GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2024

Katelyn Fuerstenberg
StoryPoint Northville
44600 Five Mile Rd
Northville, MI 48168

RE: License #: AH820399661
Investigation #: 2025A0585002
StoryPoint Northville

Dear Ms. 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 that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2025A0585002
Complaint Receipt Date:	10/02/2024
Investigation Initiation Date:	10/03/2024
Report Due Date:	12/01/2024
Licensee Name:	44600 Five Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Staci Tripolsky
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint Northville
Facility Address:	44600 Five Mile Rd Northville, MI 48168
Facility Telephone #:	(248) 697-2900
Original Issuance Date:	08/12/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had frequented falls and was not checked on every two hours.	Yes
Medication not given properly.	No
Additional Findings	No

III. METHODOLOGY

10/02/2024	Special Investigation Intake 2025A0585002
10/03/2024	Special Investigation Initiated - Telephone Contacted complainant for additional information.
10/03/2024	APS Referral Referral sent to Adult Protective Services (APS).
10/03/2024	Inspection Completed On-site Completed with observation, interview and record review.
10/03/2024	Inspection Completed – BCAL Sub. Compliance
10/13/2024	Contact – Document received. Complainant sent me additional information (videos were attached for review)
10/17/2024	Contact – Document sent. Requested information from administrator.
10/17/2024	Contact – Document received. Requested information received.
11/22/2024	Exit Conference Conducted via email to authorized representative Katelyn Fuerstenberg.

ALLEGATION:

Resident A had frequented falls and was not checked on every two hours.

INVESTIGATION:

On 10/02/2024, the department received this complaint via BCAL online complaint system. The complaint alleged that the facility is not using floor mats to help with falls from bed to ensure safety and prevent injury. The complaint alleged that the facility is not doing two-hour rounds. The complaint alleged that Resident A is having repeated falls, and facility is not following procedures to prevent injury. The complaint alleged that Resident A was left on the floor for over four hours and left on the floor with urine on the floor crawling around.

On 10/2/2024, I interviewed complainant by telephone. The complainant's statement was consistent to what she reported in the complaint. The complainant stated that Resident A had a lot of falls. She said that hospice had a mat delivered to the resident and the facility did not put it down for four days. She said that hospice go to visit Resident A two times a week. She said that Resident A is not being checked on every two hours. She said that Resident A had a fall and was on the floor for over three hours. The complainant submitted via email videos from Resident A's room.

On 10/3/2024, I made a referral to adult protective services (APS).

On 10/3/2024, an onsite was completed at the facility. I interviewed the administrator Staci Tripolsky at the facility. The administrator stated that Resident A has a high history of falls. She explained that Resident A is used to walking and she would get on the floor and crawls. She said that Resident A is on hospice, and they also assist with her care. She said that Resident A has a fall mat.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that Resident A has a fall mat next to her bed. She said they used the fall mat for Resident A because she had falls where she would try to get up.

In regard to this allegation, on 10/13/2024 the complainant provided a video recording that allegedly occurred on 8/23/2024 in Resident A's room. The complainant said the camera was set up in the resident's room by family.

The video camera was positioned to see Resident A in bed on the right side of the room, her dressers on the left side of the room and the room's entrance door and bathroom door directly ahead.

The video footage reviewed showed the following:

Friday 8/23/2024
2:12 AM staff seen in the room checking on Resident A and leave out
3:00 AM Resident A falls on the floor
5:35 AM staff walks in to check on Resident A who is still on the floor, staff looked at the resident and exit the room without going directly over to resident. Staff return a

short time later with two other staff. The three staff were seen putting their gloves on. The three staff walk over to the resident and assist her to the bed. One of the staff were checking her head.
5:45 AM staff helped Resident A up and helped her to get in the chair.

Sunday 8/25/2024
2:26 AM Resident had a fall, and a staff came into the room, looked at her and went back out again. After a minute, the staff came back in with two other staff members. The staff completed an assessment at that time.
2:37 AM falls again
2:43 AM back in bed
2:45 AM falls again although a body pillow as in the bed
2:56 AM - two staff entered the resident room
2:57 AM still on floor, Resident A reaches for pillow; 2 staff enter and check her depends
2:58 AM 2 staff came in the room and sat down in the chairs. Resident A was still on the floor wearing only depends on and a top. A third staff came in the room. The staff was around Resident A while she is still moving around on the floor. The staff put a blanket on the floor with pillows; Resident A is then lifted up to be put onto the blanket which was on the floor.
4:35 AM Resident A was seen crawling on the floor, urine all over the floor from her removing her depends, staff enters and got some paper towel and with her foot, cleans up some of the urine. Staff was seen putting brief on Resident A.

Service plan for Resident A read, “Independent with all tasks related to transfers. Assurance check provided frequently for safety awareness.”

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.
R 325.1901	**Definitions.**
	(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:	Resident A was not treated with dignity and not consistent with her service plan. According to the service plan, staff is to check on Resident A frequently which does not adequately give a time frame. A video recording show that Resident A had frequent falls, but the service plan does not contain any information about Resident A falling or how the falls would be addressed. There were no intervention methods to address her needs. On 8/23/2024, the video footage showed that Resident A was on the floor for 2 hours 35 minutes before staff came into the room. On 8/25/2024, it showed staff going in the room after Resident A fell, picked her up, and then place her back on a blanket on the floor where she slept overnight. In addition, there was no update made to Resident A's service plan to address the frequent falls or a use of a fall mat.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medication not given properly.

INVESTIGATION:

The complaint alleged that the facility did not administer Resident A's medications correctly to ensure medical safety.

The complainant stated that the staff is not giving Resident A her medication correctly to ensure medical safety.

The administrator stated that the administer Resident A's medication. The administrator stated that Resident A refused medication and the staff document it on the refusal form. She said that the medication passer makes several attempts to get Resident A to take her medication and if she still refuses to take it, they inform hospice of the refusal. The administrator shared copies of Resident A's refusal forms and her medication administration record (MAR).

Employee #1's statements were consistent with the administrator regarding Resident A's refusal of medication.

The refusal form for Resident A showed the following: On 8/4/2024- refused Metoprolol, Divalproex, Levothyroxine, omeprazole, and senna; 8/8/2024 – refused

Metoprolol, Divalproex, Levothyroxine, omeprazole, and senna; 8/10/2024 – refused Risperidone, Metoprolol, Divalproex, Levothyroxine, omeprazole, and senna; 8/15/2024 - Metoprolol, Divalproex, Levothyroxine, omeprazole, and senna;8/14/2024 – refused Metoprolol, Divalproex, Levothyroxine, omeprazole, and senna.

The MAR was reviewed for Resident A. The MAR indicated that the check mark is for medication administered and all refusals were marked.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	A review of the MAR showed that medication was given as prescribed, and any refusals were marked as well as noted on Resident A's refusal form. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

11/21/2024

Brender Howard Date
Licensing Staff

Approved By:

11/21/2024

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