GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25th, 2024

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

RE: License #: AH330405755
Investigation #: 2025A1021001
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

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 #:** | 2024A1021089 |
| | |
| **Complaint Receipt Date:** | 09/19/2024 |
| | |
| **Investigation Initiation Date:** | 09/23/2024 |
| | |
| **Report Due Date:** | 11/19/2024 |
| | |
| **Licensee Name:** | Red Cedar Senior Living Holdings, LLC |
| | |
| **Licensee Address:** | 150 East Broad Street<br>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<br>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:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A fell. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/19/2024 | Special Investigation Intake<br>2024A1021089 |
| 09/25/2024 | Special Investigation Initiated - Telephone<br>interviewed APS |
| 09/30/2024 | Inspection Completed On-site |
| 10/02/2024 | Contact-Telephone call made<br>Interviewed Dr. Dwamena office |
| 10/02/2024 | Contact-Telephone call made<br>Interviewed Dr. Eisenberg office |
| 11/25/2024 | Exit Conference |

**ALLEGATION:**

**Resident A fell.**

**INVESTIGATION:**

On 09/24/2024, the licensing department received a complaint with allegations from Adult Protective Services (APS) that Resident A had a fall on 09/13/2024 that was not reported to the family and had broken teeth because of the fall.

On 09/25/2024, I interviewed APS worker Robert Joyner by telephone. Mr. Joyner reported he completed the investigation on site. Mr. Joyner reported the incident report was not completed for the fall and the facility completed the paperwork while he was on site. Mr. Joyner reported there was discrepancies between staff statements on the events on the fall.

I reviewed incident report completed for the fall. The fall occurred on 09/13/2024 and the family was notified on 09/13/2024 and physician was notified on 09/16/2024. The report read,

*"This writer was notified by CG that there was a smell coming from one of the two residents that were standing in the area. Both residents were asked if they had to use this restroom. This resident responded and stated that they could go. Writer took resident to the bathroom in their apartment. As resident was crouching to pull pants down to sit on the toilet, the resident fell forward into the shower. The resident hit the shower bench, Writer quickly assed resident to make sure there were no major injuries before calling CG in the room to help get resident off the ground. Writer and CG got resident into chair in room and vitals were taken. Vitals were normal but resident complained of pain. Resident has a small scrape on chin area. Residents' mouth was also bleeding on the inside due to lip being busted and the lower front teeth were a tad bit loose. gave resident ice pack to ice the area to avoid/reduce swelling. WD and family was notified. (SP1), assessed resident for injury and reported to WD and ED. WD was on phone with (SP1) when she notified (Relative A1). (SP1) informed (Relative A1) that resident had a fall resulting in a cut to her lip from hitting her chin during the fall. (SP1) asked (Relative A1) if they would like to send resident out for further evaluation. (Relative A1) denied send out and med tech asked if they wanted to come in and check her out in person and family denied at that time, but said they would be in tomorrow to check in on her."*

I reviewed fall notes summary for Resident A. The notes read,

*"9.13.24 6:30pm: Resident was with Med Tech, (SP1) in her apartment headed to use the restroom. As resident was crouching to pull pants down to sit on the toilet, the resident fell forward into the shower hitting her chin against the shower bench. (SP1) assessed resident for injury and helped resident up and into a chair with another CG. Vitals were normal (see incident report) and resident reported pain to her chin and mouth. (SP1) observed a scrape on her chin and inside her lip where her teeth had hit her lip, teeth were slightly loose. (SP1) administered ice pack to avoid/reduce swelling.*
*9.13.24 6:40pm: (SP1) notified (SP2) and Ms. Mulholland, and (Relative A1). (SP1) called (SP2) first to get clinical input and while on the phone with the (SP2) called (Relative A1). (SP1) explained the fall and asked if (Relative A1) wanted resident sent out for further evaluation, (Relative A1) denied and (SP2) asked if they wanted to come in and check her out in person. Family denied at that time, but said they would be in tomorrow to check in on her.*
*9.14.24 2:55pm: (SP3) administered Xanax due to agitation. Resident observed being very unsteady while ambulating afterwards and complained of some pain to her lip. (SP3) contacted (SP2) who advised (SP3) to hold afternoon Seroquel and contact PCP on-call for possible pain medication. Seroquel is a new medication, which resident had not started taking yet, but can cause drowsiness. Orders from PCP were to hold Seroquel if started and lethargic or off balance. Xanax can have this same effect. (SP2) advised (SP3) to observe resident and contact her if condition continued or worsened.*
*9.14.24 3:10pm: (Relative A1) stated resident isn't acting like her usual self, had questions about meds that were administered today. (SP3) went over meds.*

*(Relative A1) stated that resident didn't remember his name or grandchildren's names that were here visiting. (Relative A1) didn't feel that (Relative A) is ok and requested resident to be sent out. ED and WD notified. Resident picked up around 3:45pm and transported to hospital."*

I reviewed facility observation notes for Resident A. The notes read,

*"09/14: Resident observed being very unsteady while ambulating today after taking her afternoon Xanax. Held afternoon Seroquel. Resident is currently lying in bed. Resident does have a swollen lip from her fall last night and has been complaining of pain in her face. Reached out to PCP for possible pain medication via email."*

| **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:**<br>**(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:** | Interviews conducted and review of documentation revealed Resident A had a fall on 09/13 in the evening hours. After the fall, Resident A complained of pain and only ice was provided. The following afternoon, Resident A was still complaining of pain and only an email was sent to the PCP requesting pain medication. The facility did not ensure Resident A's received appropriate medical attention and that Resident A's wellbeing was protected from harm. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Review of Resident A's medication administration record (MAR) revealed Resident A was prescribed Xanax Oral Tab 0.5mg with instruction to give 0.5mg prn for increased agitation once a day.

Resident A's service plan read,

> *"Staff will approach the resident with an understanding of their verbal behavioral behaviors. Staff will approach the resident with an understanding of their physical/intrusive 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:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
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| **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:**

Review of Resident A's MAR revealed Resident A was prescribed Seroquel 50mg with instruction to administer one tablet by mouth in the afternoon before dinner. Notes on 09/14 revealed,

*"held due to resident being unsteady and falling asleep."*

On 10/02/2024, I interviewed Resident A's physician offices. The offices reported they did not provide direction to hold this medication.

| **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 did not receive the required medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION**:

Review of Resident A's medication administration record (MAR) revealed the following:
Omeprazole Dr 20mg tablet: not administrated on 09/06-09/10 due to medication not in cart.
Seroquel Oral Tab 50mg tablet: not administered on 09/14 due to being unsteady and falling asleep.
Citalopram HBR 10mg tablet: not administered on 09/03-09/13 due to medication not in cart
Vitamin B12: not administered on 09/03-09/10 due to medication not in cart
Divalproex Sodium Oral Tablet: take 0.5Q am; medication administered twice on 09/07 and 09/08.

| **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 multiple instances in which the medication was not administered as prescribed by the licensed health care professional. |

| | |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 10/02/2024, I interviewed Resident A's physician offices, Dr. Dwamena and Dr. Eisenberg. Both offices reported they were not contacted regarding missed medications.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:**<br>**(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.** |
| **ANALYSIS:** | Interviews conducted revealed the licensed health care professional was not contacted when the medication was not administered as prescribed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

Kimberly Horst 10/02/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/21/2024

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