GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2022

Paul Meisel
Merrill Assisted Living, LLC
219 Church Street
Auburn, MI 48611

RE: License #: AL730389269
Investigation #: 2022A0572025
Merrill Fields Assisted Living

Dear Mr. Meisel:

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 responsible party 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 (906) 226-4171.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730389269
Investigation #:	2022A0572025
Complaint Receipt Date:	02/23/2022
Investigation Initiation Date:	02/25/2022
Report Due Date:	04/24/2022
Licensee Name:	Merrill Assisted Living, LLC
Licensee Address:	344 N. Midland Street Merrill, MI 48637
Licensee Telephone #:	(989) 705-2060
Administrator:	Paul Meisel
Licensee Designee:	Paul Meisel
Name of Facility:	Merrill Fields Assisted Living
Facility Address:	400 N. Midland Street Merrill, MI 48637
Facility Telephone #:	(989) 715-2060
Original Issuance Date:	04/25/2018
License Status:	REGULAR
Effective Date:	10/25/2020
Expiration Date:	10/24/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving her diabetic diet as required to prevent substantial swelling in her ankles and toes.	No
Resident A went 11 days without being bathed.	Yes
No facility maintenance is being done.	No
Resident A's room was not cleaned prior to her moving in. It was also not painted as promised and facility wants to now paint it while she resides in it.	No

III. METHODOLOGY

02/23/2022	Special Investigation Intake 2022A0572025
02/25/2022	Special Investigation Initiated - Letter
04/05/2022	Inspection Completed On-site Med Coordinator, Madison Rodriquez; Supervisor, Wendy Wolpert; Kitchen Manager, Ann Moulton and Resident A.
04/07/2022	Contact - Face to Face Home Manager, Virginia Putnam.
04/14/2022	Exit Conference Licensee Designee, Leah Allen.

ALLEGATION:

Resident A is not receiving her diabetic diet as required to prevent substantial swelling in her ankles and toes.

INVESTIGATION:

On 02/23/2022, the local licensing office received a complaint for investigation. There were no other investigative entities involved.

On 04/05/2022, an unannounced onsite was made at Merrill Fields Assisted Living, located in Saginaw County, Michigan. Interviewed were, Med Coordinator, Madison Rodriguez; Supervisor, Wendy Wolpert; Kitchen Manager, Ann Moulton and Resident A.

On 04/05/2022, I interviewed Med Coordinator, Madison Rodriquez regarding the allegation. She informed that they were not aware of Resident A having a Diabetic Order upon her arrival at the facility as they had not been given any doctor's orders indicating that she was on a diabetic diet. They have a doctor's order now and Resident A is now on a diabetic diet.

On 04/05/2022, I interviewed Supervisor, Wendy Wolpert regarding the allegation and she informed that she didn't know anything about Resident A being on a diabetic diet when she moved in.

On 04/05/2022, I interviewed Kitchen Manager, Ann Moulton regarding the allegation. Ms. Moulton wasn't aware that Resident A was supposed to be on a diabetic diet when she moved into the facility, so she went 2 or 3 days eating regular meals. She only found out because she is friends with the family and one of the family members mentioned that she should be on a diabetic diet. This information was not in her books, so there was no way for her to know.

On 04/05/2022, I interviewed Resident A regarding the allegation, and she indicated that it took a few days for everything to get organized. Staff are currently watching out for her food intake, and they prepare her a special diet.

On 04/07/2022, I interviewed Home Manager, Virginia Putnam regarding the allegation and she indicated that there was nothing that indicated that she was on a Special Diet. The Resident Assessment Plan did not indicate a Special Diet and the Healthcare Appraisal states a regular diet. Resident A is on a diabetic diet now that they are aware of her dietary needs, after being admitted to the hospital.

On 04/07/2022, I reviewed Resident A's Assessment Plan and Healthcare Appraisal. There is no mention of a special diet for Resident A. In the Healthcare Appraisal, it indicates that Resident A was on a regular diet.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Staff was unaware that Resident A was on a Special Diet as none of the paperwork in her file suggested that she was on a Special Diet. Resident A is now on a special diet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A went 11 days without being bathed.

INVESTIGATION:
On 04/05/2022, I interviewed Med Coordinator, Madison Rodriquez regarding the allegation that Resident A had went 11 days without a bath/shower. She informed that this was true as a shower schedule was not made for her initially. Staff did not know she had not had a shower until the family complained.

On 04/05/2022, I interviewed Supervisor, Wendy Wolpert regarding the allegation and indicated that she did go 11 days without a shower. She was informed by Resident A's family that she had not been showered. Med Coordinator, Madison Rodriquez makes the shower schedule, but one was not made. Resident A does not like to shower, so she never said anything to any of the staff about her not receiving a shower.

On 04/05/2022, I interviewed Resident A regarding this allegation, and she said that she believed that that the staff were doing all that they could, but somehow missed her showers. She believes that one of her family members must have gotten upset about it. She indicated that everything is good now and she now has a shower schedule.

On 04/07/2022, I interviewed Home Manager, Virginia Putnam regarding the allegation and she said that she was unaware that she had gone 11 days without a shower. Protocol is for them to ask the resident and/or family about a preferred shower schedule during their assessment. Then her and the med coordinator will come up with a shower schedule. Showers are at a minimum, twice per week. Resident A's showers are scheduled for Wednesdays and Saturdays during 1st shift.

On 04/07/2022, I reviewed Resident A's shower schedule and it indicates that she moved into the facility on 02/08/2022 and her 1st shower was on 02/16/2022.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	A shower schedule was not initially made for Resident A, therefore she went 8 days without a shower.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

No facility maintenance is being done.

INVESTIGATION:

On 04/05/2022, I interviewed Med Coordinator, Madison Rodriquez regarding this allegation and she informed that they do have some maintenance issues that needs to be addressed. Their maintenance man is scheduled to come to the facility next week to resolve those issues.

On 04/05/2022, I interviewed Supervisor, Wendy Wolpert regarding the allegation and she informed that the company has one maintenance person who receives a list from all the facilities, and he works on each facility one at a time. Their maintenance list has been submitted and the maintenance person will be at the facility sometime next week.

On 04/05/2022, I interviewed Resident A regarding the allegation, and she informed that she hasn't been there long enough to notice anything.

On 04/05/2022, I observed her room and did not notice any maintenance needs.

On 04/07/2022, I interviewed Home Manager, Virginia Putnam regarding the allegation and she informed that they have a Maintenance List that they submit to corporate. Their maintenance person now has the list, and he will be at the facility on 04/12/2022.

On 04/07/2022, I reviewed the maintenance list, and it indicates that Room # 4, 9, 10, and 21 needs to be painted and the pilot for the stove is not working correctly. In Room 11 there's an issue with the sink and toilet. One of the dryers in the laundry room is making a loud noise. Room 15 has a loose faucet. There is an issue with the dishwasher. One of the emergency exit lights were out. And the ductwork in the basement was on the list.

On 04/07/2022, I did a walkthrough of the entire facility and did not notice any potentially hazardous maintenance issues at the facility. I went into Rooms 4, 9, 10, and 21 and saw that the room walls were patched to be ready for paint. Room #11 is not occupied, and maintenance will be at the facility to repair prior to filling that room. I observed the laundry room and there are multiple dryers to utilize. I also observed the stove, which was their 2nd stove, as this facility has two stoves that they can utilize. One of the Emergency Exit lights were out, so it could be a bulb that needs to be replaced or a fuse. I observed the dishwasher but saw that they have a commercial sink in which staff can handwash dishes if need be. I also went into the basement and saw that the insulation was hanging in a couple spots and just needed to be retaped with the ductwork tape.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	The allegation was not specific as to what maintenance issues exist. I reviewed the Maintenance List, and it appears that the maintenance person is aware and is working on taking care of those issues. I also checked the rest of the facility and did not find any immediate concerns with maintenance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's room was not cleaned prior to her moving in. It was also not painted as promised and facility wants to now paint it while she resides in it.

INVESTIGATION:

On 04/05/2022, I interviewed Med Coordinator, Madison Rodriquez regarding that Resident A's bedroom was not cleaned or painted prior to Resident A moving in. She informed that the room was not cleaned or painted, so Resident A and the

family had to wait in the day room. Resident A had to go to the hospital because her foot was swollen, so staff finished painting her room while she was in the hospital. Typically, the rooms are cleaned and painted prior to a resident moving in.

On 04/05/2022, I interviewed Supervisor, Wendy Wolpert and informed that Resident A and the family knew prior to moving in that the room would not be painted prior to her moving in and they agreed to it. She indicated that she knows that it was cleaned because she did it herself. It was vacuumed, deep cleaned and dusted.

On 04/05/2022, I interviewed Resident A regarding her room not being cleaned and painted prior to her moving in and she informed that one of her daughters must have gotten a little upset. There was an obvious misunderstanding somewhere, according to Resident A. Resident A informed that the staff was a little shorthanded because some staff were out due to covid, so they had to wait for them to finish cleaning her room and her bedroom was prepped for painting but wasn't painted yet. Her bedroom was painted when she went to the hospital. She informed that her room is cleaned daily, and she has no concerns.

On 04/07/2022, I interviewed Home Manager, Virginia Putnam regarding the allegation and she informed that a previous resident moved out of the room, that Resident A was going to be moving into. The family saw the room and was told that it will take time for them to get it painted. They wanted the room anyways, because Resident A was at another facility and had to be moved out immediately. The bedroom was fully cleaned during 1st shift. The bedroom was getting painted while Resident A was in the hospital. Resident A was discharged before they were finished, so Resident A and her family waited in the dayroom for the room to be finished painting and to give the fumes time to air out.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	It appears that the family of Resident A were in a rush to get a room at the facility as there was no other place for her. Staff may have been still working on the room due to short staff and the immediate need for a placement for Resident A. Resident A has no concerns with her room. She says that her room is cleaned daily and believe that there was some sort of misunderstanding with one of her children.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/14/2022, an Exit Conference was held with Licensee Designee, Leah Allen; in place of previous Licensee Designee, Paul Meisel. She was informed of the results of the investigation and asked to submit a corrective action plan 15 days within receiving her copy of the special investigative report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

04/14/2022

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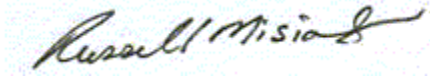
Anthony Humphrey Date
Licensing Consultant

Approved By:



for Mary Holton 04/15/2022

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Mary E Holton Date
Area Manager