



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 24, 2025

Katelyn Fuerstenberg  
Senior Living Portage, LLC  
3951 W. Milham Ave  
Portage, MI 49024

RE: License #: AH390377735  
Investigation #: 2025A1010063  
StoryPoint of Portage

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 (877) 458-2757.

Sincerely,

A handwritten signature in blue ink that reads "Lauren Wohlfert".

Lauren Wohlfert, Licensing Staff  
Bureau of Community and Health Systems  
350 Ottawa NW Unit 13 7th Floor  
Grand Rapids, MI 49503  
(616) 260-7781  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH390377735
<b>Investigation #:</b>	2025A1010063
<b>Complaint Receipt Date:</b>	07/25/2025
<b>Investigation Initiation Date:</b>	07/28/2025
<b>Report Due Date:</b>	09/24/2025
<b>Licensee Name:</b>	Senior Living Portage, LLC
<b>Licensee Address:</b>	2200 Genoa Business Pk Dr Brighton, MI 48114
<b>Licensee Telephone #:</b>	(810) 220-2200
<b>Administrator:</b>	Carrie Morris
<b>Authorized Representative:</b>	Katelyn Fuerstenberg
<b>Name of Facility:</b>	StoryPoint of Portage
<b>Facility Address:</b>	3951 W. Milham Ave. Portage, MI 49024
<b>Facility Telephone #:</b>	(269) 329-0200
<b>Original Issuance Date:</b>	04/24/2017
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	40
<b>Program Type:</b>	AGED ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A's care needs were not met on 07/20/2025.	Yes

**III. METHODOLOGY**

07/25/2025	Special Investigation Intake 2025A1010063
07/28/2025	Special Investigation Initiated - Letter Emailed assigned Kalamazoo Co APS worker Brian Simpson
07/28/2025	Contact - Document Received Email from Mr. Simpson received
07/29/2025	Inspection Completed On-site
07/29/2025	Contact - Document Received Received resident weights and vitals summary, service plan, and PRN medication report
09/24/2025	Exit Conference

**ALLEGATION:**

**Resident A's care needs were not met on 07/20/2025.**

**INVESTIGATION:**

On 07/25/2025, the Bureau received the complaint from Adult Protective Services (APS). The allegations read, "[Resident A] is in the memory care unit. She is also a hospice patient. On 07/20/2025 [sic] around 4 pm, [Resident A] was found still in bed. Her head was down off the pillow. [Resident A] cannot sit up on her own. She is not able to use a call light. [Resident A] was in her pajamas. [Resident A's] Depends was [sic] soaked/ There were what appeared to be urine stains on the linen. There was dried food all over the bed covers and carpet. There appeared to be food stains on the carpet. There is a camera in the room. Staff were aware of family members visiting. Afternoon staff came into [Resident A's] room and were very helpful. It appeared that the day shift staff had not gotten [Resident A] out of bed, attended to her, fed or changed her."

The complaint also read, “[Resident A] has lost a significant amount of weight since being at the facility. The loss of weight could be related to inconsistently receiving meals.”

On 07/28/2025, I emailed the assigned Kalamazoo County APS worker Brian Simpson. Mr. Simpson reported he completed his APS investigation, and it was not substantiated. Mr. Simpson provided me with his findings that read, “ASW spoke with [Staff Person 1] who stated that [Resident A] was checked on at 2 PM on 7/20/2024 and then again two hours later at 4 PM. During the two hours in between family arrived and found [Resident A] in the reported condition. It is believed that [Resident A] may have had an accident during this two-hour period and that is when family found her. It is reported that [Resident A] does like to eat in her room and that the room is clean by housekeeping five days a week, but by other care staff on weekends. [SP1] reports care staff do the best they can to clean rooms but have other priority responsibilities so rooms may not be as deep cleaned as they typically are when housekeeping is there. ASW spoke with [Relative A1], who believes that this is an isolated incident and reports not having any other issues with story point and is satisfied with the care that [Resident A] is receiving. To prevent this from occurring again, [SP1] reports that Story Point staff have increased check-ins with [Resident A] and besides the regular two-hour check-in, they will be checking in after each meal as well. This case will not be substantiated for Neglect it is not believed that this was done intentionally and Story Point has taken appropriate action to rectify situation [sic].”

On 07/29/2025, I interviewed the administrator at the facility. The administrator reported SP1 addressed the incident on 07/20/2025, therefore SP1 has direct knowledge regarding it.

On 07/29/2025, I interviewed SP1 by telephone. SP1’s statements were consistent with her statements provided to Mr. Simpson. SP1 stated she has not received any previous complaints from Resident A’s visitors or family regarding her care or the cleanliness of her room.

SP1 reported Resident A also has a history of refusing care from staff. SP1 stated Resident A is prescribed an as needed medication for anxiety. SP1 said Resident A has a history of yelling, hitting, and attempting to scratch staff during the provision of her care. SP1 reported Resident A currently receives hospice services through Corso Care. SP1 said hospice nursing staff are in the facility one to two times a week to see Resident A.

SP1 denied knowledge regarding Resident A experiencing weight loss. SP1 reported Resident A eats independently with cues from staff. SP1 stated Resident A is weighed monthly, therefore staff monitor her weight.

On 07/29/2025, I interviewed SP2 at the facility. SP2’s statements were consistent with SP1. SP2 provided me with a copy of Resident A’ service plan for my review.

The *Assurance Checks* section of the plan read, "Assurance checks provided every two hours for safety." The *Toileting* section of the plan read, "Resident is independent with all tasks related to toileting without reminders from staff. Care staff will report any changes in ability to toilet." The *Bladder Incontinence* section of the plan read, "Resident is independent with incontinence products (specify: pull-up, liner, brief)." The *Dining* section of the plan read, "Resident requires reminders/cueing for (specify: making meal choices, encouraging foods/fluids, ect.). Preferred Meal Location: Apt. Resident is independent with all tasks related to meal prep without reminder from staff. Care staff will report any changes in meal prep abilities or requests." The *Housekeeping* section of the plan read, "Staff cleans resident apartment."

SP2 provided me with a copy of Resident A's monthly *Weights and Vitals Summary* document for my review. SP2 stated Resident A refused to allow staff to weigh her in March and April 2025. The document read Resident A weighed 106.2 pounds in February 2025, 118.4 pounds in May 2025, 115.3 pounds in June 2025, and 136.8 pounds in July 2025. Resident A experienced a weight gain in July 2025.

On 07/29/2025, I interviewed SP3 at the facility. SP3's statements were consistent with SP1 and SP2.

On 07/29/2025, I interviewed SP4 at the facility. SP4's statements were consistent with SP1, SP2, and SP3.

On 07/29/2025, I interviewed SP5 at the facility. SP5's statements regarding her cleaning tasks were consistent with SP1, SP2, SP4, and SP4. SP5 explained her cleaning tasks are outlined in an app on the iPhone she carries on her person during her shift. SP5 stated she utilizes the task list within the app to ensure she completes all tasks.

On 07/29/2025, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A was sitting in her geri chair in a common area in the facility's secured memory care unit. Resident A was well groomed and had clean clothing on.

On 07/29/2025, I observed several residents in the common area in the facility's secured memory care unit. The residents were well groomed and wore clean clothing. I did not detect any foul odors.

On 07/29/2025, I observed Resident A's room. Resident A's room was clean and free from hazards. I did not observe any debris or food crumbs on the floor. Resident A's bedding was clean, and I did not detect any foul odors.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	<p>The interviews with SP1, SP2, SP3, and SP4 revealed resident A's care needs are met by staff. SP1 reported that on 07/20/2025, staff observed and met Resident A's care needs twice before her family arrived to visit. SP1 said in between the time staff checked on and Resident A and her family's arrival, Resident A likely had an episode of incontinence. Staff reported Resident A does eat her meals primarily in her room. Staff stated Resident A eats independently and often gets food on the floor in her room. After the incident on 07/20/2025, SP1 said staff are to observe the condition of Resident A's room after she eats a meal in it. There is insufficient evidence to suggest staff are not meeting Resident A's care needs.</p> <p>SP1 reported Resident A has a history of being verbally and physically combative during the provision of her care. SP1 said Resident A is prescribed an anxiety medication as an intervention. Resident A also requires assistance with toileting and ambulating. Review of Resident A's service plan revealed it is not updated to reflect Resident A's current care needs. Resident A's receipt of hospice services was also not outlined in her plan. As a result, the facility was not in compliance with this rule.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

I shared the findings of this report with the facility's licensee authorized representative on 09/24/2025.

#### **IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

*Lauren Wohlfert*

08/21/2025

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Lauren Wohlfert  
Licensing Staff  
Approved By:

Date

*Andrea Moore*

09/23/2025

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

Date