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 #: 2019A1019067
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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2019A1019067
Complaint Receipt Date:	09/26/2019
Investigation Initiation Date:	09/30/2019
Report Due Date:	11/26/2019
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility was negligent towards Resident H by giving her a "master key" to the facility.	Yes
Numerous medication issues involving Resident H: • Evening medications being administered late • Incorrect medications and/or dosages being given • Loose pills found on the floor • Missing medication administrations because they aren't being refilled in time	Yes No No Yes
Additional Findings	Yes

III. METHODOLOGY

09/26/2019	Special Investigation Intake 2019A1019067
09/30/2019	Special Investigation Initiated - Telephone Called complainant, interview conducted
10/01/2019	Inspection Completed On-site
10/01/2019	Inspection Completed-BCAL Sub. Compliance
10/02/2019	APS Referral Notified APS of allegations via email referral template
10/07/2019 and 10/09/2019	Contact- Telephone call made Called Relative H2 to conduct interview, left voicemail requesting return phone call.
10/09/2019	Exit Conference
10/10/2019	Contact- Telephone call received Received call from Relative H2, interview conducted.

The complainant 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:

The facility was negligent towards Resident H by giving her a "master key" to the facility.

INVESTIGATION:

On 9/26/19, the department received a complaint that the facility was negligent to Resident H by providing her with a master key to the facility.

On 9/30/19, I conducted a telephone interview with the complainant. The complainant stated that Resident H moved into the facility's memory care unit on or around 8/29/19. The complainant stated that the facility was having issues with their key fob system and that after several days of not having her own key fob, the assistant administrator, Gina Tindall, issued her an actual key until the fob issues could get resolved. The complainant stated that it was later discovered that the key was a master key that opened all facility doors. The complainant stated that this was especially a concern for Resident H who he stated is an elopement risk and the key opened the door for Resident H to get outside of the secured memory care unit. The complainant stated that this issue was addressed with management and that the administrator, Deborah Skotak, informed him that she had knowledge that the key worked for other doors and commented that Resident H "Wouldn't have figured it out". The complainant also stated that he believes that Resident I was given the same master key as Resident H.

On 10/1/19, I conducted and onsite inspection. I interviewed administrator and authorized representative Deborah Skotak at the facility. Ms. Skotak confirmed that the facility has been having ongoing issues with their key fob system and was unable to assign Resident H a fob upon move in. Ms. Skotak stated that Resident H had to get staff assistance every time she wanted to enter her apartment. Ms. Skotak stated that this went on for "about a week" and then Resident H was given a hard copy key to her room and also gave three additional copies of the key to her children. Ms. Skotak stated that on 9/25/19, she had a meeting with Relative H1 and the key issue was addressed. Ms. Skotak stated that Relative H1 reported that the key opened several other doors in the facility, including her office and the third-floor stairwell. Ms. Skotak stated she did have knowledge that the key could be used to open other resident rooms but had no knowledge it could open her office door or any

exit doors to the facility. Ms. Skotak stated that once this was brought to her attention a locksmith was called and came out the same day to resolve the issue.

On 10/1/19, I interviewed assistant executive director Gina Tindall at the facility. Ms. Tindall stated that she did not recall providing Resident H with a copy of her apartment key. Ms. Tindall stated “I really don’t know if it was me or Quincy (maintenance director) who gave the key out. It went back and both between us a few times.” Ms. Tindall acknowledged that she was aware that Resident H’s assigned key could be used to open other doors. Ms. Tindall stated “I knew it may open other resident rooms but didn’t think it would work on main doors.”

On 10/1/19, I interviewed maintenance director Quincy Franklin at the facility. Mr. Quincy stated that he didn’t recall giving any keys to Resident H but stated that he is aware that the key she was assigned could open “all resident doors”. Mr. Franklin stated “She was given a 3A key. 3A keys open all resident rooms.”

Regarding Resident I, Ms. Skotak and wellness director Elizabeth Lowe both reported that Resident I uses a key fob and does not have a hard copy key. On 10/1/19, I observed Resident I to have a key fob around his wrist. Ms. Lowe asked Resident I if she could borrow his fob and with his permission, took his fob and attempted to use it to open several other doors throughout the facility (resident rooms, staff offices, exit doors) and it did not work on any door aside from Resident I’s apartment. I then observed Ms. Lowe return the key fob to Resident I.

The facility produced an invoice from “Action Locksmith” indicating that Resident H’s door was rekeyed along with Resident J’s. Ms. Skotak stated that the Resident J was issued the same key as Resident H and could open multiple doors with it.

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 failed to protect Resident H (and Resident I) from harm when they knowingly issued a key that was not specific to her apartment. In addition to opening other resident room doors, the assigned key also opened staff offices and exit doors to the facility. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Numerous medication issues involving Resident H:

- **Evening medications being administered late**
- **Incorrect medications and/or dosages being given**
- **Loose pills found on the floor**
- **Missing medication administrations because they aren't being refilled in time**

INVESTIGATION:

The complainant stated that he has multiple issues with facility staff in relation to Resident H's medications. The complainant stated that he requested Resident H's evening medications be administered at 8:00pm. The complainant stated that Ms. Skotak informed him that anything administered after 9:00pm is considered a medication error. The complainant stated that the facility administered medications after 9:00pm on 9/20/19, 9/24/19 and on 9/29/19. The complainant stated that on 9/8/19, facility staff "Beverly" attempted to administer Prednisone eye drops to Resident H instead of Combigan eye drops. The complainant stated that he pointed the error out to the staff prior to her administering the drops and she then proceeded to retrieve the correct drops and administer them as prescribed. The complainant stated that on 9/11/19, he personally observed facility staff (could not recall staff member's name) bring the incorrect dose of Seroquel to Resident H and forgot to include her dose of Amitriptyline. The complainant stated that he corrected the med tech and that the proper dose was given. Lastly, the complainant stated that he found three pills in Resident H's apartment over the course of a four-day period. The complainant stated that he can't recall specific dates this occurred, but that it was sometime between 9/11/19-9/20/19. The complainant stated that the pills found were Methimazole, Amitriptyline and Losartan. The complainant stated that he notified

wellness director Elizabeth Lowe after the third pill was discovered. The complainant stated that Resident H's medications weren't being refilled in time, resulting in her going several days without medications. The complainant stated that Resident H went almost a week without receiving her Losartan (Cozaar), Protonix (pantoprazole sodium) and Ranitidine (Zantac) because the facility failed to obtain refills of the medications prior to them running out. The complainant stated that he personally had to refill the medications for Resident H and bring them to facility staff.

Ms. Skotak and Ms. Lowe confirmed that Relative H1 requested that Resident H receive her medications at 8:00pm. Ms. Skotak stated that she had a conversation with Relative H1 and stated that she informed him that the facility allows medications to be administrated within an hour before and up to an hour after the scheduled administration time. Ms. Skotak and Ms. Lowe stated that if a medication is administered outside of that timeframe it is considered a medication error.

While onsite, I reviewed Resident H's physician's orders for all of her prescribed medications. None of the orders specified that the evening medications are to be administered at 8:00pm and instead read to be administered "at bedtime" but on 9/26/19, Resident H's service plan was updated to read "I prefer my night time medications at 8pm." Review of Resident H's medication administration record (MAR) reveal that the medications were administered late even after this specification was added to the service plan.

Regarding incorrect medication dosages being given, the complainant stated that he observed "Beverly" bring the wrong eye drops to administer to Resident H on the evening of 9/8/19. According to the complainant, Beverly she attempted to administer Prednisone drops instead of Combigan drops. The complainant stated that Prednisone should only be administered in the morning and Combigan in the evening. The complainant stated that he corrected the staff member before she administered the wrong medication to Resident H.

Staff nurse Beverly Spillman was not working at the time of my inspection, but submitted a signed statement that read:

> One occasion I was passing medications on the 3rd floor when I walked into 306 room I met [Relative H1]. Explained I was the nurse with her medication. Stated all of her meds including her eye drop which was Combigan, handed him the medication to look over. Then I looked down and I was holding Prenosone [sic] instead of Combigan. Cordially told him I mistakenly grabbed the wrong one and will return with the right box. Returned shortley [sic] administered the eye drops and asked I could help further, he stated everything was fine. Told [Resident H] goodnight and left the room.

The complainant also referenced a medication issue on the evening of 9/11/19, in which an unknown staff member attempted to give an incorrect dosage of Seroquel and forgot to administer her Amitriptyline. The complainant stated he corrected the

med tech and the proper medication and dosage was administered. Ms. Lowe stated that the med tech the complainant was referring to is Cortez Graham.

On 10/1/19, I interviewed Mr. Graham at the facility. Mr. Graham stated that he recalled an issue with Relative H1 asking for him to administer a different dose of Seroquel than what was listed in Resident H's MAR. Mr. Graham stated he administered the dose as he saw listed on Resident H's MAR. Mr. Graham could not recall any conversation with Relative H1 pertaining to Resident H's Amitriptyline.

Review of Resident H's MAR reveal that staff documented that she received Seroquel and Amitriptyline as prescribed on 9/11/19.

Regarding the allegation of loose pills being found in Resident H's apartment, Ms. Lowe and 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. Lowe and Ms. Skotak stated that during this training staff are taught to always watch to make sure that the residents ingest the medications before leaving their rooms.

Ms. Lowe stated that Relative H1 did mention this concern during their meeting on 9/25/19. Ms. Lowe stated that she felt due to Relative H1 not brining the issue to staff's attention immediately upon discovery of the pills, it was impossible to determine when the incidents occurred or even if it was a result of staff error.

While onsite, I questioned Mr. Graham and med tech Jenna Areaux regarding medication passing procedures. Both staff members confirmed that they are trained to watch residents swallow medications to ensure all meds are taken before they leave the room. Mr. Graham and Ms. Areaux report that they follow this procedure and are unaware of any staff members who don't follow this instruction.

I reviewed med tech training records of all med techs at the facility and determined that adequate training was provided. The "medication competency test" included the following true/false question: "You need to observe the resident take his/her mediation and never leave medication unattended." All staff answered the question correctly.

Regarding Resident H's medication refills, the complainant stated that the facility ran out of Losartan (Cozaar), Protonix (pantoprazole sodium) and Ranitidine (Zantac). The complainant stated that on 9/24/19, med tech "Cortez" informed him that Resident H had been without her Protonix for almost a week and that she was also out of Ranitidine. The complainant stated that on 9/28/19, he was contacted by Ms. Lowe because the facility was unable to refill Resident H's Losartan. The complainant stated that he personally was able to obtain the refills at CVS and provided the medication to the facility.

Ms. Skotak and Ms. Lowe admitted that there has been some difficulty in obtaining some medications for Resident H but state that the facility is not to blame. Ms. Skotak stated that the facility uses a contracted pharmacy (Omnicare) as their prescription provider but that residents are not required to use Omnicare if they have a preferred provider. Ms. Skotak and Ms. Lowe stated that Resident H signed up to use Omnicare services but stated that Omnicare has been unable to fill some of Resident H's medication refills due to Resident H's family refilling the medication without their knowledge. Ms. Lowe stated in some instances Omnicare would attempt to refill a medication that the facility requested but it would show that the medication was already refilled elsewhere and was too soon to be reordered. Ms. Lowe stated that this was discussed with Relative H1 in a meeting that occurred on 9/25/19 and Relative H1 is now responsible for obtaining all of Resident H's prescription refills.

Ms. Lowe stated "[Relative H1] was administering all medication to [Resident H] prior to her coming here. He had access so all that and I think things were on auto fill. Our staff would request the refill and Omnicare would tell us they'd call [Relative H1] and [Relative H2] to try to resolve the issue but never got ahold of them. Now they no longer use Omnicare and are responsible for filling all [Resident H's] medication." Ms. Skotak stated that facility staff had a meeting with Relative H1 and Relative H2 on 10/10/19 and have now determined that they will resume using Omnicare to refill Resident H's medications.

While onsite I obtained a copy of Resident H's medication administration record (MAR) for September 2019. Review of the MAR revealed that she did not receive her Protonix (pantoprazole sodium) on 9/17/19-9/25/19. The MAR also revealed that Resident H did not receive her Losartan on 9/26/19 and 9/27/19 or her Ranitidine on 9/10/19-9/13/19 and on 9/15/19-9/17/19.

Ms. Lowe stated that the facility procedure is to reorder medications seven days before the medication runs out. Ms. Lowe stated that the refill requests are electronic and nurses or med techs can request a refill by "hitting the reorder button in Point Click Care". Ms. Lowe stated that Omnicare makes deliveries to the facility seven days per week. Per Ms. Lowe, Resident H's medication orders were obtained and submitted to Omnicare upon her move in on 8/29/19.

Resident H's last dose of Protonix was administered on 9/16/19. After her move in, facility staff submitted a refill request for Protonix on 9/19/19. Ms. Lowe stated that on 9/24, she contacted Omnicare and was told it was too soon to fill the medication and that it would be available in November. Ms. Lowe stated that the medication was refilled at CVS by Relative H1 and he brought the medication up to the facility on 9/26/19.

Resident H's last dose of Losartan was administered on 9/25/19. Ms. Lowe stated that she notified Relative H1 that Resident H's Losartan was low on 9/19 and he indicated he had some of the medication at home that he would bring in. Ms. Lowe

stated that Relative H1 was notified again on 9/26 that they hadn't received the medication. Ms. Lowe stated that on 9/28, she contacted Omnicare and was told it was too soon to fill the medication and that it would be available in November. Ms. Lowe stated that a discussion was had with Relative H1 regarding the medication issue and he was able to pick the medication up from CVS and brought it to the facility.

Resident H's last dose of Ranitidine was administered on 9/9/19. Ms. Lowe stated that on 9/6, Relative H1 requested that the medication not be refilled due to a recall. The facility did not obtain physician instruction for this but instead went off the request of Relative H1. On 9/18, Relative H1 obtained a new prescription for staff to administer to Resident H in place of the Ranitidine.

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:	Facility staff report that Relative H1 requested that Resident H's evening medications be administered at 8:00pm. Standard procedure for the facility is to administer medications within a one-hour window of the designated administration time and is considered a medication error if given outside that timeframe. Review of Resident H's physician's orders reveal that the prescriptions are written to be administered "at bedtime" and do not instruct a specific administration time, however Resident H's service plan was updated to reflect an 8:00pm administration time as the resident's preference. Resident H's MAR reveals that staff administered the medications more than an hour late even after updating the service plan. The complainant alleged medication issues arose on 9/8/19 and 9/11/19 (incorrect med dosage and not bringing all of the correct medications to Resident H's room for administration). The complainant reported that he brought the issues to the attention of staff before any errors occurred and that the medications were administered as prescribed. Given the information provided, facility staff did not actually administer the incorrect medications/dosages to Resident H. The complainant alleged that he found loose pills in Resident H's apartment. The complainant was not able to provide dates that the medications were discovered and did not immediately

	report his concerns to facility management. Interviews with staff and review of staff training records reveal that med techs are trained to observe residents ingest all of their medications. Given the information provided, I am unable to determine staff wrongdoing. Facility staff report that their contracted pharmacy Omnicare was unable to fill some of Resident H's medications due to them already being filled by an outside provider. Resident H's medication administration records were reviewed, and it was observed that Resident H missed multiple doses of Losartan (Cozaar), Protonix (pantoprazole sodium) and Ranitidine (Zantac). The facility did not take sufficient proactive measures to ensure Resident H did not run out of any medication. Additionally, facility staff report that Relative H1 requested they not refill Resident H's Ranitidine. Facility staff followed Relative H1's instruction without consulting Resident H's physician before allowing the medication to run out. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see SIR2020A1019003, SIR2020A1019004 and 2019 renewal LSR].**

ADDITIONAL FINDINGS:

INVESTIGATION:

In addition to the abovementioned medication related concerns, it was also revealed that the facility did not provide an accurate and complete medication log. Review of Resident H's MAR revealed that facility staff failed to provide any documentation for Resident H's Calcium D3 tablet on 9/3/19, 9/16/19 and 9/25/19 and the MAR was left completely blank. Ms. Skotak stated that staff should not leave any dates blank, as the MAR includes numeric codes to enter depending on the circumstance of the missed administration. Additionally, facility staff documented that Resident H was out of the medication Ranitidine from 9/10/19-9/17/19 except staff documented that it was administered on 9/14/19. The 9/14/19 documented administration is considered to be a documentation error since the medication was documented as unavailable for several days before and after 9/14.

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:	Review of Resident H'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:	**VIOLATION ESTABLISHED**

On 10/9/19, 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.

10/15/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/17/19

Russell B. Misiak Date
Area Manager