GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2019

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

RE: License #: AH630370122
Investigation #: 2020A1019003
First & Main of Auburn Hills

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. Failure to submit an acceptable corrective action plan may result in disciplinary action. 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
51111 Woodward Avenue, 4th Floor, Suite 4B
Pontiac, MI 48342
(810) 347-5503

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2020A1019003
Complaint Receipt Date:	10/04/2019
Investigation Initiation Date:	10/04/2019
Report Due Date:	12/03/2019
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?
Staff person Cortez Graham had an altercation with Resident L on 9/27/19.	Yes
Staff person Cortez Graham is working while intoxicated.	No
Staff person Cortez Graham passes medication without being trained.	No
Additional Findings	Yes

III. METHODOLOGY

10/04/2019	Special Investigation Intake 2020A1019003
10/04/2019	Comment The complaint was forwarded to LARA from APS
10/04/2019	Special Investigation Initiated - Letter Emailed APS worker Shauna Aldred for additional information
10/04/2019	Contact - Telephone call received Received call from APS worker Shauna Aldred, Ms. Aldred has not yet completed her investigation but will provide LARA with an update once she has gone out to the facility
10/07/2019	Contact - Telephone call received Call received from APS worker Shauna Aldred, interview conducted.
10/09/2019	Inspection Completed On-site
10/09/2019	Inspection Completed BCAL Sub. Compliance
10/18/19	Exit Conference

The complaint 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:

Staff person Cortez Graham had an altercation with Resident L on 9/27/19.

INVESTIGATION:

On 10/4/19, the department received a complaint forwarded from Adult Protective Services (APS) with allegations against staff member Cortez Graham. APS did not reveal the referral source of the complaint. The complaint read that Mr. Graham yell and swore at the resident, got in the resident's face and pointed his finger in his face.

On 10/9/19, I conducted an onsite inspection. I interviewed administrator and authorized representative Deborah Skotak at the facility. Ms. Skotak stated that on 9/27/19, she received a call from Mr. Cortez around 9:30pm stating there was a situation that occurred while he was attempting to check Resident L's blood sugar level. Ms. Skotak stated that Mr. Graham reported that he went into Resident L's room and another staff member (Leah Thomas) was present in the room. Ms. Skotak stated that Mr. Graham reported that Resident L began yelling at Mr. Graham and called him an "asshole". Ms. Skotak stated that Mr. Graham reported to her that he raised his voice at the resident and slammed the door as he left the room. Ms. Skotak stated that Mr. Graham reported to Ms. Thomas was instigating the situation and he was more upset with her. Ms. Skotak stated that she allowed Mr. Graham to leave his shift early because of how upset he was and stated that since the incident he has not been allowed to work on Resident L's floor.

Ms. Skotak stated that she and wellness director Elizabeth Lowe both interviewed Resident L the morning after the incident and he reported that Mr. Graham yelled at him but didn't swear at him or put his finger in his face. Ms. Skotak stated that she felt that Ms. Thomas was embellishing the situation due to personal differences with Mr. Graham and that she did not feel Ms. Thomas was credible.

On 10/9/19, I interviewed Mr. Graham at the facility. Mr. Graham stated that there was a situation with Resident L but he could not recall the date it happened. Mr. Graham stated that he went into Resident L's room to check his blood sugar. Mr. Graham stated that when he entered Resident L's apartment, Resident L began yelling at him and call him "stupid", told him to "go fuck yourself" and "get the fuck out of my room". Mr. Graham stated that Ms. Thomas was present and she "Butted in trying to get me to leave the room." Mr. Graham stated that he raised his voice at

Ms. Thomas and told her to stop talking to him but Mr. Graham denied ever yelling at the resident, getting in his face or pointing his finger at him. Mr. Graham denied any physical encounter between he and Resident L. Mr. Graham also denied that he slammed the door when he left but did state that Resident L's door is heavy and that it doesn't take much effort for it to shut on its own. Mr. Graham stated that he contacted Ms. Skotak to report the incident after it occurred and she allowed him to leave early. Mr. Graham stated that he has not seen Resident L since the incident occurred. Mr. Graham stated that another employee (Miesha Whitlock) was working on the same hallways when the incident occurred and could provide further information about what happened.

Ms. Whitlock was not present at the facility during my inspection but submitted a signed statement about the incident that read:

> During 2nd shift Cortez was doing his med pass on 2nd shifts. He went into 214 ask him can he take his blood sugar. I was sitting at the nursing station, and I heard 214 say no can you give me my pills. Heard Cortez say I need to take your blood sugar I then step into the room and asked Cortez to step out, to take a breather and I gave 214 his evening pills.

On 10/9/19, I interviewed Resident L at the facility. Resident L was alert and orientated and was able to appropriately answer all of my questions. Resident L stated that he was upset with Mr. Graham because he came into his room to check his blood sugar and he was upset because he felt that it was too late. Resident L stated "When I get upset I know it affects my blood sugar so I didn't want him taking it when I was mad so I told him to get out." Resident L stated that Mr. Graham began belligerently yelling and screaming at him but stated he couldn't even make out anything specific that was said. Resident L stated that eventually Mr. Graham stormed out and "slammed the door like a little kid". Resident L stated that Ms. Thomas was present and that she was being completely appropriate and did not escalate the situation in any way.

Ms. Thomas is no longer employed at the facility, however submitted a signed statement prior to her leaving her termination that read:

> On Friday Sept 27, 2019 I was paged to 214 [Resident L] room. When I went in he said he was still waiting for his meds and it was late. I looked at the time and it was 9:15pm. I walked out and told Cortez. He handed me the meds by the time I had [Resident L] in his bedroom Cortez came in with the blood sugar monitor. [Resident L] said you do this every time you pass meds. Cortez then said, I'm not trying to here [sic] this shit we do this every night. Then Cortez got angry and started pointing in Earl's face screaming and using inappropriate words. [Resident L] leaned in and pushed Cortez's hand away and said got out of my room. I then told Cortez that's enough you have said enough and you have this man upset. He continued argueing [sic] with [Resident L]. I told him again, "Enough go!" Cortez screamed as he walked out the room, "You bitch's always

taking his side!" By now [Resident L] is in tears telling me as I took his socks off "Do you think I'm wrong Leah". I told him no [Resident L] you deserve respect. He didn't need to be yelled at, to have his meds late and Cortez screaming was wrong. I told him I would report it and urged him to speak with Deb and Liz as well. I reported it to Liz and Deb. Deb text that she would send Cortez home @ 10pm. Liz was text at 9:36pm.

Ms. Lowe was not present during my inspection but submitted a statement that read:

I was informed of a verbal altercation between [Resident L] a resident in room 214 and Cortez Graham an employee at first and main. I was told by another staff member Leah Thomas that [Resident L] was upset about not receiving his night time medications until 9pm. Leah stated to me that she went out and asked Cortez for [Resident L] medications and Cortez said he already passed them at 8pm that [Resident L] was mistaken. According to Leah, Cortez then went into [Resident L] room and told him he already gave him the medication. [Resident L] then became upset and called Cortez a liar. According to Leah Cortez then told [Resident L] we do this S*&% every damn night I'm not doing this with you. Leah stated that she was in-between Cortez and [Resident L] and that Cortez was screaming and swearing at [Resident L] and pointing in [Resident L] face. Leah then stated that [Resident L] slapped Cortez hand away and Cortez stormed out of the room and slammed the door. I immediately removed Cortez from [Resident L] care pending investigation.

Upon speaking with Cortez, he stated that he came into the room to administer resident's night time medications and check his blood sugar. He stated that resident was already visibly upset upon entering the room and started swearing at Cortez and stated this is why its late because of this F*&#@$. He always gives me problems. Cortez stated that Leah then encouraged the behavior and became aggressive toward Cortez. Cortez stated that he was attempting to take [Resident L] blood sugar and [Resident L] smacked Cortez hand away. At that point Cortez stated that another medication tech came in and completed [Resident L] blood sugar and Cortez angrily left the room and slammed the door.

I then interviewed [Resident L] who stated that he was upset that he feels like Cortez always gives him a hard time. I asked [Resident L] if he could run me through what happened, and he stated that Cortez was late with his medication and he was upset. I asked [Resident L] if Cortez had swore at him and he stated no he just got loud and slammed the door. [Resident L] then stated that he swore at Cortez calling him an A**&%($. [Resident L] stated that he did not feel threatened in anyway and that him and Cortez just don't get along. [Resident L] stated that he no longer wished for Cortez to take care of him.

Upon completion of the interviews I spoke With Deborah Skotak ED and her, myself and our Director of memory support Darline sat down with Cortez. Cortez was reprimanded verbally for his role in the altercation and was taken completely off any care involving [Resident L]. During our conversation Cortez repeatedly stated that he felt [Resident L] was racist and that he has sworn at

several other employees and has made vulgar remarks regarding the employees' race.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1)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	**2(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:	On 9/27/19, there was a verbal encounter between Resident L and staff Cortez Graham. While there was some variation to the information provided regarding what occurred during the altercation, it is evident that Resident L felt disrespected and was not treated in accordance with the standards that staff are trained to follow. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff person Cortez Graham is working while intoxicated.

INVESTIGATION:

The complaint did not specify any dates that Mr. Graham was allegedly intoxicated while at work. Ms. Skotak stated that Ms. Thomas contacted Ms. Lowe on 9/29/19 with concerns that Mr. Graham was "wasted" during his shift on the evening of 9/29/19. Ms. Skotak stated that maintenance director Quincy Franklin was contacted to go up to the facility and check into the matter. Ms. Skotak stated that Mr. Franklin was chosen because he lives a few minutes away and could get to the facility quickly. Ms. Skotak stated that she asked Mr. Franklin to observe Mr. Graham and see if he was acting out of the ordinary. Ms. Skotak stated that Mr. Franklin reported to her that he did not think Mr. Graham was under the influence of anything and Ms. Skotak stated that did not look into the issue any further. Ms. Skotak provided me with a copy of Mr. Graham's drug screen that was completed upon hire. The drug screen was negative for all substances tested and was dated 6/12/19.

Ms. Thomas submitted a signed statement to facility management about the incident that read:

> On Sunday I was working on 2nd floor I had worked til 7am and then came back at 2:30pm-11pm. Around 7pm after getting most residents ready for bed I took the trash out. While I already had a bad migraine I walked down the hall to have a 15 min break. As I walked past the break room it smelled bac of alcohol and marijuana. Cortez, Cheneka, a girl from 3rd, and another girl were in there talking about I needed that. As I walked by Cortez said, I hate that fucking bitch. I walked out the door and called Liz. I told her I got to leave I felt sick my head was pounding and Cortez sprayed cologne all in the hall which made my head hurt so bad I wanted to throw up. She told me she would handle it and I could leave. She asked me if I worked third shift and I told her no. I then went home.

Ms. Lowe was not present at the facility during my inspection but submitted a statement that read:

> On 9/29/19 I received a phone call from employee Leah Thomas, Leah was crying hysterically, and it took a moment to calm her down so I could understand what was being said. Leah stated that she could not work like this, she had a migraine and the staff was wasted and spraying themselves with heavy cologne and not helping her. I replied who is wasted? Leah stated Cortez and Nichayla are drunk I can not work like this, I can not work with these people I have to leave. I stated if she was concerned with the resident's safety and staff was inebriated then she needed to stay there, and someone would be right up. Leah then stated no liz I can't do this, this is to [sic] much I'm leaving and hung up the phone. I immediately called Deb Skotak ED and Deborah immediately called Quincy our Head of Maintenance because he only lives about 10 min from the building. Quincy arrived at the building and made his rounds. Quincy called both

Deborah and myself on conference call and stated that none of the staff are acting inebriated in any way and that he does not smell alcohol or any other drugs on any staff. No staff was acting differently, and no one was chewing gum or had a strong smell of perfume like they were trying to cover something up. Quincy remained at the building for a while observing staff. We attempted call Leah and it went to voicemail. For several days after this incident myself and Deborah asked Leah for a statement regarding that incident. A statement was not provided to us until 10/5/2019. Deborah, Myself and Darline then had a meeting with Cortez to inquire about the situation Cortez stated he was not drinking or doing drugs nor was any other staff and that he felt like Leah was intentionally doing things to try and get him fired. We all also met with Nichayla who stated she was not drunk or on drugs during her shift and that other staff could attest to this. Other staff members that worked that night were Cheneka, Bianca, Lateyia, and Chartece. All staff stated they did not notice anyone drinking or doing any kind of drugs nor did Nichayla or Cortez appear to be on anything during their shift.

Statements were obtained from staff members Bianca Northern, Lateyia Johnson, Chartece Morris, Cheneka Fowler and Nichayla Johnson who were all present at the facility during Mr. Graham's shift on 9/29/19. All staff attested that they did not observe any staff members to be intoxicated.

On 10/9/19, I interviewed Mr. Franklin at the facility. Mr. Franklin stated that he was contacted by Ms. Skotak to observe "if staff were acting different" meaning to see if they seemed drunk or high. Mr. Franklin stated that he stayed at the facility for a few hours and he did not notice any employees acting unusual or under the influence of substances.

Mr. Graham denied every using substances while at work or being under the influence of any substances while working. Mr. Graham also denied any knowledge of any other staff using substances while working and denies the entire allegation that Ms. Thomas attested to have occurred.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Multiple staff attested that they have no knowledge of any staff using substances while at work and have not witnessed anyone under the influence. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff person Cortez Graham passes medication without being trained.

INVESTIGATION:

Ms. Skotak stated that Mr. Graham was hired on 6/18/19. Ms. Skotak stated that the facility med techs undergo classroom training, employee shadowing and competency evaluations before they are allowed to work the med carts independent. Ms. Skotak stated that former wellness director Nikisha Cobb was responsible evaluating Mr. Graham's competency.

Mr. Graham stated that he has worked as a med passer for several years prior to working at the facility. Mr. Graham also confirmed that the training he received during his onboarding was sufficient.

I reviewed Mr. Graham's training records and determined that adequate training was provided.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**

ANALYSIS:	Staff interviews and review of training records reveal that Mr. Cortez received training at the facility prior to working independently on the medication carts.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite, I obtained Resident L's medication administration record (MAR). Review of Resident L's MAR for September 2019 reveals that the records were left blank for one or more medications on the following dates: 9/3/19, 9/6/19, 9/16/19 and 9/28/19. It could not be determined if Resident L was administered his medications as prescribed on those dates.

Ms. Skotak stated that staff should not leave any dates blank, as the MAR includes numeric codes for staff to enter depending on the circumstance of the missed administration.

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. **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Review of Resident L's MAR reveal missing or incomplete records. Some dates were left completely blank with no clarification as to whether the medication was administered. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see SIR2019A1019067, SIR2020A1019004 and 2019 renewal LSR].**

On 10/18/19, I shared the findings with facility authorized representative Deborah Skotak.

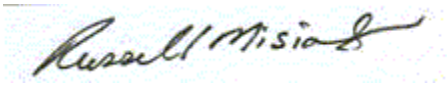
IV. RECOMMENDATION

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

10/16/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



10/17/19

Russell B. Misiak Date
Area Manager