



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 22, 2024

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

RE: License #: AH330405755  
Investigation #: 2025A1021008  
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>	2025A1021008
<b>Complaint Receipt Date:</b>	10/16/2024
<b>Investigation Initiation Date:</b>	10/16/2024
<b>Report Due Date:</b>	12/15/2024
<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>	08/01/2024
<b>Expiration Date:</b>	07/31/2025
<b>Capacity:</b>	155
<b>Program Type:</b>	ALZHEIMERS AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was not tested timely for C-Diff.	Yes
Additional Findings	No

## III. METHODOLOGY

10/16/2024	Special Investigation Intake 2025A1021008
10/16/2024	Special Investigation Initiated - On Site
10/21/2024	Contact-Telephone call made Interviewed Vecore Laboratories
10/22/2024	Exit Conference

### **ALLEGATION:**

**Resident A was not tested timely for C-Diff.**

### **INVESTIGATION:**

On 10/16/2024, the licensing department received an anonymous complaint with allegations Resident A was not tested for C-Diff. The complainant alleged concerns were paper and electronically charted. The complainant alleged these concerns have been going on for weeks. The complainant alleged a stool sample was finally taken on 10/10/2024 or 10/11/2024.

On 10/16/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A's physician was contacted for an order for a stool sample on 10/10/2024 and Resident A was tested for c-diff on Friday, 10/11. SP1 reported there was a mix up with the mail carrier and the test was not sent out until 10/12. SP1 reported if a test result is sent out over the weekend, test results are not obtained until the following week. SP1 reported she would contact the testing site today for the test results.

On 10/16/2024, I interviewed SP2 at the facility. SP2 reported Resident A has had diarrhea for around two weeks. SP2 reported a stool sample was sent on Monday 10/14 and the facility is waiting for the test results. SP2 reported Resident A has not been eating and the diarrhea smells very bad.

On 10/16/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported a staff member in memory care recently tested positive for C-diff. Ms. Mulholland reported the facility is waiting on the test results for Resident A. Ms. Mulholland reported SP1 is very attentive to the needs of the residents and has been following up on this issue.

On 10/21/2024, I interviewed Vecore Laboratories. The company reported if a sample is sent in on a weekend after 12:00pm, it will not be processed until the following Monday. The company reported the average turn around time is 36 hours. The company reported if there is an issue with the order, the turn around time can be longer.

I reviewed Resident A's electronic observations. The observation notes read,

*"10/07: The other caregiver and I transferred resident into her shower. Resident's daughter and I gave her a full shower tonight. She still has an old scab around her left shin, no other skin conditions to note. Resident is still having very loose stools."*

I reviewed Resident A's handwritten notes. The notes read,

*"09/30: Still a bit confused today. Got bed changed and a bed bath. Having loose stools.*

*10/02: Had an XL loose watery BM.*

*10/03: Very loose watery stool this morning. We had to feed her at lunchtime.*

*10/05: When getting her changed for bed, what was in her brief looked like jelly consistency.*

*10/06: Had a lot of diarrhea that was like jelly. Got her cleaned up and comfortable in bed.*

*10/07: Good day. Did not eat lunch or breakfast.*

*10/09: Good day! She didn't really touch her food.*

*10/10: She was soaked this morning and had dry BM in her brief.*

*10/11: Good day. Still very watery poop.*

*10/13: Resident was awake part of the night. Brief was changed @ 3am and 5am and 6:55am she had 2 small BM."*

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<p><b>(1) The owner, operator, and governing body of a home shall do all of the following:</b></p> <p><b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b></p>
<b>For Reference:</b>	<b>Definitions.</b>

<b>R 325.1901</b>	
	<b>(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.</b>
<b>ANALYSIS:</b>	Interviews conducted and review of documentation revealed Resident A exhibited loose and watery stools as early as 09/30/2024. The facility did not contact the physician until 10/010/2024 for a stool sample order. The facility did not act in a timely manner to ensure the protection and safety of Resident A.
<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 this license.

*Kimberly Horst*

10/21/2024

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 Kimberly Horst  
 Licensing Staff

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 Date

Approved By:

*Andrea L. Moore*

11/21/2024

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

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 Date