GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 26, 2025

Nozmi Elder
Cedar Woods Assisted Living
44401 I-94 S Service Dr
Belleville, MI 48111

RE: License #: AH820304947
Investigation #: 2025A1035039
Cedar Woods Assisted Living

Dear Nozmi Elder:

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 feel free to 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 (517) 284-9730.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820304947
Investigation #:	2025A1035039
Complaint Receipt Date:	03/04/2025
Investigation Initiation Date:	03/06/2025
Report Due Date:	05/03/2025
Licensee Name:	Willow Commons, LLC
Licensee Address:	44401 I-94 S. Service Dr. Belleville, MI 48111
Licensee Telephone #:	(734) 699-2900
Administrator:	Nozmi Elder
Authorized Representative:	Robin Wojtowicz
Name of Facility:	Cedar Woods Assisted Living
Facility Address:	44401 I-94 S Service Dr Belleville, MI 48111
Facility Telephone #:	(734) 699-2900
Original Issuance Date:	05/21/2010
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	210
Program Type:	ALZHEIMERS AGED

II. METHODOLOGY

03/04/2025	Special Investigation Intake 2025A1035039
03/06/2025	Special Investigation Initiated - Letter
03/11/2025	Contact - Face to Face
03/25/2025	Inspection Complete BCAL Sub Compliance.
03/26/2025	Exit Conference.

ALLEGATION:

Resident A experienced multiple falls at the facility and had several areas of skin breakdown.

INVESTIGATION:

On March 4, 2025, the Department received a complaint through the online complaint system which read:

> "In March 2024, Resident A fell when they were going to bathroom and had to get staples in her head. In April Resident A was sent to hospital for open wound on left heel. Resident A had another open wound on her right heel and had to go to the hospital again. Resident A was admitted again and had an open wound on her side and heel."

On March 5, 2025, a phone interview was conducted with Complainant. Complainant states Resident A had bilateral heel pressure ulcers and a pressure ulcer on her buttocks that formed at Cedar Woods Assisted Living. Resident A had multiple falls that required hospital visits and rehabilitation services at a rehab center. Post rehabilitation services Resident A returned to the facility with home care nursing services 1 x per week and therapy services. Complainant states the facility failed to reposition Resident A and implement preventative measures to reduce fall occurrences and prevent or limit skin breakdown. On October 3, 2024, Resident A was taken to a local hospital for further evaluation of wounds on bilateral heels and buttock. Complainant provided that Resident A expired October 5, 2024.

On March 11, 2025, an onsite investigation was conducted. While onsite, I interviewed Robin Wojtowicz Administrator who states the facility currently has one resident receiving wound care services, this resident is currently at the hospital and

not expected to return. Administrator states Resident A was receiving wound care services by home care nurse and outpatient wound care clinical. Family A often took Resident A home for day visits and transported Resident A to wound care appointments. Administrator states the home “did not have anything to do with” Resident A’s wounds. Administrator provided incident and accident investigation forms for all fall occurrences stating all investigations are worked on collaboratively with the team.

While onsite, I interviewed Staff Person 1 (SP1) who states she is unaware of the company Resident A was receiving wound care services through, that the family addresses all appointments and additional care.

Through record review of shower sheets for March 2024 through September 2024, no documentation noted related to increased redness to bilateral lower legs, when the resident experienced cellulitis, and bilateral heels and buttock breakdown. Shower sheet section “body assess” noted with check marks on occasion without further documentation of any skin abnormalities or breakdown.

Through record review of the service plan dated February 19, 2024, noted that the skin area only provided care staff with the fact that Resident A has hair/scalp ointment. Resident A’s service plan has minimal information related to care required to meet the Resident’s needs, including when to reach out to the home care provider on wound related concerns. The service plan was not updated to identify pressure ulcers to bilateral heel and buttocks, no preventative measures for falls nor pressure ulcers reduction or prevention noted. There is a handwritten note dated August 21, 2024, that “Trinity HC and husband will complete treatments”, with no indication of the type of treatment or location.

Through record review of incident and accident reports, Resident A fell or was observed on the floor 14 times from February 2024 through August 2024. Multiple recurrent corrective measures include “encourage resident to use her pendant, medication review, PT/OT to eval, and physician to assess next visit.”

Through record review of progress notes, the following items were noteworthy:

- February 19, 2024 - Resident A admitted to facility with no indication of skin concerns or pressure ulcers.
- July 15, 2024 - Resident A was sent to the hospital related to cellulitis and right heel ulcer.
- August 21, 2024 – Home care nurse is providing pressure ulcer care to heel twice a week, and Resident A’s spouse will complete treatment on “other days”.
- September 3, 2024 - Resident A returned from wound care physician appointment with new treatment orders for buttock. Resident A’s spouse informed, at this time facility, is unable to complete wound care services.

- October 3, 2024 - Resident A was taken to the hospital by spouse for further evaluation.
- October 7, 2024 – Facility progress note indicates that Resident A expired October 5, 2024.
- Cumulatively, there were fifteen fall occurrences noted in progress notes.

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.**
ANALYSIS:	Through record review and interview, Resident A had pressure ulcers to bilateral heels and buttock. Wound care services were provided by wound clinic and home care services. Resident A's service plan had minimal information related to care required to meet the Resident A needs, including no documentation or care guidance related to skin condition. Incident reports identified Resident A experienced fourteen falls, yet progress notes identified fifteen fall occurrences. While the incident reports identified interventions to prevent future falls, no interventions were documented on the service plan. Based on information noted above this violation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

03/17/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

03/25/2025

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