GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2021

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

RE: License #: AL670384778
Investigation #: 2021A0360031
Reed City Fields Assisted Living II

Dear Mr. Meisel:

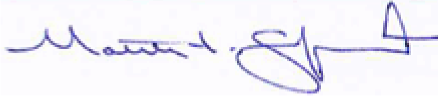
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2021A0360031
Complaint Receipt Date:	08/16/2021
Investigation Initiation Date:	08/17/2021
Report Due Date:	09/15/2021
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
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 ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medication on 8/13/2021.	Yes

III. METHODOLOGY

08/16/2021	Special Investigation Intake 2021A0360031
08/17/2021	Special Investigation Initiated - On Site Home manager Danielle Duchame, Resident A, B and C.
09/10/2021	Contact - Telephone call made DCS Melissa Richards
09/13/2021	Exit Conference With Paul Meisel

ALLEGATION: Resident A did not receive his medication on 8/13/2021.

INVESTIGATION: On 8/16/2021 I was assigned a complaint from the LARA online complaint system.

On 8/17/2021 I conducted an unannounced onsite inspection at the facility. The home manager Danielle Duchame stated on 8/13/2021 at around 8 p.m. direct care staff Melissa Richards accidentally locked the medication cart keys inside the cart. Ms. Duchame stated she received several phone calls and messages from staff about losing the keys, but she did not respond to the facility to make sure the medication cart was unlocked until the next morning on Saturday 8/14/2021. Ms. Duchame stated direct care staff Melissa Richards was unable to administer Resident A's 8 p.m., 10 p.m., and 3 a.m. medications. Ms. Duchame stated there were also two other residents who missed medication administration. She stated Resident B missed her 8 p.m. medications and Resident C missed her 8 p.m. medications. Ms. Duchame provided me with Resident A, B and C's medication administration records. Resident A's MAR documented on 8/13/21 he was not administered Baclofen 10 mg, Fish Oil 1200 mg, Ibuprofen 200 mg, Mag Oxide 400 mg, Metoprol Tar 25 mg, Nortriptylin 25 mg, Tramadol HCL 50mg, and Vitamin D3 5000 unit. Resident A was also not administered his 3 a.m. medication on 8/14/21 including Baclofen 10mg and Ibuprofen 200 mg. Resident B's MAR documented on 8/13/21 she was not administered Donepezil 10 mg, Memantine HCL 10 mg, Rosuvastatin 10 mg, Triamcinolon OIN 0.1%. Resident C's MAR document on 8/13/21 she was not administered Buspirone 7.5 mg, Eliquis 5 mg, Magnesium 500 mg, Memantine HCL 5 mg, Rosuvastatin 40 mg and Trazadone 50 mg. Ms. Duchame stated that all residents resumed their regularly schedule medications on 8/14/21. She stated she would be implementing a new procedure that if the

medication cart keys are lost or misplaced that there will be a back-up available to the medication coordinator.
While at the facility on 8/17/21 I interviewed Resident A. Resident A stated on 8/13/21 one of the staff locked the medication cart keys in the cart. He stated he missed his 8/13/21 8 p.m. and 10 p.m. medications. He stated he also was not administered his 3 a.m. medications on 8/14/21. I then interviewed Resident B. Resident B was not oriented to time and did not remember missing any medications. I then interviewed Resident C. Resident C stated she remembered the staff saying that they locked keys in the cart, but she was not sure which medications she missed.

On 9/10/21 I contacted direct care staff Melissa Richards. Ms. Richards stated she was the medication coordinator on 8/13/2021. She stated at around 8 p.m. on 8/13/21 she lost the keys to the medications cart. She stated she was unsure if she locked them in the cart or dropped them in the facility. She stated she looked through the entire facility and was unable to locate the keys. She stated she contacted the home manager to notify her that the keys were missing, and they needed another set to unlock the medications cart, but she never heard back from the home manager. She stated she was unable to administer the 8/13/21 medication for Residents A, B and C for 8 p.m. and 10 p.m. She stated she was unable to administer Resident A's 3 a.m. medication on 8/14/21.

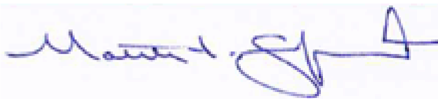
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The complaint alleged Resident A did not receive his medication on 8/13/2021. Direct care staff Melissa Richards stated on 8/13/21 she locked the medication cart keys into the cart at about 8 p.m. She stated she was unable to administer the 8 p.m. and 10 p.m. medications for Resident's A, B and C. She was also unable to administer Resident A's 3 a.m. medication on 8/14/21. Resident A, B and C's medication administration records documented the missed medications. Resident A stated he was not administered his 8 p.m. and 10 p.m. medications on 8/13/21 and did not receive his 3 a.m. medication on 8/14/21. Resident's B and C did not remember missing any medications.

	There is a preponderance of evidence that Resident A, B and C's medication was not administered as prescribed on 8/13/21 and 8/14/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/13/2021 I conducted an exit conference with the licensee designee Paul Meisel. Mr. Meisel concurred with the findings of the investigation.

IV. RECOMMENDATION

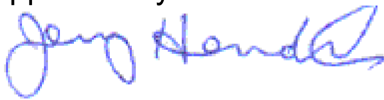
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



09/13/2021

Matthew Soderquist Date
Licensing Consultant

Approved By:



09/13/2021

Jerry Hendrick Date
Area Manager