GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2019

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

RE: License #: AH630370122
Investigation #: 2019A1019058

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.

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

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2019A1019058
Complaint Receipt Date:	08/20/2019
Investigation Initiation Date:	08/20/2019
Report Due Date:	10/19/2019
Licensee Name:	F&M Auburn Hills OPCO, LLC
Licensee Address:	#2200 2221 Health Drive SW Wyoming, MI 49519
Licensee Telephone #:	(616) 248-3566
Administrator and Authorized Representative:	Deborah Skotak
Name of Facility:	First & Main of Auburn Hills
Facility Address:	3151 E. Walton Blvd. 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 ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility is not following proper health protocol when caring for Resident G who has Clostridium difficile (C. diff).	No
Soiled linens are left in Resident G's room.	No
Resident G's bedroom and bathroom aren't cleaned on a regular schedule.	No
Additional Findings	Yes

III. METHODOLOGY

08/20/2019	Special Investigation Intake 2019A1019058
08/20/2019	Special Investigation Initiated - Letter Emailed AR to obtain facility census
08/22/2019	Contact - Document Sent Emailed APS worker to obtain status update
08/22/2019	Inspection Completed On-site
08/22/2019	Inspection Completed BCAL Sub. Compliance
08/26/2019	Contact- Telephone call made Placed call to Oakland County Health Department, interview conducted with staff epidemiologist
09/13/2019	Exit Conference

ALLEGATION:

Facility is not following proper health protocol when caring for Resident G who has Clostridium difficile (C. diff).

INVESTIGATION:

On 8/20/19, the department received an online complaint regarding Resident G. Due to the anonymous nature of the complaint, I was unable to interview the complainant to obtain additional information.

On 8/22/19, I conducted an onsite inspection at the facility. I interviewed administrator and authorized representative Deborah Skotak at the facility. Ms. Skotak stated that Resident G moved into the facility on 3/16/19 and has had chronic Clostridium difficile (C. diff). Ms. Skotak stated that Resident G has been hospitalized on several occasions for issues relating to C. diff. Ms. Skotak stated that facility staff take “contact precautions” when providing care to her. Ms. Skotak stated that Resident G does not currently have C. diff but when staff bathe or toilet her, they wear gowns and gloves and always wash their hands before and after care. Ms. Skotak stated that Resident G has had at least three recent hospitalizations pertaining to C. diff (5/1/19-5/21/19, 7/2/19-8/6/19 and 8/12/19). Ms. Skotak stated that care coordination has been difficult with Resident G because Relative G [Resident G’s daughter] will take the resident out of the facility without providing any notification to facility staff and would not always provide the facility with medical and health updates as requested. Ms. Skotak stated that they recently had a meeting with the Ombudsmen’s office due to ongoing issues with Relative G and she is anticipating better communication moving forward.

On 8/22/19, I interviewed wellness director Nikisha Cobb at the facility. Ms. Cobb stated that Resident G does not have active C. diff but stated that the facility still takes contact precautions when providing care to her. Ms. Cobb stated that Resident G has had several hospitalizations for C. diff related issues but that she does not currently have active C. diff. Ms. Cobb stated that the facility is taking precautions as a preventive measure and not out of necessity.

On 8/22/19, I interviewed care giver Sonea Jackson at the facility. Ms. Jackson’s statements were consistent with Ms. Skotak and Ms. Cobb regarding contact precautions with Resident G. Ms. Jackson also stated that Resident G does not have active C. diff. Ms. Jackson stated that she also always washes her hands before and after providing care to Resident G.

Attestations from care staff Korea Allen, Cortez Graham and Erika Rush were also obtained. Ms. Allen attested that staff take precautions such as using gloves, wearing a mask and gown when providing care to Resident G. Mr. Graham attested that universal precautions are used when caring for Resident G. Mr. Graham provided examples of precautions as staff wearing gowns, clothing protectors and

face masks. Ms. Rush attested that staff use face masks, handwashing, wear gloves and gowns when providing care to Resident G.

While onsite, Ms. Cobb provided me with a copy of Resident G's discharge instructions from her 8/12/19 hospitalization. Ms. Cobb stated that Resident G was seen in the emergency department and returned to the facility the same day. Per the discharge instructions, Resident G was seen for bacterial diarrhea and made no mention of Resident G having active C. diff.

Wellness director Elizabeth Lowe stated that following her 7/2/19 hospitalization, Resident G was discharged and transferred to Pomeroy Living Rochester Skilled Rehabilitation from 7/11/19-8/6/19. Ms. Lowe stated that she did not receive any hospital discharge instructions because Resident G was transferred directly to the rehabilitation facility. At the time of my inspection, facility staff did not produce Resident G's discharge instructions from Pomeroy. On 9/9/19, I received a copy of Resident G's discharge instructions from Pomeroy via email from Ms. Skotak. Upon review of the documentation, I did not find any evidence that Resident G had active C. diff at the time she returned to the facility.

Ms. Lowe stated that following her 5/1/19 hospitalization, Resident G was discharged and transferred to Woodward Hills Nursing Center for rehabilitation from 5/5/19-5/21/19. Ms. Lowe stated that she did not receive any hospital discharge instructions because Resident G was transferred directly to the rehabilitation facility. At the time of my inspection, facility staff did not produce Resident G's discharge instructions from Woodward Hills. On 9/11/19, I received a copy of Resident G's discharge instructions from Woodward Hills via email from corporate health and wellness director Crystal Parrish. Upon review of the documentation, I did not find evidence that Resident G had active C. diff at the time she returned to the facility. Accompanying the discharge instructions, Ms. Parrish wrote:

> There is no indication that the resident had C-Diff after discharge from the nursing home. There is also nothing in the notes that states the resident should have been on contact precaution for C-Diff after discharge from Woodward Hills. It is documented that the resident did have C-diff during her stay at Woodward Hills, but she was treated and her stool became formed, and she showed no evidence of having the C-diff after. The attached discharge instructions did not instruct the community to place the resident on contact precautions for C-diff because she was cleared of C-diff prior to discharge.

On 8/26/19, I contacted the Oakland County Health Department to obtain additional information on C. diff protocols. I interviewed epidemiologist Kayleigh Blaney by telephone. Ms. Blaney stated that C. diff is not considered a condition that is reportable to the health department. Ms. Blaney stated that C. diff is a contagious disease that is spread by spores, mostly by coming into contact with someone's infected fecal matter. Ms. Blaney stated that if someone has active C. diff or is symptomatic, contact precautions should be taken such as wearing gloves and

gowns and always washing hands with soap and water after coming in contact. Ms. Blaney stated that someone with C. diff does not require they be in isolation. Ms. Blaney stated that the only symptom for C. diff is diarrhea and medical attention should be sought if someone with chronic C. diff is symptomatic. Ms. Blaney stated that contact precautions are not necessary at all unless the person is symptomatic.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(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 by the attending physician in the medical record.**
ANALYSIS:	Resident G has been hospitalized three times in recent months for gastrointestinal issues presumably related to her chronic C. diff condition. Review of medical records from those hospitalizations do not indicate that Resident G had active C. diff upon her discharge. Numerous attestations from staff reveal that the facility is actively taking contact precautions when providing care to Resident G even without physician instruction. Interview with the Oakland County Health Department's staff epidemiologist revealed that contact precautions are only necessary when someone is symptomatic. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Soiled linens are left in Resident G's room.

INVESTIGATION:

Ms. Skotak and Ms. Cobb stated that Resident G has two separate assigned laundry days; one for clothing and another day for bedding and linens. Ms. Skotak and Ms. Cobb stated that Resident G's linens and bedding are washed on Wednesdays and her clothing is washed on Sundays but stated that the laundry is done more frequently as needed in between the laundry days. Ms. Skotak and Ms. Cobb stated that Resident G has a lot of incontinence issues and may need items washed multiple times per week. Ms. Skotak and Ms. Cobb stated that any soiled items should be removed from the resident's apartment immediately upon discovery. Ms. Skotak stated that it is possible staff have missed removing a soiled item on occasion but stated that it is not a regular occurrence and staff are trained to never leave soiled items if they are aware of them.

Ms. Jackson confirmed the laundry schedule that Ms. Skotak and Ms. Cobb referenced. Ms. Jackson denied ever leaving any soiled items in Resident G's apartment and stated that staff are taught that anything soiled should be taken out and properly placed in the soiled linen area to launder.

While onsite, I observed Resident G's apartment. I did not see any soiled items inside the apartment and did not detect any odor of urine or feces. I also observed a note posted on Resident G's bathroom door that identified Wednesday and Sunday as her assigned laundry days.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.

ANALYSIS:	Resident G has two assigned laundry days per week. Interviews with staff reveal that in addition to the two assigned laundry days, laundry is done more frequently if needed for Resident G. Facility management attest that the facility trains staff to remove soiled items upon discovery and never to leave anything behind that is soiled so long as they are aware of it. While it is possible a soiled item may have been inadvertently left on occasion due to lack of knowledge of the item (s), it is not common practice or what staff are trained to do. During observation of Resident G's apartment, no soiled items were discovered. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident G's bedroom and bathroom are not cleaned on a regular schedule.

INVESTIGATION:

Ms. Skotak and Ms. Cobb stated that Resident G's room is on a weekly housekeeping schedule but more frequently if needed. Ms. Skotak and Ms. Cobb stated that Resident G's housekeeping day is Thursday but indicated that care staff clean up daily in resident rooms and empty trash each shift or more frequently whenever incontinence products are changed. Ms. Skotak and Ms. Cobb stated that there are housekeeping staff scheduled and present in the building seven days per week. Ms. Skotak stated that housekeeping will work around residents' personal belongings but aren't instructed to move their items without permission. Ms. Skotak and Ms. Cobb stated that they are unaware of Resident G's room not being cleaned during its scheduled time but stated that Resident G used to have a cat that would often urinate on the floor and carpet in the apartment, leaving a strong odor. Ms. Skotak stated that the odor became so strong that the resident residing next door to Resident G complained about the smell and wanted to switch apartments. Ms. Skotak stated that there were discussed about having the cat removed but the cat passed away before they were able to tell Resident G she could no longer have it at the facility. Ms. Skotak and Ms. Cobb stated that the carpets in Resident G's room have been steamed and shampooed thoroughly to remove the odor and have not had any complaints since.

Ms. Jackson stated that Resident G's apartment used to smell very strongly of urine but stated that the odor has disappeared since the cat passed away. Ms. Jackson stated "It was a very old cat and it didn't always use the litter box. You could tell the smell was cat urine and not from [Resident G]." Ms. Jackson denied that Resident G's room is not cleaned regularly. Ms. Jackson confirmed that Resident G is on a

weekly housekeeping schedule and that care staff also pick up her room daily as needed.

Housekeeper Cincere Hudson attested to the following:

> When I clean the apartments, I sweep the bathroom and kitchen floors first. I spray the bathroom shower down with the cleaning spray and spray the mirrors and put toilet bowl cleaner in toilets. After I spray the entire bathroom, I wish it down. I spray and wipe down open surfaces in the kitchen. I mop the bathroom floor and kitchen floor. I remove all the trash and put new liners in the cans. I put the toilet paper in the bathroom. I dust open areas free of clutter or knickknacks. I vacuum all open carpeted areas. I spray the air with an air freshener.
>
> If items like clothes, boxes or furniture, etc. are in my way of cleaning something that I would normally clean like the shower, I let management know I was unable to clean due to articles in the way. I do not pick up and put items away.
>
> While in apartment 129 urine smell was noticed during cleaning and recleaning, thought to be both human and cat at times. This was reported to staff and management.
>
> Special attention items requested by management.
>
> I was told a few times (at least once a week if the resident was in the building) to go to apartment 129 due to bad odor and reclean the apartment. This was either after or before 129's scheduled once a week cleaning day.

While onsite, I observed Resident G's apartment. I viewed the apartment to be slightly cluttered with Resident G's person items but was not dirty and no odors were detected.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Each resident apartment is cleaned weekly by housekeeping staff and picked up daily by care staff. While I observed Resident G's apartment to be cluttered, I did not find it to be dirty. Additionally, housekeeping staff are instructed not to move or reorganize residents' personal belongings and to "work around" what they have. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident G was hospitalized from 5/1/19-5/21/19, 7/2/19-8/6/19 and 8/12/19. During my inspection, facility staff were unable to produce her hospital and/or rehabilitation facility discharge instructions for her 5/21/19 discharge and 8/6/19 discharge.

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.**
For Reference: **R 325.1901**	**Definitions.**
	(16) "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 facility lacked an overall procedure regarding the receipt and review of discharge instructions when Resident G was discharged from various medical facilities. Ms. Skotak and Ms. Lowe indicated that much of the issue was due to Relative G's lack of communication. However, the facility has a responsibility and obligation to ensure resident health and wellbeing by means of following all physician's instruction through proper and accurate discharge procedures. Based on these findings, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident G was seen in the emergency room on 8/12/19 and was treated for bacterial diarrhea. Resident G was discharged back to the facility the same day. Resident G's discharge instructions provided an order for Vancomycin 250 MG capsule and instructed Resident G to "take two caps by mouth every six hours for fourteen days". Review of Resident G's medication administration record (MAR) reveals that Resident G was administered all four doses of Vancomycin on the following dates: 8/15/19-8/20/19. Resident G's MAR indicates that only three doses were administered to Resident G on 8/13/19, 8/14/19 and 8/21/19. The MAR was left blank for the 6:00am dose on 8/13/19 and 8/14/19. Ms. Skotak was able to provide a physician's order dated 8/21/19 that instructed the Vancomycin be discontinued on that date, however could not provide any explanation as to the blank medication records on 8/13/19 and 8/14/19. Additionally, during subsequent email correspondence, Ms. Parrish wrote:

> There is no documentation that shows this resident being out of the community at this time. Therefore, this will be missed documentation by our staff. The staff did not document that these medications were administered or if they were not administered. When there is no code or documentation on a date, it is assumed that the medication was not administered. There are also no progress notes or explanation in the computer regarding theses [sic] days.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Due to insufficient documentation, facility staff could not prove that Resident G was administered her Vancomycin as prescribed on 8/13/19 and 8/14/19. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/13/19, I shared the findings of this report with facility authorized representative Deborah Skotak. Ms. Skotak verbalized understanding of the citations and did not have any further questions.

IV. RECOMMENDATION

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

9/11/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

9/12/19

Russell B. Misiak Date
Area Manager