GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 14, 2023

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

RE: License #: AH410381380
Investigation #: 2023A1021032
Provision Living at Forest Hills

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 #:	AH410381380
Investigation #:	2023A1021032
Complaint Receipt Date:	02/02/2023
Investigation Initiation Date:	02/20/2023
Report Due Date:	04/04/2023
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:	Amy Simon
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:	06/04/2022
Expiration Date:	06/03/2023
Capacity:	116
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A issued improper discharge.	No
Additional Findings	Yes

III. METHODOLOGY

02/02/2023	Special Investigation Intake 2023A1021032
02/02/2023	Special Investigation Initiated - Letter left message with complainant
02/03/2023	Inspection Completed On-site
02/14/2023	Exit Conference Exit conference with authorized representative Jennifer Hescott

ALLEGATION:

Resident A issued improper discharge.

INVESTIGATION:

On 02/02/2023, the licensing department received a complaint that alleged Resident A was issued an improper discharge. The complainant alleged the discharge notice was not provided to the appropriate person and the letter did not include details as to how to appeal the discharge.

On 02/03/2023, I interviewed administrator Amy Simon at the facility. Ms. Simon reported Resident A was issued a discharge because Resident A is often intoxicated at the facility. Ms. Simon reported Resident A will become so intoxicated she will fall and injure herself. Ms. Simon reported the facility can no longer keep Resident A safe. Ms. Simon reported the discharge letter was provided to Relative A1 and Relative A2. Ms. Simon reported Resident A's responsible person is Professional Guardian Services. Ms. Simon reported Resident A has gone through numerous guardians between family and professional services. Ms. Simon reported Relative A1 told Ms. Simon who the correct guardian was, and the discharge letter was sent on 02/06/2023. Ms. Simon reported the discharge notice was also sent via email on 02/03/2023 with a new discharge date of 3/3/2023. Ms. Simon reported the facility will not discharge Resident A until a proper placement is found.

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

> *"Resident observed on the bathroom floor of residents apartment. Resident verbalized that she did not fall and that she placed herself on the floor. Alcohol visualized in bathroom. Vitals obtained, WNL. Guardian, PCP and Director of Nursing notified. Resident to be sent out to ED for evaluation and treatment.*
>
> *Resident observed to be on the floor in front of the recliner in apartment. Resident states she placed herself on the floor. No visual injures noted. Staff noted alcohol to be present. Vital WNL. Notified guardian, PCP, and DON orders received to sent resident to ED for treatment and evaluation."*

I reviewed *Notice of An Involuntary Transfer or Discharge* document. The document was two pages and did include instructions on how to appeal the discharge. The notice was issued to Professional Guardianship Services. The narrative read,

> *"Resident was notified that she must discontinue drinking in order to remain in our community. She continues to drink to excess endangering herself and others in the community."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	The facility issued a 30-day written discharge notice to Resident A's incorrect responsible party. Upon learning of the mistake, the facility re-issued the discharge notice to the correct responsible party with a revised 30 day notice. Therefore, the facility is not in violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

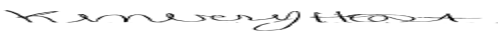
Ms. Simon reported Resident A was sent out to the hospital for alcohol abuse sometime in December and/or January.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	The facility did not complete an incident report for Resident A send out to the emergency room for evaluation and treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/14/2023, 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.



02/08/2023

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Kimberly Horst Date
Licensing Staff

Approved By:

02/14/2023

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