at Fenton
Facility Address:	440 N. Fenway Drive Fenton, MI 48430
Facility Telephone #:	(810) 936-2807
Original Issuance Date:	05/26/2022
License Status:	REGULAR
Effective Date:	11/26/2022
Expiration Date:	11/25/2023
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	Yes
Additional Findings	No

III. METHODOLOGY

11/17/2022	Special Investigation Intake 2023A1027016
11/18/2022	Special Investigation Initiated - Letter Email sent to Administrator Michael Scully and AR Jennifer Hescott requesting Resident A's admission contract, face sheet, service plan, October and November 2022 nurse/chart notes, and the discharge letter
11/21/2022	Contact - Document Received Email received from Mr. Scully with requested documentation
12/13/2022	Contact - Telephone call made Telephone interview conducted with administrator Mr. Scully. Requested Resident A's chart notes.
12/16/2022	Contact – Document Received Email received from Ms. Scully with requested documentation
12/16/2022	Inspection completed - BCAL Sub. Compliance
12/20/2022	Exit Conference Conducted with authorized representative Ms. Hescott by voicemail

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 11/17/2022, the department received a complaint forwarded from Adult Protective Services (APS) which read Resident A had dementia and resided in the facility's memory care. The complaint read Resident A became agitated and aggressive grabbing two staff members. The complaint read staff called law enforcement. The complaint read it was believed the staff did not know what to do so

they called law enforcement stating that Resident A had suicidal ideations. The complaint read it is not believed that Resident A expressed suicidal ideations.

On 12/13/2022, I conducted a telephone interview with administrator Michael Scully. Mr. Scully stated Resident A moved into the assisted living with his spouse on 10/31/2022. Mr. Scully stated Resident A was exit seeking upon admission to the facility and after multiple conversations with his family, they had agreed for Resident A to transfer to the memory care for his safety on 11/3/2022. Mr. Scully stated on 11/3/2022, Resident A became aggressive with staff and other residents as well as expressed suicidal ideations. Mr. Scully stated staff attempted to provide re-direction to Resident A without success. Mr. Scully stated Relative A2 was on-site at the same time in which she had also tried to provide re-direction to Resident A without success and agreed to have him transferred to the hospital. Mr. Scully stated he and the marketing director discussed with Relative A2 that Resident A could not return to the facility. Mr. Scully stated he did not provide Relative A2 with a discharge notification letter. Mr. Scully stated the hospital physician attempted to have Resident A return however he had continued to have behaviors at the hospital and the facility declined for him to return. Mr. Scully stated Resident A passed away at the hospital on hospice services.

I reviewed Resident A's face sheet which read he admitted to the facility on 10/31/2022. The face sheet read Resident A's emergency contacts were Relative A1 and A2.

I reviewed Resident A's admission contract dated 10/31/2022 and signed by Relative A1. The admission contract read in part:

A Provision Living Community resident may be transferred or discharged if:

1. *The Resident has harmed himself or herself or others or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others unless the Community has the capacity to manage the Resident's behavior.*

A Community may discharge a Resident before the 30-day notice if the Community has determined and documented that either or both of the following exist:

1. *Substantial risk to the Resident due to the inability of the Community to meet the Residents' needs, or*
2. *Due to the inability of the Community to assure the safety and well-being of the Resident, other Residents, visitors, or staff of the Community.*

The Community will take the following steps before discharging the Resident:

1. *The Community shall notify the Resident and /or authorized representative and the agency responsible for the Resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing.*

2. *The discharge notice will include all of the following information:*
    a. *The reason for the proposed discharge, including the specific nature of the substantial risk.*
    b. *The alternatives to discharge that have been attempted by the Community, if any.*
    c. *The location to which the Resident will be discharged.*
    d. *The right of the Resident to file a complaint with the Department.*

I reviewed Resident A's service plan dated 10/31/2022 which read in part Resident A had occasional confusion and some difficulty recalling details, needed occasional prompting or orientation. The plan read Resident A had behaviors that were non-compliant/refusals.

I reviewed incident reports submitted to the Department dated 10/31/2022 and 11/3/2022 for Resident A which read consistent with statements from Mr. Scully. Report dated 11/3/2022 read in part Resident A had become physically aggressive with Employee #1 in which he grabbed her right arm twice and punched her in the chest. The report read Resident A attempted to hit another resident. The report read Resident A stated he wanted to kill himself by walking out in front of a car. The report read Employee #2 stepped in to help keep redirect the other residents to keep them safe. The report read Mr. Scully notified [Relative A2] in the facility at that time visiting her mother that he would be emergent discharge in which 911 was contacted. The report read Resident A2 went to the hospital with him.

I reviewed Resident A's progress notes dated 10/31/2022 and 11/3/2022 which read consistent with statements from Mr. Scully and Resident A's incident reports.

I reviewed a document signed by Mr. Scully and dated 11/21/2022 titled *NOTICE OF AN INVOLUNTARY TRANSFER OR DISCHARGE which read in part:*

> *[Resident A] was discharged to Ascension Genesys Hospital on 11/3/2022. Administrator and Director of Sales had conversation w/ daughter [Relative A2] that he could no longer reside at Provision. He was discharged due to his violent behavior and multiple interventions to redirect without any success.*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.**
For Reference: **R 325.1922**	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	Review of facility documentation revealed Resident A had behaviors in which risked the safety and welfare of himself and other residents. The facility's discharge policy read consistent with Resident A's discharge; however written notification of Resident A's discharge was not provided to his authorized representatives. Based on this information, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/16/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

12/19/2022

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