GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2022

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

RE: License #: AH110405636
Investigation #: 2022A1028058
Provision Living at St. Joseph

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 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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH110405636
Investigation #:	2022A1028058
Complaint Receipt Date:	06/29/2022
Investigation Initiation Date:	06/30/2022
Report Due Date:	08/29/2022
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:	Audrey Henriquez
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:**	TEMPORARY
Effective Date:	03/09/2022
Expiration Date:	09/08/2022
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Caregiver antagonized and raised fist to resident.	No
The facility is short staffed, and third shift staff sleep on shift.	Yes
The food served is horrible.	No
Special diets are ignored by the kitchen staff.	No
Additional Findings	No

III. METHODOLOGY

06/29/2022	Special Investigation Intake 2022A1028058
06/30/2022	Special Investigation Initiated - Letter 2022A1028058
06/30/2022	APS Referral APS referral sent to Centralized Intake.
07/21/2022	Contact - Face to Face Interviewed Admin/Audrey Henriquez at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee D at the facility,
07/21/2022	Contact - Document Received Received meal and menu documentation, Resident A and Resident B face sheets, and the working staff schedule from April 2022 - July 2022 from Admin/Audrey Henriquez.

7/26/2022	Contact – Telephone call made Attempted unsuccessfully to contact Resident A's authorized representative
7/26/2022	Contact – Face to Face Interviewed Employee E via telephone.
10/17/2022	Exit – Report sent to facility AR/Jennifer Hescott and facility Admin./Audrey Henriquez

ALLEGATION:

Caregiver antagonized and raised fist to resident.

INVESTIGATION:

On 6/29/2022, the Bureau investigation received the allegations from the online system. The complainant wished to remain anonymous.

On 6/29/2022, a referral for Adult Protective Services (APS) was sent to Centralized Intake.

On 7/21/2022, I interviewed facility administrator, Audrey Henriquez, at the facility. Ms. Henriquez reported there was an incident on 7/8/22 in which a caregiver was witnessed being aggressive with Resident A. Resident A has impaired memory and does not remember the incident. However, Ms. Henriquez reported it was brought to her attention immediately by another care staff and since the facility has cameras throughout, the camera footage was reviewed then. Ms. Henriquez reported the caregiver "rammed the wheelchair into the back of [Resident A's] legs to make [them] sit. It also appears the caregiver touched or hit Resident A's cheek in an aggressive manner". Ms. Henriquez reported the caregiver involved was immediately suspended from employment pending investigation. Resident A's authorized representative, physician, APS, and the department were notified of the incident as well. A report was filed with the police later investigating the incident and caregiver on 7/11/22. Ms. Henriquez reported due to the actions of the caregiver, the facility was going to terminate employment, but the caregiver resigned first instead. Ms. Henriquez reported Resident A's authorized representative declined to press charges again the caregiver but was informed by the police of the right to do so. Ms. Henriquez provided me the incident documentation and camera footage of the incident for my review.

On 7/21/2022, I interviewed Employee A at the facility. Employee A reported a prior caregiver was aggressive with Resident A. Employee A reported there are cameras throughout out the facility and that the incident occurred in the common area of the memory care unit. Employee A reported the incident was witnessed by another

caregiver and immediately reported to management. The caregiver in question was removed from the building immediately pending investigation. To their knowledge, Resident A's physician and family were contacted along with APS and the police. Employee A reported the caregiver did not return to the facility after the incident.

On 7/21/2022, I interviewed Employee D whose statements are consistent with Ms. Henriquez's and Employee A's statements.

On 7/21/2022, I reviewed the documentation and camera footage concerning the incident which revealed the caregiver was aggressive with Resident A in the common area of the memory care unit.

On 7/26/2022, I attempted to contact Resident A's authorized representative but have been unsuccessful due to no answer and voicemail box being full.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	It was alleged a caregiver was aggressive with Resident A on 7/8/22. The incident was witnessed by another care staff and immediately reported to management, who subsequently notified Resident A's authorized representative, physician, APS, the police, and the licensing department. The caregiver in question was immediately removed from the building and is no longer employed by the facility. Interviews with facility staff, along with review of documentation and camera footage reveal the allegation to be true. However, the facility took immediate and appropriate action to ensure Resident A's safety and protection. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed, and third shift staff sleep on shift.

INVESTIGATION:

On 7/21/2022, Ms. Henriquez reported the facility is not understaffed, but “actually overstaffed”. Ms. Henriquez reported the facility just hired eight new employees and that while call-ins do occur, they are intermittent. There are currently 36 residents total at the facility with two to four care staff, a med tech, and a shift supervisor assigned to first, second, and third shifts. Ms. Henriquez reported there was a care staff caught on third shift sleeping and this person was terminated due to this. Ms. Henriquez reported “it was only the one care staff that was accused and then caught sleeping on third shift. No other care staff were accused or sleep on their shifts. That is not tolerated here”. Ms. Henriquez reported there are incentives offered to stay over on a shift or to pick up a shift if call-ins occur. Ms. Henriquez reported float staff, shift supervisors, and management will assist as needed with a shift shortage. Ms. Henriquez reported there is only one care staff assigned to memory care due to only seven residents being in the unit. However, Ms. Henriquez reported it was approved that day (7/21/22) by the facility authorized representative, Jennifer Hescott, to add one more care staff to memory care. Ms. Henriquez provided me the working staff schedule from April 2022 to July 2022 for my review.

On 7/21/2022, I interviewed Employee A who reported the facility is not short staffed. Employee A reported the facility is now overstaffed and there are currently 36 residents total in the facility. Employee A reported call-ins still occur but there are intermittent and float staff, shift supervisors, and management will fill in to prevent a shift shortage. Employee A also reported incentives are also offered to staff to pick up shifts. Employee A reported knowledge of a care staff sleeping on third shift and subsequently “being let go from the facility due to it. To my knowledge, this is the only [care staff] that did this”.

On 7/21/2022, I interviewed Employee B at the facility who reported the facility is not short staffed and that call-ins are “few and far between. My department is never short staffed”. Employee B reported a care staff was recently let go due to sleeping on third shift and that behavior is not tolerated at the facility.

On 7/21/2022, I interviewed Employee C at the facility who reported that while assisted living is not short staffed, the memory care unit only has one caregiver for seven residents. Employee C reported two of the residents just entered the memory care unit but require more supervision than the rest of the memory care residents. Employee C reported while no one is a two person assist in memory care, there are a few residents that require at minimum one person assist and “it is difficult to provide assistance in the bathroom and supervise the rest of the residents”. Employee C reported concerns were brought to management’s attention about needing another care staff in memory care for increased supervision and safety, but the facility is currently operating with one care staff only in memory care. Employee C also reported if the staff is trained, [they] are also passing medications in memory care unit as well as providing one person assist and increased supervision. If there is a caregiver that is not trained to pass medications, the med tech from assisted living will come to memory care and administer meds then, but this is the only time there are two care staff persons in the memory care unit. Employee C reported the med

tech typically only administers medications in memory care but will often assist if asked to by the other care staff on duty. Employee C also reported knowledge of a care staff person being terminated due to sleeping on third shift.

On 7/21/2022, I interviewed Employee D at the facility who reported assisted living is not short staffed, but the memory care unit is. Employee D reported there are seven residents in memory with two new residents that require more supervision than the other residents. Employee D reported the current residents in memory care require at minimum one person assist for care and increased supervision. Employee D reported one care staff cannot adequately provide the supervision necessary for the resident's safety. Employee D reported med techs will come into memory care to administer medications only if the care staff on duty in the memory care unit is not a med tech. Employee D reported the med techs will sometimes assist the other care staff if asked, but their primary duty is to administer medications only. Employee D reported Resident A and Resident B both require increased supervision and that unnecessary falls have occurred due to only one care staff member being assigned to memory care to assist and supervise. Employee D also reported knowledge of a care staff person being terminated due to sleeping on third shift and that no other care sleep on any of the shifts.

On 7/21/2022, I completed an on-site inspection of the memory care unit. Only one care staff was observed in the unit to provide assistance and supervision for the seven residents present. It was noted one resident used a cane for ambulation but also had a wheelchair parked beside their table while completing lunch. A family member was assisting this resident with lunch while the assigned caregiver supervised and assisted two other residents during mealtime. I also reviewed the internal memory care unit reports during the on-site inspection which revealed Resident A and Resident B require increased supervision and assist.

On 7/26/2022, I interviewed Employee E by telephone who reported there is only care staff person assigned to memory care and that concerns have been brought to management's attention that this not appropriate or safe for residents or care staff. Employee E's statements were consistent with Employee C's and Employee D's statements.

On 7/26/2022, I reviewed the working staff schedule from April 2022 to July 2022 which revealed the following:

- April 2022 demonstrated some call-ins throughout the month. Assisted living is assigned on the April schedules reviewed, but there is no delegation for Memory Care staff assignments.
- May 2022 demonstrated few call-ins throughout the month. There is no delegation between Assisted Living and Memory Care staff assignments. It cannot be determined who was assigned to which unit. There is no working staff schedule for May 1st – 7th, 2022.

- June 2022 demonstrated few call-ins throughout the month. There is no delegation between Assisted Living and Memory Care staff assignments. It cannot be determined who was assigned to which unit.
- July 2022 demonstrated few call-ins throughout the month. There is no delegation between Assisted Living and Memory Care staff assignments. It cannot be determined who was assigned to which unit.

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 and caregivers are sleeping on third shift. Interviews, on-site inspection, and review of documentation revealed the following: • A caregiver was sleeping on third shift and was terminated due to this. The facility appropriately addressed the incident and reassigned staff to ensure the shift was not short. • There are currently 36 residents total in the facility with three to four care staff, a med tech, intermittent float care staff, and shift supervisor assigned to each shift. • Review of working staff schedules from April 2022 to July 2022 demonstrate no clear delegation of staff assignments between Assisted Living and the Memory Care unit. It cannot be determined which unit staff worked in. • There are currently seven residents in the memory care unit who require one person assist with care and/or increased supervision. There is only one care staff assigned to memory care to provide care, increased supervision, and at times medications to all seven residents. Through interviews, on-site inspection, and review of documentation, it can be determined one care staff person for seven memory care residents who at minimum require one person assist with care and increased supervision due to impaired functional ability, impaired cognition, and impaired safety awareness, is not an appropriate resident to staff ratio. To ensure appropriate care and supervision for residents along with safety for both residents and staff during care routines and assist with transfers, two care staff should have been assigned daily to the memory care unit.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The food served is horrible.

INVESTIGATION:

On 7/21/2022, Ms. Henriquez reported there were two recent complaints from residents and their families about the menu being served due to it being more of a “fancy menu than a standard meat and potatoes menu’’. Ms. Henriquez reported the

facility follows a standard menu for seniors to ensure a nutritional diet and variety of food. Ms. Henriquez reported the facility's corporate company sent the corporate dietitian to address resident concerns about the 'fancy menu' and food selection In July 2022. The corporate dietitian along with the facility dietary director addressed the residents' concerns and established additional menu items available to all residents. Ms. Henriquez reported since meeting with the concerned residents, there have been no issues concerning the daily menus and that kitchen staff continues to actively work to address any food concerns the residents may have.

On 7/21/2022, Employee A reported there have been two complaints about the menu at the facility, but "nothing out of the ordinary like someone might not like the entrée or the vegetable that day". Employee A reported upon learning of the two residents' concerns about the menu, the corporate office sent the corporate dietitian to address those concerns. The facility kitchen staff also addressed the concerns of the residents and continue to address any concerns residents might have about what is being offered on the menu.

On 7/21/2022, Employee B reported concerns were brought to [their] attention about the daily menu that was being provided at the facility. Employee B reported the residents thought "the food was too fancy and preferred more of meat and potato type of menu". Employee B reported the menu was reviewed by the corporate dietitian and residents and was adjusted to the meet the resident's preferences and the allowed dietary standards for the residents. Employee B reported the facility follows a nutritional menu for seniors and alternative meals are offered if a resident does not like what is on the menu for that day. To their knowledge, Employee B reported since the menu was adjusted, there have been no more complaints.

On 7/21/2022, Employee C and Employee D reported no knowledge of complaints about the menu that is served at the facility.

On 7/21/2022, I completed an on-site inspection which revealed several residents during mealtime enjoying the lunchtime meal. One resident was observed telling another resident how "good supper was last night". One resident was observed telling the mealtime server that they did not want the main entrée for lunch. The mealtime server offered the resident an alternative meal the resident was agreeable to.

During my on-site inspection, I also reviewed the working daily menus from May 2022 to July 2022 which revealed that while some of the food could be considered a 'fancy meal', there was a variety of nutritious food options available for each meal.

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:	Interviews with facility staff, on-site inspection, and review of documentation demonstrate there were complaints about the menu. However, the facility took great measures to immediately address and adjust the daily menu to the resident preferences while still adhering to a nutritional diet. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Special diets are ignored by kitchen staff.

INVESTIGATION:

On 7/21/2022, Ms. Henriquez reported there are no current special diets at the facility “such as mechanical soft or pureed”. Ms. Henriquez reported if there were, the dietary manager and kitchen staff would adhere to the special diet for the resident.

On 7/21/2022, Employee A reported no knowledge of any resident being on a special diet or kitchen staff not following special diets for residents.

On 7/21/2022, Employee B reported there are no current residents that require special diets others than those with allergies to certain types of food. Employee B reported all kitchen staff would be required to follow special diets if present in the facility.

On 7/21/2022, Employee C and Employee D reported no knowledge of any resident being on a special diet other than having an allergy to a food item.

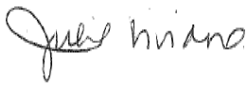
On 7/21/2022, I completed an on-site inspection of the kitchen area which revealed a visual posting with four residents who had allergies to certain food items. The posting

was displayed for all kitchen staff to review prior to mealtimes to ensure resident food allergen safety.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(4) Medical nutrition therapy, as prescribed by a license health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	It was alleged the facility was not following special diet guidelines for residents. There are currently no residents at the facility that require special diets. There is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



7/26/2022

Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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