GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2020

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

RE: License #: AH630370122
Investigation #: 2020A1019035

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

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

I. IDENTIFYING INFORMATION

License #:	AH630370122
Investigation #:	2020A1019035
Complaint Receipt Date:	02/18/2020
Investigation Initiation Date:	02/18/2020
Report Due Date:	04/19/2020
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?
Staff are not ensuring resident notification devices are functional and not responding to calls for assistance in a timely manner.	Yes
Staff did not treat Resident H with dignity.	No
Resident H didn't receive medications as prescribed.	No
Staff are leaving refuse on the counter.	No
Additional Findings	Yes

III. METHODOLOGY

02/18/2020	Special Investigation Intake 2020A1019035
02/18/2020	Special Investigation Initiated - Telephone Called complainant to conduct interview, left voicemail requesting return phone call
02/18/2020	Contact - Telephone call received Complainant returned phone call, interview conducted
02/20/2020	Inspection Completed On-site
02/20/2020	Inspection Completed BCAL Sub. Compliance
02/24/2020	APS Referral Notified APS of the allegations via email referral template
03/09/2020	Exit Conference

ALLEGATION:

Staff are not ensuring resident notification devices are functional and not responding to calls for assistance in a timely manner.

INVESTIGATION:

On 2/15/20, the department received a complaint regarding the care of Resident H at the facility. On 2/18/20, a phone interview was conducted with the complainant where she expressed numerous concerns including an issue with Resident H's call pendant and two instances that she was left on the toilet for extended periods of time. The complainant reported that the resident has since been moved out of the facility.

Regarding the call pendant, the complainant stated that Resident H's call pendant was "blinking yellow", meaning the battery was low and that this occurred from 2/1/20-2/3/20. The complainant stated that this was brought to staff's attention, but that staff indicated that they did not have access to replacement batteries for the device. The complainant stated that on 2/3/20, the assistant director replaced the battery however the complainant was concerned over the length of time it took staff to replace the battery and felt it was unsafe for the resident to have a pendant with a low battery for an extended period of time.

On 2/20/20, I interviewed associate executive director Gina Tindall at the facility. Ms. Tindall stated that the call pendant system, including battery life is documented electronically. Ms. Tindall stated that staff are notified when a pendant battery is low, as well as the pendant itself having an alert via a blinking light. Ms. Tindall stated that staff do have access to replacement batteries but stated that certain staff do not have permission to reset the battery within their electronic system. Ms. Tindall stated that the call pendant can run for several days on a low battery and that Resident H's pendant was fully functioning despite it "blinking yellow". Ms. Tindall stated that there is also a backup pendant available if a pendant requires replacing.

Regarding toileting, the complainant stated that Resident H was left on the toilet for 20 minutes on 2/4/20 and left for an hour during an incident that occurred in March 2019. The complainant could not provide the name of the staff involved in either incident.

Staff schedules and assignment sheets were reviewed for 2/4/20. Attestations from staff providing care to Resident H on 2/4/20 all deny that she was left on the toilet for an extended period of time. Call light response data was also reviewed for 2/4/20 and no excessive wait times were observed.

Ms. Tindall confirmed that there was an incident in 2019 where a staff member left Resident H on the toilet "for about an hour". Ms. Tindall stated that the facility's human resources company came in to conduct the investigation.

Ms. Tindall provided an email from the resident's daughter dated 3/1/19 that read:

> Hi Gina- I'm sure you are aware of another situation regarding Mom's lack of care yesterday. She was left to sit on the toilet for an hour. She rang her pager numerous times and no one came to assist her. She was very upset and scared with the situation. I am wondering what steps are being taken to assure that Mom feels secure and comfortable at First and Main.
>
> Please let me know that Mom's health and well being won't be endangered for a third time.
>
> Thank you for looking into this for me

Another email received by Ms. Tindall on 3/1/19 read:

> Hi Gina - Deb gave me the buzzer timeline, but I'd like some more clarification please. I do not have Deb's email address, so please forward this to her if you don't have this information.
>
> 1:46 - Mom buzzed for assistance
> 1:58 - Aid arrived and cleared buzzer and assisted Mom on toilet
> 2:22 - Mom buzzed 2X
> 2:30 - buzzer turned off - by whom and why didn't they assist Mom at that time?
> 2:30 - Mom pulled bathroom cord - why was this necessary???
> 2:41 - Buzzer reset - who came in and reset?
>
> That is 5 minutes shy of an hour from start to finish.
>
> Isn't someone else notified if a buzzer isn't responded to in 5 minutes??
>
> Please respond so we can get to the bottom of this situation.
>
> Thank you!

Ms. Tindall also provided an email sent from the former administrator/authorized representative Deborah Skotak to Resident H's daughter dated 3/7/19 that read:

> The investigation of multiple people, including Gina's conversation with your mom after the initial incident has come to a conclusion.
>
> 1) The caregiver in question responded to your moms call light (when it hadn't been answered in a timely fashion) and had her permission to help her to the bathroom
> 2) Discussion ensued between her and your mom that your mom wanted the med tech to come back to get her off the toilet.

3) Caregiver went to tell med tech that “[Resident H] is on the toilet” Med tech said ok (stated she didn’t realize that meant she was supposed to get her off) Caregiver went about her business thinking med tech had it covered.

It appears that it was a miscommunication about care that caused your moms bathroom visit to be long.

We will be doing an inservice with all staff on both protocol when someone is in the bathroom, and also on communication and making sure what you are saying is understood.

I apologize that this happened, and we are continually taking steps to improve our service.

The caregiver will not be returning to the community.

Ms. Tindall initially stated that the employee involved was terminated, but during my investigation it was discovered that the employee was approved to transfer to another facility within the organization. Ms. Tindall was able to confirm that the employee resigned before the transfer could take place.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand,**

	unless medically contraindicated as documented by the attending physician in the medical record.
ANALYSIS:	Interviews with staff reveal that Resident H's call pendant had a low battery from 2/1/20-2/3/20, however Ms. Tindal indicated that the pendants still operate for up to a week with a low battery and reported that Resident H's pendant was fully functioning during the time it had a low battery notification. Attestations from multiple staff and review of call pendant response data from 2/4/20 don't provide evidence that Resident H was left on the toilet for 20 minutes as the complaint alleges. Given the above information, those allegations are not substantiated. Per the admission of management staff and review of additional supporting documentation, it is concluded that Resident H was left on the toilet for an excessive amount of time on 2/28/19 despite Resident H alerting staff repeatedly via her call pendant and bathroom pull cord. The provision of care provided in this incident is not consistent with this rule. Based on this information the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not treat Resident H with dignity.

INVESTIGATION:

The complainant stated that staff were rude to Resident H, one instance involving a staff member named Korea and another instance where staff intentionally left Resident H's light on.

The complainant stated that Resident H informed her that on 1/29/20, staff member Korea was rude to her. The complainant stated that Resident H alleged that staff member Korea was disrespectful to her by calling a "troublemaker", and allegedly telling Resident H that staff don't want to help her and that she should be toileting herself.

On 2/20/20, I interviewed care giver/med tech Korea Allen at the facility. Ms. Allen stated that Resident H was difficult to provide care for and would often refuse assistance with activities of daily living, however denied that any verbal altercation

had occurred. Ms. Allen emphasized that Resident H required staff assistance with toileting and would never suggest that she should toilet herself due to her being a fall risk.

On 2/20/20, I interviewed administrator and authorized representative Cody Salinas at the facility. Mr. Salinas stated that Resident H nor her family ever came to him with the allegations regarding Ms. Allen and has not had any complaints regarding her conduct. Additionally, Ms. Tindall stated that she was unaware of any issues involving Ms. Allen and that no one has reported anything to her previously.

The complainant went on to state that certain staff at the facility were prohibited from providing care to Resident H, including any male staff. The complainant stated that on 2/2/20, a staff member went to assist Resident H with care but that specific staff person was not supposed to be assisting her per the resident's preference. The complainant stated that the other staff member working was male, and males were also prohibited from providing care to the resident per her preference. The complainant stated that Resident H was upset about the staff who were assigned to her floor. The complainant stated that the nurse on duty was informed of the issue and that the nurse arranged for staff from a different floor to provide assistance to Resident H.

On 2/20/20, I interviewed nurse Denelda Walker at the facility. Ms. Walker recalled a recent incident in which there were two staff members assigned to Resident H's floor that Resident H did not want providing care to her. Ms. Walker confirmed that it was arranged for care staff from another floor to provide care to Resident H when needed during that shift. Ms. Walker stated that Resident H also agreed to allow one of the originally assigned staff to work with her under the condition that a gait belt would not be used on her.

With respect to the allegation of a light being left on, the complainant stated that on one occasion staff left Resident H's light on overnight. The complainant stated that the staff member refused to turn the light off when Resident H requested. The complainant was unable to provide a date that this occurred and stated that it was told to her by Resident H.

On 2/20/20, I interviewed administrator and authorized representative Cory Salinas at the facility. Mr. Salinas stated that this concern was brought to his attention on 1/30/20 by by health and wellness director Elizabeth Lowe. Mr. Salinas stated that the staff in question was taken off assignment from working with Resident H and an investigation was initiated. Mr. Salinas stated that the investigation did not yield any evidence that the allegations were true.

Ms. Lowe was not present during my investigation but later attested via email that she was informed by the activities director that Resident H was upset about something that occurred the previous evening. Ms. Lowe reported that she had a private conversation with Resident H in which she accused a staff member of

refusing to turn her light off. Ms. Lowe attested that the resident gave her a name of the staff member who did this however it was determined that the staff member Resident H originally named was not working when the alleged incident occurred. Ms. Lowe reported that Resident H then named staff member Abby (Kenneata Rodgers) as the person involved. Ms. Lowe reported that Ms. Rodgers was immediately taken off assignment from providing care to Resident H.

Ms. Rodgers denies the allegations against her. Care staff Jenna Areaux and Qwanikque McKenzie were present during the evening in question and both deny witnessing Resident H's light being on during the night.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Ms. Allen, who was accused of being rude to Resident H adamantly denies the allegations and facility management deny that Resident H or her family approached them with any concerns over Ms. Allen's conduct. On 2/2/20, Resident H showed dissatisfaction over the caregivers that were assigned to her floor. Staff interviewed reported that they reallocated Resident H's care to a different staff member who was assigned to another floor to appease the resident and also reported that Resident H ended up giving Ms. Rodgers permission to assist her with care despite not wanting to work with her previously. There is no evidence to suggest that care was actually provided to the resident by someone she did not approve of on that date. Additionally, the accused staff member denies the allegations of leaving Resident H's light on overnight. Attestations from staff who were present during the shift in question deny observing Resident H's light on. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident H didn't receive medications as prescribed.

INVESTIGATION:

The complainant stated that Resident H did not receive any of her medications on 12/21/19 and 12/22/19. Additionally, the complainant stated that on 2/5/20, Resident H was prescribed a powder for a chest yeast infection. The complainant stated that the powder was to be applied twice daily but reported that the resident has only had the powder applied "about three times".

While onsite, I obtained a copy of Resident H's medication administration record (MAR) for review. I observed that on 12/21/19 and 12/22/19, it was documented that all of Resident H's medications were administered as prescribed.

While onsite, I obtained a copy of the physician's order for the powder. The 2/5/20 order read "Apply Nystatin powder to R breast bid & PRN if wet". Review of Resident H's MAR for February 2020 revealed that the scheduled doses of Nystatin powder were administered as prescribed on 2/5/20 until she moved out on 2/12/20. Facility staff did not document that any PRN (as needed) doses were given.

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:	Review of Resident H's medication administration record reveals that she was administered her medication on 12/1/19 and 12/22/19 as well as received her scheduled administration of Nystatin in February 2020. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are leaving refuse on the counter.

INVESTIGATION:

The complainant stated that on one occasion, Resident H's garbage was left on her kitchen counter overnight. The complainant was unable to provide a date that this occurred and stated that it was told to her by Resident H.

Mr. Salinas stated that care givers conduct “room tidies” throughout their shift and trash is collected at that time if needed. Mr. Salinas stated that in addition to the room tidies, housekeeping cleans resident rooms twice weekly and will remove any trash in the rooms at that time. Mr. Salinas stated that if something was left, it would’ve been discovered and removed during the next room tidy the following shift. Ms. Tindall along with Ms. Walker, memory care manager Darline Dowell and care giver/med tech Ms. Allen confirmed this procedure as well. Staff interviewed reported that typical procedure for staff would be to turn the light off unless the resident requested otherwise.

Mr. Salinas stated that he was informed by Ms. Lowe on 1/30/20 of a concern that a staff member intentionally left garbage on Resident H’s counter. Mr. Salinas stated that the staff member in question was immediately pulled from working with Resident H and an investigation was initiated. Mr. Salinas stated that the investigation results determined that the allegations were unfounded.

Ms. Lowe was not present during my investigation but later attested that she was informed of an incident where Ms. Rodgers intentionally left trash on Resident H’s counter. Ms. Lowe attested that this was told to her by Resident H during the same conversation where she was told about the resident’s light being left on. Ms. Lowe confirmed that Ms. Rodgers was told she could no longer provide care to Resident H after hearing about the allegation.

Attestations from Ms. Rodgers, Ms. Areaux and Ms. McKenzie were provided. Ms. Rodgers denied the allegations against her. Ms. Areaux and Ms. McKenzie were working the evening of the allegations with Ms. Rodgers and both deny witnessing any garbage left on Resident H’s counter.

APPLICABLE RULE	
R 325.1972	**Solid wastes.**
	All garbage and rubbish shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.

ANALYSIS:	The accused staff member denies the allegations of leaving garbage on the resident's counter. Attestations from staff who were present during the shift in question deny observing any garbage being left on the resident's counter. Staff interviews reveal trash removal procedures that are consistent with this rule. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Walker, Ms. Allen and Ms. Rodgers attested that Resident H required the use of a gait belt when transferring, however they also attested that Resident H did not like the gait belt to be used and report there were times they wouldn't use it with her. Attestations from Ms. McKenzie and care staff Deborah Tate make no mention of the use of a gait belt when asked to describe the procedure used with Resident H when providing assistance with mobility and transfers.

Review of Resident H's service plan reveals that it was void of any information pertaining to the use of assistive devices, including a gait belt. When attempting to obtain clarification, Ms. Lowe reported that Resident H used a walker and wheelchair and required staff assistance with both devices. Ms. Lowe indicated that gait belts are available to all care staff to use when they deem necessary in transferring residents.

Additionally, all staff interviewed reported that Resident H disliked showering and would often refuse them. Ms. Rodgers reported that Resident H would go months without taking a shower. Ms. Walker reported that the resident developed a rash as a result of her poor hygiene habits. Resident H's service plan was void of any information pertaining to this behavior and staff's difficulties bathing her. The plan did not provide any instruction to staff with alternatives or methods of redirection.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
For Reference:	

R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	While the facility did present a service plan for Resident H, it lacked significant and reasonable items to ensure her continued safe health and wellbeing. For instance, staff interviews revealed they are providing transferring assistance inconsistent with the plan. Resident H's plan did not indicate whether a gait belt was to be used by staff for her safety. Her plan was void of any detail or instruction regarding her competency and ability to use of a walker and wheelchair safely. Additionally, multiple staff reported that Resident H often refused showers and was difficult to bathe. Her plan did not identify these behaviors or provide staff any methods to implement when refusals occur. Given this information, Resident H's service plan was not sufficiently developed meet Resident H's needs. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/9/20, I shared the findings 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.

3/4/20

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

3/9/20

Russell B. Misiak Date
Area Manager