GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 17, 2019

Deborah Skotak
First & Main of Auburn Hills
3151 E. Walton Blvd.
Auburn Hills, MI 48326

RE: License #: AH630370122
Investigation #: 2019A1019037
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. 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.

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 (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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2019A1019037
Complaint Receipt Date:	04/01/2019
Investigation Initiation Date:	04/02/2019
Report Due Date:	06/01/2019
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 is understaffed.	Yes
Additional Findings	No

III. METHODOLOGY

04/01/2019	Special Investigation Intake 2019A1019037
04/02/2019	Special Investigation Initiated - Letter emailed AR requesting schedules as actually worked
04/02/2019	Comment The complaint was forwarded from APS to LARA, APS did not open the referral for investigation. Due to this, LARA is not submitting an additional referral to APS.
04/11/2019	Inspection Completed On-site
04/11/2019	Inspection Completed BCAL Sub. Compliance
04/18/19	Exit Conference

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 4/1/19, the department received a complaint alleging that the facility does not have enough staff to meet the needs of the residents. The complaint alleged that on 4/1/19, the facility only had two staff working. The complaint also alleged that about two weeks prior, only two care staff were present and they also had to prepare meals for the residents. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 4/11/19, I conducted an onsite inspection. I interviewed administrator and authorized representative Deborah Skotak at the facility. Ms. Skotak stated that there are currently 33 residents at the facility (8 residents in memory care and 25 residents in assisted living). Ms. Skotak stated that she schedules staff on three shifts; first shift is from 6:30am-3:00pm, second shift is from 2:30pm- 11:00pm and third shift is from 10:30pm-7:00am. Ms. Skotak stated that at the current census she schedules five care staff including one med tech during first and second shift and on third shift she schedules an nursing supervisor and 2-3 caregivers. Ms. Skotak stated that the third shift if the memory care unit and there is always at least one staff member present that isn't allowed to leave the unit. Ms. Skotak stated that the med tech on first and second shift floats on all three floors. Ms. Skotak stated that there are no residents who receive scheduled medications on third shift, only PRN or "as needed" medications are administered during that timeframe. Ms. Skotak stated that the med tech is also responsible for providing personal care and answering call lights. Ms, Skotak stated that the facility is actively hiring care staff but denies that they are understaffed. Ms. Skotak stated that each shift has a designated mandated employee to stay over if there is a call off or a no call no show and Ms. Skotak stated she has recently started to utilize a staffing agency to ensure adequate staffing levels.

Ms. Skotak denied ever having only two staff working but did report that on 3/23/19, the kitchen staff did not show up for their shift in the morning and stated that housekeeping and the concierge staff had to serve breakfast to the residents. Ms. Skotak stated that the first shift cook misread his schedule and did not come in for his shift starting at 6:30am. Ms. Skotak stated that breakfast is served daily from 7:00am-9:00am but stated on 3/23/19, a replacement kitchen staff did not come in until after 7:30am and residents were not served until after 8:00am.

I reviewed facility schedules "as worked" for 3/1/19-4/11/19. At no point on 4/1/19 were there only two staff working as the complaint alleged. First shift on 4/1/19 had four care staff working. Second shift on 4/1/19 had six care staff working with one leaving early. Third shift on 4/1/19 had four care staff working.

On 4/11/19, I interviewed med tech Jenna Areaux at the facility. Ms. Areaux stated that the facility experiences frequent call offs and that mandated staff do not always stay over when needed. Ms. Areaux stated that med techs are expected to provide personal care to residents but stated that due to having to pass medications to the entire building she cannot always attend to everything she needs to. Ms. Areaux stated "Sometimes we have to change shower schedules and put them off to another day and the laundry doesn't always get done." Ms. Areaux stated that she is not able to answer resident call pendants as quickly as she would like and was recently told by a resident that she experienced an episode of incontinence because staff took too long to respond to her call pendant. I attempted to interview that resident but she declined to speak with me during my inspection.

On 4/11/19, I interviewed care giver Erika Rush at the facility. Ms. Rush stated that staffing is an issue at the facility and reported that call offs occur frequently and stated that the facility is “always short staffed”. Ms. Rush stated that mandated staff do not always stay over when the facility is short staffed. Ms. Rush stated that while she is able to complete her tasks during her shifts, she is constantly rushing and not able to spend the amount of time she would like and feels that the residents deserve. Ms. Rush stated “I wouldn’t say anything is neglected, but we have to be really fast. We can’t really have conversations with the residents or pay enough attention as we want to them.” Ms. Rush also stated that med techs are supposed to provide care but are often too busy with their med passing responsibilities to help out with personal care. Ms. Rush stated “They have the whole building, they are too busy.”

On 4/11/19, I interviewed care giver Sonea Jackson at the facility. Ms. Jackson stated that most of the time the facility is understaffed. Ms. Jackson stated that sometimes showers are delayed, laundry isn’t completed and staff cannot respond to resident call pendants as quickly as expected. Ms. Jackson stated that mandated staff sometimes do not stay when they are needed but did state that agency staff is helping out to fill in as needed.

While onsite, I requested that Ms. Skotak indicate the residents who most frequently utilize their call pendants for staff assistance and she named Residents B, C, D, E and F. Ms. Skotak stated resident pendant alerts are forwarded to staff pagers and also go to the concierge desk during the hours of 8:00am-8:00pm who notify staff via walkie talkie to ensure they are acknowledged. Pages go to front desk as well from 8a-8p and concierge is on walkie to ensure pages are not overlooked. Ms. Skotak stated that pages are escalated to her after they go unanswered for 15 minutes. Ms. Skotak stated “We expect staff to answer pendants as soon as reasonably possible. We do not put a time on it, but set in place practices to reduce delay of response times.” Ms. Skotak also stated that resident pendants must manually be reset by staff when they respond to the alerts.

I reviewed the emergency response data for those residents’ call pendants for a 60-day period. Resident B experienced wait times of 15 minutes or longer on the following dates: 3/4/19, 3/6/19, 3/20/19 and 3/30/19. The longest wait time observed during the timeframe reviewed for Resident B was 52 minutes. Resident C experienced wait times of 15 minutes or longer on the following dates: 3/3/19, 3/8/19, 3/9/18, 3/11/19, 3/22/19, 3/22/19, 3/23/19, 3/31/19, 4/1/19, 4/3/19, 4/9/19 and 4/10/19. The longest wait time observed during the timeframe reviewed for Resident C was 48 minutes. Resident D experienced wait times of 15 minutes or longer on the following dates: 3/2/19, 3/4/19, 3/5/19, 3/10/19, 3/13/19, 3/16/19, 3/23/19, 3/29/19, 3/31/19, 4/5/19, 4/6/19, 4/7/19, 4/8/19 and 4/9/19. The longest wait time observed during the timeframe reviewed for Resident D was 79 minutes. Resident E experienced wait times of 15 minutes or longer on the following dates: 3/18/19, 3/25/19, 3/28/19, 3/29/19, 3/30/19, 3/31/19, 4/1/19, 4/5/19, 4/7/19 and

4/10/19. The longest wait time observed during the timeframe reviewed for Resident E was 40 minutes. I did not observe any excessive wait times for Resident F.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Facility care staff interviewed report a problem with employee call offs and enforcement of the facility mandation policy, leaving the facility understaffed at times. Staff interviewed report that there are times when personal care provided to residents are delayed or not completed at all. Employees consistently attested that the most help is needed on first shift. Review of emergency response data for resident call pendants reveal numerous excessive wait times for the timeframe reviewed. Based on these findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/18/19, 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.

4/17/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

4/18/19

Russell B. Misiak Date
Area Manager