GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 15, 2026

Rochelle Lyons
StoryPoint Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2026A0627038
StoryPoint Birmingham

Dear Ms. Lyons:

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) 335-5985.

Sincerely,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2026A0627038
Complaint Receipt Date:	03/18/2026
Investigation Initiation Date:	03/19/2026
Report Due Date:	05/17/2026
Licensee Name:	2400 East Lincoln St OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Linzie Potts
Authorized Representative/	Rochelle Lyons, Authorized Repr.
Name of Facility:	StoryPoint Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 940-2050
Original Issuance Date:	03/29/2018
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	128
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility delayed in calling Emergency Services after Resident A had fallen, the family was not notified at the time of the fall, care was not provided as stated on the service plan, Resident A was put back to bed and their condition further deteriorated.	No
Additional Findings	No

III. METHODOLOGY

03/18/2026	Special Investigation Intake 2026A0627038
03/19/2026	Special Investigation Initiated - On Site
03/23/2026	Contact - Telephone call made Birmingham Fire Dept
03/23/2026	Contact - Telephone call made complainant
03/24/2026	Contact - Telephone call made Birmingham Fire Dept

ALLEGATION: It was alleged the facility delayed calling Emergency Services after Resident A had fallen, the family was not notified at the time of the fall, care was not provided as stated on the service plan, Resident A was put back to bed and their condition further deteriorated.

INVESTIGATION: On 3/14/26 the Bureau of Community and Health Systems received a complaint that alleged the facility delayed in calling Emergency Services after Resident A had fallen, the family was not notified at the time of the fall, care

was not provided as stated on the service plan, Resident A was put back to bed and their condition further deteriorated.

On 3/19/26, I interviewed Linzie Potts, Executive Director (ED) and SP 1. ED reported that Resident A was a resident at the facility from 1/02/26 to 1/10/26. I interviewed SP1 in which it was reported that Resident A was capable of using her call light and did use her call light to ask for assistance when she needed it but did not come out of her room much and took her meals there also.

I reviewed Resident A's service plan that specified orders for every 2-hour assurance checks for toileting, safety and repositioning while in bed. Resident A's progress note dated 1/02/26 showed admission to the community and identified being a 1 person assist for all ADL's, transfer assist for toileting, and having pain related to a fall with a sternal fracture prior to coming to the community. I reviewed the call light history for the facility and noted Resident A had used the call light 12 times between 1/02/26 and 1/09/26.

On 3/19/26 I reviewed the incident report dated 1/10/26 that documented Resident A being discovered on the bathroom floor at approximately 11:30 am and unresponsive. The incident report documented a blood pressure of 163/78 and 911 being called. The late entry progress note dated 1/14/26 noted that on 1/10/26 the med tech had entered the resident's room at approximately 11:30am and observed the resident lying on the floor unresponsive. The Med Tech left the room for help and returned to the room and called 911. The note ends with documentation that staff had moved the resident from the floor to the bed. Relative to the progress notes documenting Resident A's fall on 1/10/26 at approximately 11:30am, I inquired of SP1 if there had been any documentation of an assurance check prior to the fall, to which SP1 replied that there was no documentation.

On 3/23/26 I called the Birmingham Fire Department and confirmed with the Assistant Chief that a 911 call came in for Resident A at 11:30am. A message requesting an interview was left for the responding lead paramedic on 3/24/26. On 4/15/26 I called the Birmingham Fire Department and spoke with Fire Fighter 1 who responded to the call on Saturday 1/10/26. Fire Fighter 1 stated he suspected there could have been a delay in initiating EMS but did not have any caregiver staff onsite specify that there had been a delay.

The incident report noted that Resident A's daughter was notified of the fall at 11:40am. On 3/23/26 I interviewed the complainant via phone who stated that she believed Resident A was put in bed sooner than 11:30am but does not know for sure. The complainant confirmed being notified of Resident A's fall at 11:34 am. The ED reported that the caregivers involved in this incident are no longer employed by the facility and not available for interview.

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.**
ANALYSIS:	Through interview and record review there was no conclusive evidence that the facility had delayed calling 911 or in notifying the family of Resident A's fall. Through interview and record review there was evidence that the facility failed to follow the service plan that called for every 2-hour wellness checks of Resident A and an unresponsive Resident A being moved into bed while awaiting the arrival of Emergency Medical Services.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan the status of the license should remain the same.

06/15/2026

Rick Brummette — Date
Licensing Staff

Approved By:

06/15/2026

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