GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

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

RE: License #: AH820304947
Investigation #: 2025A0628023
Cedar Woods Assisted Living

Dear Licensee:

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) 335-5985.

Sincerely,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820304947
Investigation #:	2025A0628023
Complaint Receipt Date:	09/08/2025
Investigation Initiation Date:	09/17/2025
Report Due Date:	11/07/2025
Licensee Name:	Willow Commons, LLC
Licensee Address:	44401 I-94 S. Service Dr. Belleville, MI 48111
Licensee Telephone #:	(734) 699-2900
Administrator:	Robin Wojtowicz
Authorized Representative/	Nozmi Elder
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	210
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility failed to provide adequate care for Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

09/08/2025	Special Investigation Intake 2025A0628023
09/09/2025	Contact - Document Sent email sent to administrator requesting additional information
09/09/2025	Contact - Document Received email received from administrator with requested documentation
09/10/2025	Contact - Telephone call made telephone call made to complainant
09/11/2025	Contact - Document Received additional documentation received from complainant
09/15/2025	Contact - Telephone call made with Bloom Hospice nurse, Nikki
09/15/2025	Contact - Telephone call made phone call made to daughter of resident named in complaint
09/17/2025	Special Investigation Initiated - On Site
09/24/2025	Contact – Document Sent email sent to administrator requesting additional information
09/29/2025	Contact – Document Sent email sent to administrator requesting additional information. Second request.
09/29/2029	Contact – Document Received email received from administrator with requested documentation
09/30/2025	Exit conference conducted with Nozmi Elder and Robin Wojtowicz

ALLEGATION: The facility failed to provide adequate care for Resident A.

INVESTIGATION:

On 09/08/2025, the department received a complaint that alleged Resident A had compacted, rotting food and medication stuck in the roof of their mouth. The complainant alleged that upon opening Resident A's mouth, due to an odor coming from it, the family noted black chunks of applesauce and medication stuck to the roof of Resident A's mouth.

On 09/11/2025, I received photos from the complainant with views of Resident A's mouth and visible black debris on the roof of their mouth. The photos were dated 09/01/2025.

On 09/15/2025, I had a phone conversation with Nikki Long from Bloom Hospice. Nikki confirmed that she witnessed the black debris caked to the roof of the mouth of Resident A when she was at the home of Resident A's daughter on 09/01/2025.

On 09/17/2025, while onsite, I interviewed the administrator, along with Employee #1 and Employee #2. The administrator reported that Resident A no longer resided at the home and that Resident A went home with family, on hospice care, on 08/31/2025.

Employee #1 reported that oral care expectations are as follows:
-brushing teeth
-brushing tongue
-offering water after medications

Employee #2 reported that they had directed the caregivers to complete oral care for Resident A. Employee #2 also reported that they instructed caregivers to do care checks every 30 minutes and to keep Resident A clean and dry. Employee #2 reported that they were not notified by care staff oral care wasn't being completed for Resident A or that they were unable to complete oral care for any reason. Employee #2 reported that the ADL sheet has a specific area to write the reason, if in fact, you don't or are unable to complete an ADL task.

Review of chart notes from 08/29/2025 at 7:30pm, written by Employee #2 read:

"Supervisor notice (sp?) that Resident is not responding to staff and becoming unable to take medication. She will not open her mouth wide enough and is biting down on the spoon used to give her her medication. Advised staff to keep an eye on her and let Supervisor know of any changes."

Review of chart notes from 08/30/2025 at 2:54pm, written by Employee #2 read:

"Upon rounds Supervisor noticed that Resident is still not responding to staff and physically unable to take her medication. Resident is also not eating. Vitals were taken by Med Tech and Bloom Hospice was called. Hospice came out to see her and placed new orders for Resident. Hospice(Nikki) stated that she will notify the family."

Review of the Medication Administration Record for Resident A reveals the last documented medication given to Resident A was Tramadol at 2pm on 08/30/2025. This medication administration was signed off by Employee #2.

Review of the Activities of Daily Living log for Resident A revealed that oral care was to be provided to Resident A daily in the AM and the PM. The last documented oral care was provided by Employee #3 on 08/30/2025 in the AM. Oral care documentation was blank for 08/30/2025 PM. There was no documentation that Resident A refused oral care or that the caregiver was unable to perform oral care for any reason. Oral care documentation was also left blank for 08/31/2025 in the AM. Paperwork from the facility states Resident A was discharged home with family at 2:21pm on 08/31/2025. Again, there was no documentation that Resident A refused oral care or that the caregiver was unable to perform oral care for any reason.

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:	Through interviews with staff at the home, Bloom Hospice staff, the complainant, and the daughter of Resident A along with reviewing photographs of Resident A's mouth and documentation from the home, which included the activities for daily living log and medication administration log, the home can not demonstrate that oral care was performed for Resident A up until the time Resident A left the facility. The last medication was documented as given on 08/30/2025 at 2pm and the last oral care documented was 08/30/2025 in the AM. There was no documentation from the facility stating why oral care was not performed. Review of photographs of Resident A's mouth displayed lack of recent oral care. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent on the receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

09/29/2025

Rebekah Looney
Licensing Staff

Date

Approved By:

09/30/2025

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

Date