GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

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

RE: License #: AH410381380
Investigation #: 2023A1021038
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 #:	2023A1021038
Complaint Receipt Date:	02/23/2023
Investigation Initiation Date:	02/27/2023
Report Due Date:	04/25/2023
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 #:	(314) 909-9797
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?
Facility failed to respond to door alarms.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/23/2023	Special Investigation Intake 2023A1021038
02/27/2023	Special Investigation Initiated - Letter reviewed received IR on incident
02/28/2023	Inspection Completed On-site
03/01/2023	Contact-Telephone call made Interviewed staff person 1
03/01/2023	Contact- Telephone call made Interviewed staff person 3
03/13/2023	Exit Conference

ALLEGATION:

Facility failed to respond to door alarms.

INVESTIGATION:

On 02/23/2023, the licensing department received a complaint with allegations the facility failed to respond to door alarms. The complainant alleged on 02/22/2023 Resident A was found missing from the facility. The complainant alleged staff members heard an alarm at 8:00pm and could not figure out what the sound was until midnight. The complainant alleged that the facility then found that Resident A was missing. The complainant alleged the facility contacted 911 and police spent many resources and time searching the area for Resident A. The complainant alleged Resident A was found in a resident's room sleeping. The complainant alleged staff members did not follow staff protocol on responding to door alarms.

On 02/28/2023, I interviewed administrator Amy Simon at the facility. Ms. Simon reported on 02/22/2023, Resident A pushed the exit door near her apartment and

set off the door alarm. Ms. Simon reported staff members re-directed Resident A back to her apartment. Ms. Simon reported approximately 30 minutes later Resident A pushed the door again and set off the alarm. Ms. Simon reported at this time, the alarm was never re-set. Ms. Simon reported at approximately 11:00pm, third shift caregivers arrived and inquired about the alarm. Ms. Simon reported at that time Resident A was unable to be located and it was believed Resident A exited the facility. Ms. Simon reported the caregiver contacted her and it was advised for the caregiver to contact 911. Ms. Simon reported she arrived at the facility approximately 30 minutes later and reviewed camera footage. Ms. Simon reported the video showed Resident A did not leave the facility. Ms. Simon reported caregivers checked resident rooms and Resident A was found in a resident room across the hallway from her room. Ms. Simon reported Resident A was sleeping in a recliner chair. Ms. Simon reported caregivers had checked residents' rooms but did not see Resident A sleeping in the chair. Ms. Simon reported a few days before this incident the facility conducted a fire drill. Ms. Simon reported the courtyard door alarm was tripped and was not re-set following the fire drill. Ms. Simon reported caregivers assumed the alarm was the courtyard door alarm and not an exit door. Ms. Simon reported at the time of the incident Resident A was on wellness checks and is now on hourly checks. Ms. Simon reported caregivers were not adequately trained on door alarms and elopement procedures. Ms. Simon reported the facility has implemented elopement and door alarm training.

On 03/01/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported she was the medication technician assigned to Resident A's room. SP1 reported Resident A did not require any medication and therefore she did not provide any care to Resident A. SP1 reported she arrived at the facility around 7:30pm. Ms. Simon reported during her shift, the receptionist came to her asking what an alarm noise was and that a resident reported it was a door at the end of the hallway. SP1 reported she has no training nor knowledge on how to re-set the door alarm. SP1 reported she advised the receptionist to speak with SP2 about how to re-set the alarm. SP1 reported she assumed the receptionist cleared the alarm. SP1 reported when third shift came on the caregivers inquired what the door alarm was and why it was going off. SP1 reported a room check was completed and Resident A was found to be missing. SP1 reported management and 911 was called. SP1 reported Resident A was found sleeping in a chair in a resident's room. SP1 reported she had never heard the alarm before, and she believed it was a fire alarm. SP1 reported she received no training on door alarms, sounds of door alarms, or elopement procedures.

On 03/01/2023, I interviewed SP3 by telephone. SP3 reported she was not assigned to Resident A's hallway. SP3 reported she was alerted on her facility phone there was an alarm, but she believed it was a courtyard and kitchen door alarm. SP3 reported she was not trained on how to re-set the alarms nor how to respond to door alarms.

I reviewed the completed incident report. The narrative read,

"On 2/23/23 at 12:19am staff contacted ED and WD stating the 2nd floor door alarm was going off and that staff had checked all resident apartments and noted that (Resident A) was not in her apartment. Staff then did a complete search of each community apartment, stairwells, as well as the outside perimeter of the community.

ED immediately contacted local police and there was a police presence at community immediately to aide in the search for the resident. The resident's family was also contacted and arrived at the community.

Once ED and WD arrived at the community at 12:56am, cameras were reviewed and it was observed that the resident did not exit through the door so a second search within the community began. After reviewing the door alarm report, also noted that the alarm had been going off since 8:20pm with no staff intervention or management notification.

At 01:22am, after a second search, the resident was located in an apartment across the hall from her own apartment, she was sleeping in a recliner and had not been noticed during previous apartment searches.

Foresite reviewed during this time shows the resident had been walking around her apartment, in/out of the bathroom, sorting and folding clothing at 732pm on 2/22/23 and she left the apartment at 7:38pm.

Foresite rewind shows carestaff in/out of her apartment looking for her but not doing thorough apartment checks.

(Resident A) admitted to the community in 2019 and has a diagnosis of dementia, she has exhibited wandering behaviors in the past, but is always re-directable easily and is not instructive with her wandering.

Hourly wellness checks increased from every 2 hours.

Training/Counseling on door alarms, elopement procedures, correct apartment search procedure and management notification for emergent situation for all staff.

Physician order obtained to collect UA from resident to rule out infective process that could cause increased confusion.

UA collected 022323 and sent to lab for testing-will follow up if need for antibiotic therapy.

Resident will be moved to memory support unit related as her dementia journey appears to be progressing.

APPLICABLE RULE	
R 325.1981	**Emergency Procedures.**
	(3) Personnel shall be trained to perform assigned tasks in accordance with the disaster plan.
ANALYSIS:	Interviews conducted revealed care staff were not adequately trained in responding to door alarms and elopement procedures.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's service plan revealed no information on safety checks for Resident A.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of incident report submitted to the department revealed Resident A was to be placed on hourly safety checks. Review of Resident A's service plan revealed this information was omitted from her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 02/28/2023, I interviewed SP3 at the facility. SP3 reported facility training included shadowing another caregiver and completing resident care while being observed. SP3 reported the training information presented was what the trainer felt was important to know. SP3 reported she did not receive training on service plans. resident rights, disaster plans, or abuse and neglect.

On 02/28/2023, I interviewed SP4 and SP5 at the facility and their statements were consistent with those made by SP3.

On 02/28/2023, I interviewed health and wellness director Laurel Fulz at the facility. Ms. Fulz reported the training is “on the job training.” Ms. Fulz reported the first few days are shadowing another caregiver. Ms. Fulz reported as the training progresses, the trainee is expected to complete resident care. Ms. Fulz reported there is no set training program.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Interviews conducted revealed the facility has not established and implemented a staff training program. The facility has not assured that the employee receives training related to the functions and responsibilities of their role.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

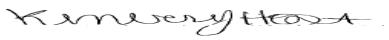
Ms. Fulz reported the facility does not have a checklist for caregiver and medication training. Ms. Fulz reported no program of ensuring training competency.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home’s administrator or its designees are responsible for evaluating employee competencies.

ANALYSIS:	Interviews conducted revealed the facility does not have a program to determine employee competencies and that the employee is fully able to demonstrate his or her learning obtained from the training program.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/09/2023

Kimberly Horst Date
Licensing Staff

Approved By:

03/09/2023

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