GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2025

Rochelle Lyons
StoryPoint West Bloomfield
5475 West Maple
West Bloomfield, MI 48322

RE: License #: AH630381200
Investigation #: 2026A0585006
StoryPoint West Bloomfield

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 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. Pease 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,

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

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

I. IDENTIFYING INFORMATION

License #:	AH630381200
Investigation #:	2026A0585006
Complaint Receipt Date:	10/29/2025
Investigation Initiation Date:	10/29/2026
Report Due Date:	12/28/2025
LicenseeName:	PVL at West Bloomfield, LLC
Licensee Address:	Suite 310 1630 Des Peres Road St. Louis, MO 63131
Licensee Telephone #:	(314) 238-3821
Authorized Representative/Administrator:	Rochelle Lyons
Name of Facility:	StoryPoint West Bloomfield
Facility Address:	5475 West Maple West Bloomfield, MI 48322
Facility Telephone #:	(248) 419-1089
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff dropped Resident A during a transfer.	Yes
Staff do not always answer Resident A's call light, and he was left on the toilet for 45 minutes.	Yes
Residents were given medication late and it was not charted correctly.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/29/2025	Special Investigation Intake 2026A0585006
10/30/2025	Inspection Completed On-site Completed with observation, interview and record review.
10/29/2026	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
10/29/2025	Inspection Completed-BCAL Sub. Compliance.
11/12/2025	Contact Telephone call made. Contact the complainant by telephone to discuss allegations.
12/02/2025	Exit Conference Conducted via email to authorized representative Rochelle Lyons.

ALLEGATION:

Staff dropped Resident A during a transfer.

INVESTIGATION:

On 10/29/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that two untrained techs dropped Resident A during a transfer attempt, causing a head injury that required EMS intervention.

On 10/30/2025 an onsite investigation was completed at the facility. The administrator was not there at the time. I interviewed operational manager Haylee Hutchinson who stated that she just got here to the community and did not know any details regarding the incidents related to this complaint.

On 10/30/2025, I interviewed Employee #1 at the facility. Employee #1 stated Resident A's call light was broken and they got him a bracelet alarm in place of the necklace. Employee #1 stated, they are expected to respond to call lights within ten minutes or less. She said there are 61 residents at the facility. She said the care staff on the morning and evening shift is 7-8 and the midnight shift is 6 staff. She said a wellness director is on duty five days a week and a receptionist is on duty from 7:30 am – 8 pm. She said that employees were getting Resident A ready for bed and his knees buckled. She said Resident A is two people assist for transfers.

On 10/30/2025, I interviewed Employee #2 at the facility. Employee #2 stated that her and Employee 3 were transferring Resident A to his bed from the wheelchair. She said Resident A wanted his bed lower and they stood him up, his knees buckled and he went down. She said that her and Employee #3 went down with him lowering him to the floor. She said he didn't fall, but he slid down. She said they called EMS and did his vitals. She said he is a 2-3 person assist.

On 10/30/2025, I interviewed Employee #3 at the facility whose state that Resident A is very independent and likes to do things on his own. Employee #3 stated that Resident A did not fall but when his knees buckled, her, along with Employee #2, lowered him down to the floor. She said they put the wheelchair close to the bed. She said that Resident A was on his knees when they lowered him and he leaned forward hitting his head. She said that Resident A always has his pendant and uses it, but he is particular about which aide he wants.

On 11/12/2025, I interviewed the complainant by telephone. The complainant's statement was consistent with what was reported. The complainant stated that she could hear everything from the ring camera in Resident A's room. The complainant stated that staff dropped Resident A. She said Resident A is in rehab now.

Resident A had a video camera in his apartment. On 9/16/2025, Employee #2 and Employee #3 in the room. Both employees leave out of the view of the camera, and it appears they are in the bedroom getting Resident A ready for bed. I could hear one of the employees telling Resident A to straighten his legs up. The employee said that all we can do is lower you to the floor and call 911 to get you up. In the video, I could hear Resident A holler out in pain.

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.**
	(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:	The complaint alleged staff dropped Resident A during transfer. Employee #2 and Employee #3 were in the bedroom to assist Resident A to get in bed. Resident A fell during the transfer causing a bump and abrasion to his head. According to Employee #2 and Employee #3, Resident A leaned forward and fell. A video footage was reviewed, although the video did not show what happened, you can hear Resident A hollering out in pain. Resident A had the fall during the transfer with two employees present; therefore, the employees did not protect Resident A from injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff do not always answer Resident A's call light and he was left on the toilet for 45 minutes.

INVESTIGATION:

The complaint alleged that on 9/6, Resident A 's call light pendant was taken off his neck, and he was left on the toilet for 45 minutes. The complaint alleged that Resident A pulled the cord on the wall to request assistance with no response. The complaint alleged that Resident A asked the caregiver about his pendant, she took off his neck and she left him in the lobby. The complaint stated they searched for Resident A's call pendant, and it was found on the floor by the med cart in the hall. The complaint alleged that a similar incident regarding the call light happened again on 9/13/14 night shift.

Employee #1 said the expected response time to call lights is 5-10 minutes. Employee #1 stated that Resident A call light was broken. She said he had a necklace pendant but went to a watch. She said the expected respond time to call lights is 10 minutes or less.

Employee #3 said that Resident A takes his call pendant off and most of the time he has it. She said that Resident A is very particular.

A review of the call light audit showed the following:

	Date	**Time**	**Respond time**	**Duration**
Pendant	9/6	07:54:19 pm	8:29:26 pm	35 m
Bath E-Call	9/6	08:01:19 pm	8:29:26 pm	28 m
Bath E-Call	9/6	08:52:48 pm	9:05:07 pm	13 m
Pendant	9/6	10:19:39 pm	10:50:21 pm	31 m
Pendant	9/6	11:05:19 pm	11:20:12 pm	15 m
Bath E-Call	9/10	04:27:06 pm	05:00:54 pm	33 m
Pendant	9/11	07:27:33 am	08:59:18 am	1 hr 32 m
Pendant	9/16	10:27:19 am	10:55:19 am	28 m
Bath E-Call	9/16	10:32:24 am	10:55:19 am	23 m
Pendant	9/16	08:30:12 pm	09:19:37 pm	49 m

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**

ANALYSIS:	The complaint alleged staff do not always answer Resident A's call light and he was left on the toilet for over 45 minutes. Resident A's call light audit was reviewed. The call light audit showed that on 9/6 the call pendant was used with a response in 35 minutes. The bathroom pull cord was pressed twice for a total of 41 minutes for a response time. There were a 1 hour 32 minutes response time on 9/11 and a 49-minute response time on 9/16. The staff did not always respond to the call pendant in a timely manner; therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were given medication late and it was not charted correctly.

INVESTIGATION:

The complaint alleged that on 9/16/25, medication was administered late, and it was signed off that it was given. The complaint alleged that one med tech signed off that the medication was given, thinking the previous med tech administered it and forgot to chart.

The complainant stated that she was told that they charted the medication as given and was not given. She said that she went back to look at the videos and did not see anyone give the medication at the time it was supposed to be given.

Employee #1 stated that on 9/16, someone incorrectly charted that the medication was given and it wasn't. Employee #1 stated that once she became aware that the medication was given, she immediately got it and had it administered to Resident A.

In a video of Resident A room, he is talking about he didn't get his 9:00 medication. When staff came in the room, Resident A told her that he did not get his medication at 9:00 pm. Employee #4 came in the room and said that Resident A had got his medication already. Resident A asked her when he got it and Employee #4 said at 8:30 pm. Resident A said no I didn't get it. Employee # 5 came into the room and said that she would ask Employee #2 about his medication. At 11:23 pm, Employee #3 came in and gave Resident A his medication.

Resident A's medication administration record (MAR) shows that all medication was administered.

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:	The complaint alleged that Resident A was given late and was not charted correctly. Based on the review of the MAR, medication was marked as given, although statement from employee, and review of the video, medication was not given at 9:00 pm as prescribed but was given after 11:00 pm. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

In one of the videos of Resident A's room, you can hear him talking on the phone, he said "it is almost 10:30 and I want to go to bed." Resident A said that no one had come to put him in bed. Employee #4 came into the room and Resident A asked her name. Employee #4 said her name, but I don't believe he could hear her, because he asked her to see her badge. Employee #4 said, "I am telling you my name". Resident A proceeded to say that Employee #4 had an attitude and Employee #4 said "no I don't", she put her hands up and she turn around leaving out of the room.

In the second video, Resident A was shown sitting in his chair talking on the phone. Resident A said, "nobody came, and it is 10 after 10 and I want to be in my bed." Resident A said, "I don't belong here, I belong where they take care of me." Resident A kept asking Employee # 5, did he do anything wrong, and was he rude because he only asked her name. Resident A had a bandage on his arm that was coming off. Employee #5 changed Resident A bandage.

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:	Employee #4 was rude with Resident A and did not treat him with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

11/20/2025

Brender Howard Date
Licensing Staff

Approved By:

11/20/2025

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