GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

Jody Linton
Red Cedar Senior Living Holdings, LLC
150 East Broad Street
Columbus, OH 43215

RE: License #: AH330405755
Investigation #: 2025A1021004
Red Cedar Lodge

Dear Jody Linton:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330405755
Investigation #:	2025A1021004
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/14/2024
Report Due Date:	12/13/2024
Licensee Name:	Red Cedar Senior Living Holdings, LLC
Licensee Address:	150 East Broad Street Columbus, OH 43215
Licensee Telephone #:	(614) 221-1818
Administrator:	Abigail Mulholland
Authorized Representative:	Jody Linton
Name of Facility:	Red Cedar Lodge
Facility Address:	210 Dori Lane Lansing, MI 48912
Facility Telephone #:	(517) 348-0226
Original Issuance Date:	10/07/2022
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	155
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Call lights are not answered properly.	No
Incidents not reported.	Yes
Resident A received incorrect medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A1021004
10/14/2024	Special Investigation Initiated - Letter reached out to complainant on complaint
10/16/2024	Inspection completed on site
10/22/2024	Contact-Telephone call made Interviewed SP2
10/24/2024	Inspection completed on site
10/25/2024	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. 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:

Call lights are not answered properly.

INVESTIGATION:

On 10/14/2024, the licensing department received a complaint with allegations call lights are not answered properly. The complainant alleged in early June 2024, Resident A called family because staff were not responding to his call light. The complainant alleged a staff member reported to family that an employee was informed approximately 45 minutes ago that Resident A requested assistance. The

complainant alleged staff members report the call lights are answered but then are transferred to another staff member to respond to the need for assistance.

On 10/16/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported call lights are answered in a timely manner. Ms. Mulholland reported the only instance in which call lights are transferred to another employee is if the resident requires medication and the employee is not a trained medication technician.

On 10/16/2024 I interviewed staff person 4 (SP4) at the facility. SP4 reported she has heard but has not observed employees clearing the call light, but not helping the resident. SP4 reported she does not believe it is a common occurrence.

On 10/16/2024, I interviewed SP5 at the facility. SP5 statements were consistent with those made by SP5.

On 10/16/2024, I interviewed Resident A at the facility. Resident A reported he is happy with the staff at the facility.

On 10/23/2024, I interviewed Resident B at the facility. Resident B reported care staff answer call lights in a timely manner. Resident B reported no concerns with care staff not responding quickly.

While onsite, I observed call lights answered, and assistance was provided to the residents.

I reviewed Resident A's call light response times. The report revealed on average Resident A's call light response time was five minutes.

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.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and

	personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Incidents not reported.

INVESTIGATION:

The complainant alleged on 05/02/2024, Resident A experienced chest pain, administered Norco, and emergency medical services responded to the facility. The complainant alleged on 10/07/2024, Resident A had a fall in his bathroom. The complainant alleged both times family was not contacted regarding these incidents.

Ms. Mulholland reported on 05/02/2024, Resident A was his own person and was independent. Ms. Mulholland reported the facility does not have to contact family if the resident is their own person. Ms. Mulholland reported on 10/07/2024, Resident A did have a fall and SP2 assisted Resident A off the floor. Ms. Mulholland reported vitals were taken and Resident A had no injuries. Ms. Mulholland reported SP2 is a newer employee and did not appropriately follow protocol by informing the medication technician of the incident. Ms. Mulholland reported the facility has completed re-education with SP2.

I reviewed Resident A's observation notes. The observation notes read,

"05/02/2024 Resident altered staff via pendent stating he had taken 3 nitroglycerin tablets d/t severe chest pain (10/10). EMS called and arrived to perform a EKG. EMS reported no concerns with EKG results however advised resident to be transported to ER for eval. Resident refused transport d/t no longer experiencing chest pain and vitals being WNL. WD notified, will report to oncoming shift for wellness checks throughout the night.
10/07/2024: I was responding to 428's pendent call. When I went into his room, he was on the floor his back against the bathroom sink. He said he just slid down and wasn't in any pain and wanted to get up and go to bed. So I assisted him back to bed. he said that he is feeling really weak in the legs and that's why he fell. His vitals were,
BP 112/63; Temp 98.4; Heart Rate 91; O2 96; Respirations 18; Location resident's bathroom"

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
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ANALYSIS:	Interviews conducted and review of documentation revealed the facility did not act in accordance with their own internal policy as the facility did not notify the appropriate parties.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A received incorrect medications.

INVESTIGATION:

The complainant alleged Resident A had incorrect medication orders and received the following medications:

- September 21, 2024, the medication technician brought the incorrect dosage of Hydroxyurea for nighttime medications.
- September 28, 2024, and September 30, 2024, the medication technician brought Gabapentin 100mg instead of the prescribed 200mg for the midday dose.
- October 2, 2024, the medication technician brought in 100mg of Gabapentin, instead of the 200mg ordered for the midday dose.
- October 6, 2024, 10-hour gap in between Gabapentin doses.

Ms. Mulholland reported Resident A is active with Sparrow Home Hospice. Ms. Mulholland reported at times the hospice registered nurse has communicated medication changes to the family but has not communicated medication changes to the facility. Ms. Mulholland reported the hospice companies are to complete the 3rd party communication form that is located at the receptionist desk, however, often Sparrow Home Hospice will not complete this form. Ms. Mulholland reported all medication changes must be placed in an order and the facility cannot accept a verbal order. Ms. Mulholland reported management at the facility is now calling Sparrow Hospice twice weekly to ensure medication orders are correct.

SP1 reported she was informed that the hospice company had faxed orders to the main fax line located on the main level of the facility. SP1 reported the facility did not receive any faxes from Sparrow Hospice. SP1 reported there was confusion with the Hydroxyurea order as Resident A receives a different dose on the weekends. SP1 reported the order is now separated out to make it less confusing for the medication technicians.

<u>September 28, 2024, the medication technician brought Gabapentin 100mg instead of the prescribed 200mg for the midday dose.</u>

I reviewed Resident A's medication administration record (MAR) for September 2024. The MAR revealed Resident A was prescribed Gabapentin Oral Capsule 100mg. The order read, "*Take 100mg in the am, 200mg at 2pm, and 200mg at bedtime.*" On 09/24/2024 and 09/30/2024, the Gabapentin 100mg dose was separated out to reflect the 100mg dose at 8:00am and 200mg dose at 2:00pm and 10:00pm.

<u>October 2, 2024, the medication technician brought in 100mg of Gabapentin, instead of the 200mg ordered for the midday dose.</u>

I reviewed Resident A's MAR for October 2024. The MAR revealed Resident A was prescribed Gabapentin Oral Capsule 100mg with instruction to take 100mg in the am. On 10/02/2024, the order was revised to reflect one capsule at 8:00am, and a dosage of two capsules at midday and in the evening.

<u>September 21, 2024, the medication technician brought the incorrect dosage of Hydroxyurea for nighttime medications</u>

I reviewed Resident A's medication administration record (MAR) for September 2024. The MAR revealed Resident A was prescribed Hydroxyurea Oral Tab 500mg with instruction to administer two capsules by mouth at bedtime. This medication was administered on 10/17/2024-10/30. However, on 09/21/2024, Resident A refused this medication and stated "*2nd tab resident states he only takes 1 tab in the evening on Sat. and Sun."*

I reviewed Resident A's MAR for October 2024. The MAR revealed Resident A was prescribed Hydoxyurea Oral Capsule 500mg with instructions to administer two capsules by mouth at bedtime all days expect Sat and Sun. The MAR revealed on 10/12, 10/13, 10/19, 10/20, 10/26, and 10/27, Saturdays and Sundays, the order was grayed out to prevent the medication technician from administering this medication. The MAR also revealed Resident A was prescribed Hydroxyurea Oral Capsule 500mg with instruction to administer one cap on Saturday and Sunday. This order was written on 10/08/2024.

<u>October 6, 2024, 10 hour gap in between Gabapentin doses.</u>

The complainant alleged Resident A's family was in the facility on 10/06/2024. The complainant alleged the mid-day dose was not administered in the afternoon and was administered around 6:00pm. The complainant alleged there was a 10-hour gap of time in between Gabapentin doses.

On 10/22/2024, I interviewed SP3 by telephone. SP3 reported at times she is the only medication technician on the assisted living portion of the facility. SP3 reported it is manageable and residents receive correct medications. SP3 reported there is a one-hour window before and after the prescribed medication time to administer the medications. SP3 reported no knowledge of Resident A not receiving medications or an extended period of time in the medication administration.

I reviewed Resident A's *Medication Edit History Report*. The report revealed on 10/06/2024, Resident A received Gabapentin at 8:15am, 4:33pm, and 10:01pm.

Resident A's October MAR revealed Resident A was prescribed Gabapentin at 8:00am, 3:30pm, and 10:00pm.

I reviewed Resident A's MAR and *Medication Edit History* Report. The reports revealed on 10/09/2024, Resident A did not receive evening medications of Atorvastatin Oral Tablet, Eliquis Oral Tablet, Gabapentin Oral Capsule, and Hydroxyurea Oral Capsule.

APPLICABLE RULE	
R 325.1932	**Resident medications.**

	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of Resident A's MARs and daily log notes revealed the following medication errors occurred: Resident A was to receive a different dose of Hydroxyurea medication on Saturdays and Sundays. Resident A expressed this to the medication technician on 09/21/2024. However, the medication order was not changed until 10/01/2024 and then the order was separated out on 10/08/2024. The facility did not act timely to ensure the correct dosage was reflected from 09/21/2024-10/01/2024. Resident A did not receive evening medications on 10/09/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interviews conducted revealed Resident A is active with Sparrow Hospice services for RN and bath aid services.
Review of Resident A's service plan read,
"*McLaren Phone Number.*
Shower full assistance: Sunday and Wednesday.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Resident A's service plan revealed Resident A's service plan was not correctly updated to reflect the current care needs of Resident A. **REPEAT VIOLATION: AH330405755_SIR_2024A1021053; corrective action plan dated 05/23/2024;**

	AH330405755_SIR_2024A1021048; corrective action plan dated 05/15/2024; AH33045755_SIR_2024A1021015 corrective action plan dated 12/17/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of SP2 employee record revealed SP2 was hired 09/05/2024, however, SP2 had not completed new employee orientation.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: (a) Reporting requirements and documentation. (b) First aid and/or medication, if any. (c) Personal care. (d) Resident rights and responsibilities. (e) Safety and fire prevention. (f) Containment of infectious disease and standard precautions. (g) Medication administration, if applicable.
ANALYSIS:	The facility was unable to demonstrate that SP2 completed new employee training. **REPEAT VIOLATION: AH330405755_SIR_2024A1021011; corrective action plan dated 12/17/2023.**
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/23/2024, I interviewed authorized representative Jody Linton at the facility. Ms. Linton reported when a new employee is hired, the employee completes a two-day orientation training. Ms. Linton reported the new employee is then placed with a trainer on the floor for at least two days. Ms. Linton reported the training can be longer if the new employee requires additional training. Ms. Linton reported there is

no documentation of this training process or that the employee is competent in care tasks.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	Review of the facility training process revealed the facility's administrator, or its designees do not evaluate new employee's competencies. **REPEAT VIOLATION: AH330405755_SIR_2024A1021011; corrective action plan dated 12/17/2023.**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

Kimberly Horst 10/24/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/21/2024

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