



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

November 21, 2024

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

RE: License #: AH330405755  
Investigation #: 2024A1021092  
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, 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>	2024A1021092
<b>Complaint Receipt Date:</b>	09/30/2024
<b>Investigation Initiation Date:</b>	09/30/2024
<b>Report Due Date:</b>	11/30/2024
<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>	08/01/2024
<b>Expiration Date:</b>	07/31/2025
<b>Capacity:</b>	155
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	Violation Established?
Insufficient staff in memory care on second shift.	Yes
Additional Findings	No

## III. METHODOLOGY

09/30/2024	Special Investigation Intake 2024A1021092
09/30/2024	Special Investigation Initiated - On Site
10/02/2024	Contact-Telephone call made Interviewed staff person 2
10/09/2024	Contact-Telephone call made Interviewed staff person 1
10/10/2024	Onsite Investigation
11/21/2024	Exit Conference

### ALLEGATION:

**Insufficient staff in memory care on second shift.**

### INVESTIGATION:

On 09/30/2024, the licensing department received a complaint with allegations there is insufficient staff in memory care on second shift. The complainant alleged in memory care, the staff are expected to serve and plate the dinner meal which takes away from resident care. The complainant alleged at times after 7:00pm, there is only one caregiver assigned to work the floor.

On 09/30/2024, I interviewed Relative J1 at the facility. Relative J1 reported there are times there are only two staff members in the unit. Relative J1 reported there is an afternoon/nighttime supervisor that is to assist, however, she does not provide hands on care to the residents. Relative J1 reported she has assisted other residents to eat during mealtimes because the caregivers are serving the food and there is not enough staff to complete all tasks.

On 09/30/2024, I interviewed Relative K1 at the facility. Relative K1 reported she is concerned about staffing at the facility. Relative K1 reported there have been times there is only two people in the unit.

On 09/30/2024, I interviewed staff person 3 (SP3) at the facility. SP3 reported there are at least four residents that are a two person assist. SP3 reported care staff are responsible for plating and serving the food to the residents. SP3 reported there are times there are only two staff members in the memory care unit. SP3 reported the afternoon/night-shift supervisor does not assist in resident care.

On 09/30/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported there is to be three staff members on second shift and two staff members on third shift. Ms. Mulholland reported the company guidelines are 1:8 in memory care and there are 16 residents in the unit. Ms. Mulholland reported if help is needed, the unit will run with only two. Ms. Mulholland reported the assisted living unit workers are available by walkie-talkie to cover breaks and assist in emergency situations. Ms. Mulholland reported there is also a care trained activities team member who works during the week and every other weekend, along with the memory care director who are typically here for the first part of second shift.

On 10/02/2024, I interviewed SP2 by telephone. SP2 reported she was in the facility common area and observed Resident A, who resides in memory care, outside the facility unattended. SP2 reported she brought Resident A back into the secure memory care unit. SP2 reported she is unsure how long Resident A was outside unattended. SP2 reported there were only two staff members working in memory care and one staff member was in the restroom and another staff member was assisting with resident care. SP2 reported the staff were unable to attend to the needs of the all the residents.

On 10/09/2024, I interviewed staff person 1 (SP1) by telephone. SP1 reported on 10/03/2024, the medication technician called off for second shift. SP1 reported only one caregiver worked the memory care unit and the night shift supervisor. SP1 reported the night shift supervisor does not assist in resident care and has told this to multiple employees. SP1 reported there is at least two residents that are a two person assist in the memory care unit. SP1 reported second shift workers are responsible for serving the dinner food.

I observed the memory care unit on 09/30/2024 and on 10/10/2024. Both times I observed a caregiver providing 1:1 assistance during the meal service.

I reviewed staffing schedules for the memory care unit at the facility. The schedules revealed on 09/15/2024 on second shift only two employees worked.

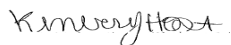
Multiple interviews conducted for 2025A1021002 revealed Resident B is a two person assist.

I reviewed service plans for four residents in memory care. The service plans revealed three residents are a two person assist, one resident that is an extensive assistance with grooming and hygiene, all residents were to be checked every two hours, one resident that wanders throughout the facility requiring re-direction, one resident that is exit-seeking, and two residents that require assistance with dinning.

<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 of providing for resident needs consistent with the resident service plans.</b>
<b>ANALYSIS:</b>	Interviews with staff, consideration of care needs as identified in their plans of care, along with schedule review revealed the facility staffing protocol is incapable of ensuring the care needs of the memory care residents are met. Interviews of staff along with document review reveals a cognitively impaired resident population that is subjected to potential harm due to the lack of available staff to ensure more than one caregiver is available to participate in two person assist transfers, assistance with dining, and supervision during periods of mobility to protect from falls.
<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.



10/10/2024

Kimberly Horst  
Licensing Staff

Date

Approved By:



11/21/2024

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

Date