



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 6, 2026

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

RE: License #: AH820399661
Investigation #: 2026A1019022

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.

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,

A handwritten signature in blue ink, appearing to read "Elizabeth Gregory-Weil".

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2026A1019022
Complaint Receipt Date:	03/06/2026
Investigation Initiation Date:	03/10/2026
Report Due Date:	05/05/2026
Licensee Name:	44600 Five Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Lisa Bullard
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	103
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being neglected.	No
Residents are not being given a choice of their home care provider.	No
Additional Findings	Yes

III. METHODOLOGY

03/06/2026	Special Investigation Intake 2026A1019022
03/10/2026	Special Investigation Initiated - Telephone Reported to APS
03/10/2026	APS Referral
03/19/2026	Inspection Completed On-site
03/19/2026	Inspection Completed BCAL Sub. Compliance

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

ALLEGATION: Resident A is being neglected.

INVESTIGATION:

On 3/10/26, the department received a complaint alleging that Resident A is being neglected. The complaint read that Resident A is left in bed all day, alleged staff take away his call pendant, barricade him in his room, fail to tend to his hygiene needs and alleged that staff unnecessarily medicate him, so he is less of a nuisance to staff.

On 3/19/26. I conducted an onsite inspection. I interviewed the administrator Lisa Bullard at the facility. The administrator reported that Resident A is a high level of

care that requires hands-on staff assistance with many activities of daily living. The administrator reported that Resident A is on hospice and due to some cognitive impairment, he is being evaluated for memory care. The administrator reported that Resident A is mainly bed bound and requires staff assistance with mobility and transferring, however she acknowledges that there are times when he has attempted to get himself out of bed. The administrator reported that Resident A has a wheelchair and geri chair for ambulation and has a call pendant for his to summon staff when assistance is needed. The administrator reported that he uses his call pendant frequently but not always appropriately, and due to this, staff conduct safety checks on him every 2-3 hours.

While onsite, I reviewed Resident A's service plan. The service plan was updated on 1/11/26 and read that Resident A requires assistance with bathing, dressing, toileting, mobility, ambulation, transfers and medication administration. Regarding the allegation of being left in bed all day, the administrator reported that he cannot safely ambulate without staff assistance. The administrator along with Employee 1, via a submitted statement, attest that he is rounded on every 2-3 hours, is escorted out of his room for all of his meals, actively participates in activities and engages with others.

Regarding his call pendant, the complainant did not provide dates that Resident A's pendant was taken away or provide names of staff that allegedly took his pendant. While onsite, I requested call light response data for the previous four weeks. I observed that Resident A used his call pendant and/or pull cord several times each day throughout the entire timeframe reviewed. There is no evidence to suggest that he was without his pendant at any point.

Regarding being barricaded in his room, the administrator reported that there was a concern that was brought to her by Resident A's son via a telephone call. The administrator could not recall when she received the phone call or the specifics of the conversation but reported that it came in after work hours and she was not present at the facility. The administrator reported that following the phone call, she contacted the wellness director, who is no longer employed at the facility, to look into the matter. The administrator reported that the wellness director at the time interviewed the caregiver working with the resident, however, the administrator could not recall who the caregiver was. Per the administrator, the wellness director reported that the caregiver said the resident's geri chair was moved between his table and couch so he could see the television better and denied he was barricaded in his room. The administrator reported that she didn't have any other correspondence with Resident A's family on this, and all follow up communication was with the former wellness director. The administrator was unable to provide any more details and considered the matter resolved.

Regarding hygiene, the complaint alleged that staff are not cleaning him up after he has an episode of incontinence. The administrator reported that hospice staff complete Resident A's showers and provided hospice documentation to support that

his showers are completed on average twice weekly. The administrator reported that staff assist Resident A with toileting via checks and changes every two hours, and sometimes more often as needed. The administrator reported that Resident A is a full assist with brief changes, however toileting tasks are not documented by staff. The administrator reported that if the resident is incontinent and requires his clothing or bedding to be changed, it will be completed at that time along with ensuring that the resident is properly cleaned as well. Employees 2 and 3 attested that Resident A uses his call pendant when he has to use the restroom, however he does occasionally experience episodes of incontinence. Employees 2 and 3 attested that when this occurs, staff will wash him up and change him and also change his linens.

Regarding medication, the complaint alleged that staff are claiming the resident is restless as a means to justify giving him medication, so he is not “*bothering them*” throughout their shift and they are not having to continuously be in his room. Resident A’s medication administration records were reviewed for the previous four weeks. I observed that Resident is prescribed gabapentin for restless legs, haloperidol for restlessness, and lorazepam for restlessness or agitation and all were prescribed on an as needed basis. Staff did not document any instances of restlessness during the timeframe reviewed and none of the medications were documented as administered.

While onsite, I interviewed Resident A. He was pleasant and engaged, however was unable to appropriately answer my line of questioning. I observed him to be well groomed, appearing in clean clothing and with clean bedding. Additionally, I observed Resident A to have his call pendant around his neck. When asked how he lets staff know he needs something, he pointed to the device.

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents;
	<p>(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:</p> <p>(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom</p>

	the physician has a practice agreement, or an advanced practice registered nurse.
ANALYSIS:	<p>Staff attestation reveals that Resident A cannot ambulate safely without staff assistance but reported that he attends meals and activities outside of his room regularly. Based on this information, the allegation that Resident A is left in bed all day is unsubstantiated.</p> <p>Direct observation of Resident A during my onsite revealed that he had his call pendant on his person. Review of call pendant response data revealed that he used his call pendant daily during the entire four week timeframe, indicating that it could not have been taken from him if it was actively used. Based on this information, the allegation that Resident A's pendant is taken away from him is unsubstantiated.</p> <p>Limited information was provided, no date of occurrence of names of staff involved, pertaining to the allegation of Resident A being barricaded in his room, however staff denied that this occurred. Given the lack of information and detail, the allegation that Resident A was barricaded in his room is unsubstantiated.</p> <p>Resident A relies on staff assistance with toileting and bathing. Hospice documentation demonstrates routine bathing activities and attestations from multiple staff reveal that Resident A is cleaned up and changed as needed after episodes of incontinence. Based on this information, the allegation that Resident A's hygiene is neglected is unsubstantiated.</p> <p>Review of Resident A's medication administration records for the previous four weeks reveals that staff never indicated a need for him to receive his "as needed" medications for restlessness. Based on this information, the allegation that staff are medicating Resident A as a means to subdue his behavior is unsubstantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not being given a choice of their home care provider.

INVESTIGATION:

The complainant alleged that the facility is trying to convince residents to use Corso Care home health agency and is not providing alternatives to families. The administrator reported that Corose Care and the facility are owned by the same company, so they are a “preferred” provider, but denied that they exclusively refer to Corso Care. The administrator reported that there are numerous home care companies that current residents are signed on to use and it is always up to the resident/family who they want to use. While onsite, the administrator provided me with a list of residents on home care and the companies they use. I observed the following companies listed: Amara, Angela, Custom Home Health, Heart to Heart, Optimal and Parc.

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents;
	<p>(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:</p> <p>(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant with whom the physician has a practice agreement, with his or her advanced practice registered nurse, with his or her attorney, or with any other individual of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.</p>

ANALYSIS:	While Corso Care and the licensee share the same ownership interest, various companies were being utilized by current residents for home care services.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

While onsite, licensing staff discovered that the administrator did not match who was appointed by the licensee. The administrator reported that she has been in her current role since August 2025. Prior to this, the department had not received notification of a change to this appointment, nor was the required paperwork submitted, which includes BCAL 1606 form and proof of education, training, and experience with the population served. In follow-up correspondence with the authorized representative Katelyn Fuerstenberg, she confirmed that notification was not provided. The AR also reported that the authorized representative appointment should have been changed as well.

On 3/23/26, the licensee submitted proper paperwork to change the administrator.

APPLICABLE RULE	
R 325.1913	Licenses and permits; general provisions.
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The licensee failed to notify the department when the administrator was changed.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



04/02/2026

Elizabeth Gregory-Weil
Licensing Staff

Date

Approved By:



04/06/2026

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

Date