GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 26, 2019

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

RE: License #: AH630370122
Investigation #: 2020A1019025

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2020A1019025
Complaint Receipt Date:	12/18/2019
Investigation Initiation Date:	12/20/2019
Report Due Date:	02/17/2020
Licensee Name:	F&M Auburn Hills OPCO, LLC
Licensee Address:	#2200 2221 Health Drive SW Wyoming, MI 49519
Licensee Telephone #:	(616) 248-3566
Administrator and 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident G didn't receive her Aricept as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

12/18/2019	Special Investigation Intake 2020A1019025
12/20/2019	Special Investigation Initiated - Telephone Called complainant to conduct interview. Complainant's voicemail box was full, writer unable to leave message.
12/23/2019	Inspection Completed On-site
12/23/2019	Inspection Completed-BCAL Sub. Compliance
12/23/2019	Exit Conference
12/23/2019	APS Referral Notified APS of the allegations via email referral template
12/23/2019	Exit Conference

ALLEGATION:

Resident G didn't receive her Aricept as prescribed.

INVESTIGATION:

On 12/16/19, the department received a complaint regarding Resident G's medications. The complaint read that on 12/14/19, it was discovered that Resident G had not received her Aricept for several days. The complaint read that this issue was brought to management's attention.

On 12/23/19, I conducted at onsite inspection. I interviewed wellness director Elizabeth Lowe at the facility. Ms. Lowe stated that she was unaware of any issues

with Resident G's Aricept. Ms. Lowe stated that staff are trained to reorder a medication when there is a seven-day supply remaining and are also supposed to document in a binder when refills are requested. Ms. Lowe stated that management reviews the binders daily and will follow up if any medications are not received by the facility in a timely manner upon refill.

While onsite, I requested a copy of Resident G's medication administration records (MAR). Review of Resident G's MAR reveals that she did not receive her Aricept on 12/11/19, 12/12/19, 12/13/19, 12/14/19, 12/15/19 and 12/16/19. Facility progress notes were reviewed to determine why the medication was not given. On 12/11/19, facility staff Jasmine Tate documented "medication on order waiting on pharmacy". On 12/12/19, facility staff Jasmine Tate documented "medication on order". On 12/13/19, facility staff Brionna Gray documented "wait on pharmacy". On 12/14/19, facility staff Jasmine Tate documented "medication on order". On 12/15/19, facility staff Jasmine Tate documented "medication not on the cart, waiting for pharmacy". Ms. Lowe stated that she could see that a refill request was made on 12/11/19 but could not verify that the medication was reordered before running out on 12/11/19. Ms. Lowe reviewed the "medication log" (the binder staff are supposed to indicate when refills are requested). The log did not list Resident G's Aricept and being refilled in December 2019.

While onsite, Ms. Lowe contacted memory care manager Darline Dowell by phone to inquire about the refill. Ms. Dowell informed Ms. Lowe that on 12/15/19, Relative G informed her that Resident G was out of Aricept. Ms. Dowell stated that she contacted the pharmacy "Omnicare" and inquire about the delayed delivery. Ms. Dowell stated that the pharmacy reported that they would make a "Stat delivery" meaning that it would be delivered to the facility within four hours, however that did not occur. The facility was unable to provide any evidence that they followed up with the pharmacy after they failed to complete the "stat delivery".

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.**
ANALYSIS:	Facility staff failed to follow their own protocol by reordering Resident G's medication seven days prior to it running out. Additionally, facility staff did not properly record when the refill was made and staff failed to follow up with the pharmacy in a

	timely manner to prevent additional missed doses. Based on this information, the allegation is substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see SIR2019A1019067, CAP dated 11/4/19].**

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 G missed six consecutive doses of Aricept. Based on this information, the allegation is substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see SIR2019A1019067- CAP dated 11/4/19, SIR2020A1019003- CAP dated 11/4/19 and 2019 renewal LSR- CAP dated 2/14/19].**

On 12/23/19, I shared the finding of this report with authorized representative Cody Salinas.

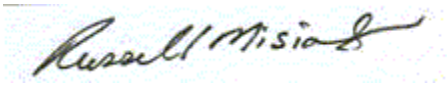
IV. RECOMMENDATION

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

12/26/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



12/26/19

Russell B. Misiak Date
Area Manager