GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

Katelyn Fuerstenberg
StoryPoint Saline
6230 State Street
Saline, MI 48176

RE: License #: AH810354781
Investigation #: 2025A0585062
StoryPoint Saline

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 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) 335-5985.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810354781
Investigation #:	2025A0585062
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/10/2025
Report Due Date:	08/09/2025
Licensee Name:	Senior Living Ann Arbor, LLC
Licensee Address:	Ste. 100 2200 Genoa Business Park Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Jodi Meier
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint Saline
Facility Address:	6230 State Street Saline, MI 48176
Facility Telephone #:	(734) 944-6600
Original Issuance Date:	12/18/2015
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	40
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff mocked and treated Resident A poorly.	Yes
Resident A was left on the toilet for an hour.	Yes
Resident A is not getting showers.	No
Staff did not feed Resident A for 23 hours.	No
Additional Findings	No

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A0585062
06/10/2025	Special Investigation Initiated - Telephone Call complainant for additional information.
06/10/2025	APS Referral Called APS to report the allegations.
06/10/2025	Inspection Completed On-site Completed with observation, interview and record review.
06/10/2025	Inspection Completed-BCAL Sub. Compliance
06/17/2025	Exit Conference Conducted via email to authorized representative Katelyn Fuerstenberg and administrator Jodi Meier.

ALLEGATION:

Staff mocked and treated Resident A poorly.

INVESTIGATION:

On 06/09/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that staff mock and treat Resident A poorly.

On 06/10/2025, I called the complainant to discuss the allegations. Complainant's statement was consistent with what was written in the complaint. The complainant said that a staff took Resident A's emotional support doll, slammed it to the ground

and laughed about it. She said the same staff took Resident A's shoes and banged them together.

On 06/10/2025, an onsite visit was completed at the facility. I interviewed the administrator Jodi Meier at the facility. The administrator stated that she was unaware of staff mocking Resident A and this has not been reported to her.

I interviewed Employee #4 who stated that they use a Hoyer lift to transport Resident A. She said they have to move her doll, but they give it back once the transfer is complete. Employee #4 stated that she took Resident A's shoes and banged them against each other to get her to laugh. She said they try to enlighten her mood.

Resident A has a camera in her room. The complainant sent me a copy of the camera footage. I reviewed video footage from 06/01/2025. The video footage showed: Employee #4 and another staff in the room. The other staff was sitting on the bed with Resident A when the resident pointed at something and you could hear the other staff told Employee #4 "no wonder she is mad with you, you threw her doll. Employee #4 began to make faces at Resident A and took her shoes while banging them together. Resident A told her to get the hell out. Employee #4 sat on the bed and continued to make faces at Resident A.

APPLICABLE RULE	
333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging; harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:
	(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall

	promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The complaint alleged that staff mocked and treated Resident A poorly. Employee #4 said that she takes Resident A's doll and shoes from her to lighten her mood. Although Resident A told Employee #4 to get out, the employee continued to stay in resident's room banging the shoes together and making faces at the resident. The video camera footage showed Employee #4 making faces at Resident A and taking her shoes banging them together while Resident A was telling her to get out. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was left on the toilet for an hour.

INVESTIGATION:

The complaint alleged that Resident A was left on the toilet by staff for an hour and the resident is in a wheelchair.

The complainant stated that staff left Resident A unattended while she was on the toilet. She said that two aids use the Hoyer lift to take Resident A to the bathroom. The complainant said that the activity aide (Employee #1) found Resident A on the toilet.

The administrator stated that Employee #2 and Employee #3 took Resident A to the bathroom and forgot about her. She said that both staff were given verbal coaching. The administrator said that Resident A is a two person assist, and they are supposed to use the Hoyer lift for transfers. She explained that Resident A is on two-hour toilet schedule for toileting.

On 06/10/2025, I interviewed Employee #1 at the facility. Employee #1 stated she found Resident A in the bathroom. She said Resident A was scared from being in the bathroom that long. Employee #1 said she left Resident A's room to go get Employee #2 and Employee #3 and she asked them did they forget about Resident A. She said Employee #2 and Employee #3 were assisting other residents at that time. She said that Employee #2 and Employee #3 went to assist Resident A.

I interviewed Employee #2 who stated, her and Employee #3 put Resident A in the Hoyer to take her to the bathroom. She said her and Employee #3 put Resident A on the toilet, and they left, but they were in the area of the room. Employee #2 stated, Resident A normally press her call pendant, but she did not press it to let them know she was finished. She said they did not go back to check on Resident A because they got tied up doing other duties. She said that they had an in-service after the incident.

I interviewed Employee #3 who stated, her and Employee #2 put Resident A om the toilet. She said, her and Employee #2 left Resident A's room, but they did not leave the neighborhood. She said her and Employee #2 were doing other things and didn't come back. She said that Resident A did not press her call pendant to let them know that she was finished. She said Resident A cannot stand up on her own and depends on them to get out of the bathroom.

Resident A's service plan, read, for transfers, resident requires assistance with – ability to get in and out of bed and chair, staff are present for duration of activity. Assurance checks provided baseline for safety and supervision. Resident requires assistance with toileting activity, toileting schedule, peri-care. Staff are present for duration of activity. Resident requires assistance with redirection due to occasional confusion, deficits in judgement.

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.

R 325.1901	**Definitions.**
	(p) "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.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged that Resident A was left on the toilet by staff for an hour. Based on interviews with staff, Resident A was put on the toilet and staff forgot about her. The staff did not return until an hour later. According to the service plan, Resident A's service plan, read, for transfers, resident requires assistance with – ability to get in and out of bed and chair, staff are present for duration of activity. Assurance checks provided baseline for safety and supervision. Residents require assistance with toileting activity, toileting schedule, peri-care. Staff are present for duration of activity. Resident requires assistance with redirection due to occasional confusion, deficits in judgement. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not getting showers.

INVESTIGATION:

The complainant alleged that Resident A is not getting showers and the last shower she had was 05/28/2025. The complainant stated, Resident A is supposed to get two showers a week but has not been getting them.

The administrator stated, Resident A is supposed to get two showers a week, but she sometimes refuses showers. The administrator sent a follow-up email that read, "that their standard approach to refusals is approaching three times whether that be with a different caregiver, different time. She said they try to turn the shower on, get the bathroom warm and comfortable for the resident, in this case they use the baby doll and almost role play that the doll needs a shower too. She notes that the company doesn't have a standard policy for the history of shower refusals, however, provided the following:

- Resident has the right to refuse first and foremost
- Multiple approaches (3x)
- Bed bath, waterless shower caps
- If there is a concern then fam & doctor would be looped in to come up with a solution, this would be in the case of skin breakdown, smell, odor, etc.
- Lastly, if there is an extreme history of refusals then the discussion would be is the resident appropriately placed

Since Resident A doesn't have skin breakdown, smell, odor, etc. they have not been concerned to that level yet and she did just get a bed bath today."

Employee #3 and Employee #4 said that Resident A sometimes refuse showers, and they try several times.

Upon request, the administrator shared copies of Resident A's shower sheets for review.

Shower sheet for Resident A shows the following:

05/07 – done by caregiver
05/10 – Resident refused shower. Caregiver stated that she will be trying tomorrow morning (Sunday) to give shower to resident.
05/14 – Shower was done. No concerns to report
05/17 – Resident refused. Staff asked and she said no
05/21 - -----No notes
05/24 – Resident refused – Resident refused due to agitation. We will try again tomorrow.

05/28 – Shower completed, fought staff about getting in the shower and using Hoyer, but overall was happy with being clean.
05/31 – Resident refused – Resident was asked multiple times and she said no.
06/04 – Resident did not want a shower, refused multiple times.
06/07 – Resident refused – Resident did not want to. We asked her multiple times.
06/11 – Resident refused.
06/13 – Bed bath

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complaint alleged that Resident A is supposed to get two showers a week but has not been getting them. Based on interviews with staff and shower sheets reviewed, Resident A refuse showers. All refusals were documented. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not feed Resident A for 23 hours.

INVESTIGATION:

The complaint alleged that Resident A was not fed for 23 hours.

The administrator stated Resident A does not refuse meals and eats in the dining room. She said, Resident A is a slow eater. She said residents eat three meals a day with the open snack bar available all the time.

Employee #2 and Employee #3's statement was consistent to the administrator.

Employee #4 stated, Resident A will tell you if she wants something. She said, Resident A did not go 23 hours before she ate. If Resident A refuses to eat, they

offer food several times and after three attempts to get her to eat, they always try to offer her some that she might like.

Resident A's service plan read, resident requires reminders/cueing for making meal choices, encouraging foods/fluids. Care staff will report, any changes in dining abilities.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	There is no evidence that to support the claim of Resident not eating for 23 hours.
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

06/17/2025

Brender Howard Date
Licensing Staff

Approved By:

06/17/2025

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