



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

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

RE: License #: AH630402476
Investigation #: 2026A0585017
StoryPoint Farmington Hills

Dear Licensee:

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,

A handwritten signature in cursive script that reads "Brender 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 #:	AH630402476
Investigation #:	2026A0585017
Complaint Receipt Date:	12/22/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	02/21/2026
Licensee Name:	30637 W 14 Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	Unknown
Administrator:	Sandra Salvati
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint Farmington Hills
Facility Address:	30637 W 14 Mile Rd Farmington Hills, MI 48334
Facility Telephone #:	(248) 983-4780
Original Issuance Date:	03/30/2022
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	No
Staff are not trained to administer medicine.	No
Residents are not receiving their medications.	Yes
Additional Findings	No

III. METHODOLOGY

12/22/2025	Special Investigation Intake 2026A0585017
12/23/2025	Special Investigation Initiated - Face to Face Interviewed staff face to face and requested resident register.
12/23/2025	Inspection Completed On-site Completed with observation, interview and record review.
12/23/2025	Inspection Completed-BCAL Sub. Compliance
01/30/2026	Exit Conference Conducted via email to authorized representative Katelyn Fuerstenberg.

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 12/08/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that the facility is understaffed. Due to the anonymous nature of the complaint, no additional information could be obtained.

On 12/23/2025, an onsite investigation was conducted. While onsite I interviewed Employee #1 who states who states Residents are provided care

in accordance with their service plan. Residents who reside on assisted living have call light pendants and Residents residing on memory care have staff rounding on them each hour. Employee #1 states the average daily census is 64 residents with staff consisting of 5-8 for the first and second shift. Employee #1 stated there are 6-7 staff on the afternoon shift. Employee #1 stated the staff work well together to provide good care for the residents. Employee #1 states that they are overstaff so they can stay ahead of call offs.

During the onsite, I interviewed Employee #2 and Employee #3 at the facility. Their statements were consistent with Employee #1 regarding staffing.

During the onsite, through direct observation, there were staff consistent to what was reported by Employee #1 and what was reviewed on the staffing sheet/sign in sheets.

I interviewed Resident A at the facility. Resident A expressed that she is happy at the facility and all her needs are being met. She said that she gets her showers and staff are very gentle when providing care.

I interviewed Resident B at the facility. Resident B stated she was okay and staff is good.

I interviewed Resident C at the facility. Resident C stated she is okay.

During the onsite, I interviewed Relative C who stated that everything is okay and staff is good. Relative C stated that whenever there is a problem, they are able to go talk about it to management and the staff are on it.

Through direct observation residents were observed well dressed and engaged with each other. Common areas are clean and free of clutter. The residents observed, appeared to be well taken care of.

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:	<p>Through record review of schedule facility is staffing in accordance with staffing goals.</p> <p>Through direct observation residents observed well-groomed and dressed appropriately.</p> <p>Based on information noted this allegation has not been Substantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are not trained to administer medicine.

INVESTIGATION:

The complaint alleged the facility allows staff to pass medication that are not trained and using other people’s credentials to pass the meds.

Employee #1 stated that all med techs have training before administering medication. Employee #1 stated that only trained staff can pass medication to residents. Employee #1 stated that they do hand on training. She said med passer also do Relias training and they shadow another med passer on the cart. She said they have a nurse on duty 5-6 days a week and she is on call over the weekend to assist.

Employee #2’s said that she is a med passer and she had training before being able to administer medication. She said that all med passers are trained before passing meds. She said a supervisor or nurse are responsible for training of all staff to ensure that medication is being administered as ordered.

Training documents were reviewed which showed that medication passers had training required to pass medication.

APPLICABLE RULE	
325.1931	Employees; general provisions.
	(6) The home shall establish and implement a staff training program based on the home's program statement, the

	<p>residents service plans, and the needs of employees, such as any of the following:</p> <p>(a) Reporting requirements and documentation. (b) First aid and/or medication, if any. (c) Personal care. (d) Resident rights and responsibilities. (e) Safety and fire prevention. (f) Containment of infectious disease and standard precautions. (g) Medication administration, if applicable.</p>
ANALYSIS:	<p>The complaint alleged that people are passing medication without getting training necessary.</p> <p>There is no evidence to support this claim.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are not receiving their medications.

INVESTIGATION:

The complaint alleged that residents are not getting their medication and they are blaming it on computer errors. The complaint alleged medication is being given late and sometimes morning medication is given with the evening medication. Due to the anonymous nature of the complaint, no additional information could be obtained.

Employee #1 states they don't give medication late. Employee #1 states their computer was not charging, and medication was slow but the medication was still given on time during shift.

Employee #2 states all medication was given to residents when it was supposed to be given. Employee #2 states there is a one-hour window for giving medication.

Employee #3's statements were consistent with Employee #3 regarding a one-hour window to administer medication.

I reviewed medication administration records (MAR) for Resident A, Resident B and Resident C.

Resident A MAR showed that all medication was administered as prescribed.

Resident B MAR showed the following:

Medication	Usage	Dosage	Missed Dose
Levothyroxine	Thyroid	1 tab every day	12/14
Pregabalin	Pain	1 cap every afternoon	12/08, 12/20

Resident C's MAR showed the following:

Medication	Usage	Dosage	Missed Dose
Carvedilol	Blood Pressure	2 times daily	1 dose missed 12/13
Dicyclomine	IBS	2 times daily	1 dose missed 12/13
Digoxin	Heart	1 every other day	12/7, 12/9, 12/11, 12/13, 12/15, 12/17
Furosemide	Edema	1 tab 2 times a day	12/1, 12/3, 12/4, 12/6, 12/8, 12/11, 12/13

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	<p>The complaint alleged the residents are not receiving medication and it is not being given on time.</p> <p>A review of the MAR for Resident B and Resident C showed days where medication was missed.</p> <p>Based on the information from MAR, this claim was substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent on the receipt of an acceptable corrective action plan, I recommend no change in the status of this license.

Brender D. Howard

01/29/2026

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

01/29/2026

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

Date