GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2025

Katelyn Fuerstenberg
StoryPoint Farmington Hills
30637 W 14 Mile Rd
Farmington Hills, MI 48334

RE: License #: AH630402476
Investigation #: 2025A1035030
StoryPoint Farmington Hills

Dear Katelyn Fuerstenberg:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630402476 |
| | |
| **Investigation #:** | 2025A1035030 |
| | |
| **Complaint Receipt Date:** | 01/23/2025 |
| | |
| **Investigation Initiation Date:** | 01/24/2025 |
| | |
| **Report Due Date:** | 03/24/2025 |
| | |
| **Licensee Name:** | 30637 W 14 Mile Rd OpCo LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | Unknown |
| | |
| **Administrator:** | Jeanae Tripp |
| | |
| **Authorized Representative:** | Katelyn Fuerstenberg |
| | |
| **Name of Facility:** | StoryPoint Farmington Hills |
| | |
| **Facility Address:** | 30637 W 14 Mile Rd<br>Farmington Hills, MI 48334 |
| | |
| **Facility Telephone #:** | (248) 983-4780 |
| | |
| **Original Issuance Date:** | 03/30/2022 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 120 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A is over medicated, Resident A has thrush that has not been treated. | No |
| Resident A is receiving poor quality of care. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 01/23/2025 | Special Investigation Intake 2025A1035030 |
| 01/24/2025 | Special Investigation Initiated - Letter |
| 02/24/2025 | Contact - Face to Face |
| 03/10/2025 | Inspection Complete BCAL Full Compliance. |
| 03/10/2025 | Exit Conference. |

## ALLEGATION:

Resident A is over medicated. Resident A has thrush that has not been treated.

**INVESTIGATION:**

On January 24, 2025, the department the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "There is concern that Resident A is being overmedicated by staff at the facility due to the way she is behaving. Staff at the facility will not share what is being given to Resident A. She does not have a condition that would make her pass quickly unless she is not getting the proper treatment from the facility. Resident A has thrush on her tongue. It has been there for the last two months."

On February 24, 2025, an onsite investigation was conducted. While onside I interviewed Staff Person (SP)1 who states Resident A is given medication as ordered. Resident A receives services through Corso Care hospice. Medications are adjusted and managed by the hospice team. SP1 continues to state during initial days of hospice services starting and medications being adjusted Resident A was

more tired, after final adjustments Resident A has stabilized. Resident A had received medication to treat thrush which has resolved at this time.

On March 3, 2025, a telephone interview occurred with Family A who states Resident A has been receiving poor care until private caregiver was hired. Resident A appeared to be overmedicated but “we were unable to confirm this.” Family A states hospice has made some adjustments to Resident A’s medication list which had helped with moments of psychosis and has adjusted medication where Resident A is no longer sedated.

Through direct observation Resident A was alert and orientated, answered questions appropriately stating she is getting good care.

Through record review of Resident A’s January 2025 medication administration record all medications had been given as ordered. Through record review of progress notes there are multiple entries related Resident A’s behavior, contact with family, and adjustments made to medication during this time. Record review notes conversations that occurred with hospice related to thrush being noted on Resident A tongue with additional medication ordered to treat.

On March 4, 2025, Corso Care provided nursing visit notes covering medication adjustments, management of thrush, care being provided, and continued communication with family related to care pathway.

| **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:** | Through record review Resident A is receiving medications as ordered.<br><br>Through direct observation, Resident A is sitting up in bed alert and orientated; and reporting no care concerns. Her mouth was observed to be pink and moist.<br><br>Based on information noted above this allegation has not been substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## ALLEGATION:

Resident A is receiving poor quality of care.

**INVESTIGATION:**

On January 24, 2025, the department the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "Resident A has not urinated in 24 hours. No one has called Hospice or the family about this. She did have a catheter that was removed about two weeks ago. Resident A is very out of it and may have the start of a bed sores. She was not like this when she moved into the facility. She does not have a condition that would make her pass quickly unless she is not getting the proper treatment from the facility."

On February 24, 2025, an onsite investigation was conducted. While onside I interviewed Staff Person (SP)1 who states Resident A's care is provided in accordance with her service plan. Resident A has a private caregiver and receives extra services through Corso Care hospice. SP1 states there are no call light on the memory care unit, all Residents are rounded on every hour and more frequently if services plan states more frequent rounds are needed. Resident A is unable to utilize a call light related to the inability to use her hands.

While onsite I interviewed SP2 who states all Residents are rounded on at a minimum of every hour. Resident A is bed bound, and the family has hired a private caregiver. SP2 states Resident A will not wait until caregiver come to room for assistance. SP states the facility staff are responsible for providing activities of daily living care (ADL) to Resident A.

While onsite I interviewed Caregiver A who states, "the girls do everything, staff check and change her hourly." Caregiver A states, she assists with feeding Resident A and companionship.

On March 3, 2025, a phone interview was conducted with Family A who states Resident A is only getting taken care of now because she has hired help. Family A states Resident A has been bedbound six years three months and has never had skin issues, recently she was informed Resident A has the beginning of a pressure ulcer on her buttock. Family A states she has concern that Resident A is being neglected and not properly cared for.

On March 3, 2025, a phone interview was conducted with Caregiver B who states she has worked with Resident A 6 plus years and has seen a significant decline since Resident A moved into Story Point Farmington Hills. Caregiver B states she does not feel Resident A's care needs are being met. Caregiver B states she observed a reddened area "which would be considered a stage 1 pressure ulcer" on Resident A's coccyx during a time she was being changed. The reddened area has since resolved. Caregiver B reports Resident A's foley catheter was removed and was notified by a staff member she had not urinated the entire shift. Caregiver B reports notifying

hospice and family of the reported findings. Hospice did come out to the facility and place a new foley catheter at this time. Caregiver B has concerns staff members at the facility are unaware of when and what to report and Resident A is being neglected.

Through record review Resident A is receiving care in accordance to service plan.

Through direct observation Resident A sitting up in bed being fed by Caregiver A. Resident A noted with food particles in mouth, mucus membrane pink and moist.

| **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:** | Through direct observation Resident A observed clean, dressed, and sitting up in bed during mealtime.<br><br>Through record review there is no indication Resident A had skin breakdown on coccyx.<br><br>Based on the information provided, unable to validate nor substantiate allegations at this time. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

03/05/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

03/10/2025

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