GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 27, 2019

Deborah Skotak
First & Main of Auburn
3151 E. Walton Blvd.
Auburn Hills, MI 48326

RE: License #: AH630370122
Investigation #: 2019A1019034
First & Main of Auburn

Dear Ms. Skotak:

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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630370122 |
| | |
| **Investigation #:** | 2019A1019034 |
| | |
| **Complaint Receipt Date:** | 03/18/2019 |
| | |
| **Investigation Initiation Date:** | 03/18/2019 |
| | |
| **Report Due Date:** | 05/17/2019 |
| | |
| **Licensee Name:** | F&M Auburn Hills OPCO, LLC |
| | |
| **Licensee Address:** | #2200<br>2221 Health Drive SW<br>Wyoming, MI 49519 |
| | |
| **Licensee Telephone #:** | (616) 248-3566 |
| | |
| **Administrator:** | Deborah Skotak |
| | |
| **Authorized Representative:** | Deborah Skotak |
| | |
| **Name of Facility:** | First & Main of Auburn |
| | |
| **Facility Address:** | 3151 E. Walton Blvd.<br>Auburn Hills, MI 48326 |
| | |
| **Facility Telephone #:** | (248) 282-4094 |
| | |
| **Original Issuance Date:** | 04/24/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/24/2018 |
| | |
| **Expiration Date:** | 10/23/2019 |
| | |
| **Capacity:** | 158 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident F was exposed to hazardous chemicals and possibly ingested Lysol. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 03/18/2019 | Special Investigation Intake<br>2019A1019034 |
| 03/18/2019 | Special Investigation Initiated - Letter<br>Emailed AR for additional information regarding incident |
| 03/18/2019 | APS referral<br>Notified APS via email referral template |
| 03/27/2019 | Exit Conference |

## ALLEGATION:

**Resident F was exposed to hazardous chemicals and possibly ingested Lysol.**

**INVESTIGATION:**

On 3/18/19, the department received an incident report submitted via email from facility administrator and authorized representative Deborah Skotak. The incident reported dated 3/16/19 at 12:45pm read “Employee walked into resident apartment, saw open spray bottle on dresser labeled Lysol and found resident in bathroom trying to get water. Resident was shaky. After he got some water, he was spitting it out to rinse mouth. There was no evidence of vomit.” The incident report also read that poison control and EMS was contacted. Resident F was taken to the hospital and returned the same day.

Licensing staff contacted Ms. Skotak by email on 3/18/19 to inquire further about the incident. Ms. Skotak stated that hazardous and toxic materials are kept in a locked cabinet in the soiled linen room and cannot pinpoint when the memory care resident

had access to the Lysol. Ms. Skotak stated that Resident F was seen roughly 30 minutes prior to the incident by memory care unit manager Jacqueline Goodgame and that nothing was noted to be out of the ordinary. Ms. Skotak stated that Resident F “could not verbalize a clear response” to explain what happened. Ms. Skotak stated that staff denied witnessing Resident F ingest the chemicals. Ms. Skotak stated “No one actually saw him ingest it, but he was spitting out the water that was given to him like he was rinsing out a bad taste out of his mouth.” Ms. Skotak stated that care staff Juanitria Magee was working in memory care at the time of the incident along with Ms. Goodgame.

Ms. Goodgame attested:

I heard [Resident F] yelling in the bathroom by the unit managers office that he needed help at 12:15pm. I assisted him out of the bathroom and pushed him into his room then assisted him to stand up and pull his pants up. He sat back down in his wheelchair and then turned out of his room to self-propel to the dining room for lunch and began talking to 2 other residents whom were in the hall during that time.

Ms. Magee attested:

> I was getting all of my memory care residents ready to go down to the dining room, and as I was going into 361’s room I seen the Lysol bottle open on his dresser and ran to the restroom where he was in his wheelchair. I quickly called for assistance and gave him some water (which he asked for as I was giving it to him).

Director of lifestyles Heather Marchi was working at the time of the incident and attested:

> Jenna called me to room 361 stat. I stopped at the med station where Beverly told me the resident consumed Lysol. I directed her to call poison control as well as his family. Then went to room 361. When I arrived, I was told resident had swallowed Lysol and was vomiting. He said he wasn’t feeling well and was trying to drink more water to make himself vomit. I directed staff to stay with him and called 911 immediately and directed Beverly to print his paperwork. After EMS arrived, I contacted Quincy (maintenance director) to get the information from the cleaning product. After EMS left, I confiscated the bottle and placed it locked in the ED office.

Ms. Marchi cannot recall which staff informed her that Resident F swallowed Lysol and was vomiting.

Med tech Jenna Areaux attested:

> Erika and Juanitria called me and or Bev to the third floor. I had told them I could be up there as soon as I was done with another resident. When I was heading

> out Erika had called and said STAT over the walkie. When I got upstairs resident was in restroom with Erika and Juanitria rinsing mouth out with water. Staff stated he had took a drink of Lysol. Bev had got up here, told Bev he needed to go out to hospital, he had drank Lysol. Bev called EMS and poison control. Went back to residents room, told resident to stop drinking the water and eat nothing per Heather. EMS arrived and took to hospital.

Med tech Beverly Merriweather attested:

> #361 care staff called for me or Jenna to come up stat for assistance. They notified us that he was found with a spray bottle in his hand drinking Pine Sol diluted. The bottle was labeled Lysol. I contacted Poison Control and notified family, nurse and doctors office. He was transported to the emergency room.

Care Staff Erika Rush attested:

> I Erika was called on 3rd floor to assite [sic] with a staff member who stated that 361 needed help when I got on the floor I was told that he consumed Lysole [sic] I then went in the bathroom to check on him he was spitting in a trash can. I asked him was he ok he said yes he just drunk something that's when the med tech arrived on the floor and I left cause I was needed back on my floor.

As a result of a citation during the facility's renewal inspection in January 2019, Ms. Skotak stated that staff were supposed to conduct "sweeps" of the floor during each shift to ensure no toxic materials were accessible to residents. Ms. Skotak attested that staff were documenting their rounds on checklists each shift. Upon review of the March 2019 checklist, facility staff did not document that "sweeps" were conducted on the following dates and shifts: 3/1/19 midnight shift, 3/2/19 afternoon and midnight shift, 3/3/19 afternoon and midnight shift, 3/8/19 midnight shift, 3/12/19 day and midnight shift and 3/14/19 midnight shift.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1979** | **General maintenance and storage.** |
| | **(3) Hazardous and toxic materials shall be stored in a safe manner.** |

| | |
|---|---|
| **ANALYSIS:** | On 3/16/18, it is suspected that Resident F ingested Lysol after an open bottle was found in Resident F's memory care apartment. While staff acted appropriately upon the discovery of the open Lysol bottle in Resident F's apartment, Resident F should not have had access to the hazardous and toxic materials which could have led to a potentially dangerous and life-threatening situation. Based on these findings, the allegation is substantiated. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED [For reference, see AH630370122_RNWL_20180904, CAP dated 2/14/19]** |

On 3/27/19, I shared the findings of this report with facility authorized representative Deborah Skotak.

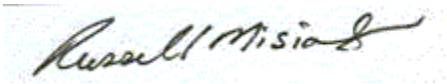
## IV. RECOMMENDATION

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

3/20/19

Elizabeth Gregory- Weil Date
Licensing Staff

Approved By:



3/26/19

Russell B. Misiak Date
Area Manager