GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Katelyn Fuerstenberg
StoryPoint of Saline
6230 State Street
Saline, MI 48176

February 6, 2024

RE: License #: AH810354781
Investigation #: 2023A1022033
StoryPoint of Ann Arbor

Dear Katelyn 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810354781
Investigation #:	2023A1022033
Complaint Receipt Date:	06/21/2023
Investigation Initiation Date:	06/22/2023
Report Due Date:	08/21/2023
Licensee Name:	Senior Living Ann Arbor, LLC
Licensee Address:	Ste. 100 2200 Genoa Business Park Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Erin Griffiths
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint of Ann Arbor
Facility Address:	6230 State Street Saline, MI 48176
Facility Telephone #:	(734) 944-6600
Original Issuance Date:	12/18/2015
License **Status:**	REGULAR
Effective Date:	06/18/2022
Expiration Date:	06/17/2023
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate care including incontinence care, skin care and hydration.	No
Employees do not wash their hands before and after providing care, exposing residents to infection.	Yes
Medications are not always passed according to the prescriber's order.	No

The complainant identified concerns that are not related to or addressed in licensing rules and statutes for a home for the aged, including issues between employees and managers. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The items listed above were those that could be considered under the scope of licensing.

III. METHODOLOGY

06/21/2023	Special Investigation Intake 2023A1022033
06/22/2023	Special Investigation Initiated - Telephone Phone call to complainant made, but no answer. Left message to call back.
06/22/2023	Contact - Telephone call received Complainant interviewed by phone.
06/29/2023	APS Referral
06/29/2023	Inspection Completed On-site
07/11/2023	Contact - Document Received Information exchanged with the facility via email.
02/06/2024	Exit Conference

ALLEGATION:

Residents do not receive appropriate care including incontinence care, skin care and hydration.

INVESTIGATION:

On 06/19/2023, the Bureau of Community and Health Systems received a complaint that in part read, "(Residents) They do not get water passed to them on a regular, only at dinner… they never give fluids other than at dinner. The staff are leaving these residents in soiled briefs… all the residents that need assistance, have broken down skin…"

On 06/22/2023, I interviewed the complainant by phone. The complainant reiterated her written allegations and further alleged that incontinence care was very poor in the facility, causing many residents to have urinary tract infections (UTIs) as well as excoriated skin on their buttocks. According to the complainant, female residents who needed assistance after having bowel movements were left with "feces in their vaginas."

On 06/29/2023, a referral was made to Adult Protective Services.

On 06/29/2023, at the time of the onsite visit, I interviewed the regional operations manager, the wellness team supervisor, and the lead caregiver. According to the regional operations manager, the facility administrator was on vacation and the facility wellness director position was vacant.

The regional operations manager stated that the most dependent residents lived in the general assisted living section of the facility. The lead caregiver was able to supply the names of 10 residents who were dependent on staff for toileting and likely to be incontinent. When asked about residents with skin breakdown on their buttocks, the lead caregiver stated that there may be some residents who displayed minor redness, but only 1 resident who had been admitted with wounds on her buttock and these were resolving. When asked about UTIs, the lead caregiver stated that there were none currently, but several who had UTIs in the past. Observations were made of Resident A, Resident B and Resident C, who were available for observation and were among the residents identified by the lead caregiver.

Resident A was sitting in a recliner chair in her room. A full water bottle with a straw had been placed on the overbed table at her side. Caregiver #1 helped Resident A to stand, and using a walker and a gait belt, assisted Resident A into the bathroom. Caregiver #1 assisted Resident A to sit on the toilet. When Resident A's incontinence brief was pulled down, it was clean and dry. Resident A urinated into the toilet. Resident A's buttock and genital areas were observed to be the color of normal skin, without redness or breaks. When Resident A told caregiver #1 that she had finished, caregiver #1 helped her to her feet and using cleansing wipes,

cleansed her, starting at the front and wiping to the back of her perianal area. According to her service plan, Resident A needed regular/frequent assistance of one person with all toileting needs, including perianal care.

Resident B, who was seated in a reclining geriatric chair had asked to lay down. He was returned to his room by the wellness team supervisor, caregiver #1, and hospice staff. A cup of fluid with a straw was observed on the table by Resident B's bed. Using a mechanical (Hoyer) left, the wellness team supervisor, caregiver #1, and hospice staff assisted Resident B into bed. His pants and his incontinence brief were removed by the wellness team supervisor. He was observed to have been incontinent of bowel. Using wipes, the wellness team supervisor and caregiver #1 first cleaned his genital area and when done, they turned Resident B on his side and cleaned his buttocks and anal area. His buttocks and anal area were observed to be the color of normal skin, without breaks or redness. According to his service plan, Resident B was incontinent of both bowel and bladder and needed regular incontinence care.

Resident C was seated at a table with other residents in the general assisted living area common room. There was an empty glass at the table where Resident C was sitting. After some coaxing from caregiver #1, Resident C reluctantly propelled herself in her wheelchair to her room. Once in the bathroom, caregiver #1 helped Resident C onto the toilet. When Resident C's incontinence brief was taken off, it was revealed that she had been incontinent of a large amount of bowel movement. On the toilet, Resident C urinated a small amount and when she stated she was done, caregiver #1 helped her to her feet and using cleansing wipes, cleansed her, starting at the front and wiping to the back of her perianal area. Due to the amount of stool, caregiver #1 used up to 15 wipes to ensure that Resident C was a clean as possible. Resident C was impatient to be done, asking caregiver #1 repeatedly if she was finished. Resident C's buttock and genital areas were observed to be the color of normal skin, without redness or breaks. According to her service plan, Resident C was incontinent of both bowel and bladder and needed assistance of 1 person for toileting.

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:	There was no evidence that residents were not being provided with appropriate services.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees do not wash their hands before and after providing care, exposing residents to infection.

INVESTIGATION:

According to the written complaint, “employees (must be asked) to wash their hands after and before giving care, going into the kitchen, etc…” When interviewed, the complainant reiterated this allegation.

Caregiver #1 was observed giving incontinence care to Resident A, Resident B, and Resident C. Although she donned gloves prior to giving care, she did not wash her hands either before or after removing the gloves. Caregiver #1 was observed leaving the room and going to the sink in the general assisted living section common area to wash her hands.

The wellness team supervisor was observed giving incontinence care to Resident B only. Like caregiver #1, the wellness team supervisor did not wash her hand either before the donning of gloves or after she removed them. The wellness team supervisor removed Resident B’s soiled brief to a disposal area, and only then was observed washing her hands in the sink in the common area.

When the regional operations manager was asked about her expectations for hand washing with glove use, the manager acknowledged that care givers are to wash their hands before donning gloves, provide the care, remove the gloves, and wash their hands. The manager acknowledged that she did not see either caregiver #1 or the wellness team supervisor wash their hands before donning gloves or after removing gloves.

Review of the facility’s Hand hygiene Policy and Compliance Program Standard Operating Procedure, “Hand hygiene will be done by all employees…Indications for hand hygiene are…Before and after direct patient care.”

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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 caregiver and the supervisor adopted the practice of using gloves without washing their hands, increasing the potential for spreading infections, which was not in accordance with facility policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are not always passed according to the prescriber's order.

INVESTIGATION:

According to the written complaint, "(a new employee) gave a resident morphine and they weren't supposed to…" When the complainant was interviewed, she acknowledged that the error regarding the morphine administration was "caught" by the facility manager, and the employee was retrained in medication administrator. The complainant then further alleged that Resident A had not been administered Imodium, an anti-diarrheal medication, as the health care provider had ordered.

At the time of the onsite visit, when the regional operations manager was asked about the medication error involving the administration of morphine, she stated that she did not have knowledge of this error but should be able to find the medication error report.

On 07/11/2023, via an email exchange with the regional operations manager, the regional operations manager explain that she and the administrator had been through all of the medication error reports for June 2023 and could not find evidence of a medication error with morphine. All morphine doses were administered in accordance with the health care providers' orders.

The medication exception report for the month of June 2023 documented medications that were not given because the resident refused, the resident was unable to take the medication, the medication had not been delivered or the resident was not in the facility at the time of the medication pass.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as-needed basis. The review process shall include the resident's prescribing licensed health care professional, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any.** **(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate licensed health care professional if a resident repeatedly refuses prescribed medication or treatment. The home shall follow and record the instructions given.** **(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.**

ANALYSIS:	There was no evidence that medications were not being administered in accordance with the health care providers' orders.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 02/06/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

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

02/04/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

01/16/2024

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