GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 11, 2023

Katelyn Fuerstenberg
StoryPoint Saline
6230 State Street
Saline, MI 48176

RE: License #: AH810354781
Investigation #: 2023A1027081
StoryPoint Saline

Dear Katelyn 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 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) 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 #:	2023A1027081
Complaint Receipt Date:	07/13/2023
Investigation Initiation Date:	07/14/2023
Report Due Date:	09/12/2023
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 Saline
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's toes were amputated due to the facility's foot doctor. Resident A lacked care consistent with her service plan. Resident A's apartment lacked cleaning.	Yes
Medications were not administered safely. Staff did not know how to administer insulin.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/13/2023	Special Investigation Intake 2023A1027081
07/14/2023	Special Investigation Initiated - Letter Email sent to Erin Griffiths requesting documentation pertaining to Resident A
07/27/2023	Contact - Document Received Email received from Erin Griffiths with requested documentation
08/09/2023	Inspection Completed On-site
08/11/2023	Contact - Telephone call made Arbor Hospice agency contacted and return call requested.
08/11/2023	Contact - Telephone call made Voicemail left with Employee #2
08/11/2023	Contact - Telephone call received Arbor Hospice manager returned call. Plan to follow up with request by email.
08/11/2023	Contact - Document Sent Email sent to Arbor Hospice manager requesting documentation for Resident A
08/11/2023	Contact – Document Received Email received from Arbor Hospice Services with requested documentation
08/22/2023	Exit Conference

	Conducted by voicemail with authorized representative Katelyn Fuerstenberg, then by email

ALLEGATION:

Resident A's toes were amputated due to the facility's foot doctor. Resident A lacked care consistent with her service plan. Resident A's apartment lacked cleaning.

INVESTIGATION:

On 7/13/2023, the Department received a complaint through the online complaint system which read Resident A had two toes were amputated due to the facility's foot doctor. The complaint read Resident A was diabetic in which her toenails were trimmed by the facility's foot doctor and her skin was cut leading to infection in her big toe which led to subsequent amputations. The complaint read a form was signed not utilize the facility's foot doctor. The complaint read Resident A's legs were not wrapped in the morning and unwrapped at night. The complaint read Resident A's bathroom was "horrible." The complaint read there was urine and feces on the floor for multiple days.

On 8/9/2023, I conducted an on-site inspection at the facility. I interviewed administrator Erin Griffiths who stated as of May 2023 a new podiatrist rounded at the facility in which he required consent and financial responsibility forms to be signed by the resident and/or their authorized representative. Ms. Griffiths stated they were able to provide some of Resident A's medical records from their computer system; however, they were unable to locate the rest of her medical record file, which included her physician consent forms.

While on-site, I interviewed Employee #1 who stated Resident A's physician orders to wrap her legs would be in her medical records that they were unable to locate.

While on-site, Ms. Griffiths stated Resident A's retained her own primary care physician, then transitioned to Arbor Hospice services. Ms. Griffiths stated Resident A discharged in July 2022 to Inpatient Arbor Hospice Services which was no longer was in operation.

While on-site, I observed six resident apartments and their bathrooms. The resident's bathrooms appeared clean including the floors in which I did not observe them soiled nor smell urine or feces. I observed one housekeeping staff with a cart cleaning a resident's room. I observed four staff members, two staff from dayshift and two staff from afternoon shift, rounding together in each room to check on each resident and provide a shift report.

On 8/11/2023, I conducted a telephone interview with an Arbor Hospice manager who stated Resident A started hospice services on 3/16/2022, transferred to their inpatient facility on 7/14/2022 and passed away on 7/18/2022.

I reviewed Resident A's admission contract dated 2/23/2021 which read in part the community would provide daily room tidying and deep cleaning twice weekly.

I reviewed Resident A's face sheet which read part she admitted to the facility on 1/18/2021 and discharged on 7/13/2022.

I reviewed Resident A's service plan which read in part Resident A could not ambulate long distances without guidance or assistance and she ambulated with a walker. The plan read in part staff were to clean up Resident A's floor after showers to prevent standing water on the floor. The plan read in part Resident A was fall risk. The plan read in part Resident A was to receive showers once every two weeks and required one staff member physical assistance. The plan read in part staff were to assist Resident A with applying leg wrappings. The plan read in part Resident A had no apparent memory loss, was oriented and able to recall or retain information, and made safe judgements. The plan read in part Resident A was continent of bowel and bladder.

I reviewed Resident A's February 2022 through July 2022 Medication Administration Records (MARs). The February 2022 MAR read in part Resident A was prescribed Cetaphil moisturizing cream, apply topically to her bilateral legs every day for dry skin in which staff documented it was administered or reasons why it was not administered.

I reviewed two Arbor Hospice notes dated 6/14/2022 and 6/16/2022 provided by Employee #1. Note dated 6/14/2022 read in part Resident A had right and left heel pressure ulcers and "UTI" (urinary tract infection) symptoms. The note read in part to cleanse Resident A's heels, pat them dry, apply non-adherent pads and wrap them with kerlix daily. The note read in part that an antibiotic was ordered for her UTI. Note dated 6/16/2022 read in part to change the wound care to her heels by washing/patting them dry, adding alginate to the wound bed, covering them with Allevyn and changing them every three to five days depending on drainage.

I reviewed Arbor Hospice nursing notes from 3/16/2022 to 7/18/2022.

> Note dated 3/16/2022 read in part Resident A's hospice services were initiated. The note read in part her primary diagnosis was cerebral vascular disease, related diagnoses were dementia, hypertension, hallucinations, anxiety, and unrelated diagnoses were diabetes mellitus type 2, chronic kidney disease, and peripheral vascular disease. The note read in part Resident A had physical decline and utilized a wheelchair in which she began using that assistive device one month prior. The note read in part Resident A was incontinent of bowel and bladder. The note read in part Resident A required assistance with toileting,

transferring, bathing, dressing and ambulation. The note read in part she had two left toes amputated in the last two years and had a clinical finding of end stage vascular disease with no further aggressive treatment wanted.

Note dated 4/6/2022 read in part the “in house” podiatrist was in Resident A’s room. The note read in part the hospice nurse made staff aware that Resident A’s daughter declined the podiatrist services prior and would no longer receive this service. The note read in part Resident A had dementia and did not pull the cord for assistance in which she attempted to get up on her own.

Note dated 4/20/2022 at 10:51 AM read in part Resident A had two falls within a week. A second note dated 4/20/2022 at 15:21 [3:21 PM] read in part Resident A was observed lying on her back on the floor in her room.

Note dated 4/27/2022 read in part Resident A had a private caregiver in place and was still a fall risk due to confusion, independence, and impulsivity in which the hospice nurse would continue to see her weekly.

Note dated 6/14/2022 read in part Resident A’s heels were open and draining serosanguinous fluid in which the hospice nurse cleansed both heels, applied a non-stick pad, covered with kerlix and an abdominal pad. The note read the hospice nurse educated staff on care of bilateral heels and continued education was needed.

Note dated 6/24/2022 read in part Resident A’s bed alarm was not being used.

Note dated 6/27/2022 read in part Resident A’s bed alarm was hooked up by a staff member but was most often found to be unplugged.

I reviewed the new podiatrist’s General Consent for Care and Treatment form which read in part that it provided the physician permission to perform reasonable and necessary medical examinations, testing and treatment. The form read in part that the resident had the right to discontinue services at any time.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	Rule 21. (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 325.1931**	**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.
ANALYSIS:	Review of Arbor Hospice notes revealed the previous podiatrist treated Resident A; however, there was insufficient information to substantiate Resident A's toes were amputated due to treatment and her physician consent forms could not be located. Observations of the facility and resident's apartments revealed they appeared clean. Review of Resident A's service plan read inconsistent with the Arbor Hospice nurse notes. Resident A's service plan lacked information pertaining to her hospice services and their role in providing showers, as well as her history of dementia and need for a bed alarm for safety. Additionally, her plan lacked her incontinence and wound care needs. Based on this information, the facility lacked an organized program of updating Resident A's service plan to reflect her personal needs for care to be provided, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications were not administered safely. Staff did not know how to administer insulin.

INVESTIGATION:

On 7/13/2023, the Department received a complaint through the online complaint system which read a medication technician on duty had "*no idea how to administer insulation* (sp)." The complaint read the medication technician was shown how to check Resident A's blood glucose and administer the insulin injection. The complaint read staff brought medications in Resident A's apartment and walked out. The complaint read medications were found under Resident A's bed, chair, and table. The complaint read medications were administered at the community dinner table in which it was observed that residents grabbed other resident's medications.

On 8/9/2023, I conducted an on-site inspection at the facility. I interviewed administrator Erin Griffiths who stated Employee #2 was a medication technician on duty at the time of Resident A's residency at the facility. Ms. Griffiths stated Employee #2's date of hire was 2/2/2017.

While on-site, I interviewed Employee #1 who stated staff were trained to administer medications, including insulin, by first taking a medication administration class, then shadowing with a mentor for two to six days. Employee #1 stated after completion of the class and shadowing, the wellness director observed and checked the staff member off for medication administration. Employee #1 stated the staff member then completed a medication administration written test in which they had to pass with an 80% or higher.

While on-site, Employee #1 reviewed previous facility records from September 2021 through February 2022 in which Resident A was the only resident who received the medication insulin. Employee #1 stated there were no residents who currently received the medication insulin or any other subcutaneous injections. Employee #1 stated the facility utilized insulin flexpens in which the medication was already loaded into the pen and staff would turn the dial on the pen to the number of units of insulin needed.

While on-site, I observed six residents' apartments in which I did not observe medications on the floor.

On 8/11/2023, I left a voicemail with Employee #2 in which a return call was not received.

I reviewed Resident A's service plan which read in part she required daily supervision of medication and insulin.

I reviewed Resident A's February 2022 through July 2022 Medication Administration Records (MARs) which read consistent with staff interviews.

> The February 2022 MARs read in part Resident A was prescribed Novolin 70-30 flexpen, inject 14 units subcutaneously two times a day for diabetes mellitus with breakfast and dinner, if blood sugar was less than 110, give only 7 units. The MARs read in part staff documented Resident A's blood sugar along with the

units of insulin administered from 2/1/2022 through 2/24/2022. The MARs read in part Resident A refused her blood sugar check and insulin on 2/5/2022 at 8:00 AM and on 2/7/2022 at 5:00 PM. The MARs read in part 2/25/2022 through 2/28/2022, Resident A was out of the facility.

The April 2022 MARs read in part Resident A's prescribed Novolin 70-30 flexpen was discontinued on 4/18/2022.

The June 2022 MARs read in part the following dates for one or more medications were left blank 6/13/2022, 6/14/2022, 6/15/2022, and 6/16/2022. Additionally, the MAR read Resident A was prescribed Lorazepam 0.5 mg tablet, take one tablet by mouth for anxiety and agitation in which there were two orders on the MAR. The orders read the Lorazepam was to be administered daily and at 4:00 PM.

I reviewed Resident A's Arbor Hospice nursing notes from 3/16/2022 to 7/18/2022.

Note dated 4/12/2022 read in part Resident A had increased use of her as needed medication Seroquel. The note read in part the hospice nurse reviewed her medications with facility staff who stated she had been out of her medication Ativan in which they could not reorder it. The note read in part the hospice nurse asked how long Resident A had been out of Ativan in which staff responded they thought a few weeks.

Note dated 4/13/2022 read in part the hospice nurse investigated with Employee #2 when Ativan was last administered in which the narcotic log read it was given on 4/6/2022 and the computer charting read it was last given on 4/10/2022. The note read in part the hospice nurse verified Ativan was available and in mediation cart.

I reviewed Employee #2's file which read she had received medication administration training 5/18/2017.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	Staff attestations and review of Employee #2's file revealed there was an organized program in which staff were trained to administer medications. There was insufficient evidence to support staff did not know how to administer insulin and there were no residents who required medications by subcutaneous injection. However, review Residents A's medication administration records revealed there were dates when one or more medications were left blank in June 2022, and it could not be verified why the medications were not administered. Additionally, the medication administration records read there were two orders for the medication Lorazepam prescribed by different licensed health care professions in which it was unclear if both were to be administered. Based on this information, Resident A did not always receive her medications as prescribed by her licensed health care professional, thus this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For Reference, see Special Investigation Report (SIR) 2023A1027031 dated 2/23/2023, CAP dated 3/9/2023]**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/9/2023, I conducted an on-site inspection at the facility. I interviewed administrator Erin Griffiths who stated the facility could not locate Resident A's medical records, except for her admission contract and financial documents. Ms. Griffiths stated additional documentation was in Resident A's medical records which were stored by the previous administrator and unable to be located.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(4) A home shall keep a resident's record in the home for at least 2 years after the date of a resident's discharge from the home.
ANALYSIS:	The facility could not locate Resident A's medical records, thus was in violation of 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.

08/17/2023

Jessica Rogers Date
Licensing Staff

Approved By:

08/21/2023

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