



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Rochelle Lyons
StoryPoint Novi
42400 12 Mile Rd
Novi, MI 48377

RE: License #: AH630404534
Investigation #: 2025A0628020
StoryPoint Novi

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 (517) 335-5985.

Sincerely,

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630404534
Investigation #:	2025A0628020
Complaint Receipt Date:	08/25/2025
Investigation Initiation Date:	08/28/2025
Report Due Date:	10/24/2025
Licensee Name:	42400 W 12 Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Tiffany Tucker
Authorized Representative	Rochelle Lyons
Name of Facility:	StoryPoint Novi
Facility Address:	42400 12 Mile Rd Novi, MI 48377
Facility Telephone #:	(248) 692-4836
Original Issuance Date:	11/25/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	116
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The sink in the bathroom on the third floor isn't working.	Yes
Additional Findings	No

III. METHODOLOGY

08/25/2025	Special Investigation Intake 2025A0628020
08/28/2025	Special Investigation Initiated - Face to Face Special investigation on site
09/30/2025	Exit Conference Conducted via email with Rochelle Lyons

ALLEGATION:

The sink in the bathroom on the third floor is not working.

INVESTIGATION:

On 08/25/2025 the department received a complaint alleging that the facility had a bathroom on the third floor that was utilized by residents, staff and visitors that did not have running water in the sink. The complainant alleged that staff were still utilizing this bathroom even though the sink was not operational and that this had been going on for weeks.

On 08/28/2025, while onsite, I interviewed Employee #1. Employee #1 reported that one of the bathrooms on the third floor does have a sink that currently is not working and that there is an "out of order" sign on the door of that bathroom. Employee #1 reported that there is another bathroom on the third floor that is fully functional.

On 08/28/2025 I interviewed Employee #2 onsite. Employee #2 reported that they were aware that the sink in one of the bathrooms on the third floor wasn't working and that there was an "out of order" sign on the door of that bathroom. Employee #2 reported that this occurred while they were on vacation and other staff members were covering their job. Employee #2 reported they were unaware of whom was covering, specifically. They reported that the procedure for reporting maintenance issues was as follows:

- Staff make the concierge aware

- Concierge submits the work order in the computer that day
- Maintenance has 24 hours to make the repair, unless a part needs to be ordered

Employee #2 reported that were not certain who put the “out of order” sign on the bathroom door, but they suspect it was the concierge.

While onsite, I observed the bathroom in question and found the door to be open, the light on, and no “out of order” sign on the door. Additionally, Employee #2 tested the sink, and it was not working. I observed the other bathroom on the third floor and found it to be fully functional.

While onsite, I interviewed Employee #3 who reported that they were aware the sink in the bathroom did not work. They reported they discovered this on 08/24/2025 when they used the bathroom and attempted to wash their hands, but the sink didn’t work.

I interviewed Employee #4 onsite, and they reported on 08/20/2025 they attempted to wash their hands after using the bathroom and found that the sink didn’t have running water.

Additionally, I interviewed Employee #5 onsite. Employee #5 reported they were unaware of the fact that the sink in that bathroom didn’t work.

Employee #2 reported that the facility does have a text system that they can utilize to let all staff know important information, but they are unsure of the last time the facility used this method to inform staff.

I reviewed the work order and found it to be dated 08/16/2025 @ 4:18pm. The work order stated that a new faucet would need to be installed. Additionally, I reviewed the purchase order for a new sink, that was placed on 08/21/2025. I confirmed, via photographic evidence that was emailed to me, that the new sink arrived on 08/28/2028 and was replaced and was working properly.

APPLICABLE RULE	
R 325.1979	General maintenance and storage.
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Through interviews with staff, review of documents and visual inspection it was found that the facility did not promptly order a replacement faucet. Additionally, the facility failed to communicate that the sink faucet was not working, and the bathroom was “out of order” for the duration of time it took to order and replace the faucet. The lack of communication and the facility’s inability to keep the bathroom from being utilized put the facility staff and visitors at risk for the spread of germs due to insufficient access to hand washing. Therefore, this allegation was substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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


09/03/2025
 Rebekah Looney Date
 Licensing Staff

Approved By:


09/30/2025

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