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 #: 2025A1021002
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 #:	2025A1021002
Complaint Receipt Date:	09/24/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/30/2024
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B has had multiple unreported falls.	Yes
Resident B has bed bugs.	No
Additional Findings	Yes

III. METHODOLOGY

09/24/2024	Special Investigation Intake 2025A1021002
09/25/2024	Contact-Telephone call made Interviewed APS worker
09/30/2024	Inspection completed on site
10/03/2024	Contact-Telephone call made Interviewed Pest Control Solutions
10/03/2024	Contact-Telephone call made Interviewed Relative A1
10/03/2024	Contact-Document Received Received University of Michigan Health-Sparrow Records
11/25/2024	Exit Conference

ALLEGATION:

Resident B has had multiple unreported falls.

INVESTIGATION:

On 09/24/2024, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident B has had multiple unreported falls. APS alleged approximately three weeks ago, Resident B had a fall that was never reported. APS alleged Resident B complained of pain in his torso and shoulder and it was found Resident B had three broken ribs.

On 09/25/2024, I interviewed APS worker Robert Joyner by telephone. Mr. Joyner reported he completed an investigation onsite regarding Resident B. Mr. Joyner

reported the facility could not provide incident report(s) for the falls nor staff member names that have found Resident B.

On 09/27/2024, the licensing department received another complaint on unreported falls for Resident B.

On 09/30/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported Resident B has had a decline in health status. Ms. Mulholland reported Resident B had a fall a few weeks ago, however, it can not be certain when the fall occurred. Ms. Mulholland reported after a resident falls, the durable power of attorney is contacted and the physician.

On 09/30/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident B has had a decline in health status. SP1 reported a few weeks ago, Resident B was complaining of shoulder pain. SP1 reported she went into Resident B's room to assist him with morning care and observed Resident B to have pain near the ribs. SP1 reported an x-ray was completed and it was found Resident B had broken ribs. SP1 reported care staff try to keep Resident B's door open and Resident B is on two-hour checks.

On 09/30/2024, I interviewed SP2 and SP3 at the facility. SP2 and SP3 reported Resident B has had multiple falls. SP2 and SP3 reported Resident B is not a reliable historian and is unable to provide accurate information on the falls.

On 10/03/2024, I interviewed Relative B1 by telephone. Relative B1 reported Resident B has vascular dementia and has had a stroke. Relative B1 reported Resident B has resided at the facility since February 2023. Relative B1 reported in August 2024, she took Resident B to a medical appointment, came back to the facility, and observed a broken table in Resident B's room. Relative B1 reported Resident B reported he had a fall, and she observed Resident B to have a cut on his hand and was wincing in pain. Relative B1 reported she is not certain if the facility knew about this fall or if Resident B informed care staff of the fall. Relative B1 reported on 08/19/2024, she received a telephone call from the facility that Resident B had fallen and was taken to the emergency room. Relative B1 reported Resident B was transported back to the facility later that day with no new orders. Relative B1 reported on 09/21/2024, Resident B was found on the floor in the bathroom and was taken to the emergency room. Relative B1 reported on 09/29/2024, Resident B was found on the floor in his bathroom and caregivers believed Resident B slid out of bed. Relative B1 reported Resident B was not transported to the emergency room for this fall due to no injuries and caregivers believed it was not a true fall. Relative B1 reported Resident B is not a reliable historian and is unable to provide accurate details.

On 10/03/2024, I received University of Michigan Health-Sparrow emergency department records. The records revealed Resident B admitted to the emergency room on 08/19/2024 and 09/21/2024 following a fall at the facility.

I reviewed facility observation notes. The notes read,

> *"08/17: Resident has shown increase of pain this evening. PRN was given and was ineffective. Staff has noticed a mood change with resident. Resident stated he doesn't feel like himself due to how much pain he is in.*
> *08/19: Resident returned from the hospital, no new orders. Resident noted with skin tear to L elbow. No wound care orders at this time, residents arm noted with Band-Aid clean and dry. Resident did not voice pain at the movement stated he "just wanted to rest." Nurse will continue to assess for any changes.*
> *0827: Will order another right shoulder xray as well as left hip and left femur d/t increased pain following recent fall.*
> *09/04: Spoke with Tiffany from Home MD regarding X-ray results. X-ray results showed fractures on right side of ribs.*
> *09/24: Resident has been complaining of 8/10 pain this morning in his R shoulder, given PRN pain med and cream, after a few hours resident stated that his pain was about a 5-6 out of 10.*
> *09/29: Resident was observed sitting on the floor next to his bed. Resident was unsure of how he got to that position. Resident reported pain in his R shoulder. Resident denied any pain located anywhere else beside his shoulder. With a 3 person assist, he was transferred to his chair next to him. Skin was assessed and did not observe any significant changes. ED and POA were both notified* within the hour it occurred. Vitals were obtained and were within normal ranges."

I reviewed Resident B's medication administration record (MAR) for August and September 2024. The August MAR revealed no 72-hour monitoring was recorded. The MAR for September 2024 revealed 72-hour monitoring was recorded on 09/29-09/30 following a fall.

I reviewed facility incident report for fall on 09/21/2024. The narrative of the report read

> "*Resident observed on floor at the end of his bed, residents pants were down to ankles, resident stated he was unaware of how he fell, resident c/o chest pain, hands and BL shoulders, resident was observed for injury, FVS taken, EMS contacted and resident transported to Sparrow ER. Daughter and PCP notified. Upon return resident will be recommended to therapy, when resident goes to bed if resident allows, remove pants to avoid potential fall if resident gets up on his own."*

I reviewed facility incident report for fall on 09/29/2024. The narrative of the report read,

> *"Resident was observed sitting on the floor next to his bed. Resident was unsure of how he got to that position. Resident reported pain in his R shoulder. Resident denied any pain located anywhere else besides his shoulder. With a 3 person*

assist, he was transferred to his chair next to him. Skin was assessed and did not observe any significant changes. ED and POA were both notified within the hour it occurred. Vitals were obtained and were within normal ranges. Check in on resident often to check if he needs to use the restroom."

I reviewed facility policy Fall Management Standard of Practice. The policy read,

"Residents experiencing a fall are to be evaluated timely by a licensed nurse for injury and medical intervention, as indicated. In the absence of a licensed nurse, a team member trained in first aid may evaluate for injury and first aid intervention or escalate to emergency medical provider, if necessary.

1. *Any resident that has a fall within the community will have an incident report completed. The form initiates the investigation process and is to be completed by the licensed nurse.*
2. *Licensed nurse to imitate neurological checks of resident if any of the following occur; if licensed nurse is not available, notify the physician for next steps.*
    a. *Unwittnessed fall*
    b. *Witnessed or resident reports hitting head*
    c. *The resident is unable to state if they hit their head*
3. *Implement intervention(s) to try to minimize complications from falls and to prevent additional falls.*
4. *Seventy-two (72) hour monitoring to be completed.*
5. *Physician, Wellness Director, and family notification will need to be completed."*

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:	Interviews conducted and review of various documents revealed Resident B had a fall on 08/19/2024, 09/21/2024, and 09/29/2024. Per the facility policy, following each fall an incident report is to be completed, appropriate parties notified, 72 hour monitoring, and interventions implemented. Upon review, the following were not completed: 08/19/2024: no incident report completed, no physician contacted, 72 hour monitoring, and interventions implemented 09/21/2024: no 72 hour monitoring recorded By not completing the required actions, the facility failed to ensure the overall protection and safety of Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B has bed bugs.

INVESTIGATION:

APS alleged Resident B has bed bugs.

SP1 reported when she provided care to Resident B, she observed Resident B to be itching and there was blood on his sheets. SP1 reported she viewed Resident B's bed and observed bed bug activity. SP1 reported Resident B was provided a shower, clothes were double washed, and Resident B was moved out of the room. SP1 reported Pest Control Specialists have provided two bed bug treatments in Resident B's room and the rooms adjacent to Resident B's room. SP1 reported the bed bugs were only found in Resident B's room.

Ms. Mulholland reported bed bugs were only found in Resident B's room under the box springs and bed. Ms. Mulholland reported Resident B's room was treated and the rooms adjacent to Resident B's room. Ms. Mulholland reported the bed bugs were caught early, and appropriate treatment was provided. Ms. Mulholland reported the facility will continue to work with the company for bed bug treatment and prevention.

On 10/03/2024, I interviewed Pest Control Solution technician Brad Trenor by telephone. Mr. Trenor reported they provided bed bug treatment on 09/23, re-treatment on 09/30, and scheduled for a re-inspection on 10/07. Mr. Trenor reported

this bed bug situation was unusual as the bed bugs were found on the blanket and the box springs but not on the mattress. Mr. Trenor reported there were approximately 60 bugs in various life stages found. Mr. Trenor reported he had to take a deeper look to find the bugs as they were not on the mattress. Mr. Trenor reported in his professional opinion, the facility acted timely to address the situation.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.
ANALYSIS:	Interviews conducted revealed bed bugs were found in Resident B's room. Once found, the facility took immediate action to treat Resident B's room and the adjacent rooms. While this event did occur, it appears it was an isolated issue and is not a systemic issue at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ADDITIONAL FINDINGS:

INVESTIGATION:

Facility policy on falls read,

"Put in an observation note- It does not matter if you observed the fall, you are the responsible person. When noting a fall that you did not observe you can chart as follows: Staff report that the resident was observed on the floor. Upon entering the room, it was noted that resident was laying on the floor. Staff report that when they were walking with the resident to the bathroom that legs become shaky, and resident fell but did not hit head. It is noted by writer that resident is laying on the floor.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; confidentiality; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. If a medical service provided

	to a patient on or after the effective date of the amendatory act that added this sentence involves the vaginal or anal penetration of the patient, a health facility or agency shall ensure that the patient's medical record expressly states that vaginal or anal penetration was performed unless the medical service meets any of the circumstances described in subsection (2)(b)(i)(A), (B), (C), or (D).
ANALYSIS:	Interviews conducted and documentation reviewed revealed Resident B had a known fall on 08/18/2024 and 09/21/2024. However, review of Resident B's observations notes revealed there were no records of these falls. By omitting these notes, the facility does not have a complete and accurate record for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

SP1 reported Resident B's needs have increased and Resident B is a two person assist.

SP2 and SP3 reported it now takes two people to assist Resident B and to transfer Resident B. SP2 and SP3 reported Resident B has had multiple falls over the past month.

Resident B's service plan read,

> *"Staff to monitor resident who is at a risk for falls.*
> *Safety checks: Check in with resident periodically throughout the day and night to ensure he has no needs."*

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:	Interviews conducted revealed Resident B has had multiple falls and is now a two person assist. Review of Resident B's service plan revealed the service plan did not contain specific and updated information to reflect the current care needs of Resident B.

	REPEAT VIOLATION: **AH330405755_SIR_2024A1021053; corrective action plan dated 05/23/2024;** **AH330405755_SIR_2024A1021048; corrective action plan dated 05/15/2024;** **AH33045755_SIR_2024A1021015 corrective action plan dated 12/17/2023.**
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

Kimberly Horst 10/03/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/21/2024

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