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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 30, 2022

Katelyn Fuerstenberg
Senior Living Portage, LLC
950 Corporate Office Dr. Ste. 150
Milford, MI 48381

RE: License #: AH390377735
Investigation #: 2022A1010046
StoryPoint of Portage

Dear Mrs. 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 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH390377735
Investigation #:	2022A1010046
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/06/2022
Report Due Date:	08/03/2022
Licensee Name:	Senior Living Portage, LLC
Licensee Address:	2200 Genoa Business Pk Dr Brighton, MI 48114
Licensee Telephone #:	(810) 220-2200
Administrator:	Martila Sanders
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint of Portage
Facility Address:	3951 W. Milham Ave. Portage, MI 49024
Facility Telephone #:	(269) 329-0200
Original Issuance Date:	04/24/2017
License Status:	REGULAR
Effective Date:	10/24/2021
Expiration Date:	10/23/2022
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff do not carry the proper equipment required to see and respond to resident pendants.	No
Staff did not weigh resident A daily.	Yes
Staff have left Resident A's prescribed arthritis cream in her room without applying it.	No

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A1010046
06/06/2022	Special Investigation Initiated - Telephone Interviewed APS complainant by telephone
06/09/2022	Inspection Completed On-site
06/09/2022	Contact - Document Received Received resident service plan and MAR
09/30/2022	Exit Conference Completed with administrator Martila Sanders

ALLEGATION:

Staff do not carry the proper equipment required to see and respond to resident pendants.

INVESTIGATION:

On 6/3/22, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, "Yesterday 6.1.22 [Resident A] rang her button at 5:32pm and at 5:55pm [Relative A1] had to go look for someone for help. The worker did not have their phone on them. In the past workers would state that their phones are only hooked up to memory care and that if someone needed help, they needed to come get them. [Resident A] cannot go get anyone for help."

On 6/6/22, I interviewed the complainant by telephone. The complainant stated last week it was observed a staff person was not equipped to receive notifications after a

resident pushed their pendant for assistance. The complainant reported the staff person said she “hadn’t turned her phone on yet.” The complainant said she observed the staff person cleaning in the kitchen area, not answering resident pendants. The complainant explained staff are supposed to carry cell phones on their person during their shift to receive notifications anytime a resident pushed their pendant for assistance.

The complainant reported there have been instances when she observed staff physically turn on their cell phones after being approached regarding resident pendants not being answered. The complainant stated staff have told her to physically find a staff person, rather than use the pendant to summon for assistance. The complainant said this is concerning because residents, such as Resident A, are unable to physically get up and get a staff person when they need help.

On 6/9/22, I interviewed wellness director Moriah Newberry at the facility. Ms. Newberry reported staff carry their personal cell phones on their person during shifts to receive resident pendant notifications. Ms. Newberry explained staff who use their personal cell phones download an app called “Atmos” to receive the pendant notifications. Ms. Newberry explained staff that do not have a personal cell phone or staff that do not want to use their personal cell phones are able to use facility provided iPhones that have the “Atmos” app already downloaded and ready for use.

Ms. Newberry reported the only complaint she received regarding staff not responding to resident pendants was from Relative A1. Ms. Newberry stated Relative A1 stated staff did not have their personal cell phones on to receive resident pendant notifications. Ms. Newberry denied knowledge regarding staff either not carrying their personal cell phones on them or not being logged into the “Atmos” app to receive resident pendant notifications.

On 6/9/22, I interviewed administrator Martila Sanders at the facility. Ms. Sanders’ statements were consistent with Ms. Newberry.

On 6/9/22, I interviewed medication technician (med tech) Jenna Overley at the facility. Ms. Overley’s statements regarding staff using their personal cell phones and the “Atmos” app or facility provided iPhones were consistent with Ms. Newberry and Ms. Sanders.

Ms. Overley reported there were instances when she approached other staff persons regarding them not answering resident pendants. Ms. Overley stated the staff persons admitted they were not logged into the “Atmos” app so they wouldn’t receive notifications. Ms. Overley said some staff have told her they “didn’t know how” to log into the “Atmos” app, therefore they were not getting pendant notifications. Ms. Overley reported she brought this issue to upper management’s attention and three staff persons who were intentionally not logging into the “Atmos” app were recently terminated.

Ms. Overley said staff were trained how to use and how to log into the “Atmos” app upon hire at the facility. Ms. Overley showed me where the facility provided iPhones are kept in the secured nurse’s station. I observed the iPhones were plugged in and ready for staff use.

On 6/9/22, I interviewed care staff person Bethany Nakken at the facility. Ms. Nakken’s statements were consistent with Ms. Overley.

On 6/9/22, I interviewed Resident A’s Corsocare Hospice nurse Carla Gaikis at the facility. Ms. Gaikis denied having concerns regarding care staff. Ms. Gaikis stated she has pushed Resident A’s pendant for staff assistance and the response time was quick.

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:	The Interviews with the complainant, Ms. Overley, and Ms. Nakken revealed there were care staff who did not log into the “Atmos” app to receive resident pendant notifications. Ms. Overley reported the staff who did this were recently terminated for poor work performance. Ms. Newberry, Ms. Sanders, Ms. Overley, and Ms. Nakken reported staff are trained how to use and log into the “Atmos” app upon hire at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not weigh resident A daily.

INVESTIGATION:

On 6/3/22, the complaint read “[Resident A] is suppose [sic] to get weighed daily to monitor her weight due to swelling. If [Resident A] gains over three pounds a nurse is suppose [sic] to be notified immediately. On 5.01.22 [Resident A] weighed 125 pounds on May 7 she weighed 139. Documents showed that she weight [sic] 125 from 5.1.22-5.7.22. Management stated that she was on monthly weights instead of daily weights.”

On 6/6/22, The complainant reported Resident A had a physician order to be weighed daily by staff. The complainant stated the facility weighed Resident A monthly, not daily. The complainant said Resident A's medication administration record (MAR) for the month of May shows she was not weighed daily.

On 6/9/22, Ms. Newberry stated Resident A was admitted to the facility in February 2022. Ms. Newberry explained before Resident A was admitted to the facility, she resided in an independent living apartment on the facility's campus. Ms. Newberry reported Resident A fell and fractured her leg when she lived in independent living. Ms. Newberry said Resident A was at a skilled nursing rehabilitation facility before she was admitted in February.

Ms. Neberry reported Resident A did not have a written physician order to be weighed daily. Ms. Newberry reported she made an error when she entered information into Resident A's MAR. Ms. Newberry said she accidently entered that Resident A was to be weighed daily, however it is the facility's policy and procedure to weigh residents monthly. Ms. Newberry reported Resident A was weighed monthly, per the facility's policy and procedure.

Ms. Newberry provided me with a copy of Resident A's service plan for my review. A handwritten note written at the bottom of the plan read, "Daily weights MN – Discontinued when signed onto hospice MN. Reposition every 3 hours and check brief MN." The plan did not outline when Resident A was to be weighed by staff.

Ms. Newberry provided me with a copy of Resident A's February, March, April, and May 2022 MARs for my review. Resident A's February MAR read, ""Daily weight If there is a 3 pound weight gain in 24 hours please alert Moriah ASAP! Resident has a personal scale in room." The MAR read Resident A's weight was taken 2/16/22 through 2/28/22.

Resident A's March MAR read Resident A's weight was taken every day as written, except on 3/21/22. The *Exceptions* section of the March MAR read, "21-Mar-2022 10:09 AM Daily weight RESIDENT REFUSSED." Resident A's April MAR read Resident A's weight was taken every day as written, except on 4/16/22 and 4/17/22. The *Exceptions* section of the April MAR read, "16-Apr-2022 11:50 am Daily weight PHYSICALLY UNABLE TO TAKE" and "17-Apr-2022 9:53 AM daily weight RESIDENT REFUSED."

Resident A's May MAR read Resident A's weight was taken every day as written except on 5/8/22, 5/9/22, 5/10/22, 5/11/22, and 5/12/22. The MAR read Resident A's daily weights were to be discontinued beginning 5/27/22. The *Exceptions* section of the May MAR read, "8-May-2022 7:52 AM Daily weight OUT OF FACILITY."

On 6/22/22, Ms. Overley reported she and other staff have been taking Resident A's weight daily as outlined on her MAR. Ms. Overley stated Resident A's daily weights

were ordered to be stopped when she started on hospice. Ms. Overley showed me the scale staff used to weigh Resident A.

On 6/22/22, I was unable to interview Resident A as she was actively dying.

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:	Review of Resident A's service plan revealed how often she was to be weighed was not outlined. A note on the service plan read Resident A's daily weights were "discontinued when signed into hospice," however when she was to be weighed was not clear in the plan. Review of Resident A's MARs revealed she was being weighed daily, despite Ms. Newberry's statements that she entered this in error. Review of Resident A's service plan, MARs, and Ms. Newberry's statements made it unclear how often Resident A was to be weighed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff have left Resident A's prescribed arthritis cream in her room without applying it.

INVESTIGATION:

On 6/3/22, the complaint read, "On 6/1/22 [Relative A1] found a cup with [Resident A's] arthritis cream in it. They did not apply the cream on [Resident A]."

On 6/6/22, the complainant reported Resident A's prescribed arthritis cream was observed in her room around 5:00 pm approximately a week ago. The complainant reported when Resident A was able to make her needs known, she often stated staff did not put her cream on her.

On 6/6/22, Ms. Newberry denied knowledge regarding staff not applying Resident A's prescribed cream on her. Ms. Newberry reported med techs are trained not to leave resident medications in their rooms. Ms. Newberry said the frequency of how often Resident A's prescribed cream was changed to three times daily.

Resident A's MAR read Resident A's "DICLOFENAC SODIUM 1% GEL" was administered as prescribed.

On 6/6/22, Ms. Sanders' statements were consistent with Ms. Newberry.

On 6/6/22, Ms. Gaikis denied ever seeing any of Resident A's medications left in her room. Ms. Gaikis reported she has not seen any prescribed creams left by staff in Resident A's room.

On 6/6/22, Ms. Overley's statements were consistent with Ms. Newberry, Ms. Sanders, and Ms. Gaikis.

On 6/6/22, Ms. Nakken's statements were consistent with Ms. Newberry, Ms. Sanders, and Ms. Gaikis.

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:	The interviews with staff, along with review of Resident A's MARs revealed her medications were administered as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with administrator Martila Sanders by telephone on 9/30/22. I left voicemails regarding the findings of this report with licensee authorized representative Katelyn Fuerstenberg on 9/26/22 and 9/30/22.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/22/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

09/26/2022

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