GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2024

Katelyn Fuerstenberg
StoryPoint Saline
6230 State Street
Saline, MI 48176

RE: License #: AH810354781
Investigation #: 2025A1027006
StoryPoint Saline

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) 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 #:	2025A1027006
Complaint Receipt Date:	10/26/2024
Investigation Initiation Date:	10/29/2024
Report Due Date:	12/25/2024
Licensee Name:	Senior Living Ann Arbor, LLC
Licensee Address:	Ste. 100 2200 Genoa Business Park Brighton, MI 48114
Licensee Telephone #:	(248) 438-2200
Administrator:	Jodi Meier
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	40
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	Yes
The facility was short staffed.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

10/26/2024	Special Investigation Intake 2025A1027006
10/29/2024	Special Investigation Initiated - On Site
10/29/2024	Inspection Completed-BCAL Sub. Compliance
11/13/2024	Exit Conference Conducted by email with Katelyn Fuerstenberg and Jodi Meier

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 10/28/2024, the Department received allegations through the online complaint system which read on 10/26/2024 at 7:30 AM, Resident A was observed on the bathroom floor and her wireless emergency pendant was not functioning. The complaint indicated it was unclear how long Resident A had been on the floor and noted this was the second time the emergency pendant system had failed.

On 10/29/2024, I conducted an on-site inspection and interviewed staff.

I interviewed administrator Jodi Meier and Employee #1. The administrator, Jodi Meier, explained that the pendant system had failed the previous Thursday during daytime hours, rendering all pendants inoperable. She noted that an outside agency had repaired the issue on Friday. The administrator also mentioned that similar problems had occurred in the past, but the technical team was typically able to resolve them remotely. This time, however, the issue was escalated to higher

management because it was imperative the emergency call system worked correctly for resident safety. The administrator further explained that staff would know the pendants were not working when the medication technician's phone displayed the message "*cannot connect to server*." When this occurs, staff were required to conduct resident checks every half hour; otherwise, regular rounds were made every two hours.

Employee #1 confirmed that the pendants were working on 10/26/2024. She also stated the expected response time for call pendants was less than ten minutes.

Employee #2, who worked on 10/26/2024, stated she was on duty with two other employees that day. She explained that while she saw Resident A's call pendant had been activated on her phone, she had stepped away for a break, and the other staff members were responsible for the residents' care in her absence. Employee #2 returned to the unit, responded to Resident A's call, and found her on the bathroom floor. She demonstrated how the system appeared on her phone.

I reviewed the incident report, which aligned with Employee #2's account of the events. I also reviewed the call log which read at 6:21 AM on 10/26/2024, Resident A's call pendant was activated, and the response time was recorded as 44 minutes and 2 seconds.

During my inspection, I observed Resident A's call pendant worked as evidence by a flashing red light when the administrator pressed it, and staff responded promptly.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(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.**
R 325.1901	**Definitions.** **Rule 1. As used in these rules:**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's

	service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	While staff attested that the facility had experienced issues with the emergency call pendant system, they also indicated there was a monitoring system in place to ensure resident safety. Despite these measures, the response time to Resident A's call pendant exceeded the expected timeframe, substantiating this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

On 10/28/2024, the Department received allegations through the online complaint system which read the facility was short staffed.

On 10/29/2024, I conducted an on-site inspection and interviewed staff.

Employee #1 reported that the facility currently had 36 residents. According to Employee #1, staff worked eight-hour shifts with a 15-minute overlap for shift handoff and reporting. On day and afternoon shifts, five staff members were scheduled, while three staff members were scheduled for the night shift. Employee #1 noted that, on several occasions, the facility had more staff on duty than required.

Employee #1 further stated that five residents required two-person assistance for transfers, with two of those needed a Hoyer lift for transfers. All other residents only required minimal assistance or one person for transfers.

During the on-site inspection, I observed ten residents who appeared well-groomed and were dressed in clean clothing. I also reviewed the staff schedule for the period from 9/29/2024 to 10/28/2024, which aligned with staff attestations.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Based on staff attestations, observations and review of facility documentation, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

11/07/2024

Jessica Rogers Date
Licensing Staff

Approved By:

11/12/2024

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