GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 5th, 2025

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

RE: License #: AH330405755
Investigation #: 2025A1021040
Red Cedar Lodge

Dear Jody Linton:

Attached is the Special Investigation Report for the above referenced facility. The violations established in this report were handled through the corrective notice order dated November 25, 2024.

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

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 #:	2025A1021040
Complaint Receipt Date:	03/04/2025
Investigation Initiation Date:	03/04/2025
Report Due Date:	05/03/2025
Licensee Name:	Red Cedar Senior Living Holdings, LLC
Licensee Address:	150 East Broad Street Columbus, OH 43215
Licensee Telephone #:	(614) 221-1818
Administrator:	Patricia Laugavitz
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are treated disrespectfully.	No
Resident A had a fall.	Yes
Resident A was not assisted with incontinence care nor checked on.	Yes
Resident A did not receive a shower.	No
Medication administered incorrectly.	No
Residents are not assisted during mealtimes.	No
Trash is not taken out.	No
Additional Findings	No

III. METHODOLOGY

03/04/2025	Special Investigation Intake 2025A1021040
03/04/2025	Special Investigation Initiated - On Site
03/10/2025	Contact- Telephone Call Made Interviewed SP5
03/13/2025	Contact-Documents Received
03/26/2025	Exit Conference
03/28/2025	Additional Information Received
04/15/2025	Contact-Inspection completed on site
05/05/2025	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:

Residents are treated disrespectfully.

INVESTIGATION:

On 03/04/2025, the licensing department received a complaint with allegations that residents are not treated respectfully. The complainant alleged that on second shift, caregivers have lost their patience and yell at the residents.

On 03/04/2025, I interviewed staff member 1 (SP1) at the facility. SP1 reported she has not had any concerns brought to her attention about caregivers treating residents disrespectfully. SP1 reported there were concerns about new staff working in the unit and now the facility has only one new worker in the unit at a time. SP1 reported the facility has cameras in the common areas but the cameras have no sound.

On 03/04/2025, I interviewed SP4 at the facility. SP4 reported the facility recently implemented a compassionate line for anonymous concerns and the facility has not received any concerns. SP4 reported no concerns with employee behaviors have been brought to her attention.

On 03/04/2025, I interviewed administrator Patricia Laugavitz at the facility. Administrator reported care concerns on second shift have not been brought to her attention.

On 03/04/2025, I observed resident and staff members interactions. I observed staff members assisting residents with the meal service, activities, and were actively engaged with the residents.

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 a lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had a fall.

INVESTIGATION:

The complainant alleged Resident A had a fall on 02/23/2025 around 04:00am, per footage on the camera in Resident A's room. The complainant alleged Resident A was on the floor for over two hours.

SP1 reported Resident A is to be checked every two hours. SP1 reported Resident A is to be physically checked every two hours and is to be physically taken to the restroom at 03:00am.

SP2 reported per the incident report, family contacted the facility on 02/23/2025 that Resident A was on the floor. SP2 reported Resident A's family has a nanny camera and was able to view Resident A on the floor. SP2 reported Resident A has a fall alarm and a bed alarm. SP2 reported families are responsible for ensuring these alarms are functioning, not the facility. SP2 reported staff members will hear the alarms but are not responsible for ensuring the alarms are set and working.

SP3 reported Resident A does have two alarms in her room. SP3 reported she will occasionally test the alarm to ensure it is working.

On 03/10/2025, I interviewed SP5 by telephone. SP5 reported when Resident A fell, she was the medication technician on both units. SP5 reported when she came into memory care at around 6:30am, she was told Resident A was on the floor. SP5 reported per the family, Resident A was on the floor at 4:00am. SP5 reported she assisted Resident A off the floor, took vitals, and initiated 15-minute checks. SP5 reported Resident A is to be checked every two hours and taken to the bathroom at 3:00am. SP5 reported this is documented in the electronic medical record (EMR). SP5 reported Resident A has two alarms in her room, but the alarms did not sound. SP5 reported Resident A's family always put Resident A to bed and ensure the alarms are working.

I reviewed the facility incident report for the fall on 02/23/2025. The incident report read,

"CG called MT informing her (Resident A) was on the floor. Per CG resident's daughter informed CG that resident was on the floor since 4AM, CG informed family that alarm did not go off so she did not understand how she was on the floor since 4AM. MT walked into resident's room she was found sitting on the floor facing the recliner feet straight out. MT asked resident if she hit her head but resident does not remember. MT did skin and head assessment no skin tear, redness or bump on resident's head. Resident's vitals were taken at 6:46am BP 139/60, HRT 59 O2 94, and temp 97.3. CG and MT stood resident up from the floor and sat in her recliner with legs up and pillow under her knees. MT checked residents eye noticed resident had a slow response to the light. Second vitals were at 7:12am BP 115/64, O2 96%, HRT 55. Temp was 96.2. Resident was asked if she was in any pain resident said no, information was passed on to morning shift and informed them about the neuro checks."

Resident A's care plan read,

"(Resident A) has sustained multiple falls. To help keep her safe, she is utilizing her bed in its lowest position, she has a safety pad to alert staff she may be getting up, and through the night she is checked on every 2 hrs and as needed for incontinence care. Attempt to anticipate her needs and intervene before she attempts to get up unassisted."
"Safety checks at least 2 restroom breaks at night PRN. 11:00pm, 12:00am, 1:00am, 2:00am, 3:00am, 4:00am, 5:00am."
Incontinence Assistance: Caregivers will provide assistance with incontinent care as needed. Monitor skin and report any redness or rash to WD. 12:00am, 2:00am, 4:00am, 6:00am."

I reviewed Resident A's medicaiton administration record (MAR) for February 2025. The MAR revealed Resident A was to be assisted with toileting at 3:00am. There were no staff initials that this occurred on 02/23/2025 at 3:00am.

I reviewed *Recorded Care Report* for 02/23/2025 12:00am-11:59pm. The report revealed Resident A was scheduled for fall risk intervention at 12:00am and this was updated on at 4:28am. The report revealed Resident A was scheduled for incontinence assistance at 12:00am, 2:00am, 4:00am, and 6:00am. All these events were updated at 4:28am. The report revealed Resident A was scheduled for safety checks at 12:00am, 1:00am, 2:00am, 3:00am, 4:00am, 5:00am, 6:00am. All these events were updated at 4:28am, which is not in real time of when the events occurred.

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:	Interviews conducted and documents reviewed revealed Resident A is to be taken to the restroom at 3:00am, checked on every two hours, and has fall alarms in place due to recent falls. On 02/23/2025, it was not documented that she was taken to the restroom at 3:00am. Also, Resident A is scheduled for incontinence assistance, safety checks, and fall risk monitoring at various times throughout the night. All of these events were documented as being completed at the same time, including some of which were documented as being completed before the event was to occur. In addition, caregivers are aware that Resident A has fall alarms, however, there is no organized program of protection to ensure the alarms in good working condition.
CONCLUSION:	**VIOLATION ESTABLISHED** **Corrective action was handled through the Corrective Notice Order dated November 25, 2024.**

ALLEGATION:

Resident A was not assisted with incontinence care nor checked on.

INVESTIGATION:

The complainant alleged Resident A was not checked on appropriately during the daytime hours on 02/20/2025- 02/22/2025. The complainant alleged care staff at times only provided meals and medications. The complainant alleged bathroom assistance was not provided to Resident A. The complainant alleged Resident A has had multiple urinary tract infections (UTI's) due to staff not cleaning Resident A properly.

SP1 reported Resident A has had UTI's and it is a chronic condition with Resident A. SP1 reported Resident A is incontinent. SP1 reported Resident A does not have any skin breakdown. SP1 reported Resident A does receive good care at the facility and is cleaned properly.

SP2 reported Resident A is to be checked every two hours and Resident A's family wants Resident A to be taken to the restroom at the time of each check.

SP5 reported Resident A is to be checked and changed every two hours. SP5 reported to her knowledge, this is completed.

On 03/07/2025, I interviewed SP6 by telephone. SP6 reported Resident A is to be checked on every two hours and taken to the restroom.

I reviewed Resident A's *Recorded Care Report* for 02/20-02/22 for the daytime hours. The report revealed caregivers did not document that incontinence assistance was provided every two hours. Review of the documentation revealed the time taken was *"N/A."*

Resident A's care plan read,

"Caregivers will provide assistance with incontinence care as needed. Monitor skin and report any redness or rash to WD."
This was to be completed 12 times a day, at 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am.

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 lack of detail on the level of assistance Resident A required with bathroom needs. It does not specify that Resident A is to be physically taken to the restroom every two hours. In addition, it does not describe the level and type of assistance Resident A requires and if Resident A can complete any portion of the activity. In addition, review of facility documentation revealed at times caregivers did not accurately document that incontinence care was provided.
CONCLUSION:	**VIOLATION ESTABLISHED** **Corrective action for clarification of the service plan was handled through the Corrective Notice Order dated November 25, 2024.**

ALLEGATION:

Resident A did not receive a shower.

INVESTIGATION:

The complainant alleged on 02/21/2025 and on 02/24/2025, Resident A did not receive a shower.

SP1 reported Resident A is scheduled to receive a shower twice a week, on Monday and Thursday. SP1 reported in memory care, they were having overnight staff start to get residents up and ready for the day to assist with dayshift. SP1 reported on these days that this occurred, the overnight staff did not know that Resident A was scheduled for a shower. SP1 reported when dayshift came in for the day, Resident A was already up and dressed for the day and refused a shower. SP1 reported in the memory care, they are no longer having overnight staff get residents up due to miscommunication with showers and residents refusing showers.

I reviewed Resident A's *Recorded Care Report* for showers for February 2024. The report revealed Resident A received a shower on 02/03, 02/06, 02/07, 02/10, 2/11, 02/17, and 02/18. Resident A did not receive a shower on 02/13, 02/20, and 02/24. It was noted on 02/20/2025 and 02/24/2025, Resident A did not receive a shower because Resident A was up and dressed when the first shift came in.

Resident A's service plan read:

"Care partners to provide extensive physical assistance for all bathing. Care partners to check skin with bath/shower and report any redden/open areas to nurse. Monday and Thursday."

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Review of facility documentation revealed Resident A did ensure Resident A was offered a shower at least once weekly. Interviews conducted revealed at times, Resident A would be dressed for the day by third shift caregivers and then Resident A would refuse a shower which was reflected in facility documentation.

CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ALLEGATION:

Medication administered incorrectly.

INVESTIGATION:

The complainant alleged Resident A was prescribed an antibiotic that was to be taken with food. The complainant alleged on 02/18/2025, Resident A was administered antibiotic without food and then vomited the medication up.

SP1 reported when the facility received the prescription order, there were no instructions for the medication to be taken with food and this request came from Resident A's family. SP1 reported there was an observation note, and shift change communication created for medications to be taken with the food and this was communicated to staff. SP1 reported reviewing the medicaiton administration time, this medicaiton was given to Resident A after meal times.

I reviewed Resident A's MAR for February 2025. The MAR read,

"Nitrofurantoin Macrocrystal Oral Capsule 100mg with instruction to take one capsule by mouth twice daily for 10 days." The medication was administered 02/14/2025-02/23/2025

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

"02/18/2025: Please hold meds until resident has eaten or had protein shake to prevent upset stomach and vomiting."

I reviewed Resident A's MAR times. The report revealed this medicaiton was administered on 02/14-02/23 around 8:40am-9:50am. In addition, after the observation note was written on 02/18/2025, the medicaiton administration time was later in the morning.

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 the review of documentation revealed lack of evidence to support this allegation.

CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ALLEGATION:

Residents are not assisted during mealtimes.

INVESTIGATION:

The complainant alleged on second shift residents are not assisted during mealtimes. The complainant alleged care staff do not always get residents out of their rooms to eat. The complainant alleged family members assist residents to eat. The complainant alleged care staff do not assist Resident A with utensils or help Resident A start to eat. The complainant alleged on 02/20/2025, Resident A was not assisted with eating breakfast in her room.

SP1 reported Resident A does require some assistance to eat. SP1 reported that if Resident A is encouraged, she will eat more. SP1 reported Resident A does require food to be cut up.

On 03/04/2025, I interviewed SP2 at the facility. SP2 reported Resident A does require assistance with eating. SP2 reported when meals were delivered to Resident A's room, staff members were to assist Resident A with eating.

On 03/04/2025, I interviewed SP3 at the facility. SP3 reported Resident A's meats are to be cut up. SP3 reported that when meals were delivered to Resident A's room, caregivers were to assist with eating.

On 04/15/2025, I interviewed SP5 at the facility. SP5 reported Resident A does require food to be cut up but does not require 1:1 feeding assistance.

While onsite at the facility, I observed a meal service. I observed the caregivers in the dining room actively engaged with the residents. I observed caregivers assisting residents with eating.

I reviewed Resident A's care plan. The care plan read,

"Requires occasionally cueing and encouragement to eat. Offer hand over hand assistance to start. She requires full set up and over sight. Cut up meats, remind resident to take drinks in between."

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary

	allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ALLEGATION:

Trash is not taken out.

INVESTIGATION:

The complainant alleged on multiple days the trash is not taken out of Resident A's room.

SP1 reported care staff and housekeeping are responsible for removing trash from residents' room. SP1 reported no knowledge of employees not removing trash from residents' rooms.

On 03/04/2025, I observed the trash in Resident A's room. The trash bins were not full and appeared to be emptied out earlier in the day.

I observed the memory care unit. I did not observe any overfilling trash bins.

APPLICABLE RULE	
R 325.1972	**Solid Wastes.**
	(1) All garbage and rubbish shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

IV. RECOMMENDATION

The violations established in this report will be handled within the corrective notice order.

05/05/2025

Kimberly Horst Date
Licensing Staff

Approved By:

05/05/2025

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