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 #: 2024A1021070
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 #:	2024A1021070
Complaint Receipt Date:	07/01/2024
Investigation Initiation Date:	07/01/2024
Report Due Date:	09/01/2024
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:	04/07/2024
Expiration Date:	07/31/2024
Capacity:	155
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident D did not have a service plan until after admission.	Yes
Facility has insufficient staff.	No
Employees are not trained.	Yes
Resident D had medication error.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/01/2024	Special Investigation Intake 2024A1021070
07/01/2024	Special Investigation Initiated - Telephone
07/02/2024	Inspection Completed On-site
07/04/2024	Contact-Documents Received
07/05/2024	Contact-Telephone call made Meeting held with HFA area manager
07/16/2024	Contact-Documents Received received additional documents
07/23/2024	Contact-Documents Received received additional documents
08/12/2024	Contact-Telephone call made Meeting held with facility management and HFA area manager
08/15/2024	Contact-Documents Received received resident service plans
08/26/2024	Special Investigation Status Report Sent
08/27/2024	Contact- Telephone call made Interviewed SP9
08/27/2024	Contact- Telephone call made

	Interviewed SP10
08/27/2024	Contact- Telephone call made Interviewed SP11
11/25/2024	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident D did not have a service plan until after admission.

INVESTIGATION:

On 07/01/2024, the licensing department received a complaint with allegations Resident D did not have a service plan until after admission.

On 07/01/2024, I interviewed the complainant by telephone. The complainant alleged Resident D admitted to the facility and did not have a service plan for many weeks after admission.

On 07/02/2024, I attempted to interview Relative D1 at the facility regarding the allegations on the service plan. Relative D1 reported it was not a good time to speak with this licensing consultant.

On 07/02/2024, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported Resident D admitted to the facility sometime in June 2024. Ms. Mulholland reported herself and staff person 1 (SP1) completed the assessment at an outside health facility. Ms. Mulholland reported Resident D and Relative D1 were present during the assessment.

I reviewed Resident D records. Resident D admitted to the facility on 06/02/2024. Resident D's service plan was signed by Ms. Mulholland and SP1 on 06/03/2024.

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:	Resident A admitted to the facility on 06/02/2024. However, the service plan was not finalized until 06/03/2024.
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:	The facility was unable to demonstrate Resident D and/or Resident D's authorized representative participated in the development of the service plan. **REPEAT VIOLATION: AH330405755_SIR_2024A1021011 Corrective Action plan dated 12/17/2023**
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged there is insufficient staff in the assisted living facility. The complainant alleged there are approximately 90 residents and there is usually about four staff.

Ms. Mulholland reported in assisted living there are 83 residents. Ms. Mulholland reported there are only 40 residents that are on a level of care. Ms. Mulholland reported there are two residents that could be a two person assist, 20 residents that require assistance with dressing and bathing, and one resident that is on frequent checks. Ms. Mulholland reported the population is cognitively intact and can press their call pendent for assistance. Ms. Mulholland reported the average call light response time is approximately six minutes. Ms. Mulholland reported if there is an unexpected staff shortage, staff members are asked to stay until a replacement worker is found. Ms. Mulholland reported for first and second shift there are four workers and on third shift there are two workers.

On 07/02/2024, I interviewed SP2 at the facility. SP2 reported there is typically two medication technicians that work on first shift. SP2 reported not all residents receive medication administration. SP2 reported medications are administered on time. SP2 reported no concerns with staffing levels.

On 07/02/2024, I interviewed SP3 at the facility. SP3 reported residents receive good care and care in a timely manner. SP3 reported there is significant staff at the facility.

On 07/02/2024, I interviewed SP4 at the facility. SP4 reported all residents receive good care. SP4 reported no concerns with staffing levels.

On 07/02/2024, I interviewed Resident E at the facility. Resident E reported care staff provide good care. Resident E reported there has been staff turnover but the staff respond quickly. Resident E reported no concerns with the amount of staff.

On 07/02/2024, I interviewed Resident F at the facility. Resident F reported she is very happy to be living at the facility. Resident F reported no concerns with staffing.

On 08/27/2024, I interviewed SP5 by telephone. SP5 reported she typically works on third shift and has worked in assisted living and memory care. SP5 reported she has no concerns with staffing levels at the facility.

On 08/27/2024, I interviewed SP9 by telephone. SP9 reported she typically works second shift. SP9 reported call lights are answered in a timely manner and residents receive good care. SP9 reported no concerns with staffing levels.

On 08/27/2024, I interviewed SP10 by telephone. SP10 reported she typically works third shift. SP10 reported there is sometimes insufficient staff due to unexpected staff shortages. SP10 reported sometimes there isn't replacement staff found.

On 08/27/2024, I interviewed SP11 by telephone. SP11 reported she typically works third shift. SP11 reported there have been times care staff will ignore pendants and not provide care to the residents. SP11 reported if there is an unexpected staff shortage, replacement staff is not always found.

I reviewed the staff schedule for 06/17/2024-06/30/2024 and 07/29/2024-08/11/2024. The schedule revealed the staffing guidelines as described by Ms. Mulholland were met.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	Interviews conducted and review of staff schedules revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees are not trained.

INVESTIGATION:

The complainant alleged staff members are not trained. The complainant alleged residents have had to teach staff how to give a shower. The complainant alleged residents have fallen, and staff are not aware of the fall policy or how to get the resident off the floor. The complainant alleged staff members are not trained in medical equipment, such as a power wheelchair.

On 07/01/2024, I interviewed Resident G by telephone. Resident G reported she had a fall in her room a few weeks ago. Resident G reported when she called for assistance, the caregiver was not sure how to get Resident G off the floor. Resident G reported the caregiver tried to pick her up incorrectly.

Resident F reported there have been new caregivers at the facility. Resident F reported she has had to educate the new caregivers on how to provide a shower.

Ms. Mulholland reported new staff go through a two-day orientation. Ms. Mulholland reported they are then paired with a season worker to shadow and complete care tasks. Ms. Mulholland reported they are paired with a seasoned worker for at least three days but can be longer depending on the experience of the worker. Ms. Mulholland reported there is one resident who uses a power wheelchair that cannot operate the wheelchair on their own. Ms. Mulholland reported most staff have been educated on how to use the wheelchair and the facilis is working on training the new staff that has been hired. Ms. Mulholland reported falls and incident reporting are trained in the medication technician training. Ms. Mulholland reported in orientation the facility reviews first aid and if there is a fall to call for medication technician for assistance. Ms. Mulholland reported there is a caregiver checklist that is to be completed. Ms. Mulholland reported it can be difficult to get the completed checklist returned to ensure competency of the worker.

SP4 reported she completed the orientation process when she began employment. SP4 reported she was appropriately trained in all caregiver tasks.

I reviewed *Continental Senior Communities New Hire Checklist*. The checklist revealed the orientation process was two days and various topics were covered as such first aid, personal care training, infection control, abuse and neglect, and facility policies and procedures. I reviewed *New Employee Training Packet*. The packet revealed the caregiver was to be trained in specific daily caregiver tasks and the supervisor was to sign for competency. Within the documents I did not observe any training on power wheelchairs.

I reviewed SP2, SP5, SP6, SP7, and SP8 employee records. SP2, SP5, SP7, and SP8 employee records did not have the *New Employee Training Packet* to ensure each caregiver was competent in caregiving tasks.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions**
ANALYSIS:	Review of employee records revealed the records had incomplete employee training documentation. **REPEAT VIOLATION: AH330405755_SIR_2024A1021011 Corrective Action plan dated 12/17/2023**
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident D medication error.

INVESTIGATION:

The complainant alleged Resident D had a medication error that resulted in a rash.

Ms. Mulholland reported no knowledge of a medication issue with Resident D. Ms. Mulholland reported management had conversations with medication technicians on

locating medications in the cart. Ms. Mulholland reported the facility was working with Resident D and Relative D1 on getting medication orders to the pharmacy.

I reviewed Resident D's medication administration record (MAR) for June 2024. The MAR revealed the following:

Medication A: Not administered 06/04-06/19, 06/21-06/23, 06/25-06/28 due to medication not in cart.
Medication B: On 06/11, 06/15, 06/20, 06/29 it was not recorded if it was administered.
Medication C: missed 25 out of 50 doses due to medication not in cart.
Medication E: not administered on 06/16 due to medication not in cart; On 06/11, 06/15, 06/16, 06/20, 06/29 it was not recorded if it was administered.
Medication F: not administered on 06/16 and 06/27 due to medication not in cart; On 06/11, 06/20, 06/29 it was not recorded if it was administered.
Medication G: 06/08, 06/15, 06/16 not administered due to medication not in cart.
Medication H: 06/04 and 06/16 medication not in cart; 06/11, 06/15, 06/16, 06/20, 06/29 it was not recorded if it was administered.
Medication I: 06/14-06/16 due to medication not in cart.
Medication J: 06/12 medication not in cart.
Medication K: 06/15-06/16 medication not in cart.
Medication L: 26 doses out of 55 not administered because medication not in cart; 4 doses it was not recorded if it was administered.
Medication M: missed three doses due to medication not in cart; nine doses were not recorded if it was administered.
Medication N: 06/11-06/17 medication not administered due to medication not in cart.
Medication O: medication not administered 06/09-06/16 due to medication not in cart
Medication P: medication not administered 06/12, 06/14, 06/16-06/19, 06/21-06/26 due to medication not in cart. 06/11, 06/15, 06/20, 06/29 it was not recorded if it was administered.
Medication Q: 06/14-06/17, 06/19-06/26 medication not in cart
Medication R: 06/14-06/16, 06/20 medication not in cart
Medication S:06/11, 06/15, 06/16, 06/20, and 06/29 it was not recorded if it was administered.
Medication T:06/04, 06/06-06/09, 06/11-06/21, 06/23, 06/27-06/28, 06/30 medication not in cart.
Medication U: 06/07, 06/15-06/27 medication not in cart.
Medication V: 6/12, 06/19, 06/26 medication not in cart.

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 D's MAR revealed multiple instances in which the medications were not administered as prescribed by the licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Mulholland reported there are 40 independent living residents in the facility and the residents are not on a plan of care.

I reviewed Resident H and Resident I service plan. The service plans revealed the residents were independent with activities of daily living and independent with medication management.

I reviewed Red Cedar Lodge program statement. The statement read,

> *"Our Mission is to provide residents, families and friends the absolute best experience in every interaction, with every person, every minute, of every day. Our activity program promotes creativity and sharing positive experiences with our residents, families, friends and care-givers through daily programs and in all interactions. We strive to meet each resident's needs and wishes as well as encouraging participation and interaction in planning daily activities and events. Our community promotes individuality and choice through menu selection, activity planning and customized daily schedules. This property is a licensed Home for the Aged (HFA) community providing support services to residents 55 and older. Red Cedar Lodge has 127 apt with the ability to serve 155 residents age 55 and older. 111 Apartments are Assisted Living 16 Apartments are designated for Memory Care."*

I reviewed Red Cedar Lodge marketing materials. The materials read,

> *"Red Cedar Lodge is the only luxury senior living community in the heart of Lansing. Adjacent to the Michigan State University campus, a vibrant and dynamic area that residents will find energizing. Red Cedar Lodge offers an unparalleled level of service and amenities from independent living to assisted living and memory care services."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**

	(2) The admission policy shall specify all of the following: **(b) That a home shall not accept an individual seeking admission unless the individual's needs can be adequately and appropriately met within the scope of the home's program statement.**
For Reference: MCL 333.21302	**“Supervised personal care" defined**
	(2) "Supervised personal care" means the direct guidance or hands-on assistance with activities of daily living offered by a facility to residents of the facility that include 2 or more of the following services provided by the facility to any resident for 30 or more consecutive days as documented in the resident's service plan: **(a) Direct and regular involvement by staff in assisting a resident with the administration of the resident's prescription medications, including direct supervision of the resident taking medication in accordance with the instructions of the resident's licensed health care professional.** **(b) Hands-on assistance by staff in carrying out 2 or more of the following activities of daily living: eating, toileting, bathing, grooming, dressing, transferring, and mobility.** **(c) Direct staff involvement in a resident's personal and social activities or the use of devices to enhance resident safety by controlling resident egress from the facility.**
ANALYSIS:	The licensee is offering independent living services to residents residing in a licensed home for the aged. In addition, the facility’s advertising of the services provided is misleading on its level of licensure.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident I’s MAR. Resident I’s June 2024 MAR revealed the following:

Medication A: 06/09-06/13 medication not administered due to medication not in cart.
Medication B: 06/01 medication not administered due to medication not in cart.
Medication C: 06/01, 06/28-06/29 medication not administered due to medication not in cart.
Medication D: 06/01 and 06/06 medication not administered due to medication not in cart.
Medication E:06/21-06/22 medication not administered due to medication not in cart.
Medication F: missed 10 out of 60 doses due to medication not in cart.
Medication G: 06/01 medication not administered due to medication not in cart.

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 I's MAR revealed multiple instances in which the medications were not administered as prescribed by the licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a corrective notice order.

Kimberly Horst 09/04/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/21/2024

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