GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Jennifer Hescott
Provision Living at East Lansing
6300 Abbot Road
East Lansing, MI 48823

RE: License #: AH330403275
Investigation #: 2023A1021015
Provision Living at East Lansing

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 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 #:	AH330403275
Investigation #:	2023A1021015
Complaint Receipt Date:	11/06/2022
Investigation Initiation Date:	11/14/2022
Report Due Date:	1/06/2022
Licensee Name:	AEG East Lansing Opco, LLC
Licensee Address:	Suite 385 1610 Des Peres Rd. St. Louis, MO 63131
Licensee Telephone #:	(314) 272-4980
Administrator:	Wendy Mehan
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at East Lansing
Facility Address:	6300 Abbot Road East Lansing, MI 48823
Facility Telephone #:	(517) 275-9916
Original Issuance Date:	07/08/2022
License Status:	TEMPORARY
Effective Date:	07/08/2022
Expiration Date:	01/07/2023
Capacity:	126
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

11/06/2022	Special Investigation Intake 2023A1021015
11/14/2022	Special Investigation Initiated - Letter left message with administrator
11/15/2022	Contact - Telephone call made interviewed administrator
11/18/2022	Contact - Telephone call made interviewed SP1
11/18/2022	Contact - Telephone call made interviewed SP2
11/21/2022	Contact - Telephone call made interviewed SP3
12/01/2022	Exit Conference Exit conference with authorized representative Jennifer Hescott

ALLEGATION:

Resident B eloped from the facility.

INVESTIGATION:

On 11/3/22, the licensing department received an incident report with narrative that read,

"staff went to resident's apartment to deliver scheduled morning medication and observed resident was not in apartment and staff observed resident's window

open and the braces damage. According to Foresight footage resident had left his apartment at 0124; staff had not done safety rounding. Staff alerted additional team members and staff looked for resident in community and outside community and could not locate him. Management, family and 911 contacted. Resident located by family and brought back to the community at 10am. He was assessed and no injuries observed."

On 11/14/22, I interviewed administrator Wendy Mehan by telephone. Ms. Mehan reported Resident B was a new admit to the facility from another assisted living in the area. Ms. Mehan reported Resident B was not at risk for elopement. Ms. Mehan reported Resident B was admitted to the memory care unit with expectation to be checked on every two hours. Ms. Mehan reported staff members reported they checked on Resident B at 4:00am but review of Foresight footage revealed Resident B was last checked on at 1:00am. Ms. Mehan reported first shift caregivers went into Resident B's apartment to administer medications and it was found that Resident B broke his window and eloped from the facility. Ms. Mehan reported Foresight revealed Resident B left his apartment around 1:24am. Ms. Mehan reported the facility started the elopement procedure and Resident B was brought back to the facility at 10:00am. Ms. Mehan reported education was re-provided to caregivers. Ms. Mehan reported review of video footage revealed the shift supervisor was not providing resident care and sat in the medication room most of the shift. Ms. Mehan reported Resident B now has a 1:1 caregiver.

On 11/18/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she worked the morning Resident B was found to eloped. SP1 reported she went into memory care unit to wake residents up. SP1 reported she went into Resident B's room and his window was lying flat on the ground and Resident B was not in his room. SP1 reported she observed footsteps on the ground. SP1 reported caregivers searched inside the facility for Resident B and then started the elopement procedure. SP1 reported Resident B was found around 11:00am and was brought back to the facility.

On 11/18/22, I interviewed SP2 by telephone. SP2 reported she was the nighttime supervisor when Resident B eloped from the facility. SP2 reported SP3 reported she checked on Resident B every two hours. SP2 reported she was not assigned to care for Resident B.

On 11/21/22, I interviewed SP3 by telephone. SP3 reported she was working the night Resident B eloped from the facility. SP3 reported she believed she checked on Resident B around 4:20am. SP3 reported she just peeked her head into Resident B's room as she did not want to wake Resident B. SP3 reported she believed she saw Resident B in his bed. SP3 reported at shift change which is 6:00am she was sent to assisted living for resident care.

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

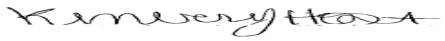
"(Resident B) was living in another assisted living prior to admission here at PLEL. When assessment was done the staff at AL stated he has never attempted to elope and his family is very involved."

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.**
	(16) "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:	Resident B was to be checked on every two hours. Review of video monitoring revealed Resident B was not checked on every two hours which resulted in Resident B eloping from the facility and being found outside several hours later. The facility failed to protect Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/01/2022, I conducted an exit conference with authorized representative Jennifer Hescott by telephone.

IV. RECOMMENDATION

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

 11/22/22

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Kimberly Horst Date
Licensing Staff

Approved By:

 11/30/2022

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