GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2026

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

RE: License #: AH630402476
Investigation #: 2026A0784033
StoryPoint Farmington Hills

Dear Katelyn 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2026A0784033
Complaint Receipt Date:	05/12/2026
Investigation Initiation Date:	05/13/2026
Report Due Date:	07/11/2026
Licensee Name:	30637 W 14 Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Administrator:	Rhandi Smith
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:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate plan for Resident A's protection and response to Resident A's call pendent.	Yes
Resident A was not administered pain medication according to physicians orders	No
Additional Findings	No

III. METHODOLOGY

05/12/2026	Special Investigation Intake 2026A0784033
05/13/2026	Special Investigation Initiated - Telephone Attempted contact with complainant. Message left requesting return call
05/27/2026	Contact - Telephone call made contact attempted with complainant
05/29/2026	Inspection Completed On-site
07/24/2026	Exit - Email Report sent

ALLEGATION:

Inadequate plan for Resident A's protection and response to Resident A's call pendent.

INVESTIGATION:

On 5/12/2026, the department received this online complaint.

According to the complaint, on the morning of 10/04/2025, Resident A had a fall after which she was transported to the hospital. The facility reported Resident A had fallen while going to the bathroom. It is unknown if this report was accurate. Resident A was known by the facility to be a high fall risk person. It is believed that the facility did not have an appropriate plan in place to address Resident A's risk for falling leading to her fall on 10/04/2025. After being taken to the hospital on 10/04/2025,

Resident A later passed away on 10/10/2025. Additionally, the complaint alleged Staff were significantly delayed in responding to Resident A when she tried to summon Staff by using her call light pendent.

On 5/29/2026, I interviewed administrator Sandra Salvati at the facility. Staff 1 was present during the interview. Administrator stated that due to the time lapse, she could not recall a lot of details regarding the incident with Resident A. Administrator reviewed notes and was able to confirm Resident A fell on the morning of 10/05/2026. Administrator stated Resident A lived in the assisted living area of the facility. Administrator stated Resident A had a pendent to summon Staff and was able to use it. Administrator stated did use the pendent for assistance regularly. Administrator stated that on the morning of 10/05/2026, Resident A had not used her pendent. Administrator stated the fall was not witness and the Resident A was discovered on or around the kitchen floor by Staff 2 shortly after 8am. Administrator stated it appeared as though Resident A was attempting to make her way to the bathroom. Administrator stated Resident A was a person who used a wheelchair and was considered a one person assist with transfers for using the restroom. Administrator stated Staff 2 reported having been in Resident A's room less than one hour before Resident A was discovered by Staff two. Administrator stated Staff 3 reported she had provided care for Resident A sometime after 7am, prior to Staff 2 going into the room. Administrator stated Staff 2 and 3 both provided written statements from the day the incident happened. Staff 1 stated Resident A was a person who was a high fall risk. Administrator stated Resident A was considered to have good safety awareness when she came to the facility. Administrator stated Resident A had been declining in her safety awareness but historically would not get out of bed without summoning Staff for assistance. Administrator stated Staff are expected to respond to the call light within at least ten minutes or less. Administrator stated she was not aware of any ongoing issues related to Resident A's call light not being responded to in a timely manner.

I reviewed the facilities *Internal incident report* form pertaining to the incident on 10/05/2026, provided by Staff 1. The form read consistently with administrator statements noting the time of incident as 8:30am and that Resident A was "laying on her right side on the kitchen floor in front of her wheelchair yelling help" when Staff discovered her.

I reviewed written statements from Staff 2 and 3, provided by Staff 1, both dated 10/05/2026. Both statements read consistently with statements provided by administrator. Staff 2's statement indicated she initially discovered Resident A at approximately 8:20am. Staff 3's statement indicated she had been in Resident A's room at approximately 7:20am and assisted her with cleaning and changing her brief before assisting Resident A back into bed.

I reviewed Resident A's service plan, provided by Staff 1. Within a section of titled *Transfers*, the plan read, in part, "Resident Requires assistance with ability to get in and out of bed, chair, car, etc. Staff are [to be] present for duration of

activity". Within a section titled Toileting, the plan read, in part, "Resident requires assistance with: toileting activity, peri-care, etc. Staff are [to be] present for duration of activity".

I reviewed Resident A's pendent call record dated between 9/28/2025 and 10/04/2025, provided by administrator. The call light record included a section titled To *Room Elapsed time*, indicating how long Staff took to respond to Resident A's pendent. Review of the record revealed that on multiple occasions Staff took over ten minutes to respond to Resident A's pendent call. The following includes the date and time of the call and the time elapsed for a response to each call:

- 9/28/2025 at 12:01am – 34min59sec
- 9/28/2025 at 7:38am – 18min42sec
- 9/28/2025 at 8:40am – 15min13sec
- 9/28/2025 at 9:23am – 11min23sec
- 9/28/2025 at 126pm – 35min56sec
- 9/28/2025 at 5:49pm – 40min57sec
- 9/29/2025 at 6:58am – 34min18sec
- 9/29/2025 at 9:54am – 12min29sec
- 9/29/2025 at 1:14pm – 16min30sec
- 9/30/2025 at 3:33am – 15min33sec
- 9/30/2025 at 3:54am – 48min55sec
- 9/30/2025 at 7:19am – 15min16sec
- 9/30/2025 at 5:45pm – 11min9sec
- 10/01/2025 at 8:22am – 18min50sec
- 10/01/2025 at 11:27am – 11min57sec
- 10/01/2025 at 9:07pm – 22min41sec
- 10/02/2025 at 5:51am – 1h42min
- 10/02/2025 at 7:47am – 15min39sec
- 10/02/2025 at 8:22am – 10min53sec
- 10/02/2025 at 8:47am – 22min3sec
- 10/02/2025 at 9:55am – 17min24sec
- 10/02/2025 at 12:29pm – 11min35sec
- 10/02/2025 at 4:52pm – 14min25sec
- 10/03/2025 at 12:45pm – 11min33sec
- 10/03/2025 at 5:42pm – 11min34sec
- 10/03/2025 at 6:03pm – 40min24sec
- 10/04/2025 at 9:21am – 18min41sec
- 10/04/2025 at 11:40am – 16min34sec
- 10/04/2025 at 5:14pm - 12min54sec

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:	The complaint alleged Resident A did not have an adequate plan for her supervision and that Staffs response to Resident A's calls for assistance were not adequate. Interviews and document review revealed Resident A's supervision plan was appropriate for her needs. While the plan in place did address her needs, review of the call pendent response times revealed that over just an eight-day period, it took Staff over ten minutes, and at times much longer, to respond to Resident A's call light which is even beyond the facilities own reported expectations for an adequate response time. Based on the findings, the facility is not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not administered pain medication according to physicians orders

INVESTIGATION:

According to the complaint, Resident A was left in pain for hours because Staff did not administer her pain medication as prescribed by her physician.

When interviewed, administrator stated she was not aware of any issues related to Resident A having her pain medications administered. Administrator stated she did remember that Resident A was on pain medication but could not recall what it was called.

I reviewed Resident A's medication administration record (MAR) for September and October 2025. According to the MAR's, Resident A was prescribed *TRAMADOL HCL 100 MG* to be taken "by mouth 3 times a day for pain" initially on 9/11/2025. Review of the MAR revealed this prescription was discontinued on 9/18/2025 with and replaced with an updated prescription for 150 MG of *Tramadol HCL* to be administered "3 times a day" with a stop date of 10/08/2025. According to the MAR, this medication was administered consistently with the orders. Further review

revealed an additional prescription for TRAMADOL HCL 50 MG to be administered up to "Three Times Daily As Needed [PRN] For Pain". The PRN medication indicated an original prescribed date of 9/11/2025 with a stop date of 9/18/2025. Additionally, Review of these MAR's revealed these medications were administered consistently as prescribed.

APPLICABLE RULE	
R 325.1932	**Residents 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:	Based on the findings, there is insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Aaron L Clum 7/09/2026

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 07/23/2026

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