STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 23, 2023

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

RE: License #: AH810354781
Investigation #: 2023A1027031
StoryPoint of Ann Arbor

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 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 (517) 241-1970.

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 #:	AH810354781
Investigation #:	2023A1027031
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/12/2023
Licensee Name:	Senior Living Ann Arbor, LLC
Licensee Address:	Ste. 100 2200 Genoa Business Park Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Erin Griffiths
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 lacked care prior to passing away.	Yes
Resident A's medications were not administered as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023A1027031
01/13/2023	Special Investigation Initiated - Letter Email sent to administrator Ms. Griffiths requesting documentation pertaining to Resident A
01/18/2023	Contact - Document Received Email received from Ms. Griffiths with requested documentation
02/20/2023	Contact - Document Sent Email sent to Ms. Griffiths requesting additional documentation
02/20/2023	Contact - Document Received Email received from Ms. Griffiths with requested documentation
02/22/2023	Contact - Telephone call made Voicemail left with Ms. Griffiths.
02/22/2023	Contact - Telephone call made Voicemail left with Employee #2
02/22/2023	Contact - Telephone call received Telephone interview conducted with Ms. Griffiths and Employee #1
02/22/2023	Contact - Document Received Requested documentation received after telephone interview
02/22/2023	Contact - Telephone call made Telephone interview conducted with Resident A's daughter
02/23/2023	Contact - Document Sent Two emails sent to Ms. Griffiths requesting additional documentation and information

02/23/2023	Contact – Document Received Two emails received from Ms. Griffiths with information requested
02/23/2023	Contact - Telephone call received Telephone interview conducted with Employee #2
02/23/2023	Inspection Completed-BCAL Sub. Compliance
02/27/2023	Exit Conference Conducted by telephone with Ms. Fuerstenberg

ALLEGATION:

Resident A lacked care prior to passing away.

INVESTIGATION:

On 1/13/2023, the Department received a complaint from Adult Protective Services (APS) which read Resident A resided in memory care and passed away on 1/5/2023. The complaint read Resident A lacked care prior to passing away. The complaint read Resident A's compression socks were not properly changed. The complaint read staff did not elevate Resident A's neck when she had the flu. The complaint read staff did not take proper care of Resident A's diabetes. The complaint read Resident A's influenza and urinary tract symptoms were not properly managed. APS did not open investigation for the allegations.

On 2/22/2023, additional allegations were received which read consistent with the allegations from APS. Additionally, the allegations read Resident A lacked a way to summon staff for assistance in which she required a wheelchair for transportation as well as staff assistance for her activities of daily living. The allegations read there was vomit on Resident A's wall in which staff had stated she would cough up phlegm and throw it on the wall.

On 2/22/2023, I conducted a telephone interview with Resident A's daughter who stated Resident A's death certificate read the cause of her death was Alzheimer's however she had requested it be changed since Resident A was positive for Influenza.

On 2/22/2023, I conducted a telephone interview with administrator Erin Griffiths and Employee #1. Employee #1 stated Resident A had been diagnosed with Influenza A which her family was notified of the positive result on 1/1/2023. Employee #1 stated Resident A also had a cough in which she was prescribed Tessalon pearls. Employee #1 stated Resident A's family had brought in a hospital bed which was

broke. Employee #1 stated staff did not have any concerns regarding changing her compression stockings, however her family was charged money for them through the pharmacy. Employee #1 stated during Resident A's care conference on 1/3/2023, there was discussion about the hospital bed not being plugged in which was addressed at that time, however it was unplugged at the time of her death. Employee #1 stated when staff were questioned why the bed was unplugged, they had reported that her hospital bed was still not working at the time of her death. Employee #1 stated Resident A was also positive for a urinary tract infection the week of her death. Employee #1 stated staff continued to monitor Resident A's vital signs during the time she was positive for influenza and urinary tract infection.

On 2/23/2023, per email correspondence with Ms. Griffiths the facility did not maintain a log of Resident A's vital signs. The email read Resident A's daughter requested her vital signs be obtained on 1/2/2023 at 5:40pm in which they were: 98.9 temperature, 22 respiratory rate, 112/89 blood pressure and 89 pulse

On 2/23/2023, per email correspondence with Ms. Griffiths read all memory care apartments have two pull cords, one in the bedroom and one in the bathroom.

On 2/23/2023, I conducted a telephone interview with Employee #2 who stated Resident A required full assistance with her care. Employee #2 stated Resident A was usually the first resident assisted in the morning. Employee #2 stated caregivers would assist Resident A with her morning care then she would be in her wheelchair in the common areas throughout most of the day. Employee #2 stated Resident A was quiet but would summon staff by yelling. Employee #2 stated memory care residents did not have pendants like the assisted living residents but had pull cords in their apartments. Employee #2 stated all residents minimally received two-hour checks, however staff usually conducted checks more frequently. Employee #2 stated Resident A's bed was initially placed in the center of the room by the pull cord. Employee #2 stated Resident A had a fear of falling, even while in bed, so her bed was moved across the room next to the wall in which there was not a pull cord located in that area. Employee #2 stated most memory care residents did not utilize the pull cords appropriately nor would they remember how to use them. Employee #2 stated Resident A did not remember how to utilize the pull cord. Employee #2 stated Resident A's hospital bed had worked appropriately however it was next to the wall so it would become unplugged. Employee #2 stated Resident A was usually a "good eater and drinker" however around 1/3/2023, her appetite had decreased, and she was not wanting to get out of bed. Employee #2 stated staff would get Resident A up later in the morning due to her illness. Employee #2 stated Resident A had a cough when she moved into the facility, however it developed mucous in which she would cough the mucous into her hands and wipe it on the walls or her sheets. Employee #2 stated staff provided Resident A with cloths or tissues for the mucous however she had not utilized them. Employee #2 stated the day before Resident A passed away, she lost her voice in the morning from coughing and then had a fever the night before. Employee #2 stated staff obtained Resident A's vital signs however they were not documented. Employee #2 stated on 1/5/2023, staff

had conducted checks on Resident A in which she had observed her snoring around 8:00 AM, then was summoned by caregivers sometime after 9:00 AM when they attempted to get her out of bed for an appointment and observed that she had passed away.

I reviewed Resident A's admission contract dated 10/26/2022. The contract read Relative A1 signed and dated the contract on 10/31/2022.

I reviewed Resident A face sheet which read Resident A moved into the facility on 11/9/2022 into the memory care and discharged on 1/5/2023. The face sheet read Resident A's daughter was her emergency contact and power of attorney.

I reviewed Resident A's pre-admission wellness evaluation dated 10/18/2022 which read in part Resident A was to be admitted to memory care, utilized a wheelchair, did not require escort to meals or activities and had fallen in the past three months. The evaluation read in part Resident A required one caregiver for the following: transfers, ordering meals, bathing, dressing, grooming, utilizing the bathroom.

I reviewed Resident A's service plan dated 11/9/2022 which read consistent with the pre-admission wellness evaluation. The plan read in part Resident A had mild to moderate disorientation or difficulty recalling/retaining information. The plan read in part Resident A displayed deficits in judgement.

I reviewed a diet order form dated 10/31/2022 which read Resident A was prescribed a regular diet and signed by the physician on 11/1/2022.

I reviewed Resident A's healthcare provider plan of care dated 10/31/2022 which read consistent with the pre-admission wellness evaluation. The plan of care read Resident A had a diagnosis of Alzheimer's dementia.

I reviewed Resident A's medication administration records (MARs) for November 2022, December 2022, and January 2023 in which staff initialed applying Resident A's compression stockings in the morning and taking them off at night. The MARs read Resident A was prescribed Nitrofurantoin for seven days, which is commonly prescribed for urinary tract infections, from 11/28/2022 to 12/5/2022, then prescribed the medication again from 1/2/2023 through 1/9/2023. The MARs read Resident A was prescribed as needed Benzonatate for cough and Guaifenesin for cough/congestion in which there was no documented doses administered in December 2022 nor January 2023. The MARs read Resident A was prescribed Prednisone for five days from 12/28/2022 through 1/3/2023. The MARs read consistent with the physician orders dated 1/5/2023.

I reviewed Resident A's shower sheets dated 11/14/2022, 11/17/2022, 11/21/2022, 11/26/2022, 11/28/2022, 12/1/2022 and 12/5/2022 which read she received her showers for those dates.

I reviewed Resident A's physician notes dated 11/21/2022, 12/6/2022, 12/19/2022, 12/28/2022, and 1/2/2023:

Note dated 11/21/2022 read in part Resident A's type 2 diabetes mellitus was stable in which she was tolerating her medications and the plan was to continue with current medications.

Note dated 12/6/2022 read in part Resident A was tolerating her glipizide well and her type 2 diabetes mellitus stable in which the plan was to continue her current medications and monitoring. The note read a referral was made to home health care for physical and occupational therapy.

Note dated 12/19/2022 read in part the physician ordered a speech evaluation and treatment for expressive aphasia. The note read in part to obtain a urine analysis to check for reinfection as well as no change in her current plan for type 2 diabetes mellitus.

Note dated 12/28/2022 read in part staff noted Resident A had a persistent dry cough. The note read in part Resident A's daughter stated to the physician that her cough had been there for a few weeks in which a chest x-ray was negative for acute infection. The note read a steroid and benzonatate were prescribed for the cough. The note read in part labs were reviewed with Resident A's power of attorney who expressed understanding. The note read in part Resident A's power of attorney agreed with the physician to increase her glipizide medication for type 2 diabetes mellitus.

Note dated 1/2/2023 read in part Resident A tested positive for influenza last week. The note read in part Resident A was positive for dry cough. The note read in part read Resident A had an acute cough most likely secondary to influenza and benzonatate was refilled for the cough. The note read in part the plan was to continue to closely monitor in which her daughter agreed.

I reviewed an incident report dated 1/5/2023 at 10:00 AM which read in part Resident A was observed by staff at 6:05 AM then again around 8:00 AM and was snoring. The report read in part Resident A's daughter visited around 9:50 AM in which staff arrived at Resident A's apartment to assist her and observed she was unresponsive. The report read in part staff called Resident A's name, checked her pulse, noted her face was discolored and body was warm. The report read in part staff called for their manager's assistance and ambulance services. The report read in part Resident A had the flu, diarrhea, and was feverish the night before. The report read in part Resident A had lost her voice the morning before and was coughing up mucous.

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.
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:	Review of facility documentation revealed Resident A admitted to the facility’s memory care unit in which she required one person assist for her activities of daily. Review of physician notes revealed a healthcare professional evaluated Resident A in which her type 2 diabetes mellitus was monitored, as well as implementation of medications for urinary tract infections and Influenza. However, care was not always consistent with Resident A’s plan of care and service plan. Interview with Employee #1 revealed it was required for staff to document resident’s showers twice weekly in which the facility lacked shower sheets for Resident A after 12/5/2022. Review of documentation and staff attestations revealed Resident A had a harsh cough with mucous and a fever, in which medications were prescribed as treatment for her acute illnesses and not administered. Additionally, it cannot be determined if Resident A’s hospital bed worked appropriately or not, however there was lack of sufficient detail in Resident A's service plan for maintenance and use of the device. Based on the above information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were not administered as prescribed.

INVESTIGATION:

On 1/13/2023, the Department received a complaint from Adult Protective Services (APS) which read Resident A's medications were not administered properly. APS did not open an investigation.

On 2/22/2023, additional allegations were submitted to the Department in which read Resident A's physician had changed the prescribed dosage of MiraLAX from once to twice daily in which she didn't need medication for constipation and had diarrhea, however that information was not communicated.

On 2/23/2023, I conducted a telephone interview with Employee #2 who stated Resident A had a cough since admission to the facility. Employee #2 stated Resident A was coughing up mucous.

I reviewed Resident A's service plan dated 11/9/2022 which read in part Resident A would be supported to take all medications safely and as ordered.

I reviewed Resident A medication administration records (MARs) for November 2022, December 2022 and January 2023 which read staff signed her medications as administered or documented reasons why they were not administered. The MARs read Resident A was prescribed Nitrofurantoin two times daily for seven days on 11/28/2022 in which staff documented the 11/28/2022 evening dose was not administered because they were waiting for delivery from the pharmacy. The MARs read staff documented administration Nitrofurantoin from 11/29/2023 through the morning dose on 12/5/2022. The MARs read Resident A was prescribed Prednisone for five days starting 12/28/2022 through 1/3/2023 in which staff documented on 12/29/2022 and 12/30/2022, two doses were not administered because they were waiting for delivery from the pharmacy. The MARs read staff initialed Resident A's Prednisone as administered form 1/1/2023 to 1/3/2023. The MARs read Polyethylene Glycol (MiraLAX) was prescribed twice daily in which staffed documented doses were not administered on the following dates due to Resident A having diarrhea: 11/15/2022, 11/16/2022, 11/18/2022, 11/19/2022, 11/26/2022, 11/27/2022, 12/17/2022, 12/18/2022, 12/22/2022, 12/26/2022, 12/28/2022, 12/31/2022, and 1/2/2023. The November 2022, December 2022 and January 2023 MARs read staff held Resident A's doses of MirLAX on other dates per physician orders.

I reviewed an incident report dated 1/5/2023 at 10:00 AM which read consistent with statements from Employee #2.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's medication administration records revealed staff initialed her prescribed medications as administered. Review of physician notes and the incident report revealed Resident A had a cough in which she was prescribed as needed medication. Review of the December 2022 and January 2023 MARs revealed both as needed cough medications Benzonatate and Guaifenesin were not administered as needed for her cough. The MARs read Resident A lacked administration of one dose of Nitrofurantoin prescribed from 11/28/2022 through 12/5/2022. Additionally, Resident A was prescribed Prednisone one tablet daily for five days in which the MARs read she had received only three doses. Based on this information, Resident A lacked administration of her prescribed medications and as needed medications, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Department's incident report file revealed Resident A's death was not reported licensing staff.

On 2/22/2023, I conducted a telephone interview with administrator Ms. Griffiths and Employee #1. Employee #1 stated Resident A's death was reported to the facility's corporate team but not licensing. Employee #1 stated she had heard Resident A's cause of death was Alzheimer's but that it had changed to Influenza A. Employee #1 stated she did not have a copy of Resident A's death certificate to confirm her cause and manner of death.

On 2/23/2023, I conducted a telephone interview with Employee #2 who stated the facility had an Influenza outbreak during the time frame Resident A was diagnosed in which affected both residents and staff.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The Department requires reporting of unnatural deaths. Resident A's death was unexpected and facility staff did not know the cause and manner of her death, so it could not be confirmed if it was unnatural or not. Reporting the death to the Department would have been prudent to obtain clarification on this rule. Additionally, an influenza outbreak would place residents at risk for more than minimal harm. Based on this information, a violation was established for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's November and December 2022 MARs revealed Resident A was prescribed Mupirocin 2% ointment which read apply to affected area three times per day. The MARs read staff initialed and circled the Mupirocin as not administered from 11/7/2022 through 12/31/2022, except for two doses during that time frame. The MARs read staff documented the reason for not administering the medication was due it being unknown where to apply the cream on Resident A.

Review of Resident A's physician orders dated 1/5/2023 revealed the order for Mupirocin read consistent with the MAR.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Review of Resident A's MARs and physician orders revealed Resident A was prescribed Mupirocin 2% ointment in which staff did not obtain clarification of where to apply the medication, thus was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

2/23/2023

Jessica Rogers — Date
Licensing Staff

Approved By:

02/27/2023

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