GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 22, 2021

Sunil Bhattad
Auburn Fields Assisted Living II, LLC
219 Church Street
Auburn, MI 48611

RE: License #: AL090356074
Investigation #: 2021A0572042
Auburn Fields Assisted Living

Dear Mr. Bhattad:

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 (810) 787-7031.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090356074
Investigation #:	2021A0572042
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	09/25/2021
Licensee Name:	Auburn Fields Assisted Living II, LLC
Licensee Address:	219 Church Street Auburn, MI 48611
Licensee Telephone #:	(248) 765-5209
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Auburn Fields Assisted Living
Facility Address:	4710 Stephanie Court Auburn, MI 48611
Facility Telephone #:	(248) 765-5209
Original Issuance Date:	09/16/2014
License Status:	REGULAR
Effective Date:	03/16/2021
Expiration Date:	03/15/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility fired all the cooks and now have the aides cook the food.	No
The facility does not have enough personnel to care for the residents.	No
Resident A has discussed an issue of another resident coming into her room multiple times, yet it continues to happen causing concern for safety.	No
Antibiotic given when resident had no infection.	No
Resident A showers were given by 3rd shift workers instead of 1st shift workers, making for a long day.	No
Money was stolen from Resident A's room.	Yes

III. METHODOLOGY

07/27/2021	Special Investigation Intake 2021A0572042
07/28/2021	Special Investigation Initiated - Letter
08/20/2021	Contact - Face to Face Home Manager, Desiree Biggs.
09/16/2021	Contact - Face to Face Staff, Ashley Minton and Staff, Nicole Good.
09/20/2021	Inspection Completed-BCAL Sub. Compliance
09/20/2021	Contact - Telephone call made Resident A's Family Member #1.
09/20/2021	Exit Conference Licensee Designee, Sunil Bhattad.
09/21/2021	APS referral Licensing made the referral.

ALLEGATION:
The facility fired all the cooks and now have the aides cook the food.

INVESTIGATION:
On 07/27/2021, the local licensing office received a complaint for investigation. Adult Protective Service received a referral for further investigation.

On 08/20/2021, an unannounced onsite was made at Auburn Fields Assisted Living II, located in Bay County, Michigan. Interviewed was Home Manager, Desiree Biggs.

On 08/20/2021, I interviewed Home Manager, Desiree Biggs regarding an allegation that the facility fired all the cooks and now have the aides cook the food. She informed that the owner noticed that the cooks were only busy during certain hours of the day and had a lot of down time, so he revamped their schedules. He added resident care as part of their task, and they did not like this, so they quit. 3rd shift prepares the meals for the next day, while 1st and 2nd shift cooks the meals. Residents are aware of what they are eating as they have the menu posted on a monitor in the dining room. Ms. Biggs informed that she is Safe Serv trained and provides in-service training for the staff.

09/16/2021, I interviewed Staff, Ashley Minton regarding an allegation that the facility fired all the cooks and now have the aides cook the food. She informed that staff on 3rd shift preps the food and the case aides on 2nd and 3rd shift cooks the food. She informed that the home manager trains them on how to work in the kitchen. There's a menu in the kitchen for the residents to view.

09/16/2021, I interviewed Staff, Nicole Good regarding an allegation that the facility fired all the cooks and now have the aides cook the food. She informed that 3rd shift preps the food for 1st and 2nd shift. Residents are able to view the menu on the monitor that sits on the kitchen countertop, facing the dining room. Ms. Biggs provides in-service training for their staff.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(14) A licensee shall employee at least 1 individual who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to ensure regular and timely meals.

ANALYSIS:	There is at least one staff person who is trained in food prep for a large population. In-service training is provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
The facility does not have enough personnel to care for the residents.

INVESTIGATION:
On 08/20/2021, I interviewed Home Manager, Desiree Biggs regarding an allegation that the facility does not have enough personnel to care for the residents. Ms. Biggs denies this allegation and informed that they have at least 2 staff on all three shifts and sometimes more on 1st shift. Due to their census being between 12 and 14 residents for several months, they had to go down to just 2 staff on 1st shift, but she is working on the floor with staff, so she makes 3 staff. They have a resident who is a 2-person assist so they keep two staff on 3rd shift even when the census is low. Ms. Biggs informed that she is trying to get more staff, but nobody wants to work. I reviewed employee files and the facility has 9 new hires from the past 30 days.

On 08/20/2021, I reviewed the staff schedule for the past 2 months and there is sufficient staff for all three shifts. I observed that they had a split shift worker who comes in from 10am to 6pm up until their census decreased.

On 09/16/2021, I interviewed Staff, Ashley Minton regarding an allegation that the facility does not have enough personnel to care for the residents. Ms. Minton informed that they have 2 staff on each shift and sometimes they have 3 on 1st shift. Although it is much easier to have 3 staff during the day shift, she believes that they do have enough staff on each shift.

On 09/16/2021, I interviewed Staff, Nicole Good regarding an allegation that the facility does not have enough personnel to care for the residents. Ms. Good informed that they do have enough staff for each shift. There are 2 staff on each shift, but the Home Manager works on the floor with them and she's there during 1st and 2nd shift, so they actually have 3 staff.

On 09/16/2021, I interviewed Ms. Biggs regarding the staffing issues, and she informed that things are still the same as they're unable to keep people. She informed that she had a new staff start on 09/15/2021 and she told her that she can't do this type of work and quit on her first day. Most staff that they hire quits within 2 weeks. Employees are working 12 and 16 hour shifts to ensure that they have enough staff to cover each shift.

On 09/20/2021, I conducted an interview with Resident A's Family Member #1 regarding staffing issues. She did not think that they had enough staffing for the residents but was not aware of what the staff to resident ratio is.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	There are two staff currently on 1st, 2nd and 3rd shift. Desiree Biggs is the Home Manager, and she also works the floor during 1st and 2nd shift. When the census increase, it will go back to 3 staff on 1st and 2nd shift. I reviewed the staff schedule to confirm this.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A has discussed an issue of another resident coming into her room multiple times, yet it continues to happen causing concern for safety.

INVESTIGATION:
On 08/20/2021, Home Manager, Ms. Biggs was interviewed regarding an allegation that another resident keeps coming into Resident A's room, causing concern for safety. Ms. Biggs informed that there was a resident who was coming into Resident A's bedroom, and she would intervene and take the resident back to his room. She said that Resident A pushed the call light and she heard Resident A screaming at the other resident. Since the resident has dementia and didn't know why Resident A was screaming, he yelled back. Resident A was given a key for her bedroom so it could be locked.

On 09/16/2021, Staff, Ashley Minton was interviewed regarding an allegation that another resident keeps coming into Resident A's room, causing concern for safety. She informed that they had a dementia resident who was a wanderer that would go into Resident A's bedroom. The resident would think that it was his room and just try to sit down with Resident A. Resident A did not like people coming into her room uninvited. She was given a key to keep her room locked.

On 09/16/2021, Staff, Ashley Minton was interviewed regarding an allegation that another resident keeps coming into Resident's room, causing concern for safety. Ms. Minton informed that Resident A was in the process of moving out when she began working at the facility, so she was not aware that a resident was coming into her room but knows that Resident A was given a key so that she can lock her bedroom door.

On 09/20/2021, I conducted an interview with Resident A's Family Member #1 regarding an issue of another resident coming into Resident A's room multiple times, yet it continues to happen causing concern for safety. She informed that it occurred on more than one occasion, and they were worried because this particular resident had law enforcement called on him one night due to his behavior issue. Resident A's Family member #1 confirmed that Resident A received a key so she can keep her door locked.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Resident A had an issue with a resident coming into her bedroom uninvited. The resident had dementia and was not aware that it was not his bedroom. Ms. Biggs intervened because Resident A was screaming at him, causing the resident to yell back at her. Resident A was given a key in order to keep her door locked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Antibiotic given when resident had no infection.

INVESTIGATION:
On 08/20/21, I interviewed Home Manager, Desiree Biggs regarding an allegation that antibiotics were given to Resident A although she did not have an infection. Resident A had a virtual visit with her physician, and she gave the doctor her symptoms which appeared to be a UTI, so the physician prescribed antibiotics. When staff tried to administer the antibiotics, Resident A was questioning why she was on antibiotics and said that she didn't need it. Ms. Biggs contacted that doctor's office and they confirmed that Resident A was complaining of symptoms of a UTI and that's why the antibiotics were prescribed. When it was prescribed, the pharmacy put it in the electronic med sheet, but it was discontinued because Resident A didn't want it.

On 09/16/2021, I received a printout of Resident A's medications and Resident A was prescribed Cephalexin 500mg, but according to the electronic med sheet, it was never administered.

On 09/16/21, I interviewed Staff, Ashley Minton regarding an allegation that antibiotics were given to Resident A although she did not have an infection. She does not recall Resident A taking any antibiotics. Resident A has never complained to her about issues regarding her medications and indicated that she will tell staff if something was wrong. Ms. Minton explained, "In order for us to give (Resident A) antibiotics, it has to be prescribed by a doctor and the pharmacy will enter it in the MAR's (electronic med sheet)."

On 09/16/21, I interviewed Staff, Nicole Good regarding an allegation that antibiotics were given to Resident A although she did not have an infection. Ms. Good was not aware that Resident A was on any antibiotics. She stated, "The doctor has to prescribe an antibiotic in order for them to give them to her. Then we document in the e-MAR's that it was given to her."

On 09/20/2021, I conducted an interview with Resident A's Family Member #1 regarding an antibiotic being given to Resident A when she had no infection. Resident A's Family Member #1 informed that Resident A was prescribed the antibiotic, but she did not take them because she refused.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Staff informed that in order for Resident A to be given an antibiotic, a physician would have to prescribe it to her. The Home Manager informed that Resident A complained of symptoms of a UTI and that is the reason why she was prescribed the antibiotics. I reviewed the Med Sheet and Resident A was never administered the antibiotic. Resident A's Family Member #1 confirmed that the antibiotics were not administered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A showers were given by 3rd shift workers instead of 1st shift workers, making for a long day.

INVESTIGATION:
On 08/20/2021, I interviewed Home Manager, Desiree Biggs regarding an allegation that Resident A showers were given by 3rd shift workers instead of 1st shift workers, making for a long day. Residents are asked when they like to take their showers, so there is no set time or shift for showers, but most are done by 1st and 2nd shift workers. Resident A liked her showers in the morning before breakfast, but she did not like to come out to breakfast in her robe, so they thought it would be easier to have 3rd shift give her, her shower so she can be dressed for breakfast. Med passing starts at 7am and breakfast is at 7:30am, so 3rd shift would have to get her up at 6am to take a shower, in order for 1st shift to pass meds and have breakfast ready. Resident A did not like this either, so they switched her back to 1st shift showers.

On 09/16/2021, I interviewed Staff, Ashley Minton regarding an allegation that Resident A showers were given by 3rd shift workers instead of 1st shift workers, making for a long day. She informed that showers are normally given on 1st and 2nd shift, but Resident A was switched to 3rd shift. She was not sure why, but assumed it was to accommodate a need for Resident A and it would be easier to do it on 3rd shift. Resident A did not like this because she had to get up too early, so she was switched back to 1st shift showers.

On 09/16/2021, I interviewed Staff, Nicole Good regarding an allegation that Resident A showers were given by 3rd shift workers instead of 1st shift workers, making for a long day. She was not aware that Resident A showers were given on 3rd shift as Resident A was in the process of moving when she started working. Resident A was given showers during 1st shift up until she moved out. 1st and 2nd shift gives showers and 3rd shift usually only gives showers if a resident has an accident.

On 09/20/2021, I conducted an interview with Resident A's Family Member #1 regarding an Resident A showers were being given by 3rd shift workers instead of 1st shift workers, making for a long day. She confirmed that the showers were switched to 3rd shift due to Resident A preference to be fully dressed for breakfast. Resident A did not like showers on 3rd shift due to being awaken at 5am to 6am for showers. Resident A's Family Member #1 confirmed that the shower schedule was changed back to 1st after Resident A complained about the showers being too early.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A was given 1st shift showers, but she did not like to come out in her robe, so they tried given her showers on 3rd shift. Because shower times during 3rd shift was too early, they put her back on 1st shift showers.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Money was stolen from Resident A's room.

INVESTIGATION:
On 08/20/2021, an interview took place with Home Manager, Desiree Biggs regarding an allegation that Money was stolen out of Resident A's room. Ms. Biggs informed that it was brought to her attention that money was stolen from Resident A's bedroom and after an investigation, that staff member was terminated. The former staff had stolen $20.00. Ms. Biggs informed that she had tried to give Resident A the $20.00 back out of her own pocket, but she refused to take it.

On 09/16/2021, an interview took place with Staff, Ashley Minton regarding an allegation that Money was stolen out of Resident A's room. She informed that a staff was fired for stealing money out of her room. To ensure that it didn't happen again, they gave Resident A a key so she could lock her door. She is unaware of how much money was stolen and if Resident A was paid back.

On 09/16/2021, an interview took place with Staff, Nicole Good regarding an allegation that Money was stolen out of Resident A's room. She was not aware of any money being stolen from Resident A as this may have occurred prior to her employment at the facility.

On 09/20/2021, I conducted an interview with Resident A's Family Member #1 regarding money being stolen from Resident A's room. There was some money stolen from her room, but it was not a large sum of money. It was more of the principle of the matter and Resident A had lost some sense of security because residents were entering Resident A's room and apparently a former staff member had stolen money out of her bedroom.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	The Home Manager, staff and Resident A's Family Member #1 all informed that money was stolen from Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/21/2021, an Exit Conference was held with the licensee designee regarding my findings. He was informed that a corrective action plan would be needed within 15 days of this report.

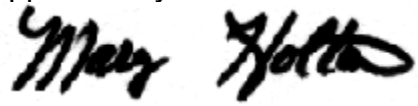
IV. RECOMMENDATION

I recommend no changes to the licensing status of this large adult foster care facility, pending an acceptable corrective action plan (Capacity 1-20).

09/21/2021

Anthony Humphrey Date
Licensing Consultant

Approved By:



09/22/2021

Mary E Holton Date
Area Manager