GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2022

Erin Ottenbreit
CSL Rochester Master Operator, LLC
1450 West Long Lake, Suite 300
Troy, MI 48098

RE: License #: AH630387151
Investigation #: 2022A1019053
Cedarbrook Of Rochester

Dear Ms. Ottenbreit:

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 (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630387151
Investigation #:	2022A1019053
Complaint Receipt Date:	05/23/2022
Investigation Initiation Date:	05/24/2022
Report Due Date:	07/22/2022
Licensee Name:	CSL Rochester Master Operator, LLC
Licensee Address:	Suite 300 1450 West Long Lake Troy, MI 48098
Licensee Telephone #:	(248) 583-6020
Administrator:	Alfred Moschetta
Authorized Representative:	Erin Ottenbreit
Name of Facility:	Cedarbrook Of Rochester
Facility Address:	790 Letica Drive Rochester, MI 48307
Facility Telephone #:	(248) 583-6020
Original Issuance Date:	11/21/2019
License Status:	REGULAR
Effective Date:	05/21/2022
Expiration Date:	05/20/2023
Capacity:	85
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Improper supervision of Resident B.	Yes
The facility is insufficiently staffed.	No
Additional Findings	No

III. METHODOLOGY

05/23/2022	Special Investigation Intake 2022A1019053
05/24/2022	Special Investigation Initiated - Letter Emailed administrator requesting resident roster and employee schedules.
05/25/2022	APS Referral Notified APS of the allegations via email referral template.
05/25/2022	Comment Due to the COVID-19 pandemic, this investigation is being conducted remotely.
06/02/2022	Contact - Document Received Email received from APS worker S. Aldred informing that she is substantiating for neglect and improper supervision.
06/02/2022	Contact - Document Sent Emailed facility staff requesting documentation.
06/02/2022	Contact - Telephone call received Telephone call with Employee A and authorized representative to discuss allegations.
06/07/2022	Contact - Document Received All requested information has been provided by facility staff.
06/07/2022	Inspection Completed-BCAL Sub. Compliance
06/08/2022	Exit Conference

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Improper supervision of Resident B.

INVESTIGATION:

On 5/23/22, the department received a complaint that Resident B went missing from 11pm-6am the previous evening. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 6/2/22, a telephone call was had between licensing staff, authorized representative Erin Ottenbreit and Employee A. During the call, Employee A explained that Resident B is a memory care resident and acknowledged that he left the secured memory care unit and was found later in the assisted living area of the building. Employee A went on to state that Employee B was working in memory care and mistook Resident B for a visitor and voluntarily allowed him to leave the unit. Employee A stated that Resident B was out of the memory care unit and in the general assisted living area of the facility for a period of 5-6 hours (roughly from midnight to somewhere between 5-6am). Employee A stated that Resident B was discovered in the library by Employee C when he began his shift. Ms. Ottenbreit and Employee A stated that Resident B was unharmed and easily redirected back to the memory care unit. Employee A stated that hourly checks are to be conducted in memory care, but it went unnoticed that Resident B was not in his room.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference R 325.1901	**Definitions.**

	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Memory care staff mistakenly allowed Resident B to leave the secured unit resulting in him being unaccounted for overnight for several hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

The complaint alleged that the facility is understaffed. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

Employee A provided a copy of the facility census, which listed 48 residents (25 in general assisted living and 23 in memory care). Employee A reported that the facility schedules care staff on three eight-hour shifts and nursing staff on two twelve hour shifts. At the current census and resident acuity level, Employee A described staffing levels as follows:

To meet the resident's needs staffing is scheduled as follows:

Assisted Living
First/Day Shift (7am-3pm)– 2 staff members at least (1 Caregiver/CENA and 1 Med-Tech or Nurse)
Second/Afternoon Shift (3pm-11pm) – 2 staff members at least (1 Caregiver/CENA and 1 Med-Tech or Nurse)
Third/Night Shift (11pm-7am) – 1 staff member at least (1 Caregiver/CENA)

Memory Care
First/Day Shift (7am-3pm)– 3 staff members at least (2 Caregiver/CENA and 1 Med-Tech or Nurse)
Second/Afternoon Shift (3pm-11pm) – 3 staff members at least (2 Caregiver/CENA and 1 Med-Tech or Nurse)
Third/Night Shift (11pm-7am) – 2 staff members at least (1 Caregiver/CENA and 1 Med-Tech or Nurse)

Employee A reported that in addition to the staffing above and depending on the shift, there are other staff who are available to help out on the floor as needed (e.g., director of operations, director of nursing, scheduling and programming staff). Employee A added that there are other ancillary staff who take the burden of caregivers such as servers, housekeepers, dining room managers and maintenance staff.

Schedules were reviewed for April and May 2022. The schedules were overall consistent with Employee A's depiction and at times, had more staff than described. Employee A also provided an outline of the facility protocols to combat unforeseen employee absences. Employee A listed the following:

- *All Clinical and Administrative staff step in to offer support such as the DON, Executive Director, Business Office Director, Activities Director, Sales Director and Move In Coordinator. When available and on site we also have other support that step in to offer support such as the Director of Operations, Social Worker, and Dietitian.*
- *We call, text, or send out an OnShift notice for additional staff to pick up a shift and/or shifts. A bonus is offered as an incentive.*
- *We contact our Executive Director at our sister communities to see if they can offer additional support from their staffing pool.*
- *Staff who are currently at the community are asked to stay and cover until replacement staff are available to report to the community.*
- *Time flexible duties may be reassigned to another shift.*

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:	Attestations from facility staff, combined with review of employee schedules and employee coverage procedures reveal that staffing is consistently at the levels described by management staff as being necessary to meet current resident needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/8/22, I shared the findings of this report with authorized representative Erin Ottenbreit.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

06/07/2022

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/07/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section