GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2021

Paul Meisel
Reed City Fields Assisted Living II
219 Church St
Auburn, MI 48611

RE: License #: AL670384778
Investigation #: 2021A0360023
Reed City Fields Assisted Living II

Dear Mr. Meisel:

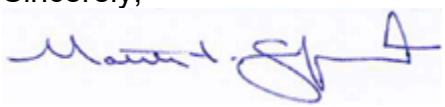
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL670384778
Investigation #:	2021A0360023
Complaint Receipt Date:	04/30/2021
Investigation Initiation Date:	05/03/2021
Report Due Date:	05/30/2021
Licensee Name:	Reed City Fields Assisted Living II
Licensee Address:	22109 Professional Dr. Reed City, MI 49677
Licensee Telephone #:	(231) 465-4371
Administrator:	Paul Meisel, Designee
Licensee Designee:	Paul Meisel, Designee
Name of Facility:	Reed City Fields Assisted Living II
Facility Address:	22109 Professional Dr. Reed City, MI 49677
Facility Telephone #:	(231) 465-4371
Original Issuance Date:	10/13/2017
License Status:	REGULAR
Effective Date:	04/13/2020
Expiration Date:	04/12/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A ran out of pain medication because the staff neglected to make sure she had an adequate supply of her medications.	Yes

III. METHODOLOGY

04/30/2021	Special Investigation Intake 2021A0360023
05/03/2021	Special Investigation Initiated - Letter Email to APS
05/03/2021	APS Referral
05/06/2021	Inspection Completed On-site Home manager Danielle Duchame
05/06/2021	Contact - Face to Face Resident A, Relative 1-A
05/21/2021	Contact - Telephone call made DCS Sara Nelson
05/24/2021	Exit Conference With licensee designee Paul Meisel

ALLEGATION: Resident A ran out of pain medication because the staff neglected to make sure she had an adequate supply of her medications.

INVESTIGATION: On 4/30/2021 I was assigned a complaint from the LARA online complaint system.

On 5/3/2021 I completed an adult protective services referral.

On 5/6/2021 I conducted an unannounced on-site inspection at the facility. The home manager Danielle Duchame, stated Resident A ran out of her PRN (as needed) pain medication Oxycodone 5 mg. She stated Resident A requires a new prescription from the doctor every month. She is then provided a month's supply of 90 pills and can take up to 3 per day as needed. Ms. Duchame stated on 4/24/2021 Resident A only had 6 pills left. She stated her medication coordinator Sara Nelson noted that Resident A only had 6 pills left for the month but did not initiate action to refill the prescription. She stated on 4/29/2021 Resident A ran out of Oxycodone and went without it. She stated on 5/3/2021 Resident A's nephew, Relative 1-A, discharged her from the home and she was admitted to Big Rapids Fields Assisted Living. She stated it was Ms. Nelson's responsibility as the medication coordinator to

make sure the medication was reordered and refilled prior to Resident A running out. She stated Ms. Nelson has been disciplined and as of 5/1/2021 is no longer the medication coordinator. Ms. Duchame provided me with a copy of Resident A's April Medication Administration Record which documented she was administered her last Oxycodone at 5:47 a.m. on 4/29/2021. She also provided me with a copy of a medication sheet that documented Resident A was down to 6 pills on 4/24/2021 and needed to be reordered.

On 5/6/2021 I conducted an unannounced on-site inspection at Big Rapids Fields Assisted Living. Resident A and Relative A were just leaving the facility to go to a dentist appointment. Relative A stated Resident A moved into Reed City Fields Assisted Living in January 2020. He stated Resident A has been on pain management for the past 15 years and is prescribed Oxycodone. He stated the expectation when she moved in was that Reed City Fields Assisted Living staff would reorder her pain medication. He stated he picked up Resident A last Thursday for the weekend and she was out of Oxycodone. He stated he ended up calling the doctor and pharmacy on Friday and was able to get a 15-day supply on Friday so Resident A only went one day without the pain medication, but she typically takes 2-3 Oxycodone for pain each day. He stated that a similar situation happened when Resident A first moved into the home in January. He stated he let that go but because it happened a second time, he decided to move Resident A to another facility.

On 5/21/2021 I contacted direct care staff Sara Nelson. Ms. Nelson stated that she was previously the medication coordinator for Reed City Fields Assisted Living. She stated she noticed on 4/24/2021 that Resident A only had 6 more Oxycodone pills. She stated she was distracted by other duties and did not call Resident A's nephew to assist in getting another prescription and refill for the medication. She stated on 4/29/2021 Resident A ran out of her Oxycodone medication. She stated she resigned as the medication coordinator and is now a direct care staff with no medication responsibilities.

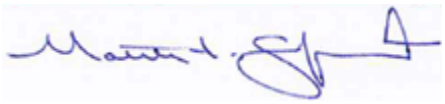
On 05/24/2021 I conducted an exit conference with the licensee Paul Meisel. Mr. Meisel concurred with the findings of the investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled

	Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complaint alleged that Resident A ran out of pain medication because the staff neglected to make sure she had an adequate supply of her medications. It was confirmed that Resident A ran out of prescription medication Oxycodone PRN on 4/29/2021. Reed City Fields Assisted Living medication coordinator Sara Nelson was responsible for facilitating the refill of the medication and did not refill. The home manager, Danielle Duchame stated Ms. Nelson has been removed as the medication coordinator due to her failure to ensure Resident A's Oxycodone did not run out. Relative 1-A stated he picked up Resident A on 4/29/2021 and she was out of Oxycodone. He stated he contacted the doctor and pharmacy and was able to receive a 15-day supply of Oxycodone for Resident A on 4/30/2021. There is a preponderance of evidence that Resident A was not administered her Oxycodone medication as prescribed due to running out of the medication on 4/29/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

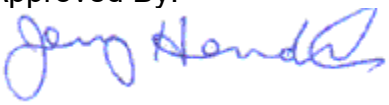
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



05/24/2021

Matthew Soderquist — Date
Licensing Consultant

Approved By:



05/25/2021

Jerry Hendrick — Date
Area Manager