GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

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

RE: License #: AH330405755
Investigation #: 2024A1021082
Red Cedar Lodge

Dear Jody Linton:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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, 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 #:	2024A1021082
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/29/2024
Report Due Date:	10/28/2024
Licensee Name:	Red Cedar Senior Living Holdings, LLC
Licensee Address:	150 East Broad Street Columbus, OH 43215
Licensee Telephone #:	(614) 221-1818
Administrator:	Abigail Mulholland
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?
Resident A neglected at the facility.	No
Resident A improperly discharged.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A1021082
08/29/2024	APS Referral referral came from APS
08/29/2024	Special Investigation Initiated - Telephone interviewed APS worker
09/04/2024	Contact - Telephone call made interviewed APS worker
09/04/2024	Contact - Document Received received resident documents
09/06/2024	Contact-Telephone call made Interviewed SP2
09/06/2024	Contact-Telephone call made Interviewed SP3
11/25/2024	Exit Conference

ALLEGATION:

Resident A neglected at the facility.

INVESTIGATION:

On 08/29/2024, the licensing department received a complaint with allegations Resident A was neglected at the facility.

On 09/04/2024, I interviewed Adult Protective Services (APS) worker Michelle Hardman by telephone. Ms. Hardman alleged there was a camera placed in Resident A's room by the family. Ms. Hardman alleged Resident A's family observed for Resident A to be naked and calling for help for over 30 minutes. Ms. Hardman alleged Resident A was put to bed at 7:00pm and wished to stay up. Ms. Hardman alleged there was a female resident that agitated Resident A and the facility did no steps to keep the residents separated.

On 09/04/2024, I left a message with Relative A1 with no response.

On 09/05/2024, the administrator Abigail Mulholland confirmed the facility was aware there was a camera in Resident A's room.

On 09/06/2024, I interviewed staff person 1 (SP1) by telephone. SP1 reported staff were always attentive to Resident A's needs. SP1 reported Resident A preferred not to spend much time in his room and was usually in the common areas. SP1 reported Resident A was typically went to bed very late and was not placed in his room early. SP1 reported when Resident A would get agitated, caregivers would attempt to place Resident A in his room to get a break, but he was not forced in his room. SP1 reported Resident A's door was always left open and caregivers would hear if he was yelling for help. SP1 reported there was a female resident that was friends with Resident A and at times they would cling to each other. SP1 reported Resident A was not agitated with the other resident.

On 09/06/2024, I interviewed SP2 by telephone. SP2 reported Resident A never wanted to spend much time in his room. SP2 reported Resident A interacted well with other residents and staff members. SP2 reported it was difficult because Resident A would get agitated, but caregivers could never figure out what triggered Resident A. SP2 reported once he did get agitated, after some time he would calm down and could not recall what happened. SP2 reported caregivers treated Resident A well and Resident A received good care.

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:	**Definitions.**

R 325.1901	
	(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 revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A improperly discharged.

INVESTIGATION:

Ms. Hardman alleged Resident A was transported to the emergency room and the facility refused to accept Resident A back to the facility. Ms. Hardman alleged Resident A was placed under observation at McLaren Greater Lansing and is ready for discharge but has no place to go. Ms. Hardman reported APS is sustaining the allegations on neglect and abandonment.

On 08/30/2024, the licensing department received another complaint with allegations the facility was refusing to accept Resident A back to the facility.

On 08/29/2024 at 1:10pm, I interviewed Ms. Mulholland by telephone. Ms. Mulholland reported the facility issued a less than 24-hour discharge notice to Resident A and Resident A's durable power of attorney (DPOA) due to the behaviors Resident A was exhibiting at the facility. Ms. Mulholland reported the discharge notice was provided on 08/19/2024 and Resident A was discharged on 08/20/2024 to the care of the DPOA. Ms. Mulholland reported Resident A's family had moved some belongings out of the facility, medications were destroyed, and Resident A was discharged from the facility.

I reviewed Resident A observation notes. The note occurred on 08/20/2024 but was entered on 08/29/2024 at 1:45pm. The note read,

> *"Resident and (DPOA) refused to sign 24 hour discharge notice, stated that she was going to have to take resident back to her house stated "which is a bad idea*

because I am scared of him, he has hit me over the head with a wine bottle and then self harmed himself", this nurse gave resident an option for placement at AFC in Charlotte, MI called Golden Days after this nurse spoke with Brandy on placement options. Resident and (DPOA) left this nurses office stating "well come on (Resident A) were going home".

I reviewed Resident A's discharge notice. The notice was dated 08/19/2024 at 8:50pm and discharge was to be on 08/20/2024. The document read it was provided to the DPOA. The location of discharge was to be told by the family. The notice read,

"if less than 30 days notice is being provided, this is because:
The resident's health has improved sufficiently to allow a more immediate discharge or transfer to a less skilled level of care.
The resident has resided in the home less than thirty days.
An emergency exists in which the safety of individuals in the home is endangered.
The welfare and needs of the resident cannot be met in the facility.
The safety of individuals in the home is endangered.
The resident's health has improved sufficiently
The resident has failed, after reasonable and appropriate notice to pay or to have the Medicare, Medicaid, or long term care insurance pay on their behalf.

If additional support is needed, you can contact LARA."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(iv) The right of the resident to file a complaint with the department.**

ANALYSIS:	Review of Resident A's discharge notice revealed the reasoning for the discharge was not specified and there was not a statement on the resident's ability to file a complaint.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's medication administration record (MAR) revealed Resident A was prescribed Seroquel 25mg tablet with instruction to administer one tablet PRN for anxiety/agitation.

Review of Resident A's service plan revealed lack of detail on the exhibit of these behaviors.

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:	Review of Resident A's service plan lacked detailed information on how the resident demonstrates agitation and what behaviors require the administration of the medication or if staff can use nonpharmaceutical interventions.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed the admission agreement for Resident A. The admission agreement and service plan were signed by Relative A1.

I reviewed the DPOA paperwork for Resident A. The paperwork read,

"My agent may exercise this authority only when I am unable in participate in medical treatment decisions."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
ANALYSIS:	Review of Resident A's paperwork revealed the DPOA was not active, as two physicians did not state Resident A lacked decision making capacity. The facility had Relative A1 sign the admission agreement and not Resident A. Therefore, the admission agreement is not valid as it was not appropriately signed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.**
ANALYSIS:	Review of Resident A's admission documents revealed Resident A has no activated DPOA and therefore Resident A was to assist in the development of the service plan. Therefore, the facility did not appropriately develop Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A's August 2024 medication administration record (MAR) revealed Resident A was prescribed the following medications:

- Aspirin 81mg with instruction to administer one tablet daily. This medication was not administered on 08/01 and 08/02 due to medication was not in the cart.

- Atorvastatin 10mg tablet with instruction to administer one tablet nightly by mouth. This was not administered on 08/01-08/05 due to medication was not in the cart.

- Memantine Oral Tablet 10mg with instruction to administer one tablet by mouth twice a day. This was not administered in the evening on 08/01-08/05.

- Mirtazapine Oral tablet 7.5mg with instruction to administer one tablet by mouth every night. This medication was not administered on 07/30 and was administered twice on 08/05.

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:	Review of Resident A's MAR revealed Resident A was not administered multiple medications as prescribed by the licensed health care professional
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

09/09/2024

Kimberly Horst Date
Licensing Staff

Approved By:

11/21/2024

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