GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

Jennifer Hescott
Provision Living at Oshtemo
210 N. 9th Street
Kalamazoo, MI 49009

RE: License #: AH390412281
Investigation #: 2023A1028021
Provision Living at Oshtemo

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AH390412281
Investigation #:	2023A1028021
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/25/2023
Report Due Date:	03/19/2023
Licensee Name:	AEG Oshtemo Opco LLC
Licensee Address:	Ste 2017 9450 Manchester Rd. St. Louis, MO 63119
Licensee Telephone #:	(314) 272-4980
Administrator:	Janna Ritter
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at Oshtemo
Facility Address:	210 N. 9th Street Kalamazoo, MI 49009
Facility Telephone #:	(269) 231-3550
Original Issuance Date:	01/24/2023
License Status:	TEMPORARY
Effective Date:	01/24/2023
Expiration Date:	07/23/2023
Capacity:	99
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide appropriate care, protection, or safety for Resident A resulting in increased falls and injury.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A1028021
01/24/2023	Special Investigation Initiated - Letter No APS referral due to Resident A being deceased.
01/24/2023	Contact - Face to Face Interviewed Admin/Janna Ritter at the facility.
01/24/2023	Contact - Face to Face Interviewed Employee A at the facility.
01/24/2023	Contact - Face to Face Interviewed Employee B at the facility.
01/24/2023	Contact - Document Received Received Resident A's record from Admin/Janna Ritter.
01/24/2023	Inspection Completed On-site On-site inspection completed due to special investigation.

ALLEGATION:

Staff did not provide appropriate care, protection, or safety for Resident A resulting in increased falls and injury.

INVESTIGATION:

On 1/20/2023, the Bureau received the allegations through the online complaint system from a forwarding department.

On 1/24/2023, I interviewed the facility administrator, Janna Ritter, at the facility who reported Resident A was admitted to the facility in September 2022 and resided at the facility until December 2022 until Resident A was sent to the hospital and did not

return to the facility. Ms. Ritter reported it was later learned that Resident A passed at the hospital. Ms. Ritter reported Resident A was declining in health upon admission to the facility and received dialysis three days per week. Resident A was oriented x 3 with histories of chronic obstructive pulmonary disease (COPD) and was on supplemental oxygen, type II diabetes, end-stage renal disease, hypertension, history of cerebral aneurysm, and several other co-morbidities. Resident A was considered a fall risk due to left above the knee amputation and a prior fall history, resulting in Resident A requiring one person assist with transfers. However, Resident A could self-propel wheelchair and staff often escorted Resident A to and from dining and activities. Ms. Ritter reported Resident A would often get up on [their] own despite being instructed to use the call light system to request assistance. Ms. Ritter reported the facility has a motion and infrared fall monitoring system in each resident's room to monitor for falls and to alert staff as well. Resident A also had a transfer pole and pivot disc to use when transferring and staff were trained in the use of each. Ms. Ritter reported due to Resident A's falls, home health physical therapy and nursing were ordered with Resident A demonstrating some improvement but still requiring prolonged services. Ms. Ritter reported the facility conferenced with Resident A's authorized representative to update the service plan due to Resident A's falls and declining health. Ms. Ritter also reported the facility encouraged the family to consider hospice services for Resident A. Ms. Ritter reported Resident A was open to receiving hospice services, but Resident A's authorized representative declined hospice services. Ms. Ritter reported when Resident A was sent to the hospital on 12/13/2022, the facility attempted several times to reach out to Resident A's authorized representative to inquire on Resident A's status and to appropriately care plan once Resident A was released from the hospital, but the phone calls were never returned. Ms. Ritter provided me Resident A's record for my review.

On 1/24/2023, I interviewed Employee A at the facility who reported Resident A entered the facility in September 2022 with declining health. Resident A had COPD, type II diabetes, and end stage renal failure in which Resident A attended dialysis three times per week. Resident A was often very tired after dialysis, sometimes requiring increased assistance. Employee A reported knowledge that Resident A had prior fall history due to overall weakness and a left above the knee amputation. Resident A required a one person assist with all transfers. Employee A reported Resident A "was very with it and sharp. [Resident A] could advocate for [their self], but for whatever reason would not use the call light consistently even when told to". Employee A reported Resident A could self-propel the wheelchair independently, but staff often escorted Resident A to and from dining, common areas, and/or activities. Employee A reported Resident A would get up on [their] own despite reminders from staff to not get up on their own and to use the call light to request assistance. Employee A reported Resident A often like to sit on the edge of the bed and watch TV or read, with staff reminding Resident A to either sit in the wheelchair or to sit back in the bed to prevent falls. Employee A reported knowledge of two of Resident A's falls incurring from sitting on the edge of the bed and then dozing off despite staff instructing Resident A to not sit in that position. Employee A reported to their

knowledge Resident A's physician and therapy team were aware of Resident A's falls; and that while Resident A showed some improvement with therapy, Resident A still required prolonged training due to weakness. Employee A reported the facility conferenced with Resident A's authorized representative routinely to ensure appropriate care, and even encouraged hospice services, but Resident A's authorized representative declined hospice services. Employee A reported after the last fall occurred on 12/13/2022, the facility continued to reach out to Resident A's authorized representative to continue care planning for Resident A's return to the facility, but no communication was returned. Employee A reported the facility was initially unaware that Resident A had passed at the hospital.

On 1/24/2023, I interviewed Employee B at the facility whose statements are consistent with Ms. Ritter's statements and Employee A's statements. Employee B reported despite staff instructing Resident A to use the call light system and to not sit edge of bed, Resident A was often not compliant.

On 1/24/2023, I completed an on-site inspection due to this special investigation and no concerns were noted.

I reviewed Resident A's service plans dated 9/20/2022 and 10/26/2022 which revealed the following:

- Resident A was oriented x 3.
- Resident A did not exhibit behaviors or wandering.
- Requires assist/set-up with dressing and grooming.
- Requires physical assistance with bathing, toileting and managing lower extremity brace.
- Requires one person assist with all transfers. Resident A has a transfer pole and pivot disc to assist with transferring.
- Staff are to escort Resident A to desired destination(s) routinely.
- Uses a manual wheelchair and can self-propel.
- Requires assistance with Oxygen use and TED hose.
- Attends dialysis every Monday, Wednesday, and Friday.

I reviewed Resident A's therapy notes dated 10/11/2022 to 11/15/2022 which revealed Resident A was demonstrating some progress with completion of home exercise program, standing endurance, and transfers. However, Resident A still required moderate assist intermittently to complete transfers due to poor knee flexion, swelling, and poor standing endurance. Progression of transfer training was recommended by the therapy team.

I also reviewed Resident A's fall reports which revealed the following:

- Resident A's first fall occurred on 9/22/2022. Staff was assisting Resident A to transfer from bed to wheelchair when Resident A's *leg gave out and staff assisted resident down to the floor. No injury; and ROM and vitals were good.* Resident A's physician and authorized representative were notified.

- On 10/7/2022, Resident A incurred a second fall during a transfer from bed to wheelchair with staff assist. Resident A *experienced a standing problem with leg* when attempting transfer with staff assistance. Staff guided Resident A to the floor. *No injury and vitals were normal.* Resident A's physician and authorized representative were notified.
- On 10/11/2022, staff was assisting resident with transfer *and during transfer, [Resident A's] leg went out when reaching for the wheelchair.* Staff assisted resident to the floor and obtained vitals. Resident A's physician and authorized representative were notified.
- On 10/20/2022, Resident A incurred an unwitnessed fall and was found by staff on the floor. Resident A reported *"It was my fault, my leg gave out".* Resident A reported *[they] did not call [staff], [they] just got to the floor.* Resident A's physician and authorized representative were notified.
- On 11/4/2022, Resident A *was found laying on the floor close to bed and claimed to have pulled a pillow to put behind her head from the bed. Fall was not witnessed. Skin tear to right upper arm and back pain.* Skin tear was addressed and bandaged, and vitals were obtained. Resident A's physician and authorized representative were notified.
- On 12/9/2022, Resident A fell due to *sitting up at side of bed reading. [Resident A] dozed off while reading and fell forward onto the floor. [Resident A] scraped arm on wheelchair on the fall to floor. Hit head on floor.* Resident A's physician and authorized representative were notified.
- On 12/13/2022*, [Resident A] was sitting up at side of bed. [Resident A] dozed off while watching TV. Fell forward on to the floor.* A cut and bruise were reported to be observed by staff completing the report but unable to determine their locations on the body, as it is not marked on incident report. Resident A was educated on not sitting on edge of bed and subsequently sent to the hospital due to complaints of pain. Resident A's physician and authorized representative were notified.

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 staff did not provide appropriate care for Resident A resulting in increased falls with injury. Interviews and review of documentation reveal Resident A demonstrated an increase in falls, with seven falls occurring in less than three months from September 2022 to December 2022. Resident A used a transfer pole and pivot disc when transferring but it cannot be determined if staff implemented the use of these devices when assisting Resident A to transfer; as there is no evidence of documentation of staff using either. Review of documentation also reveals Resident A's care plan was not updated on 10/26/2022 or after to address demonstrated increase in falls, as Resident A continued to be a one person assist until the last fall at the facility occurred on 12/13/2022. There is evidence staff encouraged Resident A to use the call light system and to not sit edge of bed, however, there is no evidence Resident A's care plan was updated to address Resident A's demonstrated non-compliance with use of call light system and non-compliance of staff instruction to not sit edge of bed. Review of documentation also revealed a fall occurred on 12/9/2022 with Resident A hitting [their] head on the floor. There is no documentation Resident A was sent to the hospital or received further evaluation, despite documentation of hitting head during fall. The facility did not provide appropriate care, protection, or safety in relation to Resident A's demonstrated increase falls and/or falls with injury. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 1/24/203, I reviewed the department facility incident report file which revealed only one incident report from 12/13/2022 was provided to the department. No other incident reports from Resident A's falls and/or falls with injuries were provided to the department prior to this special investigation.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	At the on-site inspection, the facility provided me with six additional incident reports in which Resident A fell and/or fell with injury. Review and comparison of the department facility file after on-site inspection revealed only one incident report was submitted to the department on 12/13/2022 concerning Resident A's fall with injury and subsequent hospital visit. Incidents and/or accidents are to be reported to the department within 48 hours of the occurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

1/30/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

03/21/2023

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