GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 16, 2024

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

RE: License #: AH410381380
Investigation #: 2024A1021021
Provision Living at Forest Hills

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 #:	AH410381380
Investigation #:	2024A1021021
Complaint Receipt Date:	12/14/2023
Investigation Initiation Date:	12/14/2023
Report Due Date:	02/13/2024
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 #:	(314) 909-9797
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?
Resident A had undiagnosed urinary tract infection resulting in falls and cognitive decline.	No
Additional Findings	Yes

III. METHODOLOGY

12/14/2023	Special Investigation Intake 2024A1021021
12/14/2023	Special Investigation Initiated - Telephone message left with administrator
12/15/2023	Contact - Telephone call made interviewed administrator
12/19/2023	Contact - Document Received received Resident documents
01/05/2024	Contact-Telephone call made Interviewed complainant
01/05/2024	Contact - Telephone call made interviewed SP1
01/08/2024	Contact - Telephone call made interviewed SP2
01/08/2024	Contact - Telephone call made interviewed SP3
01/12/2023	Contact-Telephone call made Interview conducted with Jennfier White, NP
01/16/2024	Exit Conference

ALLEGATION:

Resident A had undiagnosed urinary tract infection resulting in falls and cognitive decline.

INVESTIGATION:

On 12/14/2024, the licensing department received a complaint with allegations Resident A fell at the facility and suffered three fractured vertebrae. The complainant alleged Resident A had a cognitive decline and had an undiagnosed urinary tract infection (UTI).

On 01/05/2024, I interviewed the complainant by telephone. The complainant alleged Resident A had a rapid decline within a week. The complainant alleged she spoke with Staff Person 1 (SP1) at the facility and requested a urinalysis test be completed to diagnose a potential UTI. The complainant alleged this test was never completed. The complainant alleged that Resident A had a few falls in which she was caught, or the fall had no injury. The complainant alleged on 10/21/2023, Resident A had two falls at the facility. The complainant alleged Resident A reported she laid on the floor for a long time waiting for assistance. The complainant alleged a caregiver tried to get Resident A off the floor and reported the caregiver was hurting her. The complainant alleged it then took two caregivers to get Resident A off the floor. The complainant alleged then Resident A was left on the edge of bed and then was incontinent. The complainant alleged Resident A then went into the hallway and started yelling for assistance. The complainant alleged Resident A then had another fall in her bedroom and appeared to be fine and was taken to lunch. The complainant alleged Resident A was transferred to lunch sitting on her four-wheel walker. The complainant alleged she then came to the facility and observed Resident A to be in pain with a large hematoma on her back. The complainant alleged she observed Resident A's bed to be made but there was urine on the sheets. The complainant alleged the facility attempted to provide Resident A with Tylenol, but family took Resident A to the emergency room. The complainant alleged Resident A was diagnosed with a UTI and three fractured vertebrae and is now wheelchair bound.

On 12/15/2023, I interviewed administrator Jamie Palma by telephone. Ms. Palma reported Resident A was a resident at the facility for approximately two years. Ms. Palma reported prior to Resident A’s discharge, she had started to have a decline. Ms. Palma reported Resident A had a fall at the facility and family transported her to the hospital.

On 01/05/2024, I interviewed staff person 2 (SP2) by telephone. SP2 reported on 10/21/2023, Resident A had two falls. SP2 reported initially Resident A had no pain or injuries due to the fall. SP2 reported within hours after the second fall, Resident A reported back and leg pain and the family transported Resident A to the hospital. SP2 reported Resident A was able to vocalize her needs and wants and there were no concerns about an UTI. SP2 reported Resident A was able to ambulate with her walker but at times staff would push her on the seat of her walker if Resident A got tired while ambulating. SP2 reported when Resident A was traveling longer distances, a manual wheelchair was used. SP2 reported Resident A was active and was seen by the facility physician, Jennifer White. SP2 reported Resident A was

seen by the physician in July and August. SP2 reported after Resident A was transferred to the emergency room, there was a care conference held for Resident A. SP2 reported at that time, Relative A1 reported concerns about SP1 not ordering a urine analysis test for Resident A. SP2 reported SP1 reported she did not recall the request for this test. SP2 reported she was not employed by the facility when this conversation may have occurred and never received any requests from family or physician for a urinalysis test to be completed. SP2 reported Resident A received good care and was well taken care of at the facility.

On 01/05/2024, I interviewed SP1 by telephone. SP1 reported Resident A had started to have a gradual decline due to the aging process. SP1 reported Resident A was unable to sequence events with toileting and showering. SP1 reported she had multiple conversations with Relative A1 regarding Resident A's needs but was never made aware of a request for a urinalysis test. SP1 reported she did not believe Resident A had an undiagnosed UTI as she did not exhibit symptoms of an UTI. SP1 reported Resident A was seen by the house physician and there were no requests for testing.

On 01/08/2024, I interviewed SP3 by telephone. SP3 reported that on 10/21/2023, SP4 requested assistance with Resident A. SP3 reported she observed Resident A to be in her room by her bed and reported she hit her nightstand. SP3 reported herself and another employee assisted Resident A off the floor. SP3 reported Resident A reported no pain and there were no injuries. SP3 reported Resident A was placed in her wheelchair. SP3 reported within a few hours, Resident A reported pain in her back. SP3 reported Relative A1 came to the facility and transported her to the emergency room. SP3 reported she did observe Resident A's bed to be made with dried urine on the bed. SP3 reported Resident A was a check during the night and she is unsure if this check was completed as she does not work third shift.

I reviewed observation notes for Resident A. The notes read,

> *"10/04: Staff was walking resident from room and while on elevator resident began to lose balance. Staff was able to go under resident arms and prevent from falling. Another staff member arrived and helped regain balance. Resident denied pain and had no injuries noted. Will instruct staff to use w/c for distances as needed.*
> *10/06: Staff reported that resident was toileted prior to going to an activity. Resident was ambulating with 4ww and 1x SBA from staff when legs became weak resulting in resident going down to floor. No injuries were noted and resident denied pain. Up with 2x assist ROM WBL and VSS. DON ordered PT/OT with family consent, Fox Therapy to follow. Staff to continue to provide x1SBA when ambulating and use w/c for distances. Also to ask resident when walking if she feels steady.*
> *10/21/23: Per staff call light was activated and upon entering staff noted resident on floor next to bed. When asked staff reports that resident stated she fell out of bed. Staff noted bleeding of elbow from a previous wound. Resident does not*

specific the affected elbow. Per staff report to DON, (Relative A1) was notified of this incident. Per staff report resident denied pain and was assisted to side of bed by x2 staff members. DON instructed staff to monitor for any pain or new injuries. Staff to continue wellness rounds with toileting during night.
10/21/23: per staff resident was in hallway at 1126 in need of assistance. Per staff resident was escorted to room and morning cares were provided. Resident was left in room awaiting meal when call light was activated at 1140. Upon arrival staff noted resident on buttocks near dresser. Per staff resident initially denied any pain or hitting head. Resident was assisted up then c/o back pan. Per staff report resident was taken to dining room for lunch. Resident's daughter later arrived to community and resident had continued c/o back pain. (Relative A1) self-transported resident to Blodgett ER for evaluation and treatment. (Relative A1) notified Jamie Palma ED of incident who then notified DON. Resident is admitted to Blodgett Hospital with compression fx of L-4 and L-5 with UTI, receiving abx treatment."

I reviewed Resident A's service plan. The service plan read,

"is incontinent of bowel and/or bladder and requires staff assistance with all toileting needs." (Resident A) requires a wheeled walker for ambulation for longer distances. Manuel wheelchair for longer distances."

I reviewed the October medication administration record (MAR) for Resident A. The MAR read,

"Assist to toilet at 3:00am." The MAR revealed this was completed 10/01-10/21.
"*Toilet resident and ensure she has a clean and dry liner in her brief every time."* This was completed on 10/01-10/21.

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.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and

	personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and document review, revealed Resident A had a cognitive decline prior to the falls. There is lack of evidence to support the allegation the facility did not complete a urinalysis test.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Encircle documentation for care conference held on 09/27/2023. The documentation read,

> *"Have noticed some cognition changes with bingo and card playing, as well as physical with walking distances and utilizing a wheelchair on outings-provide assistance as needed/wanted. (Resident A) has a decline in cognition. (SP2) will complete a mini mental test on (Resident A) to see where she is with cognition."*

SP2 reported the resident provider is to complete the mini mental exam.

On 01/12/2024, I interviewed Home MD nurse practitioner Jennfier White by telephone. Ms. White reported she was not made aware of any cognitive changes or possible urinary tract infections for Resident A. Ms. White reported the facility does a good job of communicating with her on resident medical needs.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
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ANALYSIS:	Interviews conducted and document review, revealed Resident A had an increase in falls and a cognitive decline as documented in progress and care conference notes. The facility did not take reasonable action to ensure the protection of Resident A by these changes were not addressed nor communicated to Resident A's physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 01/09/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 01/16/2024

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