GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 6, 2023

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

RE: License #: AH630387151
Investigation #: 2023A0784056
Cedarbrook Of Rochester

Dear Ms. 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 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630387151
Investigation #:	2023A0784056
Complaint Receipt Date:	04/21/2023
Investigation Initiation Date:	04/24/2023
Report Due Date:	06/20/2023
Licensee Name:	CSL Rochester Master Operator, LLC
Licensee Address:	Suite 300 1450 West Long Lake Troy, MI 48098
Licensee Telephone #:	(248) 583-6020
Administrator:	Patricia Spina
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:	05/21/2023
Expiration Date:	05/20/2024
Capacity:	85
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care for Resident A.	No
Resident A was administered the wrong medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/21/2023	Special Investigation Intake 2023A0784056
04/24/2023	Special Investigation Initiated - Telephone Attempted with complainant. Message left requesting return call
04/25/2023	Inspection Completed On-site
04/25/2023	Contact - Telephone call made Attempted contact with complainant.
04/25/2023	Exit Conference Conducted with authorized representative Erin Ottenbreit

ALLEGATION:

Inadequate care for Resident A

INVESTIGATION:

On 4/21/2023, the department received this complaint.

According to the complaint, on 2/16/2023, Resident A fell while attempting to get out of a chair in the dining room resulting in a shoulder fracture. Resident A was supposed to receive assistance from staff for transfers, however staff did not assist her. On 2/25/2023, it was reported that Resident A was being transferred improperly by staff and was dropped during the transfer. As a result of being dropped, Resident A's left shoulder was shattered and required surgery for a total shoulder replacement.

On 4/25/2023, I interviewed director of nursing Megan Lang at the facility. Administrator Patricia Spina and authorized representative Erin Ottenbreit were present during the interview. Ms. Lang stated that on 2/16/2023, Resident A did have a fall in the dining area resulting in a fracture to her left shoulder. Ms. Lang stated Resident A had been eating dinner and decided to get up to retrieve a "to-go"

box for her food when she lost her balance. Ms. Lang stated staff contacted emergency medical services (EMS) to have Resident A transferred to the hospital as she was expressing pain visibly and verbally. Ms. Lang stated that prior to the fall, Resident A had been living at the facility for less than a week when this happened. Ms. Lang stated that based on Resident A's initial assessment coming to the facility, she was service planned to transfer and ambulate independently. Ms. Lang stated Resident A did use a walker, but was able to, and preferred to, transfer herself and ambulate on her own. Ms. Lang stated that at the time of the fall, Resident A did not require staff assistance, unless requested, and that it was an unforeseen situation. Ms. Lang stated that after this fall, Resident A's service plan was updated to require one staff member to assist her with transferring as she would now be in a wheelchair and needed assistance to both transfer and ambulate. Ms. Lang stated that on 2/25/2023, Resident A was being assisted from her bed to her wheelchair by Associate 1 when Resident A's "legs gave out" and she fell to the floor during the transfer. Ms. Lang stated this fall did aggravate the left shoulder fracture from 2/16/2023 resulting in the need for shoulder surgery. Ms. Lang stated Associate 1 was properly trained on transfers and that Resident A's legs giving out was unexpected and uncommon at that time.

I reviewed Resident A's initial *Resident Assessment*, dated 2/09/2023 and provided by Ms. Lang. The assessment read consistently with statements she provided noting specifically that Resident A was "independent with walker", "independent with positioning" and "eats independently".

I reviewed Resident A's initial service plan, dated 2/09/2023, provided by Ms. Lang. The plan read consistently with Ms. Langs statements noting specifically that Resident A was independent with "transfers" and "ambulation" while "using her walker".

I reviewed Resident A's updated service plan, dated 2/17/2023, provided by Ms. Lang. The plan read consistently with Ms. Langs statements noting Resident A requires staff assistance to "propel with wheelchair" and requires a "1 person assist with transfers".

I reviewed training documents for Associate 1, provided by Ms. Ottenbreit, which included training on proper "Lifts", "Transfer Into Wheelchair Competency", "gait-belt transfers" and training on proper "sit to stand" procedures. The documents read confirmed Ms. Lang's statements regarding Associate 1 being appropriately trained.

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:	The complaint alleged Resident A was not provided adequate care when she fell on 2/16/2023 while self-ambulating and when she had a subsequent fall on 2/25/2023 while being assisted with a transfer by Associate 1 and ultimately aggravating a shoulder injury sustained when she fell on 2/16/2023. While Resident A did sustain an injury and subsequently aggravated the injury, evidence in the investigation did not support a lack of adequate care by staff. Based on the findings the allegation is not supported.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was administered the wrong medications.

INVESTIGATION:

According to the complaint, on 2/26/2023, the facility reported Resident A was not given her correct medication.

When interviewed, Ms. Lang stated that on 2/26/2023, Associate 2 and Associate 3 heard a loud crash in Resident A's room. Associates 2 and 3 went into Resident A's room to assess the situation and observed Resident A's food tray had fallen to the floor and a glass on the tray had broken on the floor. Ms. Lang stated that prior to the crash heard in Resident A's room, Associate 2 was in the process of taking medication to a resident for administration and, due to the crash, quickly went to Resident A's room with those medications in her hand. Ms. Lang stated that when Associate 2 noticed the broken glass, she set the cup of medications, meant for another resident, on the table next to Resident A's bed. Ms. Lang stated that shortly after this, while Associate 2 was cleaning the glass, Associate 4 came into the room, noticed the medications next to Resident A's bed and administered those medications to Resident A in an attempt to be helpful, not knowing the medications were not prescribed to Resident A. Ms. Lang stated the error was quickly noticed and Resident A's physician was contacted immediately for guidance. Ms. Lang stated Resident A did not have any adverse reactions to the medications.

I reviewed facility incident reporting, provided by Ms. Lang, dated 2/26/2023, which read consistently with statements she provided.

I reviewed facility *Progress Notes* for Resident A, provided by Ms. Lang and dated 2/26/2023, which read consistently with statements she provided. The notes indicated an incident time of 7:10pm and indicated Resident A's physician was notified and provided instructions to staff on how to proceed.

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:	The complaint alleged that on 2/26/2023, Resident A was administered the incorrect medication. The investigation revealed Resident A was administered medications which were not hers. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Lang stated Associate 4, who administered Resident A the incorrect medication on 2/26/2023, had not been trained by the facility to pass medications. Ms. Lang stated Associate 4 was reprimanded in relation to this incident.

I reviewed a *COUNSELING DOCUMENTATION FORM*, provided by Ms. Lang and signed by Associate 4 with a date of 2/26/2023. The form read consistently with statements provided by Ms. Lang.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a

	resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	During the investigation it was discovered that Associate 4 administered medication to Resident A while having not been trained by the facility for medication administration. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

6/01/2023

Aaron Clum Date
Licensing Staff

Approved By:

06/06/2023

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