GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

Jami McDaniel
Provision Living at Canton
49825 Ford Road
Canton, MI 48187

RE: License #: AH820412296
Investigation #: 2025A1027058
Provision Living at Canton

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 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 #:	AH820412296
Investigation #:	2025A1027058
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/12/2025
Report Due Date:	08/08/2025
Licensee Name:	AEG Canton Opco LLC
Licensee Address:	Ste 207 9450 Manchester Rd. St. Louis, MO 63119
Licensee Telephone #:	(314) 272-4980
Authorized Representative/ Administrator:	Jami McDaniel
Name of Facility:	Provision Living at Canton
Facility Address:	49825 Ford Road Canton, MI 48187
Facility Telephone #:	(734) 589-0380
Original Issuance Date:	07/17/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	95
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home was short staffed.	Yes
Resident C lacked protection.	No
The food was unhealthy.	No
Residents were not being showered.	No
Residents' laundry was not completed.	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A1027058
06/12/2025	Special Investigation Initiated - On Site
06/20/2025	Contact - Document Sent Email sent to the administrator requesting additional documentation
06/23/2025	Contact – Document Received Requested documentation received
06/23/2025	Inspection Completed-BCAL Sub. Compliance
06/30/2025	Exit Conference Conducted by email with Jami McDaniel

ALLEGATION:

The home was short staffed.

INVESTIGATION:

On 6/9/2025, the Department received a report from Adult Protective Services (APS) alleging that the facility was understaffed, particularly on Mondays, Wednesdays, and weekends. The complaint read that only one resident assistant was on duty during the morning shift, one staff member worked the midnight shift, and that

management staff did not assist when staffing levels were low. APS did not open an investigation related to the allegations.

On 6/12/2025, APS submitted additional allegations, reporting that Resident A had fallen several weeks prior, struck his head, and was hospitalized—allegedly due to staffing shortages.

That same day, 6/12/2025, I conducted an on-site inspection and interviewed staff.

The facility's authorized representative and administrator, Jami McDaniel, stated that the home currently housed 57 residents, including a recent admission. Staffing was divided between assisted living and memory care units. Staff worked in three shifts:

- 7:00 AM – 3:00 PM
- 3:00 PM – 11:00 PM
- 11:00 PM – 7:00 AM

According to the administrator:

- Memory Care had one medication technician and one resident assistant on both the first and second shifts, and one medication technician on the third shift.
- Assisted Living was staffed with two resident assistants and two medication technicians on day and afternoon shifts, and two medication technicians on the night shift.

She stated that four residents required a Hoyer lift and two-person assistance for transfers, while one additional resident required two-person assistance without the use of a Hoyer lift. The Director of Nursing (DON) and Clinical Coordinator were responsible for arranging coverage in the event of call-offs and would fill in if necessary. The administrator reported she had also assisted on the floor during staffing shortages. Per diem staff were available to be contacted for coverage as well.

The administrator confirmed that Resident A had experienced a fall, to which staff responded promptly and notified his family. She stated that, according to his hospitalization records, the fall was attributed to an ulcer and low hemoglobin levels, which ultimately required surgical intervention.

During my visit, I observed 20 assisted living residents who appeared clean and well groomed. Resident A confirmed that staff regularly checked on him and assisted during showers. Resident B reported satisfaction with the care received.

On 6/13/2025, the administrator sent an email clarifying that three residents required a Hoyer lift and two-person assistance, though one did not require the lift consistently. Additionally, a fourth resident began requiring a Hoyer lift as of that day. This information was consistent with the assisted living assignment sheets. The memory care assignment sheet indicated one resident required two-person assistance.

Review of the resident census indicated 49 residents in assisted living and 8 in memory care. Assignment sheets reviewed aligned with staff statements. A review of the staff schedule from 5/18/2025 to 6/14/2025 showed that some staff worked partial shifts from 4:00 PM to 8:00 PM. Staffing levels in assisted living were as follows:

- 7:00 AM – 3:00 PM: 3 to 6 staff
- 3:00 PM – 11:00 PM: 3 to 5 staff
- 11:00 PM – 7:00 AM: 1 to 3 staff

In memory care:

- 7:00 AM – 3:00 PM: 2 to 3 staff
- 3:00 PM – 11:00 PM: 1 to 2 staff
- 11:00 PM – 7:00 AM: 1 staff member

On 5/18/2025, the schedule read that midnight shift (11:00 PM – 7:00 AM) had only two staff were on duty total—one in memory care and one in assisted living. It also read there were no staff assigned to memory care on 5/30/2025, 5/31/2025, and 6/2/2025.

Review of Resident A's incident report on 5/21/2025 at 4:03 AM confirmed he had fallen. Staff responded immediately. The staff schedule for that date indicated three staff were present: two in assisted living and one in memory care.

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.
For Reference: R 325.1944	**Employee records and work schedules.**

	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	Review of the home's documentation revealed on 5/18/2025 only two staff members were on duty with residents who resided in the home requiring two-person assistance and/or a Hoyer lift for transfers. Additionally, the schedule read there were instances when no staff were assigned to the memory care unit. Given this information, it could not be determined if the home's schedule was not updated to reflect the staff who actually worked. Therefore, the home did not adequately staff to ensure to meet residents' needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C lacked protection.

INVESTIGATION:

On 6/9/2025, the Department received a report from Adult Protective Services (APS) indicating that Resident C had passed away in March 2025. The complaint alleged that she choked on a piece of meat, was hospitalized, returned to the facility, and subsequently passed away. APS did not open an investigation related to the allegations.

On 6/12/2025, I conducted an on-site inspection and interviewed staff.

The administrator reported that Resident C had been experiencing a general decline but remained independent with eating and was on a regular diet prior to the incident. She stated that Resident C had choked on a piece of rib meat, at which point staff performed the Heimlich maneuver and cardiopulmonary resuscitation (CPR), and emergency medical services (EMS) were contacted. According to the administrator, EMS personnel indicated that the facility staff had followed appropriate procedures. Resident C returned to the home under hospice care and was placed on a pureed diet.

Resident C's face sheet indicated she moved into the home on 3/15/2022 and discharged on 3/29/2025. Her hospital after-visit summary, covering the period from 3/17/2025 to 3/21/2025, instructed that she return to her previous diet. A diet order dated 12/9/2024 listed a regular diet with regular texture and thin liquid consistency,

which was discontinued on 3/22/2025. A new diet order on 3/22/2025 changed her to a regular diet with pureed texture and nectar/mildly thick liquid consistency. Hospice notes dated 3/22/2025 were consistent with this updated diet order.

Resident C's updated service plan identified her as high risk for aspiration and specified that she was not to be given straws. The plan also indicated she was independent during meals in the dining room, required reminders to eat, and needed encouragement to consume food and fluids. Staff were directed to report any changes in her ability to eat or drink.

An incident report dated 3/17/2025 at 12:30 PM read that staff immediately notified the DON when Resident C appeared to be choking in the dining area. Upon arrival, the DON observed Resident C seated, gasping for air with blue lips. Staff were instructed to call 911. The Heimlich maneuver and a finger sweep were performed, during which a piece of rib meat was removed from her airway. Despite this, Resident C continued to appear distressed and became unresponsive. She was lowered to the floor, where staff noted no pulse and began CPR. After several rounds, Resident C began breathing again and attempted to communicate with her eyes. CPR was then stopped. EMS arrived shortly after, and both Resident C's physician and daughter were notified.

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:	Resident C was prescribed a regular diet at the time of the choking incident in which staff responded, and emergency intervention sought. Given this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The food was unhealthy.

INVESTIGATION:

On 6/9/2025, the Department received allegations from APS claiming that the food provided at the facility was unhealthy. APS did not open an investigation related to the allegations.

On 6/12/2025, I conducted an on-site inspection and interviewed staff.

The administrator explained that the menus were developed by the home's corporate office, and food supplies were provided by Gordon's. She noted that a dietician visits quarterly to meet with the dietary manager to ensure meals meet residents' nutritional needs. The administrator also acknowledged that some residents had expressed concerns about the lack of salt in the food, and the facility was exploring options to address these complaints.

Resident A reported the food was acceptable and healthy. Resident B reported she didn't mind the food.

While on-site, the lunch served that day matched the menu, appeared appetizing, and was served in adequate portions.

I reviewed the weekly menu, which included protein and carbohydrate choices for both breakfast and lunch, vegetables served at lunch, and a daily soup option. The dinner included protein and carbohydrates choices, along with vegetables for some meals. The menu also included desserts served at lunch and dinner.

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.
ANALYSIS:	Based on staff and resident interviews, documentation review, and meal observations, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents were not being showered.

INVESTIGATION:

On 6/9/2025, the Department received allegations from APS claiming that residents were not being showered. APS did not open an investigation related to the allegations.

On 6/12/2025, I conducted an on-site inspection and interviewed staff.

The administrator explained that each resident receives showers twice weekly, unless otherwise specified, on designated days. These shower schedules are documented on the daily assignment sheets provided to care staff. The administrator added that if staff are unable to complete a shower during their shift, they report it to the next shift. Shower completion is documented in each resident's record within the Point Click Care charting system.

During the visit, I observed 15 residents who appeared clean and well-groomed. Resident A stated she showers independently but receives staff assistance when needed. Resident B reported that staff provide stand-by assistance during his showers on assigned days.

Review of staff assignment sheets were consistent with these statements.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on interviews with both staff and residents, observations, and document review, the home maintains an organized system to ensure showers are completed as scheduled.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' laundry was not completed.

INVESTIGATION:

On 6/9/2025, the Department received allegations from APS which read that residents' laundry was not being completed. APS did not open an investigation related to the allegations.

On 6/12/2025, I conducted an on-site inspection and interviewed staff.

The administrator explained that each resident is assigned a specific laundry day, with designated staff responsible for handling laundry tasks. The daily assignment sheet given to staff lists each resident's laundry day. Staff were responsible for washing, drying, folding, and putting away residents' laundry.

During the visit, I observed ten resident rooms where laundry appeared to have been completed. Some residents placed their laundry baskets outside their apartments on their designated laundry days. Interviews with Residents A and B confirmed their laundry was being done regularly. Resident A stated laundry was completed in a timely manner, while Resident B noted that although laundry service had been inconsistent previously, it was now reliably done on assigned days.

The staff assignment sheets were consistent with these statements.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Based on staff and resident interviews, observations, and document review, the home maintains an organized system to ensure residents' laundry is completed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the staff schedule from 5/18/2025 to 6/14/2025 revealed there were instances when there were two shift supervisors designated on the 7:00 AM to 3:00 PM shift such as on 5/19/2025, 5/21/2025, 5/23/2025 through 5/26/2025, 5/30/2025, 6/2/2025, 6/4/2025, 6/6/2025 through 6/9/2025. There was no shift supervisor designated for the 3:00 PM to 11:00 PM shift on the following dates 5/19/2025, 5/28/2025 through 5/31/2025, 6/1/2025, and 6/13/2025. A shift supervisor was not designated for the 11:00 PM to 7:00 AM shift on 5/18/2025, and on some occasions,

the assigned supervisor was scheduled from 11:30 PM to 6:00 AM without an alternate listed on the schedule to cover the remaining time.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	Review of the facility's staff schedule revealed multiple instances where either two shift supervisors were assigned, no supervisor was designated, or the assigned supervisor did not work the entire shift without an alternate supervisor identified; therefore, a violation of this rule was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/24/2025

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Jessica Rogers Date
Licensing Staff

Approved By:

06/30/2025

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