STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 28, 2022

Katelyn Fuerstenberg
StoryPoint of Midland
2329 Rockwell Drive
Midland, MI 48642

RE: License #: AH560342673
Investigation #: 2022A0784052
StoryPoint of Midland

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.

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) 284-9730.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560342673
Investigation #:	2022A0784052
Complaint Receipt Date:	05/09/2022
Investigation Initiation Date:	05/09/2022
Report Due Date:	07/08/2022
Licensee Name:	Senior Living Midland, LLC
Licensee Address:	2200 Genoa Business Pk Dr Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Sara Schram
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint of Midland
Facility Address:	2329 Rockwell Drive Midland, MI 48642
Facility Telephone #:	(989) 839-2114
Original Issuance Date:	08/29/2014
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/27/2023
Capacity:	42
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

05/09/2022	Special Investigation Intake 2022A0784052
05/09/2022	Special Investigation Initiated - Telephone Interview with authorized representative Katelyn Fuerstenberg
05/09/2022	APS Referral
05/09/2022	Contact - Document Sent Document/Information request sent to AR Katelyn Fuerstenberg and admin Sara Schram via email
05/10/2022	Contact - Document Received Documents/Info received from Ms. Fuerstenberg via email
06/17/2022	Contact - Document Sent Additional document request sent to Ms. Ms. Fuerstenberg and administrator Sara Schram
06/22/2022	Contact - Document Received Email received from Ms. Fuerstenberg with response to additional request
06/28/2022	Exit Conference – Telephone Conducted with authorized representative Katelyn Fuerstenberg

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 5/07/2022, the department received an email from authorized representative Katelyn Fuerstenberg reporting that on the previous evening, the facility had “a significant resident [Resident A] to resident [Resident B] incident that occurred last night. We had a male resident who went in another resident apartment and beat her so badly that she is in the ICU”.

On 5/09/2022, I interviewed authorized representative Katelyn Fuerstenberg by telephone. Ms. Fuerstenberg stated Resident B is currently still at the hospital. Ms. Fuerstenberg stated Resident A is currently at the hospital also and the intention is to find him a new placement. Ms. Fuerstenberg stated Resident A was new to the facility on 5/02/2022. Ms. Fuerstenberg stated that Resident A came from another facility who had reported, as a part of his initial assessment, that he did not have behaviors. Ms. Fuerstenberg stated that prior to the incident with Resident B, Resident A had one incident in which he had hit a visitor at the facility. Ms. Fuerstenberg stated that due to this incident and the likelihood that Resident A is not appropriate for the facility, the facility will be moving to discharge him.

On 5/10/2022, I received an email from Ms. Fuerstenberg which included a document she typed regarding the timeline of events relevant to Resident A and the investigation. Events noted read as follows:

> “05/02/2022 – [Resident A] arrived to StoryPoint Memory Care around 5:30pm to Apt 23 and was signed onto CorsoCare Hospice services.
>
> 05/04/2022 – at about 1:10pm [Resident A] hit another resident’s daughter in the jaw, when we looked at the camera we saw [Resident A] standing near other residents daughter as she was visiting with her dad in the living area sitting on the couch. We observed [Resident A] fumbling with paper towels that were on the couch, pulling out his wallet and putting it back in his pocket and then proceeding to punch other resident’s daughter. We investigated the incident, talked with other resident’s daughter and she stated that [Resident A] was asking her where the dogs went, daughter told him she didn’t know and he punched her. She sustained no injury. We redirected resident and called hospice. Hospice nurse came out to evaluate [Resident A] and administered Ativan for [Resident A’s] increased anxiousness. Later in the day [Resident A] was found in another resident’s apartment going through papers, hospice was called again and orders were given to add Haldol routinely.
>
> 05/07/2022 - Approximately around 12:15am, [Associate A] was coming out of another residents apartment when he saw [Resident A] heading to his apartment,

> [Associate A] went down to check on [Resident A] and he was arranging his blankets to get into bed. [Associate A] walked out of his apartment, door closed and [Associate A] went back to living room area with 2 other residents. [Associate A] then heard [Associate B] call for help, he went and found [Associate B] in with [Resident B]. At around 12:30am [Associate B] went to deliver [Resident A's] medication, opened residents door to discover [Resident A] was not in there. [Associate B] then looked and saw [Resident A] coming out of [Resident B's] apartment. [Associate B] went to give [Resident A] his medication and noticed blood on his hands, she checked him for a cut/injury and discovered no injury so she went in to check on [Resident B]. When [Associate B] saw [Resident B], [Resident B] had blood coming from her mouth and nose. [Associate B] called for other care giver to help and called 911. Midland EMS and Police Department came, interviewed [Resident A] (he stated he knew he was going to jail) [Resident B] and [Resident A] were taken to Midland ER for further evaluation. "

I reviewed a document titled *Wellness Evaluation*, provided by Ms. Fuerstenberg, which she indicated was the initial assessment completed for Resident A by the facility prior to him moving in. The evaluation was dated 5/02/2022. The evaluation consisted of several sections of assessment with check boxes denoting relevant areas of "Focus" for Resident A. Under a section titled Behavior Service Plan, the assessment box checked read "Interventions: Behaviors: History of harming self/others/property. (Specify) While on Keppra [medication used to treat seizures] resident struck staff at Bickford. Staff reports improved when Keppra discontinued. No further episodes".

I reviewed Resident A's service plan provided by Ms. Fuerstenberg. The plan was dated from 5/07/2022, the last date which Resident A was living at the facility.

On 6/22/2022, I received an email from Ms. Fuerstenberg in response to an additional requesting confirmation regarding Resident A's potential return to the facility. Ms. Fuerstenberg confirmed Resident A has not and will not be returning to the facility. Ms. Fuerstenberg also confirmed the facility did not have a service plan for Resident A dated between 5/02/2022 and 5/07/2022.

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.**

For Reference: R 325.1901	Definitions
	(16) "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.
R 325.1922	Admission and retention of residents.
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
For Reference: R 325.1901	Definitions
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each 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 department received reporting from the facility on 5/07/2022 indicating Resident A was discovered to have physically assaulted Resident B. When interviewed, the Authorized Representative Katelyn Fuerstenberg reported that Resident A had only been at the facility since 5/02/2022 and that the previous facility had not reported issues of aggressive behaviors during Resident A's pre-move in assessment. Review of Resident A's assessment, referred to as a *Wellness Evaluation,* revealed at least one incident of physical aggression was noted in which Resident A struck a staff member at the previous facility after a change in his medication. Additional reporting from Ms. Fuerstenberg revealed that on 5/04/2022, Resident A struck a visitor at the facility, at which time Resident A's medication was again adjusted by hospice. Additionally, the facility was unable to demonstrate that appropriate actions were taken to ensure Resident A was supervised adequately. Upon request, the facility was unable to provide a service plan for Resident A dated between his initial placement date, 5/02/2022 and the date of his last day at the facility on 5/07/2022. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L. Clum 6/27/2022

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L. Moore 06/27/2022

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