GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

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

RE: License #: AH410381380
Investigation #: 2023A1021039
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 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 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 #:	2023A1021039
Complaint Receipt Date:	02/16/2023
Investigation Initiation Date:	02/17/2023
Report Due Date:	04/18/2023
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?
Multiple residents have fallen at the facility.	No
Call lights are not answered timely.	No
Caregivers are under influence of marijuana.	No
Medications are not administered.	Yes
Residents are not bathed.	No
Additional Findings	No

III. METHODOLOGY

02/16/2023	Special Investigation Intake 2023A1021039
02/16/2023	APS Referral referral came from APS
02/17/2023	Special Investigation Initiated - On Site
02/20/2023	Contact - Document Received Received facility documents
02/21/2023	Contact-Document Received Received complaint with additional information
02/28/2023	Inspection completed on site
04/20/2023	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Multiple residents have fallen at the facility.

INVESTIGATION:

On 02/16/2023 and 02/21/2023, the licensing department received an anonymous complaint from Adult Protective Services (APS) with allegations multiple residents have fallen at the facility. The complainant alleged numerous residents have fallen and later pass away. The complainant did not provide resident names.

Due to the anonymous nature of the complaint, I was unable to contact the complainant for additional information.

On 02/17/2023, I interviewed administrator Amy Simon at the facility. Ms. Simon reported the facility has had two deaths since January 2023. Ms. Simon reported both deaths were expected as the residents were active with hospice care. Ms. Simon reported there have not been any suspicious deaths or deaths that were not expected. Ms. Simon reported the facility has not experienced an increase in falls.

On 02/17/2023, I interviewed staff person 6 (SP6) at the facility. SP6 reported the facility has not had an increase in deaths or any suspicious deaths. SP6 reported there are some residents that fall, but the falls cannot always be prevented. SP6 reported no concerns with the care the residents receive.

On 02/17/2023, I interviewed SP7 at the facility. SP7 reported there have not been any suspicious deaths at the facility. SP7 reported residents receive adequate care.

On 02/17/2023, I interviewed SP4 at the facility. SP4 statements were consistent with those made by SP6 and SP7.

On 02/28/2023, I interviewed Resident I at the facility. Resident I reported the facility is a good place to live and caregivers provide good care. Resident I reported no concerns about the care provided at the facility.

I reviewed facility incident reports submitted to the department. The incident reports revealed in February there were two residents that fell that required medical evaluation.

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:	Interviews conducted and review of documentation revealed lack of evidence to support the allegation there is an increase in falls and deaths at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Call lights are not answered timely.

INVESTIGATION:

On 02/17/2023, a complaint was received with allegations residents will go two-three hours without their call light answered.

Ms. Simon reported the expectation is for call lights to be answered within 15 minutes or less. Ms. Simon reported she reviews the call light response time, and the average response time is between 12-18 minutes. Ms. Simon reported call light response time has improved over the past few months. Ms. Simon reported the facility recently changed staffing assignments which has helped with residents that are a two person assist. Ms. Simon reported the facility recently conducted a resident council meeting and family council meeting and no concerns were raised about call light response time.

SP3 reported all employees are expected to respond to call light response times. SP3 reported it may take staff some time to respond to the call light, but it is never more than 20 minutes.

I reviewed call light response time log for 02/11/2023 to 02/17/2023. The report revealed the average call light response time was 16 minutes.

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.**
	(4) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.
ANALYSIS:	Interviews conducted and review of call light response times revealed overall the facility is consistent with meeting the response time expectation set forth by the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Caregivers are under influence of marijuana

INVESTIGATION:

The complainant alleged about three months ago, care aides were smoking marijuana on the job. The complainant did not provide any employee names.

Ms. Fultz reported a few months ago, management reported to the facility after hours to assist caregivers with an unexpected death. Ms. Fultz reported there was a smell of marijuana in the facility. Ms. Fultz reported the administrator, Dolanda Scott, completed an investigation and no evidence was found to support the concern of marijuana use.

While onsite I observed multiple employees at the facility. I did not smell any marijuana or observe any caregivers to be acting erratically.

On 03/07/2023, I interviewed interim administrator Dolanda Scott by telephone. Ms. Scott reported she was at the facility after normal business hours and smelt

marijuana on a caregiver. Ms. Scott reported the investigation determined marijuana was not consumed within the building. Ms. Scott reported the staff member might have had the smell on her clothes or from her vehicle. Ms. Scott reported an all-staff meeting was held to discuss drug use and the caregiver resigned at that time. Ms. Scott reported the facility does not conduct drug screening upon hire and only screens caregivers when the caregiver is acting out of character. Ms. Scott reported this was an isolated incident and was handled appropriately.

APPLICABLE RULE	
R 325.1923	**Employee's health.**
	(1) A person on duty in the home shall be in good health. Files shall be maintained containing evidence of adequate health, such as results of examinations by a qualified health care professional and tuberculosis screening which consists of an intradermal skin test or chest x-rays, or other methods recommended by the local health authority. Records of accidents or illnesses occurring while on duty that place others at risk shall be maintained in the employee's file.
ANALYSIS:	Interviews conducted revealed there was an isolated incident of possible marijuana use. While this event did occur, it was an isolated incident and is not a systemic issue throughout the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are not administered.

INVESTIGATION:

The complainant alleged residents will go days without their medications and residents are being given the wrong medications.

Ms. Simon reported the facility has a medication compliance report that is generated weekly. Ms. Simon reported the number of missed medications has declined. Ms. Simon reported the facility re-structured the medication cards to ensure residents are receiving medications on time. Ms. Simon reported there are always medication technicians scheduled to work.

On 02/17/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported there is always a medication technician in the building. SP1 reported sometimes medications are late but residents receive medications.

On 02/28/2023, I interviewed wellness director Laurel Fultz at the facility. Ms. Fultz reported the facility's preferred pharmacy, Guardian Pharmacy, provides a shipment of medications monthly. Ms. Fultz reported if a new medication is ordered after 4:00pm, the resident may not receive the medication that day as the shipment for medications was already placed. Ms. Fultz reported at times the medication technicians will not administer a medication because the medication technician cannot find the medication in the medication cart.

I reviewed Medication Compliance Report. The report revealed the following non-compliance issues:

Resident B: 02/17/2023 Ropinirole: drug unavailable: Drug in cart
Resident C: 02/16/2023: Omeprazole: drug unavailable: Drug in cart
Resident D: 02/13/2023: Atenolol: drug unavailable: Drug in cart
Resident E: 02/20/2023: Folic Acid: drug unavailable: Drug in cart
Resident E: 02/20/2023: Polyethylene glycol: Drug unavailable: Drug in cart
Resident F: 02/16/2023: Gabapentin: Drug unavailable
Resident G: 02/19/2023: Lorazepam: Drug unavailable
Resident H: 02/20/2023: Estradiol Cream: Drug unavailable

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Medication Compliance Report revealed multiple residents missed medications due to the fact that the medication was unavailable or the medication could not be found in the medication cart.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not bathed.

INVESTIGATION:

The complainant alleged many residents have odors and are not bathed regularly. The complainant did not provide resident names.

Ms. Fultz reported the facility has a Care Assist Application that populates resident showers. Ms. Fultz reported the medication technician has the application and tells the caregivers who is to receive a shower that day. Ms. Fultz reported the medication technician is responsible to ensure residents receive showers. Ms. Fultz reported there is a shower schedule in the memory care unit. Ms. Fultz reported in assisted living, is the responsibility of the medication technician to inform the care staff of the showers.

SP4 reported some if the resident is cognitively able to do so, the resident will request a shower. SP4 reported otherwise the medication technician informs the caregivers which residents are scheduled for a shower. SP4 reported the medication technician documents that a shower was provided.

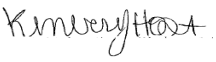
Onsite I observed multiple residents. The residents appeared to be well kept as observed by their hair was washed, skin was clean, and the residents did not have an odor.

I reviewed medication administration records (MAR) for four residents. The MAR revealed residents were showered twice a week.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Observations made and review of documentation revealed lack of evidence to support the allegation residents are not showered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



3/7/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

04/18/2023

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