



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

Rochelle Lyons
StoryPoint West Bloomfield
5475 West Maple
West Bloomfield, MI 48322

RE: License #: AH630381200
Investigation #: 2026A1027023
StoryPoint West Bloomfield

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 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 877-458-2757.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Rogers".

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2026A1027023
Complaint Receipt Date:	01/26/2026
Investigation Initiation Date:	01/28/2026
Report Due Date:	03/25/2026
Licensee Name:	PVL at West Bloomfield, LLC
Licensee Address:	Suite 310 1630 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 238-3821
Administrator:	Sara Morris
Authorized Representative:	Rochelle Lyons
Name of Facility:	StoryPoint West Bloomfield
Facility Address:	5475 West Maple West Bloomfield, MI 48322
Facility Telephone #:	(248) 419-1089
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	113
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
A medication was found on the floor, and Resident A's inhaler was not administered correctly.	Yes
Resident A was left on the floor, and medical attention was not sought.	Yes
Notification about a billing increase was not received.	Yes
Additional Findings	No

III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A1027023
01/28/2026	Special Investigation Initiated - Letter Email sent to complainant
01/28/2026	Contact - Document Received Email received from complainant with additional information and documentation
01/29/2026	Inspection Completed On-site
01/30/2026	Contact - Document Sent Email sent to Employees #2 and #3 requesting additional documentation
01/30/2026	Contact - Document Received Email received with requested documentation
02/10/2026	Contact - Document Sent Email sent to Employees #2 and #3 requesting additional information and documentation
02/11/2026	Contact - Document Received Email received from Employee #2 with information
02/12/2026	Inspection Completed-BCAL Sub. Compliance
03/11/2026	Exit Conference Conducted by email with Rochelle Lyons and Sara Morris

ALLEGATION:

A medication was found on the floor, and Resident A's inhaler was not administered correctly.

INVESTIGATION:

On January 26, 2026, the Department received an allegation regarding medication administration concerns. The allegation read that on December 15, 2025, a pill was found on the floor, raising concern that residents may not be receiving their medications and that misplaced medications could be ingested by another resident.

The allegation further reported that on December 24, 2025, Resident A's inhaler was not administered properly or that doses were being skipped, with six missed doses reported between November 12, 2025, and December 24, 2025.

On January 29, 2026, an on-site inspection was conducted, and staff interviews were completed.

Employee #2 reported that a pill was found on the 200-hallway floor by Relative A1. The pill could not be identified from the photograph provided. Employee #2 described the pill as appearing "rough," without an identifiable score line or number, and stated it appeared the pill may have been in a resident's mouth. Employee #2 stated she walked the 200 hallway and did not identify any additional pills on the floor. She also interviewed residents located on the 200 hallway, all of whom denied missing their medications.

Employee #2 stated that when a pill is found on the floor, staff attempt to identify the medication and investigate further, taking additional action as required.

During the on-site inspection, I observed the 100 and 200 hallways, as well as several resident rooms, and did not observe any medications on the floor.

Regarding Resident A's inhaler administration, Employee #2 stated that medication technicians receive training through a medication administration class that includes inhaler administration. Medication technicians were required to pass a medication exam and shadow another medication technician for three days or longer while working on the medication cart. Competency was assessed and documented, including inhaler administration. Employee #2 further stated that staff were tracking Resident A's inhaler doses due to raised concerns regarding administration of the medication.

Employee #6 described the steps she used to instruct Resident A on proper inhaler use which was consistent with the instructions on the training reviewed.

During the inspection, I observed the January 2026 inhaler tracking calendar for Resident A, which aligned with the current dose count on the inhaler.

I reviewed the December 2025 medication administration records (MARs) for Residents A, B, C, D, and E, whose apartments were located on the 200-hallway. The MARs indicated that Resident A self-administered all medications except the Breo inhaler, and that Residents B, C, D, and E were administered medications as prescribed on December 15, 2025. However, Residents B and D's December 2025 MARs contained blank entries for one or more medication doses on December 6, 2025, and Resident B's MAR also contained blank entries on December 24, 2025. Employee #2 reported that Residents B and D were out of the facility during the scheduled medication administration times on those dates.

A review of Resident A's November and December 2025 MARs indicated she was prescribed a Breo inhaler, to inhale one puff by mouth once daily and rinse and spit after use. Per the MAR, staff were instructed to document both the number of puffs administered and the remaining dose count on the inhaler. Staff documentation was inconsistent, with entries occasionally reflecting "2" for either the number of puffs or the remaining inhaler count. On multiple dates in November and December, the inhaler dose count was not documented consecutively and, at times, remained the same across multiple days. For example, in December 2025, the inhaler count was documented as "11" on December 19, 20, and 21.

Additionally, a review of Relative A1's Breo inhaler dose count log indicated missing doses that corresponded with the dates of inconsistencies identified on the MAR.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	<p>Despite the absence of observed medications on the floor and no confirmed missed doses among residents on the 200 hallway, incomplete MAR documentation for Residents B and D prevented determination of whether their medications were administered on the identified dates. Additionally, while staff initialed that Resident A's inhaler doses were administered, the documented inhaler counts did not align with expected dose progression.</p> <p>Based on the inconsistencies in medication administration documentation and inhaler administration records, this allegation was substantiated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A was left on the floor, and medical attention was not sought.

INVESTIGATION:

On January 26, 2026, the Department received an allegation regarding Resident A. The allegation read that on January 7, 2026, at approximately 6:43 PM, Resident A slid to the floor in her bedroom, as observed on camera footage. It was alleged that Resident A remained on the floor for approximately 15 hours, during which time she was incontinent with urine and feces, and that required wellness checks were not conducted. The allegation further read that Resident A was discovered on January 8, 2026, at approximately 9:46 AM by Employee #1 and that no medical care or emergency services were sought.

On January 28, 2026, the Department received additional information from the complainant via email which read that Resident A experienced a decline in physical and cognitive functioning because of the incident. Reported outcomes included decreased independence with activities of daily living, fatigue, weakness, shortness of breath, increased incontinence, abnormal laboratory findings, dehydration, anemia, muscle breakdown, and worsening kidney disease. The complainant reported that Resident A received antibiotic injections, ongoing IV hydration, and continued medical evaluations with multiple providers. Physical Therapy and Occupational Therapy services were initiated due to her functional decline. The complainant indicated that Resident A had not returned to her prior level of functioning.

The complainant reported being informed by Employee #2 that Resident A was “fixing her shoe.” The complainant reported the camera footage showed that Resident A was not wearing shoes and was unclothed from the waist down. It could not be determined whether Resident A sustained a head injury or the exact duration she remained on the floor.

The email read the complainant was initially informed by Employee #3 that wellness checks were required every two hours, and Employee #4 was identified as the supervisor on duty on January 7, 2026.

Additionally, the email read that a subsequent email correspondence dated January 14, 2026, with Employees #2 and #3 read that wellness checks were conducted every eight hours based on Resident A’s level of independence. The complainant reported that this change was not communicated. On January 18, 2026, the complainant contacted the former Director of Nursing, who confirmed that Resident A’s wellness checks were previously scheduled every two hours.

An on-site inspection was conducted on January 29, 2026, and staff interviews were completed.

Employee #2 stated that Resident A was observed sitting on the floor next to her bed and denied falling, reporting that she had placed herself on the floor while getting dressed. Employee #2 reported that Resident A was wearing a shirt and brief, was incontinent with urine, denied pain, and had vital signs within normal limits. Employee #2 stated that Resident A was independent with ambulation and dressing and had not activated her call pendant. Employee #2 contacted Relative A1, who requested medical testing. Relative A1 subsequently transported Resident A from the facility for evaluation and later returned her to the community the same day. Employee #2 reported that following the incident, Resident A participated in activities and that wellness checks were increased. Employee #2 further stated that the Forsite camera system maintained by the home did not cover the bedroom area where Resident A was found, only the living room area.

Employee #1 stated that on January 8, 2026, at approximately 9:45 AM, she observed Resident A sitting on the floor beside her bed while preparing for scheduled activities. Employee #1 reported that Resident A stated she was okay and that additional staff were summoned for assistance. Employee #1 later observed Resident A participating in activities and in the dining room with Relative A1.

Employee #8 provided statements consistent with Employee #1 regarding Resident A’s participation in activities.

Employee #3 added that Employee #4 no longer worked for the home. Additionally, she stated that Relative A1 had been contacted in January 2026 regarding an assessment for a care level change; however, it was declined.

Review of Resident A's service plan dated December 24, 2025, indicated that Resident A was independent with ambulation using a walker, personal care, dressing, toileting, and transferring, and that safety checks were to be conducted once per shift. The plan identified Resident A as a fall risk and noted mild cognitive impairment requiring reminders. The updated service plan dated December 28, 2025, indicated that Resident A required regular assurance checks for safety and additional needs and that staff were to provide reminders and assistance related to incontinence as needed.

Review of the incident report dated January 8, 2026, documented that Resident A was found sitting on the floor and was assessed by nursing staff. Resident A reported that she sat on the floor while sorting her shoes. Assessment findings included no complaints of pain, full range of motion, and vital signs within normal limits. Staff assisted Resident A to a standing position and provided hygiene and dressing assistance. Relative A1 was notified and reviewed camera footage showing Resident A on the floor at approximately 6:43 PM on January 7, 2026. Resident A had not activated her call pendant. Relative A1 transported Resident A for medical evaluation and returned her to the facility the same day. Resident A later ate in the dining room and participated in activities. Test results were negative for COVID-19 and influenza, with inconclusive results for a urinary tract infection.

Review of the employee schedule for January 7 and 8, 2026, indicated that two staff members were assigned to Resident A's hallway during the second shift (3:00 PM–11:30 PM), third shift (11:00 PM–7:30 AM) on January 7, 2026, and the first shift (7:00 AM–3:30 PM) on January 8, 2026.

Review of the facility's "Resident Falls" policy, updated March 22, 2023, indicated that emergency services are to be summoned when a resident experiences a fall involving head trauma, deformity, altered level of consciousness, or significant injury, and that caregivers are to immediately notify the wellness leader following a fall.

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,

	<p>supervision, assistance, and supervised personal care for its residents.</p> <p>(c) Assure the availability of emergency medical care required by a resident.</p>
ANALYSIS:	<p>Based on staff interviews and documentation, Resident A was found on the floor next to her bed on January 8, 2026. A review of Resident A's personal camera footage by Relative A1 showed that she had been on the floor since approximately 6:43 PM on January 7, 2026. Although staff implemented the facility's fall protocol once she was discovered, the facility could not verify that required safety or assurance checks were completed in accordance with her service plan. Additionally, the frequency of "regular" assurance checks was not clearly defined. Therefore, this allegation was substantiated due to the home's inability to ensure Resident A's protection and safety in accordance with her service plan.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Notification about a billing increase was not received.

INVESTIGATION:

On January 26, 2026, the Department received an allegation alleging that on December 30, 2025, Relative A1 received a billing statement for Resident A via email. On January 2, 2026, an increased billing statement was issued reflecting a 10% rate increase. It was alleged that notification letters regarding the rate increase were sent to residents' families in November 2025; however, the notification letter for Relative A1 could not be located.

On January 29, 2026, an on-site inspection was conducted, and staff were interviewed.

Employee #3 stated that notification letters regarding the billing increase were mailed to each resident's authorized representative in November 2025. She reported that Relative A1 was the only authorized representative who indicated she did not receive the notification. Employee #3 stated that Relative A1 was reimbursed for the billing increase in January 2026 and that the increased rate would take effect beginning February 2026.

Employee #7 provided statements consistent with Employee #3. She added that authorized representative mailing addresses were obtained at the time of lease signing during the transition from Provision to StoryPoint. Employee #7 stated that although Relative A1's invoices were sent via email, the previous Executive Director required billing increase notification letters to be mailed to all authorized representatives. Employee #7 confirmed the address on file for Relative A1 matched the address listed on the face sheet. Employee #7 also showed a billing statement with a \$580 credit applied to Resident A's January 2026 invoice.

A review of the billing increase notification letter dated November 23, 2025, showed it was addressed to Resident A at a billing address that differed from Relative A1's address.

A review of Resident A's updated residency agreement dated January 5, 2026, signed by Relative A1, indicated on page 8 that the facility was to send notices and monthly billing statements to Relative A1 and provided an address that aligned with the address listed on the face sheet.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	<p>(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following:</p> <p style="padding-left: 40px;">(c) The notice to be provided by the home to the resident and/or the resident's authorized representative, if any, upon any change in fees.</p>
ANALYSIS:	Although the billing issue was subsequently corrected, the billing increase notification letter was addressed incorrectly and did not provide proper notification to Relative A1. Therefore, a violation was substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Jessica Rogers

02/12/2026

Jessica Rogers
Licensing Staff

Date

Approved By:

Andrea Moore

03/11/2026

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

Date