GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 14, 2022

Katelyn Fuerstenberg
Senior Living Portage, LLC
Ste. 150
950 Corporate Office Dr.
Milford, MI 48381

RE: License #: AH390377735
Investigation #: 2022A1028084
StoryPoint of Portage

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. 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. 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH390377735 |
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| **Investigation #:** | 2022A1028084 |
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| **Complaint Receipt Date:** | 09/15/2022 |
| | |
| **Investigation Initiation Date:** | 09/15/2022 |
| | |
| **Report Due Date:** | 11/15/2022 |
| | |
| **Licensee Name:** | Senior Living Portage, LLC |
| | |
| **Licensee Address:** | 2200 Genoa Business Pk Dr<br>Brighton, MI 48114 |
| | |
| **Licensee Telephone #:** | (810) 220-2200 |
| | |
| **Administrator:** | Martila Sanders |
| | |
| **Authorized Representative:** | Katelyn Fuerstenberg |
| | |
| **Name of Facility:** | StoryPoint of Portage |
| | |
| **Facility Address:** | 3951 W. Milham Ave.<br>Portage, MI 49024 |
| | |
| **Facility Telephone #:** | (269) 329-0200 |
| | |
| **Original Issuance Date:** | 04/24/2017 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/24/2021 |
| | |
| **Expiration Date:** | 10/23/2022 |
| | |
| **Capacity:** | 40 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was found urine soaked. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

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|---|---|
| 09/15/2022 | Special Investigation Intake<br>2022A1028084 |
| 09/15/2022 | Special Investigation Initiated - Letter |
| 09/15/2022 | APS Referral<br>APS referral made to Centralized Intake |
| 09/26/2022 | Inspection Completed On-site<br>On-site inspection completed due to investigation. |
| 09/26/2022 | Contact - Face to Face<br>Interviewed Admin/Martila Sanders at the facility. |
| 09/26/2022 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 09/26/2022 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 09/26/2022 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 09/26/2022 | Contact - Document Received<br>Received Resident A's service plan with record notes from Admin/Martila Sanders. |
| 11/14/2022 | Exit – Report emailed to AR/Katelyn Fuerstenberg and Admin/Martila Sanders. Requested to phone conference to address any questions or concerns. |

**ALLEGATION:**

**Resident A was found urine soaked.**

**INVESTIGATION:**

On 9/15/2022, the Bureau received the allegations from the online complaint system.

On 9/15//2022, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 9/26/2022, I interviewed the facility administrator, Martila Sanders, at the facility. Ms. Sanders reported until recently Resident A was modified independent with care, requiring very little to no assist or cueing from staff. Resident A could use the call light but did not call for staff assistance. Resident A was provided routine daily checks by staff to ensure care and safety though. However, Resident A was found urine soaked on 9/12/2022. Ms. Sanders reported she entered Resident A's room and detected the smell of urine. Ms. Sanders also alerted staff to assist Resident A. Ms. Sanders reported Resident A's family was also present during the incident and spoke with staff about Resident A being found urine soaked in three prior occurrences. Ms. Sanders reported she spoke with care staff as well and reported the family never notified staff or herself about any prior occurrences of Resident A being urine soaked. Ms. Sanders reported due to this incident a care conference was held with the family to determine Resident A's increased needs and Resident A's service plan was updated. Ms. Sanders reported she will also follow up with Resident A and Resident A's family in one month to ensure appropriate level of care. Ms. Sanders provided me a copy of Resident A's service plan with record notes for my review.

On 9/26/2022, I interviewed Employee A at the facility who reported Resident A was modified independent with care at admission to the facility and would not ask staff for assistance. Resident A could use the call light but would not and would often refuse help from staff if staff offered. Employee A reported Employee A reported knowledge of Resident A's family finding Resident A urine soaked in bed on 9/12/2022. Employee A reported the family stated it was a fourth occurrence, but staff had never been notified by the family that Resident A was beginning to have accidents. Employee A reported staff completed routine checks on Resident A daily and to [their] knowledge, there were no issues with Resident A's care. Employee A reported knowledge of Resident A's service plan being updated with increased level of care.

On 9/26/2022, I interviewed Employee B at the facility who reported Resident A was modified independent with care at upon admission to the facility. Resident A did not use the call light and would often decline staff assistance when offered. Employee B reported knowledge of Resident A being found urine soaked by family. Employee B

reported the family alerted staff that it was the fourth occurrence of Resident A being found urine soaked but staff were unaware of this. Employee B reported staff complete routine checks on Resident A, but [they] noticed a faint smell of urine during a recent check. Resident A's bedding was changed but Resident A was not urine soaked at that time. Employee B reported knowledge of Resident A's service plan and care levels being updated and reported Resident A now has increased checks throughout the day.

On 9/26/2022, I interviewed Employee C at the facility who reported Resident A was recently found to be urine soaked in bed. Employee C admitted [they] had detected a faint smell of urine during prior routine checks, but Resident A was not urine soaked at that time. Employee C reported knowledge of Resident A's service plan and level of care being updated to reflect Resident A's recent decline.

On 10/5/2022, I reviewed Resident A's service plan which was signed and dated by Ms. Sanders and Resident A's authorized representative on 9/15/2022. The service plan revealed the following:

- Resident A requires supervision to one person assist with transfers from bed and ambulation.
- Resident A requires one person assist with bathing, dressing, grooming, and toileting to include bladder and bowel management.
- Resident A requires set-up with feeding as needed.
- The facility manages all medication administration.
- Resident A is provided four safety checks each day and night.
- Resident A requires reminders for activities and meals due to cognition and is demonstrating a pattern of wandering aimlessly.

| **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.** |

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|---|---|
| **ANALYSIS:** | Interviews, on-site inspection, and review of documentation reveal that while Resident A was modified independent upon admission to the facility, Resident A began to experience a decline with independence in September 2022.<br><br>Resident A was found urine soaked on 9/12/2022. Facility staff acted immediately upon notification of the incident and Resident A's service plan was updated to reflect increased and appropriate levels of care as well. However, during interviews facility staff admitted to detecting a urine smell in Resident A's room on several occasions prior to the incident on 9/12/2022. Facility staff did not act in a timely manner to address Resident A's decline and did not provide Resident A care consistent with Resident A's demonstrated needs. Violation found. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Julie Viviano

10/6/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

11/02/2022

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