GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2023

Jennifer Hescott
Provision Living at Livonia
33579 8 Mile Road
Livonia, MI 48152

RE: License #: AH820405630
Investigation #: 2023A1027065
Provision Living at Livonia

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 represent 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 877-458-2757.

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 #:	AH820405630
Investigation #:	2023A1027065
Complaint Receipt Date:	05/01/2023
Investigation Initiation Date:	05/01/2023
Report Due Date:	07/03/2023
Licensee Name:	AEG Livonia Opco, LLC
Licensee Address:	Ste 385 1610 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 272-4980
Authorized Representative/ Administrator:	Jennifer Hescott
Name of Facility:	Provision Living at Livonia
Facility Address:	33579 8 Mile Road Livonia, MI 48152
Facility Telephone #:	(615) 630-3376
Original Issuance Date:	03/09/2022
License Status:	REGULAR
Effective Date:	09/09/2022
Expiration Date:	09/08/2023
Capacity:	58
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	No
Additional Findings	Yes

III. METHODOLOGY

05/01/2023	Special Investigation Intake 2023A1027065
05/01/2023	Special Investigation Initiated - Letter Email sent to administrator Tangie Garner requesting the following documentation: Resident A's face sheet and service plan, Employee #1's background check and training records, and the facility's incident report and abuse policy
05/03/2023	Contact - Document Received Email received from Ms. Garner with requested documentation
05/16/2023	Contact - Document Sent Email sent to Ms. Hescott and Ms. Nagle informing them some of the requested documentation was not received from Ms. Garner and provided a list of documentation needed
05/17/2023	Contact - Document Received Email received from Ms. Nagle with requested information and documentation
05/19/2023	Inspection Completed-BCAL Sub. Compliance
05/26/2023	Exit Conference Conducted by voicemail, then by email with authorized representative Ms. Hescott

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 5/1/2023, the Department received a complaint forwarded from Adult Protective Services (APS) which read on 04/28/2023, Resident A was aggressive, and Employee #1 “swatted her hands and grabbed her wrists.” The complaint read Employee #1 was forceful with Resident A. The complaint read Resident A did not require medical care and did not have any marks or bruises. The Complaint read Employee #1 was suspended pending an investigation by the facility. The complaint read APS did not open an investigation and their referral source was the facility’s administrator.

I reviewed Resident A’s face sheet which read in part she admitted to the facility on 11/21/2022.

I reviewed Resident A’s service plan dated 11/21/2022 which read she resided in memory care. The plan read in part Resident A’s diagnoses were dementia, mental health issues, and depression. The plan read in part Resident A required regular prompting due to confusion and disorientation. The plan read in part Resident A had active behavioral issues in which staff were to use a calm and gentle approach.

I reviewed the incident report for Resident A dated 4/28/2023. The report read the administrator was informed by two care staff that Resident A had a physical and verbal altercation with Employee #1. The incident report read video footage was observed in which Employee #1 was assisting another resident when Resident A became physically aggressive towards Employee #1. The report read Employee #1 took Resident A by the upper arms and forced her away from another resident. The report read Employee #1 was removed from the memory support area, her statement was obtained, and she was suspended until an investigation was completed. The report read Resident A was assessed, no injuries were observed on 4/28/2023 but reassessment on 5/2/2023 showed yellow bruising on both upper arms. The report read on 4/28/2023, Resident A’s physician, designated representative, APS, and Livonia Police Department were all notified. The report read Employee #1 was terminated.

I reviewed a copy of a Livonia Police Department card dated 5/1/2023 which read in part the service number was 23-18210 and was signed by the police officer.

I reviewed Employee #2’s written witness statement which read consistent with the incident report and that she informed the executive director.

I reviewed Employee #3’s written witness statement which read consistent with the incident report.

I reviewed Employee #1’s new hire information form which read in part she was hired on 1/12/2023.

I reviewed Employee #1’s training records which read she signed resident rights and responsibilities on 12/22/2022.

I reviewed the facility's abuse policy which read in part:

> "When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution or disciplinary action against the employee. The administrator and/or the nursing supervisor or designee will relay this suspension. At that time, the alleged staff member will be advised of the allegation and encouraged to assist in completing a statement relevant to the facts. The employee shall be instructed that the suspension is without pay and will be in effect as long as the investigation is ongoing. The investigation and due process rights of the alleged perpetrator/s will be observed. If days missed that the employee was originally scheduled to work. If the allegation is substantiated, the employee will be terminated."

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.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Review of the facility's abuse policy revealed it was consistent with actions taken by the facility to ensure Resident A's protection. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/17/2023, email correspondence with the regional operations director read there was one training record for Employee #1. The training record read Employee #1 reviewed and signed resident rights and responsibilities on 12/22/2022.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Employee #1's file lacked training records consistent with this rule, thus a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/17/2023, email correspondence with the regional operations director read she was unable to locate a workforce background check for Employee #1.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all of the following: **(i) Criminal background information, consistent with MCL 333.20173.**
ANALYSIS:	Employee #1's file lacked criminal background information; thus, a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/19/2023

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Jessica Rogers Date
Licensing Staff

Approved By:

05/26/2023

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