GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 20, 2020

Cody Salinas
First & Main of Auburn Hills
3151 E. Walton Blvd.
Auburn Hills, MI 48326

RE: License #: AH630370122
Investigation #: 2020A0465012
First & Main of Auburn Hills

Dear Mr. Salinas:

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) 284-9727.

Sincerely,

Stephanie Gonzalez, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-6063

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2020A0465012
Complaint Receipt Date:	01/21/2020
Investigation Initiation Date:	01/22/2020
Report Due Date:	02/20/2020
Licensee Name:	F&M Auburn Hills OPCO, LLC
Licensee Address:	#2200 2221 Health Drive SW Wyoming, MI 49519
Licensee Telephone #:	(616) 248-3566
Administrator:	Cody Salinas
Authorized Representative	Cody Salinas
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:	10/24/2019
Expiration Date:	10/23/2020
Capacity:	158
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not signing the *Medication Administration Record* each time they administer prescribed medication to residents.	No
Residents' prescribed medications are being left unlabeled and unsupervised by direct care staff.	Yes
The facility bathrooms are not clean.	No

III. METHODOLOGY

01/21/2020	Special Investigation Intake 2020A0465012
01/22/2020	Special Investigation Initiated - Letter APS Referral
02/07/2020	Inspection Completed-BCAL Sub. Compliance
02/07/2020	Exit Conference Conducted an Exit Conference with Cody Salinas
02/20/2020	Exit Conference Follow-up Exit Conference with Cody Salinas

ALLEGATION:

Direct care staff are not initialing the *Medication Administration Record* when they administer prescribed medication to residents.

INVESTIGATION:

On 1/21/2020, a complaint was received, alleging that direct care staff are not initialing the *Medication Administration Record* (MAR) when they administer prescribed medication to residents. The complaint stated that direct care staff do not know if resident medications have been administered due to staff not signing the *Medication Administration Record* until several days after they have administered the medication.

On 1/22/2020, I submitted a referral to Adult Protective Services to complete initiation of this complaint.

On 2/7/2020, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were 59 residents residing at the facility. I reviewed the *Medication Administration Records* for the months of January 2020 and February 2020 for 10 residents. I determined all the *Medication Administration Record* documents to be properly completed and included staff initials for all dates and times that medication was administered.

I interviewed direct care staff, Paris Brown. Mrs. Brown reported that she has worked at the facility for approximately eight months. Mrs. Brown reported that she is trained and knowledgeable on how to properly document administered prescribed medications to residents. Mrs. Brown reported that all administered medications are documented via the electronic computer system used by the facility. Mrs. Brown reported that she has no knowledge of a time when other direct care staff did not properly document medication administration on the MAR's.

I interviewed direct care staff, Alivia Eaton. Mrs. Eaton reported that she has worked at the facility for approximately 1 ½ years. Mrs. Eaton reported that she is trained and knowledgeable on how to properly document administered prescribed medications to residents. Mrs. Eaton reported that all administered medications are documented via the electronic computer system used by the facility. Mrs. Eaton reported that she has no knowledge of a time when other direct care staff did not properly document medication administration on the MAR's.

I interviewed direct care staff Mariam Kufakunoga. Mrs. Kufakunoga reported that she is trained and knowledgeable on how to properly document administered prescribed medications to residents. Mrs. Kufakunoga denied any knowledge of the information contained in this complaint.

I interviewed Mr. Salina, who reported that he has been the authorized representative and administrator for the facility for approximately one month. Mr. Salinas acknowledged that the facility has struggled with maintaining compliance with medication rules in the past but stated that he believes the facility has made significant improvement. Mr. Salinas stated that all direct care staff have undergone extensive medication management refresher training to ensure compliance. Mr. Salinas reported that he does not believe this allegation is true.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(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:	On 2/7/2020, I conducted an onsite investigation at the facility and reviewed the *Medication Administration Records* for the months of January 2020 and February 2020 for 10 residents. I determined all the *Medication Administration Record* documents to be properly completed and included staff initials for all dates and times that medication was administered. Mrs. Brown, Mrs. Eaton and Mrs. Kufakunoga reported that they are trained and knowledgeable on how to properly document administered prescribed medications to residents via the electronic computer system used by the facility. Mrs. Brown, Mrs. Eaton and Mrs. Kufakunoga reported that they have no knowledge of a time when other direct care staff did not properly document medication administration on the MARS. Mr. Salinas acknowledged that the facility has struggled with maintaining compliance with medication rules in the past but stated that he believes the facility has made significant improvement. Mr. Salinas stated that all direct care staff have undergone extensive medication management refresher training to ensure compliance. Mr. Salinas reported that he does not believe this allegation is true. Based on the information above, direct care staff are properly documenting prescribed medication as required per licensing rules.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' prescribed medications are being left unlabeled and unsupervised by direct care staff.

INVESTIGATION:

The complainant alleged that residents' prescribed medications are being left unlabeled and unsupervised by direct care staff. The complaint stated that loose prescription pills have been observed in the medication carts and in resident bedrooms.

I conducted an inspection of the facility's four medication carts located on multiple levels of the facility, in addition to multiple resident bedrooms. I did not observe any prescription medication in resident bedrooms. I observed one medication cart to have two plastic cups filled with multiple loose pills. Both plastic cups did not have labels nor any identifying information to confirm who the medication belonged to nor what medication was in the cups.

I interviewed Resident A, who reported that direct care staff have never left prescription medications unsupervised in her bedroom. Resident A stated that she is not aware of a time when direct care staff left prescription medication in any resident bedroom.

I interviewed Resident B, who reported that direct care staff have never left prescription medication unsupervised in his bedroom. Resident B stated that he is not aware of a time when direct care staff left prescription medication in any resident bedroom.

I interviewed Mrs. Brown, who reported that she has never left loose pills in the medication cart but acknowledged that she has observed loose pills in the medication cart on several occasions. Mrs. Brown reported that when she has observed the unlabeled loose pills in the med cart, she was uncertain of who the medication belonged to. Mrs. Brown reported that she has never observed loose pills in resident bedrooms.

I interviewed Mrs. Eaton, who reported that she has never left loose pills in the medication cart but acknowledged that she has observed loose pills in the medication cart on several occasions. Mrs. Eaton reported that when she has observed the unlabeled loose pills in the med cart, she was uncertain of who the medication belonged to. Mrs. Eaton reported that she has never observed loose pills in resident bedrooms.

I interviewed Mrs. Kufakunoga, who reported she has never observed loose pills in medication carts nor in resident bedrooms. Mrs. Kufakunoga denied any knowledge of the information contained in this complaint.

I interviewed Mr. Salina, who was present when I conducted the inspection of the medication carts. Mr. Salina acknowledged that there were two plastic cups filled

with unlabeled loose resident medication. Mr. Salinas reported that he would implement additional staff training to ensure this does not happen in the future.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	On 2/7/2020, I conducted an onsite investigation at the facility and observed one medication cart to have two plastic cups filled with multiple loose pills. Both plastic cups did not have labels nor any identifying information to confirm who the medication belonged to nor what medication was in the cups. Resident A and Resident B reported that direct care staff have never left prescription medications in their bedrooms. Mrs. Brown and Mrs. Eaton reported that they have observed loose pills in the medication cart on several occasions. Mrs. Brown and Mrs. Eaton reported that they have never observed prescription medications and/or loose pills in resident bedrooms. Mr. Salina acknowledged that there were two plastic cups filled with unlabeled loose resident medication. Mr. Salinas reported that he would implement additional staff training to ensure this does not happen in the future. Based on the information above, resident prescribed medications are being left unlabeled and loose in the medication cart, therefore not assuring that the resident for whom the medication is prescribed is being given those medications. There is sufficient information to confirm that the facility is not taking reasonable precautions to assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility bathrooms are not clean.

INVESTIGATION:

The complainant alleged that the facility's bathrooms have not been cleaned in over a month.

I conducted a thorough walk-through of the common areas of the facility as well as resident bedrooms and bathrooms. I did not smell any odors of feces or urine. I observed the facility to be clean and well maintained.

I interviewed Resident A, who reported that she feels the facility is adequately cleaned and maintained. Resident A stated, "When they didn't have housekeepers a while ago, it was hard. Things are good now and they {staff} clean and do a really good job." Resident A did not vocalize any concerns related to the cleanliness of the facility.

I interviewed Resident B, who reported, "The rooms and other areas are clean. I don't have any issues." Resident B did not vocalize any concerns related to the cleanliness of the facility.

I interviewed Mrs. Brown, who reported that the facility is adequately cleaned on a daily basis by direct care and housekeeping staff. Mrs. Brown reported that the facility has housekeepers on duty, that complete a deep cleaning of the facility on a daily basis. Mrs. Brown did not vocalize any current concerns related to the cleanliness of the facility.

I interviewed Mrs. Eaton, who reported that the facility is adequately cleaned on a daily basis by direct care and housekeeping staff. Mrs. Eaton did not vocalize any current concerns related to the cleanliness of the facility.

I interviewed Mrs. Kufakunoga, who reported that the facility is adequately cleaned on a daily basis by direct care and housekeeping staff. Mrs. Kufakunoga did not vocalize any current concerns related to the cleanliness of the facility.

I interviewed Mr. Salina, who reported that the facility is adequately cleaned and maintained on a consistent basis. Mr. Salinas reported that there are three housekeeping staff on duty from 7:00am to 7:00pm daily, with direct care staff completing light housekeeping duties during third shift. Mr. Salinas did report that there was a short duration of time, approximately one month ago, in which there was limited housekeeping staff on duty, which led to increase cleaning duties for direct care staff. Mr. Salinas reported that even when there was a shortage of housekeeping staff, the facility was still adequately cleaned and maintained.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	On 2/7/2020, I conducted an onsite investigation at the facility. I conducted a thorough walk-through of the common areas of the facility as well as resident bedrooms and bathrooms. I did not smell any odors of feces or urine. I observed the facility to be clean and well maintained. Resident A and Resident B reported that the facility is adequately cleaned and maintained. Mrs. Brown, Mrs. Eaton and Mrs. Kufakunoga reported that the facility is adequately cleaned on a daily basis by direct care and housekeeping staff. Mrs. Brown, Mrs. Eaton and Mrs. Kufakunoga did not vocalize any current concerns related to the cleanliness of the facility. Mr. Salinas reported that there are two housekeeping staff on duty from 7:00am to 7:00pm daily, with direct care staff completing light housekeeping duties during third shift. Mr. Salinas reported that there was a short duration of time, approximately one month ago, in which there was limited housekeeping staff on duty, which led to increased cleaning duties for direct care staff. Mr. Salinas reported that even when there was a shortage of housekeeping staff, the facility was still adequately cleaned and maintained. Based on the information above, the facility is being adequately cleaned and maintained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 2/20/2020, I conducted an Exit Conference with Cody Salinas. Mr. Salinas is in agreement with the findings of this report. Mr. Salina reported he is making continued efforts to improve in the area of medication administration training for direct care staff.

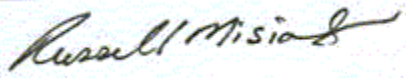
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the license remains unchanged.

2/20/2020

Stephanie Gonzalez Date
Licensing Staff

Approved By:



2/20/2020

Russel Misiak Date
Area Manager