GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2025

Kristie Nagle
Provision Living at Forest Hills
730 Forest Hill Avenue
Grand Rapids, MI 49546

RE: License #: AH410381380
Investigation #: 2025A1028056
Provision Living at Forest Hills

Dear Kristie Nagle:

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 responsible 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH410381380
Investigation #:	2025A1028056
Complaint Receipt Date:	05/07/2025
Investigation Initiation Date:	05/08/2025
Report Due Date:	07/06/2025
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:	Courtland Halleck
Authorized Representative:	Kristie Nagle
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	116
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell on 4/18/2025 resulting in injury and the facility did not seek medical attention for Resident A after the fall. The family was not notified of the fall.	No
Resident B went 24 hours without medication.	Yes
Additional Findings	No

III. METHODOLOGY

05/07/2025	Special Investigation Intake 2025A1028056
05/08/2025	Special Investigation Initiated - Letter
05/08/2025	APS Referral Referred to HFA
05/08/2025	Contact - Face to Face Interviewed the facility administrator at the facility.
05/08/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
05/08/2025	Contact - Document Received Received requested documentation from the administrator.
05/08/2025	Contact - Face to Face Interviewed Resident A at the facility.

Please note the facility is a Homes for the Aged (HFA) facility and is not licensed to provide medical care or continuous nursing care.

ALLEGATION:

Resident A fell on 4/18/2025 resulting in injury and the facility did not assess Resident A for injury after the fall. The family was not notified of the fall.

INVESTIGATION:

On 5/8/2025, the Bureau was forwarded the allegations through the online complaint system from Adult Protective Services (APS) by Centralized Intake.

On 5/13/2025, I interviewed the facility administrator at the facility who reported Resident A is their own person and their assigned authorized representative is [their] spouse who resides with [them]. The administrator confirmed Resident A fell on 4/18/2025 due to self-transferring while attempting to stand on the scale in the exercise room. Resident A's spouse was present during the fall and staff were alerted to the fall. Staff arrived and assessed Resident A for injury. Resident A was oriented x 4 and was assisted back to the wheelchair. Resident A made no complaint at that time about pain or discomfort and did not present with any observable injuries, but staff completed a fall report and monitored Resident A for the remainder of the day to ensure health and wellbeing. On 4/19/2025, Resident A complained of pain and Resident A was sent to the hospital for evaluation. It was determined at the hospital that Resident A incurred rib fractures. Resident A returned to the facility later with no new physician orders. The administrator provided me with the requested documentation for my review.

On 5/13/2025, I interviewed Employee 1 at the facility who confirmed Resident A fell on 4/18/2025 and did not complain of any pain or discomfort at that time but was monitored by facility staff to ensure health and well-being. Resident A did not demonstrate any injury at that time either. On 4/19/2025, Resident A began to complain of pain and was sent to the hospital for treatment. It was determined that Resident A incurred rib fractures related to the fall. Resident A returned to the facility with no new physician orders. Employee 1 reported [they] checked on Resident A on 4/22/2025 with a family member present and no concerns were expressed by Resident A or the family member at that time. Employee 1 reported [they] also re-confirmed at this time that Resident A had no new physician orders from the hospital visit. Resident A did not have any new physician orders at that time either.

On 5/13/2025, I interviewed Resident A at the facility who confirmed [they] fell on 4/18/2025, but did not experience any pain until 4/19/2025. Resident A reported that [they] had pain in the hips and ribs to a visiting family member, but did not tell facility staff about it. The family member reported it to staff and Resident A was sent to the hospital. Resident A reported they did not have any new orders or medication when they returned to the facility, but that family took [them] to a doctor appointment on 5/3/2025. Resident A reported a CT scan was completed at the doctor appointment and it showed [they] had sacral fractures from the fall as well. Resident A reported they were told to take Tylenol for treatment. When asked if the facility was aware [they] had sacral fractures and that [they] were prescribed Tylenol, Resident A reported [they] did not say anything to staff about it, that [they] thought the doctor would tell the facility.

On 5/13/2025, after interviewing Resident A, I spoke with the administrator and Employee 1 to inquire if either were aware that Resident A had a CT scan on 5/3/2025 that showed sacral fractures. I also informed them Resident A was prescribed Tylenol to treat. Employee 1 reported Resident A uses an outside physician and not the facility's visiting physician, and there has been no communication from the physician, Resident A, or Resident A's family about any new diagnoses. The administrator and Employee 1 reported the facility was not notified of the CT scan or that Resident A had sacral fractures. Employee 1 reported Resident A self-administers medication, but the facility was not aware that Resident A had a new prescription for Tylenol. The facility administrator reported that despite some residents being deemed appropriate to self-administer medications, the facility still documents all medications in the facility. The administrator and Employee 1 went to Resident A to discuss this new information.

On 5/13/2025, I reviewed the requested documentation:

***Please note at the time of the investigation, the facility was unaware of and was not informed that the family took Resident A to the doctor on 5/3/2025 for an outpatient CT scan of the hip and pelvis until I presented this information to them during the interview. The CT scan showed Resident A has bilateral sacral fractures. The facility was also not aware Resident A was given a prescription for Tylenol for treatment.

***Please note that Resident A (and Resident B's) durable power of attorney (DPOA) documents were reviewed during this investigation. The documents showed that Resident A (and Resident B) are the primary DPOA's for each other. While family members are listed as secondary on the DPOA documents, Resident A and Resident B are not deemed incompetent and are considered each other's primary person. Due to the DPOA specification and the fact that Resident A's spouse witnessed Resident A's fall at the facility, the facility was not legally required to notify Resident A's extended family about the fall. However, after speaking with the administrator and Employee 1, they both reported to me that they will obtain Resident A and Resident B's permission to notify the extended family members going forward of any incidents that may occur.

Resident A's service plan shows the following:

- Resident A is oriented x 4 and demonstrates no cognitive or memory issues/deficits.
- Resident A requires assistance with bathing and transferring in/out of the shower, dressing, toileting, and stand by assistance to assistance for mobility and transferring.
- Resident A self-administers medication.
- Transportation is provided by the family.

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.**

ANALYSIS:	It was alleged Resident A fell on 4/18/2025 resulting in injury and the facility did not assess Resident A for injury after the fall. The family was not notified of the fall. Interviews, onsite investigation, and review of documentation reveal the following: • Resident A incurred a fall on 4/18/2025 and did not express pain or discomfort at that time, but facility staff completed an incident report and monitored Resident A. • Resident A complained of pain on 4/19/2025 to a visiting family member with the family member informing staff. • Resident A went to the hospital on 4/19/2025 and returned later with no new physician orders. • The facility followed up with Resident A and the family member on 4/22/2025 to ensure no new physician orders were received. • On 5/3/2025, the family took Resident A to an outpatient appointment for a CT scan of the hips and pelvis. It showed Resident A had sacral fractures and was prescribed Tylenol to treat. • The facility was not informed by the physician, Resident A, or Resident A's family that Resident A had sacral fractures or that Tylenol was prescribed to treat. • The facility was not legally obligated to notify Resident A's family of the fall because Resident A's primary DPOA is [their] spouse, who witnessed the fall. The facility took appropriate measures to ensure Resident A was monitored after incurring a fall while attempting to self-transfer. Resident A was sent to the hospital in a timely manner for evaluation and treatment after staff were notified of Resident A's complaints of pain. The facility also ensured Resident A's physician orders were up to date upon return from the hospital. Communication between the facility, Resident A, Resident B, the family, and the physician could be enhanced to ensure knowledge sharing, however, there is no violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B went 24 hours without medication.

INVESTIGATION:

On 5/13/2025, the administrator reported knowledge that Resident B went without medications in May 2025 due to an issue with the pharmacy medication cycling re-order system. Refills are supposed to be automatically sent to the facility by the pharmacy every 28 days, however, the administrator reported that the medication had not been sent to the facility by the pharmacy on the automatic system. Staff attempted to enter emergency orders into the system and the orders were rejected multiple times because the system error showed the orders were being entered too soon. Staff contacted the pharmacy to inform them that Resident B was out of 3 medications, that the automatic system was rejecting orders, and to place a rush order for the 3 medications. Resident B and [their] authorized representative, (Resident A) were notified of the medication order issues and that the 3 medications were not available, but that the facility was working with the pharmacy to obtain the 3 medications. The administrator provided the requested documentation for my review.

On 5/13/2025, Employee 1's statement was consistent with the administrator's statement. Employee 1 also reported that Resident B is on hospice services, and they also monitor medications. Employee 1 also confirmed that pharmacy's automatic medication cycling system was fixed and there have been no issues with medications since.

On 5/13/2025, Resident A confirmed that Resident B had missed 3 medications in early May 2025. Resident A reported the facility staff told [them] that the medications were not sent to the facility by the pharmacy and that the facility was working with the pharmacy to obtain them.

On 5/13/2025, I reviewed the requested documentation which revealed the following:

- Resident B is to take one tablet of Carbidopa-Levodopa (Sinemet) 25-100 mg by mouth three times daily 45 minutes before or after meals.
    - From 5/5/2025 from 2:00 pm to 5/7/2025 at 8:00 am, the medication was unavailable to administer.
    - Resident B also did not receive the medication on 5/7/2025 at 2:00pm and 5/8/2025 at 2:00 pm. There was not a reason other than "Other/See Progress Notes" documented in the record as to why Resident B did not receive the medication. No further progress notes were provided in the medication administration record.
    - Evidence that on 5/6/2025, an order was entered for the medication, but the pharmacy rejected the order because the refill was entered too soon.
    - On 5/12/2025, the medication administration record is blank for the 8:00 am entry and it cannot be determined if Resident B received the medication or not.

- Resident B is to take one capsule of Gabapentin 300 mg by mouth twice daily.

- From 5/5/2025 at 7:00 pm to 5/6/2025 at 7:00 pm, the medication was not available to administer.
- Evidence that on 5/7/2025, an order was entered for the medication, but the pharmacy rejected the order because the refill was entered too soon.
- On 5/12/2025, the medication administration record is blank for the 8:00 am entry and it cannot be determined if Resident B received the medication or not.

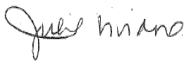
- Resident B is to take one tablet of Senna-Time-8.6 mg by mouth twice daily.
  - From 5/2/2025 at 4:00 pm to 5/7/2025 at 4:00 pm, the medication was not available.
  - Evidence an order was entered for the medication and that the pharmacy rejected the order because the refill was entered too soon, but the dates listed are 3/1/2025 and 3/17/2025. No other reorder evidence for this medication was provided for the month of May 2025.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	It was alleged that Resident B went 24 hours without medication. Interviews, onsite investigation, and review of documentation revealed the following: • Resident B missed medication administration for Carbidopa-Levodopa (Sinemet) from 5/5/2025 at 2:00 pm to 5/7/2025 at 8:00 am due to the medication being unavailable. • It cannot be determined whether Resident B received Carbidopa-Levodopa (Sinemet) or not on 5/7/2025 at 2:00pm and 5/8/2025 at 2:00 pm because there are no reasons or progress notes in the record. • The medication administration record (MAR) was blank on 5/12/2025 for Carbidopa-Levodopa (Sinemet). It cannot be determined whether Resident B received the medication or not due to the blank entry. • Resident B missed medication administration of Gabapentin from 5/5/2025 at 7:00 pm to 5/6/2025 at 7:00 pm due to the medication being unavailable. • The MAR was blank on 5/12/2025 for Gabapentin. It cannot be determined if Resident B received the medication or not due to the blank entry. • Resident B missed medication administration for Senna from 5/2/2025 at 4:00 pm to 5/7/2025 at 4:00 pm. • The documentation for the facility's attempts to reorder Senna does not match. The documentation provided listed reorder dates as 3/1/2025 and 3/17/2025, but the medication was not available from 5/2/2025 at 4:00 pm to 5/7/2025 at 4:00 pm. • There is evidence that the facility attempted to reorder all of the medications, but the orders were rejected by the pharmacy's automatic medication cycling system because the refill orders were entered too soon to dispense. Due to the multiple discrepancies in the record, the facility is in violation of not administering medications in accordance with Resident B's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.



5/20/2025

Julie Viviano Date
Licensing Staff

Approved By:

05/29/2025

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