STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 26, 2023

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

RE: License #: AH810354781
Investigation #: 2023A1027070
StoryPoint of Ann Arbor

Dear Licensee:

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 877-458-2757.

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) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810354781
Investigation #:	2023A1027070
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/24/2023
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 was mistreated.	No
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A1027070
05/26/2023	Special Investigation Initiated - Letter Email sent to Ms. Griffiths inquiring if Resident A resided in the licensed HFA
05/26/2023	Contact - Document Received Email received from Ms. Griffiths with requested information
06/06/2023	Inspection Completed On-site
06/22/2023	Contact - Document Sent Email sent to Ms. Griffiths requesting documentation
06/22/2023	Contact - Document Received Requested documentation received from Ms. Griffiths
06/26/2023	Inspection Completed-BCAL Sub. Compliance
08/21/2023	Exit Conference Conducted with authorized representative Katelyn Fuerstenberg by telephone

ALLEGATION:

Resident A was mistreated.

INVESTIGATION:

On 5/25/2023, the Department received an anonymous complaint through the online complaint system which read Resident A had history of dementia and resided with his spouse at the facility. The complaint read Resident A was mistreated by Employee #1 due to his color. The complaint read “[Resident A] was threw out by Employee #1 due to his skin color being black.”

On 6/6/2023, I conducted an on-site inspection at the facility. I interviewed administrator Erin Griffiths who stated Resident A and his spouse initially resided in the facility's enhanced living area, then transitioned to the facility's licensed home for the aged memory care unit in November 2022. Ms. Griffiths stated both Resident A and his spouse had a diagnosis of dementia. Ms. Griffiths stated Resident A required medications changes for his behaviors along with redirection. Ms. Griffiths stated Resident A had hit a caregiver and had altercations with other residents. Ms. Griffiths stated Resident A and his spouse both transferred to inpatient psychiatry unit at the end of April 2023. Ms. Griffiths stated the facility's nurse assessed Resident A and his spouse at the psychiatry unit in May 2023 due to being notified that they were ready for discharge. Ms. Griffiths stated both Resident A and his spouse were receiving intramuscular medications and Resident A's spouse was in seclusion. Ms. Griffiths stated due to not being able to meet both resident's medical needs, a discharge letter was sent to Resident A's family. Ms. Griffiths stated the psychiatry unit then delayed Resident A and his spouse's discharge, in which a meeting was held with Resident A's family and the discharge letter was rescinded pending another evaluation closer to discharge. Ms. Griffiths stated Resident A and his spouse remained hospitalized at psychiatry unit at the time of inspection in which they had not been discharged and their apartments remained on hold. Ms. Griffiths stated Employee #1 had a great relationship with all staff and residents regardless of color. Ms. Griffiths stated upon hire, all staff reviewed and signed the employee handbook which included the facility's policy for non-discrimination.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Griffiths. Employee #1 stated Resident A and his spouse resided in separate memory care apartments however they would visit each other, then not want to separate. Employee #1 stated when Resident A had behaviors, it would trigger his spouse to have behaviors. Employee #1 stated Resident A was both verbally and physically aggressive with staff and other residents. Employee #1 stated Resident A would call staff names and swear at them. Employee #1 stated Resident A and his spouse did not have behaviors continuously; however, there were times it was difficult for staff to manage them with both non-pharmacological and pharmacological methods.

While on-site, I observed Resident A's apartment in which his belongings were intact.

I reviewed Resident A's admission contract dated 11/29/2022 and signed Relative A1 which read in part the facility could discharge and terminate the contract for medical reasons.

I reviewed Resident A's service plan dated 11/29/2022 which read in part "*Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing.*" The plan read in part "*Exhibits normal, functional behavior patterns.*"

I reviewed the employee handbook which read in part:

"Discrimination, harassment, fighting, immoral conduct, threats or intimidation of customers and/or employees is not tolerated."

I reviewed Employee #1's file which read in part she had reviewed and signed the employee handbook on 11/11/2022.

On 6/21/2023, I received email correspondence from Ms. Griffiths which read Resident A's family would be moving Resident A and his spouse to a small adult foster care home which could provide the level of care needed.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(a) A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.**
ANALYSIS:	Review of facility documentation revealed Resident A was hospitalized for behaviors and was not discharged from the facility. Staff attestations revealed there was insufficient evidence for lack of care related to racial discrimination. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interview with Employee #1 revealed staff utilized pharmacological and non-pharmacological interventions for Resident A's behaviors.

Review of Resident A's service plan dated 11/29/2022 read in part "*Exhibits normal, functional behavior patterns.*"

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.** **Rule 1. As used in these rules:**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the 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:	Staff attestations revealed Resident A was prescribed medications for behaviors as well as implementation of non-pharmacological methods for redirection in which required hospitalization in April 2023. Thus, there was a violation established for 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.

06/26/2023

Jessica Rogers
Licensing Staff

Date

Approved By:

08/21/2023

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