GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 16, 2023

Jennifer Hescott
Provision Living at St. Joseph
3351 Niles Road
St. Joseph, MI 45069

RE: License #: AH110405636
Investigation #: 2024A1028006
Provision Living at St. Joseph

Dear Jennifer 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 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH110405636
Investigation #:	2024A1028006
Complaint Receipt Date:	10/16/2023
Investigation Initiation Date:	10/17/2023
Report Due Date:	12/15/2023
Licensee Name:	AEG St Joseph Opco, LLC
Licensee Address:	Ste 385 1610 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 272-4980
Administrator:	Eric Hiemstra
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at St. Joseph
Facility Address:	3351 Niles Road St. Joseph, MI 45069
Facility Telephone #:	(269) 247-5635
Original Issuance Date:	03/09/2022
License Status:	REGULAR
Effective Date:	09/09/2023
Expiration Date:	09/08/2024
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A demonstrated stroke like symptoms and was not sent to the hospital by facility staff in a timely manner.	No
The facility is short staffed.	Yes
Pills were found in an unknown resident's room several times.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/16/2023	Special Investigation Intake 2024A1028006
10/17/2023	Special Investigation Initiated - Letter
10/17/2023	APS Referral APS referral made to Centralized Intake
11/07/2023	Contact - Face to Face Interviewed facility Admin/Eric Hiemstra at the facility.
11/07/2023	Contact - Face to Face Interviewed Employee A at the facility.
11/07/2023	Contact - Face to Face Interviewed Employee B at the facility.
11/07/2023	Contact - Face to Face Interviewed Employee C at the facility.
11/07/2023	Contact - Face to Face Interviewed Employee D at the facility.
11/07/2023	Contact - Face to Face Interviewed Resident A at the facility.
11/07/2023	Contact - Document Received Received resident records and staff documentation from Admin/Eric Hiemstra.

ALLEGATION:

Resident A demonstrated stroke like symptoms and was not sent to the hospital by facility staff in a timely manner.

INVESTIGATION:

On 10/16/2023, the Bureau received the allegations anonymously through the online complaint system.

On 10/16/2023, an Adult Protective Services (APS) referral was made to Centralized Intake.

On 11/7/2023, I interviewed facility administrator, Eric Hiemstra, at the facility, who reported Resident A recently demonstrated weakness and some stoke like symptoms on 10/16/2023 and was sent to the hospital for further evaluation. Mr. Hiemstra admitted there was some confusion among the new staff working that day about whether to call 911 but 911 was called in a timely manner by the lead supervisor. New staff were re-educated on emergency policies and procedures that day and an in-service was provided two days later for all staff as well to ensure competency. Mr. Hiemstra reported Resident A has a prior history of seizures and is monitored routinely due to health history. Resident A returned from the hospital the same day with no new diagnosis and staff continued routine monitoring. Mr. Hiemstra provided me with Resident A's record and in-service documentation for my review.

On 11/7/2023, I interviewed Employee A, Employee B and Employee C at the facility and their statements were consistent with Mr. Hiemstra's statements.

On 11/7/2023, I reviewed Resident A's record which revealed the following:

- Has a diagnosis of Parkinson's disease, muscle wasting, GERD, anxiety disorder, major depressive disorder, type II diabetes etc.
- Resident B demonstrates impulsivity, confusion and disorientation resulting in poor judgement.
- Has a history of falls.
- Demonstrates some noncompliance with use of call light.
- Was sent to the hospital on 10/16/2023 due to demonstrating weakness and unresponsiveness.

I reviewed the in-service documentation for all staff which was held on 10/18/2023. No concerns were noted.

I also observed Resident A being assisted by staff appropriately and later in the common area. Resident A was clean and content and no concerns were noted.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	It was alleged Resident A demonstrated stroke like symptoms on 10/16/2023 and was not sent to the hospital in a timely manner. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. Resident A was sent to the hospital on 10/16/2023 and returned the same day with no new diagnosis. Also, to ensure competency of all staff, the facility held an in-service on resident emergency protocols and procedures on10/18/2023. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 11/7/2023, Mr. Hiemstra reported the facility is not short staffed, but call-ins do occur. There are currently several new hires onboarding at the facility. If a call-in occurs, float staff, on-call staff, and/or management will assist to prevent a shift shortage, but the facility has had to work short in the recent past due to staff not being able to fill a call-in shift shortage. There are 45 residents in the facility with one medication tech and two caregivers scheduled for first and second shifts in assisted living. There are two caregivers assigned to the memory care unit on first and second shifts. There are two caregivers and a float staff scheduled for third shift for both assisted living and the memory care unit. Currently, no medications are passed on third shift in assisted living or the memory care unit. Mr. Hiemstra reported if a medication were required to be passed to a resident on third shift, then a medication tech would be scheduled for third shift. Mr. Hiemstra provided the working staff schedules for my review.

On 11/7/2023, Employee A confirmed call-ins are still occurring but there is float staff, on-call staff, and management to assist to cover the call-in. However, despite float staff, on-call staff, and management assisting to cover call-ins, the facility is short staffed, and shift shortages are still occurring due either the number of call-ins for a shift or due to float staff or on-call staff being unable to come in and assist to prevent shift shortages. Employee A confirmed there is one medication tech and two caregivers assigned to assisted living for first and second shifts. The memory care unit has two caregivers assigned during first and second shifts. However, third shifts have one caregiver assigned to assisted living and one assisted to the memory care unit with a third staff member that floats between the assisted living and memory care unit. Employee A reported second shift and third shift have the most call-ins and there needs to be two staff members in the memory care unit during third shift for appropriate assisting of residents and for safety. Employee A reported there have also been times when care was not completed for residents or not completed in a timely manner due to call-ins and a shift being left short without coverage.

On 11/7/2023, Employee B's statements and Employee C's statements were consistent with Employee A's statements.

On 11/7/2023, I reviewed the working staff schedules from September 2023 to November 2023 which revealed multiple call-ins across all shifts from September 2023 to November 2023. It also revealed the working staff schedules demonstrated on-call staff, float staff, and management assisting to cover the shift shortages, but there were 47 shifts that were not covered and/or that were short.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	It was alleged the facility is short staffed. Interviews, on-site investigation, and review of documentation reveal that while there are on-call staff, float staff, and management to assist when a call-in occurs and to help prevent a shift shortage, there were multiple shifts that were not covered from September 2023 to November 2023. It was also revealed that while there are two care staff members working in the memory care unit for first and second shifts, there is only one care staff member working third shift in the memory care unit with an additional staff member floating between assisted living and the memory care unit. The facility cannot provide appropriate care in accordance with the service plans and/or appropriate safety and supervision of residents with impaired cognition with one care staff member in the memory care unit during third shift. Appropriate care, safety, and supervision cannot be provided for residents when call-ins occur and there is no available staff to cover the call-in to prevent a shift shortage. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Pills were found in an unknown resident's room several times.

INVESTIGATION:

On 11/7/2023, Mr. Hiemstra reported no knowledge of any pills being found in any resident's room on the floor. He reported if this were to occur, the pills would be destroyed, an investigation would be opened, and an incident report would be completed. Mr. Hiemstra reported staff that administer medication are supposed to ensure medication is swallowed by the residents. Mr. Hiemstra reported no residents or families have many any complaints about medication being found on the floor of any resident's room. Mr. Hiemstra provided me Resident B's and Resident C's medication administration record (MAR) for my review.

On 11/7/2023, Employee A reported knowledge of residents being administered medication late for Resident B and Resident C as recently as 11/6/2023. Employee A also reported knowledge of medications found on the floor of resident rooms 107 and room 127 within the past three weeks but could not provide an exact date. Employee A reported the medications were destroyed immediately and it was reported to the shift supervisor. Employee A reported [they] are unsure if the shift supervisor passed the incident information along to upper management as the shift

supervisor recently exited employment at the facility. Employee A reported [they] are unsure if an incident report and/or documentation was completed about the incident because it did not occur on [their] shift.

On 11/7/2023, Employee B's statements and Resident C's statements were consistent with Employee A's statements.

On 11/7/2023, I interviewed Employee D at the facility who confirmed resident medications were administered late on 11/6/2023 for second shift due to the shift being short staffed.

On 11/7/2023, I interviewed Resident B at the facility who reported [their] medications were late on 11/6/2023 and the medications have been routinely late when Employee D administers medications. Resident A reported [they] have no other concerns about the facility but would like their medications to be administered in a timely manner.

On 11/7/2023, I reviewed Resident B's MAR which revealed the following:

- A full set of vitals is to be recorded once every month on the first Monday of each month; and PRN for a change in condition in blood pressure. The physician is to be notified of Systolic Blood Pressure (SBP) > 160 < 80; Heart Rate (HR) is < 55 > 100; Pulse Oxygen (OX) is < 90%; Weight within +/- 5lbs from previous month.
- No vitals were obtained on 11/6/2023, which is the first Monday of the month. There is also no documentation Resident B refused the vital check.

I reviewed Resident C's MAR which revealed the following:

- Resident C's blood sugar is to be checked before breakfast and prior to breakfast and prior to bed.
- On 10/29/2023, the MAR is blank for bedtime blood sugar check. The reason documented is "Not administered: Other comment: prior shift." It cannot be determined if Resident C's blood sugar was checked or if it was checked on the prior shift due to the blank record.

No documentation could be provided or was found pertaining to the allegation of medication found on the floor of resident room 107 and 127. The residents of rooms 127 and 107 were not available for interview. There were no concerns when the MARs for resident rooms 107 and 127 were reviewed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
es	**(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.**

ANALYSIS:	It was alleged pills were found in an unknown's resident's room. Interviews, on-site documentation, and review of documentation determined staff interviewed had knowledge that medication was found on the floor of resident rooms 107 and 127. Staff interviewed confirmed the medication was destroyed, and the shift supervisor was notified but it could not be determined if the shift supervisor notified the physician, the resident's authorized representatives, and facility management. Review of the MARs for resident rooms 107 and 127 revealed no concerns, but documentation pertaining to this allegation could not be provided by the facility, despite staff interviews confirming knowledge of the allegation. Review of documentation revealed it was physician ordered that Resident B receive a full vital check to monitor health. Resident B was to receive this the first Monday of each month. Resident B did not receive the vital check as ordered on 11/6/2023. There is also no documentation Resident B refused the vital check. Review of documentation also revealed it was physician ordered that Resident C's blood sugar was to be checked before breakfast and prior to breakfast and prior to bed every day. On 10/29/2023, the MAR is blank for bedtime blood sugar check. The reason documented is "Not administered: Other comment: prior shift." It cannot be determined if Resident C's blood sugar was checked or if it was checked on the prior shift due to the blank record. Facility staff did not follow physician orders for Resident B or Resident C. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 11/7/2023, I requested documentation pertaining to Resident A's hospital visit and documentation concerning the medication found in resident rooms 107 and 127. The facility was unable to provide any documentation and Mr. Hiemstra reported no incident report was completed concerning Resident A's incident on 10/16/2023 which resulted in Resident A being sent to the hospital for weakness and unresponsiveness.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
ANALYSIS:	No incident report was completed or maintained by facility staff to demonstrate incident reporting for Resident A's hospital visit on 10/16/2023. No incident report or documentation within the resident record was completed pertaining to medications found on the floor of resident rooms 107 and room 127 during October 2023 to November 2023, despite facility staff demonstrating knowledge about this incident. The facility must complete and maintain incident reports and documentation for review by the facility quality program team.
CONCLUSION:	**VIOLATION ESTABLISHED**

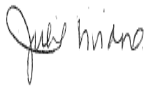
On 11/7/2023, Mr. Hiemstra reported no incident report was completed pertaining to Resident A's hospital visit on 10/16/2023. It cannot be verified if facility staff appropriately notified Resident A's authorized representative or designated health care professional.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Facility staff must report an incident within 48 of the occurrences to resident's authorized representative or designated health care professional and this communication must be documented in the record as well. Due to no incident report being completed by facility staff pertaining to Resident A's hospital visit on

	10/16/2023, it cannot be determined if the residents' authorized representative(s) and/or designated health professional(s) was notified of the hospital visit. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



11/16/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/02/2024

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