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 #: 2020A1019004
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 #:	2020A1019004
Complaint Receipt Date:	10/06/2019
Investigation Initiation Date:	10/07/2019
Report Due Date:	12/05/2019
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?
Resident I didn't receive his medication for several days due to a medication error.	Yes
Additional Findings	No

III. METHODOLOGY

10/06/2019	Special Investigation Intake 2020A1019004
10/07/2019	Special Investigation Initiated - Letter Emailed administrator/ AR and wellness director for additional information
10/09/2019	Inspection Completed On-site
10/09/2019	Inspection Completed-BCAL Sub. Compliance
10/09/2019	Exit Conference Conducted with AR while onsite
10/09/2019	APS Referral Notified APS of the allegations via email referral template

ALLEGATION:

Resident I didn't receive his medication for several days due to a medication error.

INVESTIGATION:

On 10/5/19, the department received an incident report submitted by the facility that read:

> [Resident I] had a script written for Penlac solution and Melatonin. Medication was not entered into the system in a timely manner delaying the resident receiving the medication. This resident was entered into another resident's chart

> [Resident K]. Neither resident received any of either medication. As soon as the error was discovered it was immediately corrected in the MAR system. Both residents were assessed. Vitals for both residents were within normal limits. Neither resident had any complaints of pain or discomfort. [Resident I] had no complaints of inability to sleep at night and the fungal issue with his nail had not worsened. Both residents responsible parties were contact [sic]. Physician was contacted and E.D. was informed.

On 10/9/19, I conduced an onsite inspection. I interviewed administrator an authorized representative Deborah Skotak at the facility. Ms. Skotak stated that Elizabeth Lowe, the facility wellness director was handling this situation and her knowledge of what occurred was limited. Ms. Skotak stated that she was informed that some of Resident I's medications were entered into Resident K's MAR (medication administration record) and wasn't discovered until over a week later when nurse Beverly Spillman was doing an audit.

Ms. Lowe was not in the facility the day of my inspection but reported via email:

> On September 24th 2019 Orders were given from Ben Lee PA on [Resident I] for Melatonin 10mg and Penlac topical nail solution. The orders were mistakenly entered into [Resident K] MAR. On 10/3 During chart audits nurse supervisor Beverly Spillman discovered this error and immediately corrected it. The residents personal physician Ben Lee PA, Responsible party [name omitted] who is his wife, DHW and ED were notified. [Resident I] was evaluated for any side effects of the missed medication. Resident stated he was sleeping fine and staff reported they had no issues with him being up at night. The nail fungus on residents nails had not worsened. Residents vitals were stable and with in normal limits. The resident missed a total of 8 doses for both medications.

Ms. Spillman was not in the facility at the time of my inspection but submitted a signed statement that read:

> On 10/2/19 at 0527 while auditing medical charts and entering orders in the EMAR I entered an order for [Resident I] #221. The next day when I returned to work, I was helping with med pass on the 3rd floor I discovered a resident had the same exact orders as [Resident I]. For confirmation I gathered both residents medical charts to confirm orders. It was discovered [Resident K] Rm #304 had orders entered in error that was [sic] not his. I immediately pulled the administration history, all stated medication was not available, check the cart for visual observation. None of the medications present he had not received any of the medications listed. I then began to D/C the orders entered in the error and notified med techs to inform them of the error to protect the safety of the resident moving forward. I entered the medications in [Resident I] EMAR for administration, made all necessary corrections and notified pharmacy. After all deletions and corrections were completed I immediately called my supervisor to inform her of the discovered med errors, informing her of the deletions and

correction made in the error. I then made copies of the actual order & corrections to both residents EMAR and placed the printed copies on her desk for review. Went down to 2nd floor to talk with med techs and assess [Resident I], no distress noted, asked about his sleep habits no new problems noted. Later in the afternoon text supervisor to follow-up stated she received everything and all corrections was [sic] in place.

While onsite, I reviewed physician's orders for Resident I's Melatonin and Penlac. I observed that both orders were written on 9/24/19. I also reviewed Resident I's MAR and confirmed the he did not receive his Melatonin from 9/24/19-10/1/19 and didn't receive his Penlac solution from 9/24/19-10/2/19.

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:	Resident I was prescribed Melatonin and Penlac solution on 9/24/19. Facility staff inadvertently entered the two orders into Resident K's MAR instead of Resident I's, resulting in Resident I missing several doses of both medications. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see SIR2019A1019067, SIR2020A1019003 and 2019 renewal LSR].**

On 10/9/19, I shared the findings of this report with authorized representative Deborah Skotak. Ms. Skotak verbalized understanding of the citation being issued.

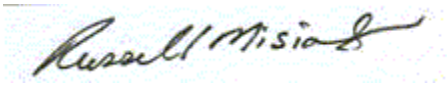
IV. RECOMMENDATION

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

10/11/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



10/17/19

Russell B. Misiak Date
Area Manager