GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 9, 2024

Jennifer Hescott
Provision Living at Forest Hills
730 Forest Hill Avenue
Grand Rapids, MI 49546

RE: License #: AH410381380
Investigation #: 2023A1010085
Provision Living at Forest Hills

Dear Licensee

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 (616) 356-0183.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410381380
Investigation #:	2023A1010085
Complaint Receipt Date:	09/08/2023
Investigation Initiation Date:	09/08/2023
Report Due Date:	11/08/2023
Licensee Name:	PVL at Grand Rapids, LLC
Licensee Address:	Suite 310 1630 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 909-9797
Administrator:	Jamie Palma
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at Forest Hills
Facility Address:	730 Forest Hill Avenue Grand Rapids, MI 49546
Facility Telephone #:	Unknown
Original Issuance Date:	06/04/2019
License Status:	REGULAR
Effective Date:	06/04/2023
Expiration Date:	06/03/2024
Capacity:	116
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility would not allow Resident A to return to the facility from the hospital on 9/8/23.	Yes

III. METHODOLOGY

09/08/2023	Special Investigation Intake 2023A1010085
09/08/2023	Special Investigation Initiated - Telephone Interviewed AR by telephone
09/08/2023	Contact - Telephone call received Interviewed assigned Kent Co APS worker Bryan Kahler by telephone
09/08/2023	Contact - Document Received Received resident's petition for mental health treatment
09/08/2023	Contact - Document Received Interviewed facility's authorized representative by telephone
09/19/2023	Inspection Completed On-site
09/19/2023	Inspection Completed On-site
09/19/2023	Contact - Document Received Received resident service plan and staff progress notes
01/09/2024	Exit Conference

ALLEGATION:

The facility would not allow Resident A to return to the facility from the hospital on 9/8/23.

INVESTIGATION:

On 9/8/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “[Resident A] abuses alcohol and was petitioned by staff member at Provision Living for a mental health evaluation. [Resident A] does not meet the criteria for mental health services. She was medically cleared to return to the facility. The staff member are refusing to allow her to return. They are refusing to

house her because of her alcohol abuse and belligerent behavior when she is intoxicated."

On 9/8/23, I received a telephone call from the facility's authorized representative Jennifer Hescott. Ms. Hescott reported Resident A was transported to the hospital yesterday because she was intoxicated. Ms. Hescott stated Resident A has a history of intoxication and being non-compliant with care staff at the facility. Ms. Hescott reported Resident A's room at the facility is also very dirty and hazardous because she will not allow housekeeping staff in to clean it.

Ms. Hescott reported for these reasons, and because Resident A threatened to "kill" the facility's administrator Jamie Palma yesterday, Resident A will not be permitted to return to the facility. Ms. Hescott said Resident A was given a less than 30-day discharge notice yesterday. Ms. Hescott said Resident A was given three previous 30-day discharge notices due to her behavior, however the facility was unable to find an alternative placement. Ms. Hescott reported there were no other facilities who would admit Resident A due to her alcohol abuse and behavioral issues.

Ms. Hescott stated Resident A left the hospital against medical advice today. Ms. Hescott reported Resident A allegedly reported she was going to go to Arizona. Ms. Hescott said Resident A is her own decision maker, however she has a court appointed limited guardian.

Ms. Hescott provided me with a copy of Resident A's less than 30-day discharge notice for my review. The notice was dated 9/7/23. The notice read, "This letter is to inform you that Provision Living Forest Hills is formally providing you with a 30 day discharge notice to vacate your apartment by October 7th, 2023. Due to continued drinking and behavior that creates an unsafe environment for yourself and our residents, we are no longer able to provide the care you need. We will provide a copy of any records you need and help facilitate placement in an environment that will better meet your needs should you require assistance to do that."

On 9/8/23, I interviewed assigned Kent County Adult Protective Services (APS) worker Bryan Kahler by telephone. Mr. Kahler reported he interviewed Resident A at the hospital this morning. Mr. Kahler stated Resident A did leave the hospital today against medical advice. Mr. Kahler reported he did observe Resident A exhibit behavioral issues while she was in the hospital, such as refusing to allow hospital staff to change her when she was incontinent. Mr. Kahler said Resident A smelled like urine.

Mr. Kahler reported Resident A told him she was going to Arizona. Mr. Kahler's statements regarding Resident A's guardian were consistent with Ms. Hescott. Mr. Kahler stated staff at the facility petitioned to get Resident A admitted for psychiatric treatment, however the petition was denied. Mr. Kahler said the petition staff at the facility submitted to hospital did not outline "threatening behavior." Mr. Kahler denied knowledge that Resident A threatened to "kill" Ms. Palma.

On 9/19/23, I interviewed Ms. Palma at the facility. Ms. Palma reported Resident A has a court appointed guardian for her finances only, therefore Resident A was still her own decision maker. Ms. Palma said the less than 30 day discharge notice for Resident A was sent to her guardian by staff with the facility's corporate office on 9/7/23.

Ms. Palma's statements regarding Resident A's behavior were consistent with Ms. Hescott. Ms. Palma reported while Resident A was in the hospital on 9/7/23, Resident A called her work cell phone and threatened to "shoot her" when she returned to the facility. Ms. Palma reported this information was not on Resident A's petition for inpatient psychiatric treatment that was submitted to hospital staff because the incident occurred after the petition was submitted. Ms. Palma said an updated petition to include this information was not submitted to the hospital.

Ms. Palma reported Resident A went to several hotels after she left the hospital against medical advice on 9/8/23. Ms. Palma stated Resident A got kicked out of multiple hotels because she got intoxicated and belligerent in the hotel bars. Ms. Palma said to her knowledge, Resident A did not want to return to the facility.

Ms. Palma stated while Resident A resided in the facility, she was able to leave the facility unsupervised. Ms. Palma reported Resident A often signed herself out of the facility to go into the community. Ms. Palma said Resident A had a "paid car service" and would go into the community to purchase alcohol on a regular basis. Ms. Palma reported Resident A also had alcohol delivered to the facility frequently.

Ms. Palma reported because Resident A would not allow staff into her room to clean it, therefore it was unsanitary. Ms. Palma reported most of Resident A's belongings are still in her room. I observed Resident A's room was cluttered, unclean, and had debris strewn about. Resident A's room had a foul odor.

Ms. Palma provided me with a copy of Resident A's August and September staff *Progress Notes* for my review. Notes dated 8/9/23, 9/5/23, and 9/7/23 read Resident A was intoxicated. A note dated 9/7/23 at 2:22 pm read, "Staff requested Nurse to assess resident due to suspicion of being intoxicated. Per staff resident has been consuming large amounts of alcohol over the last 4 days and has fallen, been combative, and refusing personal cares. Upon arrival to room this nurse noted resident sitting in wheelchair alert with slurred speech. When asked, resident admitted to consuming ETOH and stuck up both middle fingers. Resident was having mood swings crying then wanting to hold hands. Resident was swaying side to side in wheelchair and wasn't able to hold head up. Strong smell of urine resonated from resident's peri area and body is unkempt. Resident has been refusing to perform personal cares nor will allow staff to assist. Resident has not been eating meals stated she only ate a piece of bacon today. When asked about alcohol in room resident told nurse 'take what you can find, I don't give a fuck.' Nurse removed four pints of FireBall liquor from room stashed in various cabinets.

Residents room is cluttered with hoarded food and various other items. Clinical staff contacted residents Guardian and PCP to alert of excessive drinking and staff being unable to provide cares or safety. Orders received to transport resident to Butterworth ER with petition for inpatient detox and psych treatment."

A note dated 9/7/23 at 4:49 pm read, "Resident was successfully transported to Butterworth Hospital via Rockford Ambulance. Upon leaving resident asked who was sending her and that 'she would blow their head off' staff noted numerous bottles of meds, creams, and patches that were either prescribed by outside physicians that PCL had no knowledge of or either purchased over the counter. Some of the medications are narcotics, muscle relaxers, and diet medications that should not be mixed with ETOH. This resident does not have a physicians order to self administer medications. It is unknown to staff what meds resident was dosing herself with. Report given to ER nurse and social worker." These notes were written by the facility's director of nursing Shawn Fields.

Ms. Palma provided me with a copy of Resident A's service plan for my review. The *Orientation* section of the plan read, "[Resident A] is able to make her needs known, however she is an active alcoholic and will bring alcohol into the community when she leaves the community. She will order a taxi cab to leave the community. She will become intoxicated in her apartment and will become verbally aggressive with staff when she is intoxicated, she will self harm when intoxicated, she bit herself before and staff had to call emergency services for assistance. [Resident A] does have a pendant and will use it to ask for assistance with laundry, if she is intoxicated she will use pendant to ask for transfer assistance. [Resident A] does resist safety/wellness checks being performed by staff and will put a sign on her apartment door to notify staff not to come in. This usually happens when she is intoxicated. [Resident A] has been sent to ER multiple times after she has fallen while fallen while [sic] intoxicated. Staff have removed many bottles of liquor from [Resident A's] apartment, but she continues to but it. [Resident A's] guardian as well as her financial DPOA are aware of these situations."

The *General* section of Resident A's plan read, "Care staff are to tidy apartment as needed, check for expired food and dispose of. [Resident A] hoards expired food and leaves food out that is required to be refrigerated. Care staff to remove all trash and record and dispose of any alcohol that is found in apartment."

On 9/19/23, I interviewed Ms. Fields at the facility. Ms. Fields' statements were consistent with Ms. Hescott, Ms. Palma, and her written *Progress Notes* for Resident A. Ms. Fields showed me the bottles of alcohol and narcotic medications that were in Resident A's room. Ms. Fields expressed concerns regarding Resident A mixing narcotic and various other medications with alcohol while she was in the facility. Ms. Fields reported staff were not aware Resident A was getting prescriptions from physicians outside of the one she designated while she resided in the facility.

Ms. Fields reported there was no way to ensure Resident A's safety while she resided in the facility due to her behaviors. Ms. Fields stated she wrote and submitted Resident A's petition for psychiatric treatment. Ms. Fields provided me with a copy of Resident A's *PETITION FOR MENTAL HEALTH TREATMENT* document for my review. Section four of the document read, "a. My personal observation of the person doing the following acts and saying the following things: [Resident A] has been consuming large volumes of alcohol over the last 4 days. There is a history of alcoholism and liver disease. [Resident A] has been not eating and refusing personal cares, has been combative with staff and refusing personal care. b. the following conduct and statements that others have seen or heard have told me about: staff reported falls, combativeness, incontinence, hoarding, and refusing to self perform hygiene. Resident is calling cabs to go purchase large amounts of alcohol."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, 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. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(i) A resident does not have an authorized representative or an agency responsible for the resident's placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:**

	(i) The reason for the proposed discharge, including the specific nature of the substantial risk. **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**
ANALYSIS:	The interviews with Ms. Palma, Ms. Fields, Ms. Hescott, along with review of Resident A's staff *Progress Notes* and service plan revealed Resident A had a history of alcohol abuse and noncompliance with staff as a result. The facility identified its inability to ensure Resident A's safety, however the facility did not locate an alternate placement for Resident A. Resident A was not permitted to return to the facility on 9/8/23, however an alternate placement was not found. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licnsee authorized representative Jennifer Hescott on 1/9/24.

IV. RECOMMENDATION

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

10/16/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

01/03/2024

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