GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2025

Katelyn Fuerstenberg
StoryPoint Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2025A0585019
StoryPoint Birmingham

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 #:** | AH630381578 |
| | |
| **Investigation #:** | 2025A0585019 |
| | |
| **Complaint Receipt Date:** | 12/11/2024 |
| | |
| **Investigation Initiation Date:** | 12/11/2024 |
| | |
| **Report Due Date:** | 02/10/2025 |
| | |
| **Licensee Name:** | 2400 East Lincoln St OpCo LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | (419) 247-2800 |
| | |
| **Administrator:** | Crystal Smith |
| | |
| **Authorized Representative:** | Katelyn Fuerstenberg |
| | |
| **Name of Facility:** | StoryPoint Birmingham |
| | |
| **Facility Address:** | 2400 E. Lincoln Street<br>Birmingham, MI 48009 |
| | |
| **Facility Telephone #:** | (248) 940-2050 |
| | |
| **Original Issuance Date:** | 03/29/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 128 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A wandered outside of the facility. Resident A lost personal items | Yes |
| Resident A were left in soiled clothes for hours. | No |
| Staff are not properly trained. | No |
| The facility is not clean, and Resident A's restroom was unsanitary. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 12/11/2024 | Special Investigation Intake<br>2025A0585019 |
| 12/11/2024 | Special Investigation Initiated - Telephone<br>Attempted contact with complainant. |
| 12/19/2024 | Contact - Telephone call made<br>Contacted complainant to discuss allegations. |
| 12/19/2024 | Inspection Completed On-site<br>Completed with observation, interview and record review. |
| 12/19/2025 | Inspection Completed-BCAL Sub. Compliance |
| 01/22/2025 | Exit Conference.<br>Conducted via email to authorized representative Katelyn Fuerstenberg. |
| | |

**ALLEGATION:**

**Resident A wandered outside of the facility. Resident A lost personal items.**

**INVESTIGATION:**

On 12/11/2024, a complaint was received via BCHS complaint online. The complaint alleged that staff let residents wander outside on multiple occasions. The

complaint alleged that facility has loss possessions such as glasses, wallet and clothing.

On 12/19/2024, I interviewed the complainant by telephone. The complainant stated that Resident A was able to leave the facility unattended. The complainant stated that Resident A left the facility and walked to a family member's home one and a half mile away.

On 12/19/2024, an onsite was completed at the facility. I interviewed newly appointed administrator Haylee Hutchinson. The administrator stated that there are 118 residents at the facility with 82 in assisted living and 26 in memory care. She said that if a resident miss items, the staff will look for it in an attempt to locate it. The administrator shared copies of facility policy in regard to residents' missing items, Resident A's service plan, apartment cleaning policy and staff competency checklist.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that Resident A was moved from the assisted living side to the memory care side after he was reassessed. She said that Resident A was exit seeking and they decided to move him to memory care. She said that after Resident A left out of the facility, they reassessed him.

I interviewed Employee #2 at the facility. Employee #1 stated that Resident A was moved from assisted living to memory care because he eloped from the facility. Employee #1 stated that they look for residents' lost things.

A review of residency agreement, it shows in the section *Accommodations*, "The Community cannot be held responsible for any lost or damaged items.

Service plan for Resident A read in the section *Assurance Checks*, "Will maintain safety while living in community. In the section marked *Reasoning* it read, "will make appropriate decisions about there are and environment with assistance. Resident requires assistance with (redirection due to occasional confusion and deficits in judgement)."

A review of Resident A's incident report read in part, "On 9/21/2024 during rounds I notice resident missing."

Attempts were made to contact Employee #3 who worked the day of the incident. As of the date of this report, no contact has been established.

Attempts were made to contact Employee #4 who was a witness to the incident that occurred on 9/21/2024. Employee #4 no longer is employed at the facility as of 10/25/2024.

| 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:**<br><br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **ANALYSIS:** | Resident A had missing items. Staff made an attempt to look for the missing items. This claim could not be substantiated due to residency agreement indicating that facility is not responsible for missing items.<br><br>Resident A left the facility without staff knowing he was gone and was found over a mile away. Therefore, the facility did not provide protection to Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A were left in soiled clothes for hours.**

**INVESTIGATION:**

The complaint alleged that residents are left in soaked clothes. The complainant stated that the staff left Resident A in soiled underwear. The complainant stated that when they told staff, the staff told them they would clean it and left for four hours, and it still was not clean. The complainant stated that the family had to clean Resident A themselves because staff did not clean him.

Employee #1 stated that Resident A gets frequent changes. She said Resident A get change at least three times a day. She said Resident A is being monitored every two hours because he doesn't always go to the toilet.

Employee #2 stated that Resident A is provided care, and he is not left in soiled clothing.

During the onsite, I observed residents throughout the facility. No issues were noted at that time. I did not see residents in soiled clothing.

The service plan for Resident A read, independent with all tasks related to grooming without reminders from staff. Resident is independent with all tasks related to toileting without reminders from staff.

| 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.** |
| **ANALYSIS:** | According to Resident A's service plan he was independent in grooming and toileting. Therefore, this claim could not be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff not properly trained.**

**INVESTIGATION:**

The administrator stated that all staff are trained before working with the residents. The administrator shared copies of training documents.

Employee #1 stated that all staff goes through seven days of training and medication technicians have to do two weeks of training. Employee #1 explained that regular in-service is completed throughout the year and they use Relias training module.

Training documents show that staff have training that is necessary to provide care to residents in the facility.

Employee #2's statements were consistent with the administrator and Employee #1 regarding the training. She said that her training consisted of computer and shadowing.

| APPLICABLE RULE | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | (**6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:**<br>**(a) Reporting requirements and documentation.** |

| | |
|---|---|
| | **(b) First aid and/or medication, if any.**<br>**(c) Personal care.**<br>**(d) Resident rights and responsibilities.**<br>**(e) Safety and fire prevention.**<br>**(f) Containment of infectious disease and standard precautions.**<br>**(g) Medication administration, if applicable.** |
| **ANALYSIS:** | Based on review of training documents, staff had training to care for the needs of the residents. Therefore, this claim could not be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## ALLEGATION:

The facility is not clean, and Resident A's bathroom was unsanitary.

**INVESTIGATION:**

The complainant stated that feces was found in Resident A's living area and staff said that they did not have proper cleaning material. The complainant shared pictures of Resident A's bathroom.

Employee #1 stated that Resident A don't always go to the toilet. She said that this was a new behavior. She said that feces matter was in the shower, and they had to re-educate the staff on what to do when he displays that type of behavior.

During the onsite, I interviewed Employee #5 at the facility. Employee #5 stated that they clean residents' room at least once a week which includes the cleaning of the bathroom, living and bedrooms. She said that each housekeeper is assigned to a floor. Employee #5 stated that they sweep, mopped, sanitize and disinfect.

During the onsite, I walked around the facility. I observed a housekeeper in the process of cleaning. I inspected Resident A's room. The room was cleaned at that time, but it had a bad odor.

During the onsite, administrator explained that the bad odor in Resident A's room was due to him using the bathroom 20 minutes earlier.

I reviewed the picture of Resident A's room. The picture showed that Resident A's shower had feces in it and there was a towel on the floor covered in feces.

| APPLICABLE RULE | |
|---|---|
| **R 325.1979** | **General maintenance and storage.** |
| | **(1) The building, equipment, and furniture shall be kept clean and in good repair.** |
| **ANALYSIS:** | Resident A's room had a bad odor, and it does not appear that it was sanitized to prevent odors. Although, Resident A was independent in toileting, picture showed the unsanitary condition that was not cleaned up. For this reason, the facility did not comply with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Brender L. Howard

01/21/2025

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore

01/21/2025

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