GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2026

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

RE: License #: AH630402476
Investigation #: 2026A1027037
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 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,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2026A1027037
Complaint Receipt Date:	04/17/2026
Investigation Initiation Date:	04/21/2026
Report Due Date:	06/16/2026
Licensee Name:	30637 W 14 Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(248) 983-4780
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?
Medications were not administered consistent with the physician's orders.	Yes
Residents lacked care consistent with their service plans.	Yes
Fire exits were blocked. Staff were not provided with gloves or gait belts.	No
Resident records were incomplete.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

Allegations regarding medications not being administered and the home being understaffed were investigated under Special Investigation Report 2026A0585017. The allegation concerning medications not being administered was substantiated, and a Corrective Action Plan was submitted indicating that corrective measures had been implemented as of February 16, 2026. Allegations related to staff training on the use of Hoyer lifts and Resident A not receiving showers were investigated under Special Investigation Report 2026A1035014.

III. METHODOLOGY

04/17/2026	Special Investigation Intake 2026A1027037
04/21/2026	Special Investigation Initiated - Letter Email sent to the administrator Sandra Salvati and AR Katelyn Fuerstenberg requesting documentation
04/23/2026	Contact - Document Received Email received from the administrator with requested documentation
04/24/2026	Contact - Document Sent Email sent to the complainant requesting additional information
04/24/2026	Contact - Document Received

	Email received from the complainant with additional information
04/28/2026	Inspection Completed On-site
04/28/2026	Inspection Completed-BCAL Sub. Compliance
05/06/2026	Contact - Telephone call made Voicemail left with Employee #5
05/11/2026	Contact - Telephone call made Voicemail left with Employee #5
05/12/2026	Contact – Telephone call received Interview conducted with Employee #5
05/22/2026	Exit Conference Conducted by email with Katelyn Fuerstenberg and Sandra Salvati

ALLEGATION:

Medications were not administered consistent with the physician's orders.

INVESTIGATION:

On April 17, 2026, the Department received allegations which read that medications were not administered to Residents B, C, D, E, F, G, H, I, J, K, L, and M. The complaint further alleged that missed medications occurred during February and March 2026; that Resident M's medications were left at bedside; and that Resident N experienced medication errors, and that staff took medications home.

On April 24, 2026, email correspondence with the complainant indicated that Resident N's Parkinson's pen had been taken home by staff, and that his medications were not administered from March 9–16, 2026. The email also read that on March 27, 2026, a second-floor medication cart that was no longer in use due to consolidation contained medications belonging to both current and former residents.

On April 28, 2026, I conducted an on-site inspection and interviewed staff.

> The Administrator and Employee #1 were interviewed. Employee #1 reported that he had been auditing medication carts. The Administrator stated that medications were not left at bedside for any residents and that staff observe residents taking medications during administration. She explained that Resident M intermittently had a private caregiver and required prompting to take medications. Additionally, Employee #1 confirmed that Resident N's Parkinson's

pen was accidentally taken home by Employee #3 and returned immediately. Employee #2 addressed the incident with Employees #3 and #4. The Administrator and Employee #1 stated that Resident N did not miss any doses as a result of the incident.

During the inspection, Employee #4 was interviewed regarding Resident N's Parkinson's pen. She stated that she and Employee #3 conducted a medication count during shift change. After the count, Employee #4 discovered the Resident N's Parkinson's medication pen was in her pocket. Because the medication cart keys had already been passed to Employee #3, Resident N's pen was given to her, and she inadvertently took it home. Employee #4 stated she received verbal coaching from Employee #2 about not placing medications in her pocket.

A review of Employees #3 and #4's files showed they completed medication administration observation training on March 8, 2024, and January 27, 2025, respectively.

On the day of the inspection, Resident M and her private duty caregiver were out of the home on an outing with other residents. I observed Resident M's room and noted that no medications were present.

While onsite, both second-floor medication carts were observed to be in active use and contained current residents' medications. On the third floor, one medication cart was actively used; the second cart contained medications belonging to former residents as well as current residents. The cart contained unlabeled medications stored in a medication dispenser, bags of medications, powders, patches, and creams. A suppository medication for Resident Q was noted to be expired on April 11, 2026.

I reviewed Residents B through N's March 2026 medication administration records (MARs). Multiple residents had blank entries for one or more medications on various dates throughout the month. Findings included:
– Resident B: blanks on March 4, 8, and 19.
– Resident C: the Estradiol tablet order date written December 5, 2025 was supposed to be administered twice weekly and had no initials from March 1 to March 8; and additional blanks for other medications were noted on March 5, 7, 8, 17, and 19.
– Resident D: blanks on March 1, 5, 7, 9, 23, and 24.
– Resident E: blanks on March 8 and 19.
– Resident F: blanks on March 6, 8, 14, 17, 18, 19, and 20. Resident F was prescribed Metoprolol to be held for systolic blood pressure less than 110. Staff initialed the medication as administered on March 23–25 despite documented blood pressures below 110, though pass notes for March 23 and 24 indicated the

medication was held and staff did not circle the initials as required for held medications.
– Resident G: blanks on March 7, 13, and 19.
– Resident H: blanks on March 4, 6, 7, 8, 19, and 20.
– Resident I: blanks on March 1, 23, 24, and 26.
– Resident J: blanks on March 6, 8, and 19.
– Resident K: blanks on March 1, 5, 7, 8, 9, and 24.
– Resident M: blanks on March 3, 5, 8, 15, 17, and 27.
– Resident N: blanks on March 3, 4, 5, 6, 8, 10, 14, 15, 22, and 27. For Apokyn (the Parkinson pen), the 6:00 p.m. dose was blank on March 4, 6, and 10. Additionally, the as needed or PRN order for Apokyn lacked a listed reason or diagnosis for administration.

The home's Medication Disposal–Destruction Policy dated November 21, 2025, read that medications for residents who move out must be returned to the resident or pharmacy, or destroyed within 30 days if not accepted. Discontinued medications must also be destroyed or returned within 30 days. Medications belonging to deceased residents must be destroyed at the community. Over-the-counter medications may be released to a resident representative.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.

ANALYSIS:	Review of medication records showed multiple missed medications throughout March 2026. The incident in which Employee #3 took Resident N's medication home was confirmed to have occurred; however, the exact timing of the error could not be established because only verbal education was provided. Although Resident N had missed medications including the Parkinson medication taken home by staff, it could not be confirmed Resident N missed his medications due to this specific incident. Additionally, the third-floor medication cart stored medications belonging to former residents, current residents, unlabeled items, and expired medications contrary to the home's policy. Based on the number of blank MAR entries across multiple residents, the presence of medications for former residents in active medication storage, and the home's failure to follow its own medication disposal policy, a violation of this rule was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see SIR 2026A0585017 dated 1/29/2026, CAP dated 2/26/2026]**

ALLEGATION:

Residents lacked care consistent with their service plans.

INVESTIGATION:

On April 17, 2026, the Department received allegations which read that Resident L's supervision checks were not completed and that Resident P did not receive her scheduled showers.

On April 28, 2026, I conducted an on-site inspection and interviewed staff members.

> The Administrator reported that Resident L had been receiving hourly checks and had recent medication changes but no longer required those checks. She stated that staff documented by exception and did not consistently record the checks. Regarding Resident P, the Administrator stated that showers were provided according to the shower schedule, documented on a shower sheet, and then filed. She reported that Resident P received a shower the day prior to the inspection.

Interviews with Employees #4 and #6 were consistent with the Administrator's statements regarding Resident L. They explained that Resident L had been receiving hourly checks due to increased anxiety but had since improved following medication adjustments. They stated that the hourly supervision checks were recorded on the MAR. They also reported that Resident P received showers every other day, despite the shower schedule indicating one shower per week.

While on-site, I reviewed the shower schedule, which indicated that Resident P was scheduled to receive showers on Wednesday mornings. Review of the shower logbook revealed only one shower sheet for Resident P, dated March 19, 2026.

Review of Resident L's service plan updated February 27, 2026, showed that assurance checks were required but did not specify the frequency or the reason for the checks.

Review of Resident L's March 2026 MAR showed that staff were required to initial hourly supervision monitoring beginning March 11, 2026, through April 21, 2026. Although most entries were initialed by staff, some entries were circled, and others contained lines instead of initials. For example, on March 14, 17, and 19, 2026, between 12:00 AM and 6:00 AM, staff did not initial the hourly checks. Additionally, on March 17, 2026, between 3:00 PM and 11:00 PM, a line was present in place of initials for the hourly checks.

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:	Overall, Resident L’s records showed that her service plan lacked specificity regarding the required frequency of assurance checks and the reason for them. The March 2026 MAR also demonstrated gaps where checks were not initialed and no explanation was documented. Review of Resident P’s shower records revealed only one shower sheet, making it impossible to confirm she received showers in accordance with the schedule or at the frequency staff described. Based on this information, these allegations were substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Fire exits were blocked. Staff were not provided with gloves or gait belts.

INVESTIGATION:

On April 17, 2026, the Department received allegations that staff were blocking doors to prevent wandering residents from leaving the building. The complaint also alleged that staff were not provided gloves or gait belts.

On April 24, 2026, email correspondence with the complainant indicated that exit doors were blocked on the second and third shifts on March 19 and 20, 2026.

On April 28, 2026, I conducted an on-site inspection and interviewed staff.

The Administrator reported that Employee #5 had sent a group text to the home’s leadership team on March 20, 2026, at 10:16 AM, advising that chairs were blocking an exit door and that this posed a dangerous situation and fire hazard. She stated this was an isolated incident and that staff were educated immediately following the report. Additionally, the Administrator further stated that the facility had an adequate supply of gloves and gait belts, noting that not every resident required a gait belt. She explained that staff request glove orders through Employee #1, who ordered supplies through Medline.

During the inspection, I observed that the second- and third-floor exit doors were not blocked. Employees #4 and #6 reported that they had never observed chairs blocking any doorways.

Interviews with Employees #4, #6, #7, and #8 indicated that they all had access to gloves and gait belts. While on-site, I observed boxes of gloves available on all three floors. Employees #4, #6, and #8 demonstrated that gait belts were stored

in each floor’s medication cart. Additionally, 11 extra boxes of gloves were observed in the wellness director’s office, accessible to staff.

On May 12, 2026, I conducted a telephone interview with Employee #5, who stated that the chairs placed in front of the exit doors had been an isolated incident and that he had not observed the issue again following the text message he sent to the leadership team.

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:	Staff interviews and on-site observations confirmed that there was one isolated incident involving chairs blocking an exit door, which was promptly addressed by leadership. Further, the evidence did not support the allegation that staff lacked access to gloves or gait belts.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident records were incomplete.

INVESTIGATION:

On April 17, 2026, the Department received an allegation which read that residents’ face sheets were incomplete and that resident data had not been entered into the MAR or the Pointe Click Care system.

On April 28, 2026, I reviewed the home’s resident census book, which contained face sheets for all current residents.

I conducted a detailed review of Residents B, C, D, E, F, G, H, I, J, K, L, M, and N’s face sheets and noted multiple areas of missing information. Specifically:

- Residents F, H, I, J, K, L, M, and N were missing entries for marital status.

- Residents F, H, I, J, K, and N were missing the address for either their first or second emergency contact.
- Resident K's face sheet did not include any diagnoses.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(a) Identifying information, including name, marital status, date of birth, and gender.** **(b) Name, address, and telephone number of next of kin or authorized representative, if any.** **(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.** **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.** **(g) Name, address, and telephone number of resident's licensed health care professional.** **(h) The resident's service plan.**
ANALYSIS:	Based on this review, several resident face sheets were found to be incomplete. Therefore, the allegation regarding incomplete face sheets is 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 05/12/2026

Jessica Rogers Date
Licensing Staff

Approved By:

05/21/2026

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