GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2021

Kaitlyn Fuerstenberg
Story Point of Grand Ledge
11555 Silverstone Lane
Grand Ledge, MI 48837

RE: License #:	AH230342257
Investigation #:	2021A1021034
	Story Point of Grand Ledge

Dear Ms. Fuerstenberg:

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 #:	AH230342257
Investigation #:	2021A1021034
Complaint Receipt Date:	06/25/2021
Investigation Initiation Date:	06/25/2021
Report Due Date:	08/25/2021
Licensee Name:	Senior Living Grand Ledge, LLC
Licensee Address:	2200 Genoa Business Pk Dr Brighton, MI 48114
Licensee Telephone #:	(517) 622-0625
Administrator:	Holly Ridenour
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	Story Point of Grand Ledge
Facility Address:	11555 Silverstone Lane Grand Ledge, MI 48837
Facility Telephone #:	(517) 622-0625
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	05/22/2021
Expiration Date:	05/21/2022
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered injuries at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/25/2021	Special Investigation Intake 2021A1021034
06/25/2021	Special Investigation Initiated - Telephone contacted admin to request census to ensure resident was a resident of facility
06/29/2021	Inspection Completed On-site
06/29/2021	Contact - Telephone call made interviewed caregiver Erin Perlick
06/29/2021	Contact - Telephone call made interviewed caregiver Sharee Landers
06/29/2021	Contact-Telephone call made Interviewed caregiver Erin Perlick
07/02/2021	Contact-Telephone call made Interviewed caregiver Derek Brainard
07/07/2021	Contact-Telephone call made Interviewed caregiver Dixie
	Exit Conference

ALLEGATION:

Resident A suffered injuries at the facility.

INVESTIGATION:

On 6/25/21, the licensing department received a complaint with allegations Resident A had bruising on her arms, legs, and thighs. In addition, Resident A had skin tears and bruising on her hands.

The complaint was forwarded from Adult Protective Services (APS) and the complaint was denied.

On 6/28/21, I interviewed Brightwell Behavioral Health social worker Allison Stockmeyer by telephone. Ms. Stockmeyer reported Resident A admitted to Brightwell Behavioral Health on 6/24 from Sparrow Hospital. Ms. Stockmeyer reported the facility completed a skin assessment on Resident A and found Resident A to have multiple bruises and skin tears. Ms. Stockmeyer reported Resident A is a poor historian and is oriented only to herself. Ms. Stockmeyer reported Resident A reported falling on her bottom, but the bruises do not reflect a fall on her bottom. Ms. Stockmeyer reported Resident A has bruising on her arms, legs, and inner thighs. Ms. Stockmeyer reported Resident A also has skin tears and wounds on her hands.

On 6/29/21, I interviewed resident supervisor Helen Sheets at the facility. Ms. Sheets reported Resident A was sent to the hospital on 6/23 due to agitation with staff members and other residents. Ms. Sheets reported Resident A became agitated and started digging her nails into her hands and that is where the hand wounds came from. Ms. Sheets reported Resident A did not allow caregivers to provide medical attention. Ms. Sheets reported emergency medical services (EMS) was called and transported Resident A to the hospital. Ms. Sheets reported Resident A did have a fall on 6/17. Ms. Sheets reported Resident A fell on her bottom but did not have any injuries. Ms. Sheets reported Resident A was independent with dressing herself and required minimal assistance with showering. Ms. Sheets reported Resident A wore pants and therefore no bruises were noted on Resident A's legs. Ms. Sheets reported no knowledge of bruising on Resident A's legs.

On 6/29/21, I interviewed supervisor Chelsea Montgomery at the facility. Ms. Montgomery reported the wounds on Resident A's hands occurred during the transfer to the hospital. Ms. Montgomery reported Resident A was very agitated and dug her hands into her arms and caused them to bleed and have skin tears. Ms. Montgomery reported Resident A and Resident B had a verbal altercation, but it was not physical. Ms. Montgomery reported Resident A was unsteady and could have fallen and not told caregivers. Ms. Montgomery reported no knowledge of bruising on Resident A's legs.

On 6/29/21, I interviewed caregiver Sharee Landers by telephone. Ms. Landers reported she showered resident once and noticed bruising on her thigh. Ms. Landers reported the bruise was from an altercation with Resident B. Ms. Landers reported Resident B shoved Resident A into a corner with her walker and hit Resident A in

the legs. Ms. Landers reported the wounds on Resident A's hands occurred when Resident A was agitated and dug her own nails into her hands and arms.

On 6/29/21, I interviewed caregiver Erin Perlick by telephone. Ms. Perlick reported Resident A was sent to the hospital on 6/23 due to agitation. Ms. Perlick reported she provided care to Resident A on 6/23. Ms. Perlick reported Resident A was observed to hit another resident in the head and was verbally aggressive to staff and other residents. Ms. Perlick reported Resident A grabbed her hair and pushed her. Ms. Perlick reported it was determined to send Resident A to the hospital and EMS was called for transport. Ms. Perlick reported Resident A dug her nails into her arms and hands which caused Resident A to have skin tears. Ms. Perlick reported Resident A did have a bruise on her thigh from an altercation with Resident B. Ms. Perlick reported this altercation happen approximately two weeks ago. Ms. Perlick reported she observed Resident B hit Resident A with her walker. Ms. Perlick reported after the altercation she observed Resident A's leg was swollen and a bruise was on her leg. Ms. Perlick reported she reported this to Ms. Montgomery and Ms. Montgomery advised caregivers to put ice on Resident A's leg. Ms. Perlick reported she told Ms. Montgomery an incident report was needed but she is unsure if an incident report was completed. Ms. Perlick reported the next day Resident A and Resident B got into a verbal altercation, the following day Resident B hit another caregiver, and then Resident B was sent to the hospital for a medical evaluation. Ms. Perlick reported caregivers were to watch Resident A and Resident B for altercations, but this instruction was never formally communicated.

On 7/2/21, I interviewed caregiver Derek Brainard by telephone. Mr. Brainard reported Resident B was known to verbally harass Resident A. Mr. Brainard reported he observed Resident A and Resident B have a verbal altercation, but it was not physical. Mr. Brainard reported caregivers were able to separate the two residents.

On 7/7/21, I interviewed Dixie by telephone. Ms. Dixie reported she showered Resident A at the facility and observed a large bruise on Resident A's leg. Ms. Dixie reported she did not know where Resident A received the bruise, and she informed the lead caregiver of the large bruise on Resident A's leg.

I reviewed the *Shower Sheet for* Resident A that was dated 6/11/21. Within the note section, caregiver noted "bruises on right thigh and left buttocks."

I reviewed the *Shower Sheet* for Resident A that was dated 6/15/21. Within the note section, caregiver noted "bruised on R thigh."

I reviewed the service plan for Resident A. The service plan read,
"Wanders aimlessly or in undirected fashion without definable or obtainable purpose. Not a disturbance to others."

I reviewed Resident A's record. The record revealed no documentation nor incident report completed of the altercations between Resident A and Resident B. In addition,

there was no documentation of follow up regarding the bruising on Resident A's legs that was noted on the 6/11 and 6/15 Shower Sheet.

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 with staff members revealed Resident A and Resident B had a physical altercation which resulted in bruising on Resident A's legs. After this altercation, there was no update to her service plan, interventions, or medical attention, to ensure the well-being and safety of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A was sent to the hospital on 6/23 for behavioral issues and was admitted to the hospital.

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 the behaviors and aggression towards others that resulted in hospitalization for change in status for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident B was sent to the hospital on 6/10 for a behavioral assessment.

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 or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	The facility did not submit an incident report to the department regarding Resident A's hospitalization for aggression towards caregivers and change in status.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

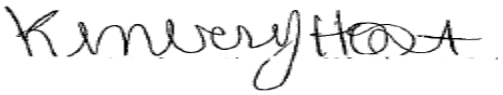
Review of Resident A's medication administration record (MAR) revealed Resident A was prescribed Clonazepam 0.5mg tablet with instruction to administer ½ tablet by mouth three times a day as needed for agitation. Review of Resident A's service plan revealed no methodologies for staff to implement regarding aggressive behavior in Resident A.

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:	Review of Resident A's service plan revealed the service plan omits information regarding aggression. The service plan neglects how Resident A exhibits these behaviors and what behaviors require the administration of the medication or if staff can use nonpharmaceutical interventions.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/19/21, I conducted an exit conference with authorized representative Kaitlyn Fuerstenberg by telephone. Ms. Fuerstenberg reported corporate has planned an in-serivice on service planning and incident reporting later this month. Ms. Fuerstenberg had no questions regarding the findings in this report.

IV. RECOMMENDATION

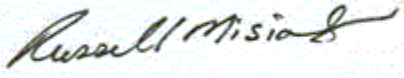
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



7/16/21

Kimberly Horst — Date
Licensing Staff

Approved By:



7/16/21

Russell B. Misiak — Date
Area Manager