GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

Katelyn Fuerstenberg
StoryPoint of Ann Arbor
6230 State Street
Saline, MI 48176

RE: License #: AH810354781
Investigation #: 2022A1019058

Dear Mrs. 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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810354781
Investigation #:	2022A1019058
Complaint Receipt Date:	06/23/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	08/23/2022
Licensee Name:	Senior Living Ann Arbor, LLC
Licensee Address:	Ste. 100 2200 Genoa Business Park Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Dustin Stolzman
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint of Ann Arbor
Facility Address:	6230 State Street Saline, MI 48176
Facility Telephone #:	(734) 944-6600
Original Issuance Date:	12/18/2015
License Status:	REGULAR
Effective Date:	06/18/2022
Expiration Date:	06/17/2023
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive proper wound care.	Yes
Resident rooms are not cleaned.	No
Additional Findings	Yes

III. METHODOLOGY

06/23/2022	Special Investigation Intake 2022A1019058
06/27/2022	Special Investigation Initiated - Letter Emailed administrator requesting information.
07/20/2022	Inspection Completed Onsite
07/20/2022	Inspection Completed BCAL Sub. Compliance
07/20/2022	APS referral
07/20/2022	Contact- Document Sent
08/10/2022	Comment SIR submitted to area manager for review.
08/08/2022	Exit Conference

ALLEGATION:

Resident A did not receive proper wound care.

INVESTIGATION:

On 6/23/22, the department received a complaint alleging that a resident was being neglected, as evidenced by wound care not being given properly, or at all. The complaint did not provide the name of the resident in question but mentioned that the resident was female, had wounds on her feet and received private duty care. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 7/20/22, I conducted an onsite inspection. I interviewed Employee A and administrator Dustin Stolzman at the facility. Given the information provided, Employee A felt confident that the complaint was referring to Resident A. Employee A stated that Resident A had moved out of the facility on 7/13/22 and into a residential hospice facility but confirmed that she had bilateral heel wounds and a private duty companion care aide.

Regarding wound care, Employee A stated that Resident A had wounds on her heels and on her coccyx. Mr. Stolzman stated the efforts were collaborative between the facility and hospice staff. When asked to provide wound care orders, Employee A provided a handwritten progress note from hospice staff but admitted that it did not constitute an order. While onsite, facility staff could not produce wound care orders for Resident A that they were to follow, but Employee A admitted that she and another staff member would provide wound care to Resident A as needed. Authorized representative Katelyn Fuerstenberg stated during follow up correspondence "Our staff can only apply what we have a physician order for and for small, limited skin concerns. We require hospice/ home care to manage all wounds." Ms. Fuerstenberg also acknowledged that what Employee A provided was not a wound care order and that Employee A did not follow protocol when performing wound care on the resident. Repeated requests were made to the facility following my onsite for the wound care orders however at the time of this report, the orders were not provided. During additional follow up, Mr. Stolzman stated:

- *Our staff is not responsible for providing wound care to residents; in this case, Arbor Hospice was responsible for the resident's wound care needs…*
- *Because Arbor Hospice was managing the resident's wound care, the physician with Arbor Hospice was responsible for wound care orders that the nurse from Arbor Hospice was expected to follow…*
- *Again, any documentation we received from the Arbor Hospice nurse following a visit, specific to what wound care was provided in accordance with their order, would be requested through Arbor Hospice.*

On 7/20/22, I interviewed Employee B at the facility who was familiarized with Resident A's care. Employee B stated that hospice would come three times per week for wound care. Employee B was adamant that facility staff were not to touch Resident A's wounds and should notify hospice of any issues.

Five progress notes were provided to licensing staff authored by Arbor Hospice, for the timeframe of 6/29/22-7/13/22. Only one note referenced wound care specific to Resident A's heels, which was from the date she moved out. On 7/13/22, hospice staff wrote "Wound care provided for bilateral heels and coccyx wound."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
ANALYSIS:	The facility was unable to provide wound care orders for Resident A, therefore they were also unable to demonstrate that those orders were followed, and that adequate and appropriate care was provided to her. Additionally, staff interviewed gave inconsistent information pertaining to wound care tasks and responsibilities.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident rooms are not cleaned.

INVESTIGATION:

The complaint alleged that housekeeping does not clean resident rooms. No additional information was provided.

Mr. Stolzman stated that the facility has fulltime housekeeping staff and has a housekeeper onsite seven days per week. Mr. Stolzman stated that care givers complete daily room tidy tasks such as making the bed, taking out trash, picking up any items that are on the floor or out of place and that housekeeping conducts deep cleans on resident rooms biweekly. Mr. Stolzman stated that the facility also has a designated laundress, so caregivers are only responsible for pulling the linens and clothing and bringing them to the laundry room to be washed.

Mr. Stolzman provided a housekeeping cleaning list that identified what the biweekly cleanings entail, which include but are not limited to high and low dusting, disinfecting all hard surfaces including the bathroom, refilling paper towels and soap, vacuuming and mopping.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews with staff reveal that the facility has a cleaning schedule and routine daily cleaning procedures. Additionally, direct observation of Resident A's former room, bathroom and common areas of the facility revealed that it was clean and in good condition. There is a lack of evidence to substantiate the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During interviews with staff, it was confirmed that Resident A was on hospice, received wound care services and had a private duty caregiver. Upon review of Resident A's service plan, it was discovered that the plan was void of the above-mentioned care related services. Employee A stated "admission to hospice, wound care orders and how those orders would be carried out, and the resident's private duty companion role should have been reflected in the resident's service plan."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
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:	Resident A's service plan was not updated to include that she was under hospice care, received wound care services or that she had a private duty companion.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

08/23/2022

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/23/2022

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