GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5th, 2023

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

RE: License #: AH230342257
Investigation #: 2023A1021044
Story Point of Grand Ledge

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 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 #:	2023A1021044
Complaint Receipt Date:	03/10/2023
Investigation Initiation Date:	03/13/2023
Report Due Date:	05/09/2023
Licensee Name:	Senior Living Grand Ledge, LLC
Licensee Address:	2200 Genoa Businss 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:	05/22/2022
Expiration Date:	05/21/2023
Capacity:	40
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A provided inadequate care.	Yes
Insufficient staffing	Yes
Resident A had unreported fall.	No
Additional Findings	No

III. METHODOLOGY

03/10/2023	Special Investigation Intake 2023A1021044
03/13/2023	Special Investigation Initiated - Letter referral sent to APS
03/14/2023	Inspection Completed On-site
03/15/2023	Contact-Telephone call made Interviewed complainant
03/17/2023	Contact- Document Received Received additional service plans
04/05/2023	Exit Conference Exit conference with authorized representative Katelyn Fuerstenberg

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:

Resident A provided inadequate care.

INVESTIGATION:

On 03/10/2023, the licensing department received a complaint with allegations Resident A had to sit in his urine for over an hour. The complainant alleged Resident A has had bleeding testicles.

On 03/15/2023, I contacted the complainant by telephone. The complainant reported Resident A requires assistance with going to the bathroom and care staff do not always provide this assistance.

On 03/14/2023, I interviewed health and wellness director Tia Glass at the facility. Ms. Glass reported Resident A has a tendency to need to go to the bathroom at shift change and at times staff cannot get to Resident A in time. Ms. Glass reported the facility has implemented a toileting schedule for 5:30am and 4:00pm. Ms. Glass reported care staff are to initial when they toilet Resident A. Ms. Glass reported no knowledge of bleeding testicles. Ms. Glass reported facility provides twice weekly showers and there has been no documentation of bleeding. Ms. Glass reported Resident A has skin irritation in his groin area and Resident A has cream to administer to this area.

On 03/14/2023, I interviewed Resident A at the facility. Resident A reported he has had a few accidents at the facility because care staff do not assist him with toileting. Resident A reported he is now on a set toileting schedule. Resident A reported he has not had bleeding testicles.

I reviewed Resident A's toileting documentation that was placed in Resident A's room. The documentation revealed care staff were to initial when they assisted Resident A to the bathroom at 5am and 4pm. The documentation revealed lack of documentation on 3/2 at 5am, 3/9 at 4pm, 3/12 at 5am, and 3/13 at 5am.

I reviewed Resident A's service plan. The service plan read,

"need assistance with all toileting activities male only or 2 female care staff."

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:	Interviews conducted revealed Resident A is on toileting schedule twice daily. Documents reviewed revealed this information was not in Resident A's service plan. In addition, the toileting documentation revealed Resident A was not toiled on multiple days and times.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged the facility has insufficient staff on second and third shifts.

Ms. Glass reported on second shift there is two staff members in assisted living and a staff member that floats between assisted living and memory care. Ms. Glass reported on third shift there is one staff member and a staff member that floats between the two units. Ms. Glass reported the facility has a mandation policy in which a staff member may be mandated to stay past their shift. Ms. Glass reported the facility does not work below their staff ratios. Ms. Glass reported the facility is not using agency staff. Ms. Glass reported the facility is fully staffed and is currently not hiring. Ms. Glass reported in assisted living there are 19 residents. Ms. Glass reported there are three residents that are a two person assist, two residents that require assistance with toileting, two residents that require assistance with feeding, and one resident that is incontinent. Ms. Glass reported she has not received any complaints about staffing levels.

Resident A reported he takes staff a long time to help him. Resident A reported he has had a bathroom accident because it took so long for staff to help him to the bathroom. Resident A reported the care staff are nice but there are not enough staff.

SP1 reported on second shift there is typically only four people that work in the facility. SP1 reported there are three residents that are a two person assist, two residents with behaviors, one or two residents that require assistance with feeding, and many residents that are incontinent. SP1 reported it is difficult to provide quality care to the residents.

SP2 reported typically there are only four people that work in the facility on second shift. SP2 reported there are four residents that are a two person assist, one resident that requires assistance with feeding, one resident with behaviors, and multiple residents that are incontinent. SP2 reported the floor staff are responsible for serving dinner to the residents. SP2 reported the meal service takes approximately two hours to get all residents to the dining room, serve the food, and assist with feeding. SP2 reported there are seven residents that eat in their room and the caregivers are responsible for serving these residents as well.

SP3 reported the facility tires to schedule five people on second shift but caregivers often call off for their shift. SP3 reported it is difficult to meet the needs of the residents when there are only four employees working.

I reviewed staff schedule for 02/26/2023-03/11/2023. The schedule revealed the following open shifts:

02/27: no float caregiver on second shift
03/08: no care associate 3:00am-6:00am

I reviewed service plans for four residents in assisted living. The service plans revealed two residents required staff assistance in ambulation, three residents required two-person assist for transfers, three residents required assistance with bathroom, two residents are incontinent, two residents required redirection, and two residents required assistance with feeding/eating.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility does not have adequate staffing levels as evidenced by review of daily staff assignment sheets revealed the facility operated below their staffing levels on two occurrences. In addition, review of service plans revealed three residents in assisted living required two person assists with transfers yet at times there are only two or three staff members scheduled.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had unreported fall.

INVESTIGATION:

The complainant alleged that Resident A had a fall approximately three or four months ago and Resident A's DPOA was not notified. The complainant alleged Resident A had a fall last week and it is unknown if Resident A's DPOA was notified.

Ms. Glass reported Resident A did have a fall on 03/10/2023. Ms. Glass reported Resident A slid out of his lift chair and was found on the floor. Ms. Glass reported Resident A had no injuries and no medical attention was needed. Ms. Glass reported Resident A's DPOA was notified.

I reviewed the incident report for 11/05/2022 and 11/06/2022. The incident report revealed Relative A1 viewed Resident A falling out of his chair on their visual monitoring system. Relative A1 contacted the facility to inform them Resident A was falling out of his chair. The incident report revealed on 11/06/2022 Resident A started to fall out of his chair again. Resident A's DPOA was contacted immediately following the incident on 11/06/2022. Resident A did not sustain any injuries and no medical attention was needed from these falls.

I reviewed the incident report that was completed for the fall on 03/10/203. The incident report revealed Resident A's DPOA was notified on 03/10/2023 at 5:29pm.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Review of incident reports completed for Resident A's falls revealed Resident A's DPOA was contacted following the falls. There is lack of evidence to support the allegation.
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.

03/23/2023

Kimberly Horst Date
Licensing Staff

Approved By:

03/27/2023

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