GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

December 9, 2022

RE: License #: AH630387151
Investigation #: 2022A1022009
Cedarbrook Of Rochester

Dear Erin 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. 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.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630387151
Investigation #:	2022A1022009
Complaint Receipt Date:	07/06/2022
Investigation Initiation Date:	07/06/2022
Report Due Date:	09/05/2022
Licensee Name:	CSL Rochester Master Operator, LLC
Licensee Address:	Suite 300 1450 West Long Lake Troy, MI 48098
Licensee Telephone #:	(248) 583-6020
Administrator:	Lauren Costigan
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

The complainant identified a number of concerns that are not related to or addressed in 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.

	Violation Established?
In the memory care unit, there are uncovered electric outlets near the head of the bed, which could constitute a safety hazard.	No
Resident records are not current and contain erroneous data.	No
The Resident of Concern's (ROC) bill increased because the resident needed additional care, but the family was never informed of the ROC's care changes by the way of a care conference until just before the bill was due to be paid.	Yes
The ROC sustained a fall at 4:30 a.m., but the facility did not notify the family until 12:57 p.m.	Yes

III. METHODOLOGY

07/06/2022	Special Investigation Intake 2022A1022009
07/06/2022	Special Investigation Initiated - Telephone Phone call to complainant. Left message to call back.
07/07/2022	Contact - Telephone call made Spoke by phone with complainant
07/14/2022	Inspection Completed On-site
07/14/2022	APS Referral
08/23/2022	Contact - Document Received Additional documents from the facility received by email
12/06/2022	Exit Conference

ALLEGATION:

In the memory care unit, there are uncovered electric outlets near the head of the bed, which could constitute a safety hazard.

INVESTIGATION:

On 7/6/2022, the Bureau of Community and Health Systems received a written complaint that alleged there was a safety issue at the facility because there were uncovered electrical outlets located in the memory care unit rooms where residents with poor cognition could access them. When I interviewed the complainant on 7/7/2022, the complainant explained her concern that the Resident of Concern (ROC) lived in a room where the outlet was right at the head of her bed and that the ROC could place her finger into the outlet and be seriously injured due to an electrical shock or burn. The complainant said, “We cover electrical outlets for young children. Why wouldn’t we do the same for elderly folks who might not realize that it could be dangerous?”

On 7/14/2022, a referral was sent to Adult Protective Services.

On 7/14/2022, during the onsite visit, I toured the room where the ROC had lived. There was an electrical outlet on the wall and depending on how a hospital bed was placed in the room, the outlet would be flush with the head of the mattress. The administrator explained that the ROC had left the building before she became the administrator and was not sure where the ROC’s bed was located. According to the administrator, residents and family members were free to place the bed however they thought would be most comfortable for the resident.

When the administrator was asked about the availability of electrical outlet covers in resident rooms, the administrator stated that the facility would be more than willing to provide covers on request. The complainant stated that this had not been an issue she brought to the facility’s attention while the ROC had lived in that building. The ROC had left in February 2022.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(1) A building shall be of safe construction and shall be free from hazards to residents, personnel, and visitors.
ANALYSIS:	The facility had safety measures that could be deployed for any resident assessed to be not safe around electrical outlets.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident records are not current and contain erroneous data.

INVESTIGATION:

The ROC's medication list dated 11/18/2021 was included with the written complaint. The medication list identified the ROC's physician as physician #1 and the ROC's code status as "Resuscitate." According to the complainant, these two items from the ROC's health record were incorrect. The complainant stated that the ROC's status should not have ever been entered as "Resuscitate," because when the ROC had been admitted in July 2020, the family informed the facility that the ROC's status was DNR (Do Not Resuscitate) and that had never changed. The complainant went on to say the physician #1 was not the ROC's doctor, her doctor was physician #2. A second medication listing for the ROC, dated 1/14/2022, also incorrectly identified physician #1 as the ROC's doctor, although the code status had been changed to DNR.

During the onsite visit, 7/14/2022, I interviewed the administrator and director of nursing (DON). When I asked them about the facility's record keeping system, the DON explained that they utilized an electronic record. If some aspect of the record was changed in the electronic file, that the changed aspect, such as the physician or the code status would be reflected throughout the entire file.

When specifically asked about the ROC's documented code status, the administrator stated that they had no official record of the ROC being any code status other than "Resuscitate" before January 2022. According to the admission contract signed by Family Member (FM) #1, as the Power of Attorney (POA) for the ROC, dated 7/6/2020, the family acknowledged the facility's policy: "It is Cedarbrook's policy to have physicians clearly document orders for withholding or withdrawing treatment, including DNR orders, in the Resident's health record." According to the administrator, the only DNR order received for the ROC was dated 1/16/2022.

When asked about the listing for the physician, the administrator explained that the facility had used physician #1 as their contracted medical services provider until the spring of 2021, when they switched to physician #2; however, residents and families could choose to remain with physician #1 if they wished. According to an Authorization for Medical Treatment consent, on 4/22/2021, FM #1 agreed to authorize physician #2 as the medical provider for the ROC. Physician #2 entered progress notes for the ROC dated 6/1/2021, 6/21/2021, 7/12/2021, 8/31/2021, 10/13/2021, and 11/17/2021. At the time of these visits, physician #2 made changes to the ROC's medications as well as ordered diagnostic testing.

It was not clear why physician #1's name appeared in the health record for dates after April 2022.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	The ROC's code status was documented accurately but the physician's name was not. However, having the incorrect physician's name on the medication list did not impede physician #2 from providing medical care to the ROC. It apparently was a clerical error.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The ROC's bill increased because the resident needed additional care, but the family was never informed of the ROC's care changes by the way of a care conference until just before the bill was due to be paid.

INVESTIGATION:

On 7/7/2022, when the complainant was interviewed by phone, she was informed that billing issues were not related to or addressed in licensing rules and statutes for a home for the aged and would not be considered in the investigation; however, that did not change the facility's obligation to involve either the resident (when appropriate) and/or responsible family members in formulating their service plan.

At the time of the onsite visit, the administrator and the DON were asked to describe the facility's process for ensuring service plan input from residents if they were capable of providing input and responsible family members. According to both the administrator and the DON, when a resident had a status change that required a change in the service plan, they would hold a care conference to involve the family or resident.

Review of the ROC's service plan revealed three significant changes to the ROC's service plan:

- On 9/3/2021, the ROC was deemed to be totally dependent on care staff for dressing.
- On 10/25/2021, after sustaining a fall, the ROC was deemed to be totally dependent on care staff for bathing and transfers.

- On 12/23/2021, the facility deemed that the ROC needed a mechanical lift for transfers.

When the administrator and the DON were asked to produce documentation that showed the resident's family members were consulted or informed of these changes to the ROC's service plan, the facility provided a "Resident Assessment" form, dated 10/25/21, that indicated a family member was "notified." Although the form was marked "Daughter," there was no name, no date, nor any further indication of what information was provided to the family member. The facility did not provide any documentation that indicated family members had been informed or consulted on changes made on either 9/3/2021 or 12/23/2021.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Changes were made to the ROC's service plan without the input of the ROC's family members.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC sustained a fall at 4:30 a.m., but the facility did not notify the family until 12:57 p.m.

INVESTIGATION:

According to the complainant, on 10/25/2021, the ROC sustained a fall at 4 am, but the facility did not call her until almost 1 pm.

During the onsite visit, the administrator and the DON were asked to describe their policy for notifying family members if a resident falls. According to the DON, the care staff member is to immediately notify either the nurse or medication technician, the physician, and the family member, preferably the family member designated as POA. The DON went on to say that even if the incident occurs in the middle of the night, the staff is to call the POA.

According to the incident report, dated 10/25/2021, the ROC fell at 4:40 a.m. The incident report documented that the physician was notified at 11:55 a.m., the manager on duty was notified at 11:58 a.m., and the complainant was notified at 12

p.m. There was no evidence that the care staff notified either FM #1 or FM #2, both designated as POA for the ROC.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The facility did not immediately notify the family members identified as the ROC's POA. After almost 8 hours, the facility notified the complainant, who was not the ROC's POA.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 12/06/2022. When asked if there were any comments or concerns with the investigation, the AR stated that she questioned the violations, but after discussions she stated that her concerns were satisfied.

IV. RECOMMENDATION

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

12/09/2022

Barbara Zabitz Date
Licensing Staff

Approved By:

12/02/2022

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