



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

May 28<sup>th</sup>, 2024

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

RE: License #: AH330405755  
Investigation #: 2024A1021053  
Red Cedar Lodge

Dear Jody Linton:

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 authorized representative 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,

*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**

<b>License #:</b>	AH330405755
<b>Investigation #:</b>	2024A1021053
<b>Complaint Receipt Date:</b>	04/15/2024
<b>Investigation Initiation Date:</b>	04/15/2024
<b>Report Due Date:</b>	06/15/2024
<b>Licensee Name:</b>	Red Cedar Senior Living Holdings, LLC
<b>Licensee Address:</b>	150 East Broad Street Columbus, OH 43215
<b>Licensee Telephone #:</b>	(614) 221-1818
<b>Administrator:</b>	Abigail Mulholland
<b>Authorized Representative:</b>	Jody Linton
<b>Name of Facility:</b>	Red Cedar Lodge
<b>Facility Address:</b>	210 Dori Lane Lansing, MI 48912
<b>Facility Telephone #:</b>	(517) 348-0226
<b>Original Issuance Date:</b>	10/07/2022
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/07/2023
<b>Expiration Date:</b>	04/06/2024
<b>Capacity:</b>	155
<b>Program Type:</b>	ALZHEIMERS AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Facility has insufficient staff.	Yes
Additional Findings	No

## III. METHODOLOGY

04/15/2024	Special Investigation Intake 2024A1021053
04/15/2024	Special Investigation Initiated - Letter email sent to complainant for additional information
04/18/2024	Inspection Completed On-site
05/28/2024	Exit Conference

### **ALLEGATION:**

**Facility has insufficient staff.**

### **INVESTIGATION:**

On 04/15/2024, the licensing department received a complaint with allegations there is lack of staff in the memory care unit. The complainant alleged there are residents that need skilled level care because they are a two-person assist, need assistance with eating, and often require 1:1 assistance.

On 04/15/2024, I emailed the complainant for additional information. The complainant alleged there was insufficient staff on 04/09/2024 on second shift and on 04/13/2024 on first and second shift. The complainant alleged there were also staffing concerns the week of 04/01/2024.

On 04/18/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported staffing has improved at the facility. Ms. Mulholland reported there are 84 residents in assisted living and 14 residents in the memory care. Ms. Mulholland reported the facility schedules three employees for first shift and second shift and one employee for third shift. Ms. Mulholland reported on third shift there are two employees in the assisted living unit that can float to the memory care unit for assistance, if necessary. Ms. Mulholland reported if there is an unexpected call in, management will work to find a replacement. Ms. Mulholland reported there is always a manager on duty that can come in, if necessary. Ms. Mulholland reported

on 04/09/2024 and 04/13/2024 there were unexpected call ins, but the facility found replacement workers and management worked the floor.

On 04/18/2024, I observed the layout of the facility. The facility is a five-story facility with the facility's main entrance enters to a common area with the assisted living unit on the right and the memory care unit on the left. The assisted living unit has residents scattered throughout all four floors. There are elevators in the center of the facility and stairways on the side of the facility. For staff to respond to a request for assistance, it can take upwards of ten minutes.

On 05/06/2024, I interviewed staff person 1 (SP1) by telephone. SP1 reported there is typically three employees in the memory care unit. SP1 reported she has not observed any issues with staffing. SP1 reported the residents receive good care and their needs are met.

On 05/06/2024, I interviewed SP2 by telephone. SP2 reported she typically works first shift. SP2 reported she typically works with two other employees. SP2 reported the shift is busy but all tasks are completed. SP2 reported no concerns with staffing.

I reviewed the memory care staff schedule for 04/01/2024-04/13/2024 for first and second shift. The schedule revealed on first shift there were two caregivers and one medication technician. On second shift there were two caregivers scheduled and one medication technician. The schedules revealed there were instances in which an employee worked a partial shift to assist with shift coverage.

I reviewed service plans for residents in the memory care unit. The service plans revealed there was one resident that required two person assist with transfers and a resident that occasionally required 1:1 continuously.

I reviewed service plans for residents in the assisted living unit. The service plans revealed there was a resident that required two person assistance with ambulation during weak times.

I reviewed the facility staff schedule for 04/01/2024-04/13/2024 for third shift. The following were noted:

04/01, 04/02, 04/06, 04/07: one employee memory care

04/05: one employee in assisted living 3:00am-6:00am

04/08: one employee in assisted living

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable</b>

	<b>of providing for resident needs consistent with the resident service plans.</b>
<b>ANALYSIS:</b>	Interviews conducted, observations made, and review of resident services plan revealed there is insufficient staff at the facility as evidenced by there are two residents that require two persons to assist, yet on multiple occasions there is only three staff persons in the facility, indicating other residents that require supervision or assistance are without it during that time. In addition, the utilization of using a float staff member from other areas of the facility potentially leaves those areas understaffed if not already understaffed.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Kimberly Horst*

05/22/2024

Kimberly Horst  
Licensing Staff

Date

Approved By:

*Andrea L. Moore*

05/28/2024

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

Date