GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

Erin Ottenbreit
CSL Rochester Master Operator, LLC
1450 West Long Lake, Suite 300
Troy, MI 48098

RE: License #: AH630387151
Investigation #: 2025A1019063

Dear Licensee:

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.

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) 335-5985.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630387151
Investigation #:	2025A1019063
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/18/2025
Report Due Date:	08/17/2025
Licensee Name:	CSL Rochester Master Operator, LLC
Licensee Address:	1450 West Long Lake, Suite 300 Troy, MI 48098
Licensee Telephone #:	(248) 583-6020
Administrator:	Patty Spina
Authorized Representative:	Erin Ottenbreit
Name of Facility:	Cedarbrook Of Rochester
Facility Address:	790 Letica Drive Rochester, MI 48307
Facility Telephone #:	(248) 583-6020
Original Issuance Date:	11/21/2019
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	85
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff failed to respond to Resident A's call light timely.	Yes
Additional Findings	No

III. METHODOLOGY

06/17/2025	Special Investigation Intake 2025A1019063
06/18/2025	Special Investigation Initiated - Telephone Notified APS of the allegations.
06/18/2025	APS Referral
06/23/2025	Inspection Completed On-site
06/23/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff failed to respond to Resident A's call light timely.

INVESTIGATION:

On 6/18/25, the department received a complaint that read Resident A was left on the toilet for two hours on the morning of 6/18/25. The complaint alleged that staff assisted Resident A to the toilet around 6:20am but didn't return until around 8:20am, despite him using his call pendant and pull cord to summon assistance.

On 6/23/25, I conducted an onsite inspection. I interviewed administrator Patty Spina and Employee 1 at the facility. The administrator and Employee 1 reported that Resident A is fully alert and oriented and can make his needs known, however has physical limitations. Employee 1 reported that per his service plan, Resident A requires staff assistance ambulating and getting to the restroom. The administrator and Employee 1 reported that Resident A has a call pendant kept on his person, and there is a pull cord located in the bathroom, which Resident A uses appropriately. When asked about the incident in question, both staff confirmed that the incident occurred. Employee 1 reported that call pendant/pull cord response data was reviewed, and Resident A pressed his call pendant at 6:21am and that Employee 2 responded at 6:29am prompting her to assist him to the bathroom. When interviewed, Employee 1 reported that Employee 2 reported that she left the

bathroom to get trash bags, responded to another resident's call pendant alert and ended up finishing her shift at 7:00am and forgot to return to Resident A's room. Employee 1 reported that Employee 2 reported that she did not notify the oncoming shift that Resident A needed to be tended to. Employee 1 reported that Resident A pushed his pendant three more times at 6:49am, then pulled his bathroom cord at 7:36am. Employee 1 reported that Employees 3 and 4 responded to the alert at 8:17am.

Employee 1 reported that all care staff carry iPads where the call pendant/pull cord alerts go to and reported that the alerts also go to the nurses' station. Employee 1 reported that after 20 minutes, the alerts get escalated to the managers and directors. The administrator reported that it was "*a failure on all levels"* and that the system in place during this event was ineffective.

A progress note authored by Employee 1 read:

> *Writer met with resident and private caregiver after staff alerted writer that resident was upset. Resident stated he was put on the toilet by midnight shift, his CNA was going to get trash bags and come back to assist him, and did not return. Resident's call light answered around 8:15AM. Writer spent time with resident, stated this was not normal for call lights to not be answered in a timely manner, and that staff education would be completed. Resident calmed down, stated that the girls do a good job with him and take care with him but that he was very upset due to the delay in care. Writer provided listening support. Writer also spoke to daughter twice the same day about incident and that education with staff will be completed. Will continue with current plan of care at this time.*

Employees 2, 3, and 4 were not present during my onsite visit but submitted statements attesting to the incident. Employee 2's statement read:

> *I [Employee 2] was the midnight aide assigned to care for [Resident A]. At around 6:20am [Resident A] pushed his pendant, alerting me he needed assistance. I answered his call, assisted him to the restroom, took his soiled underwear off, and realized his trash needed bags. So as he was using the restroom I proceeded to go get trash bags. In the process I answered call lights, lost track of time, and realized I needed to clock out. Totally forgetting [Resident A] was on the toilet and needed trash bags.*

Employee 3's statement read:

> *June 18th 2025 when I came on my shift I did my normal make breakfast orders and began to get everyone up around 8am I went into [Resident A's] room he was in the bathroom I asked him did he place hisself [sic] in the bathroom he said someone took him an [sic] said their [sic] going to get trash bags an [sic] from there I began to clean him up.*

Employee 4's statement read:

I got on my shift at 7am. I was getting my set of residents ready for breakfast. The caregiver on the set of [Resident A] came to ask me to help her with [Resident A]. it was 8:15am. he was on the toilet. He stated he was on the toilet since 6:20am. I was not on that set and didn't notice he was paging because I was getting everyone ready on my set.

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	**(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.** **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: (iv) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	On the morning of 6/18/25, facility staff assisted Resident A to the bathroom but admittedly forgot to return and assist him off the toilet, leaving him for a period of almost 90 minutes. Emergency response data confirms that Resident A intermittently utilized his call pendant and bathroom pull cord to summon staff, however staff did not respond to the alerts timely.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/25/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/30/2025

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