GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2025

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

RE: License #: AH330405755
Investigation #: 2025A1021067
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 was required. On 07/22/2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

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 #:	2025A1021067
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/21/2025
Report Due Date:	09/15/2025
Licensee Name:	Red Cedar Senior Living Holdings, LLC
Licensee Address:	150 East Broad Street Columbus, OH 43215
Licensee Telephone #:	(614) 221-1818
Administrator:	Patricia Laugavitz
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A1021067
07/21/2025	Special Investigation Initiated - On Site
07/23/2025	Contact-Telephone call made
07/31/2025	Exit Conference

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 07/16/2025, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A eloped from the facility. The APS reporting source alleged Relative A1 was initially told that Resident A was in the parking lot for approximately 10 minutes and was then coaxed back into the facility. The APS reporting source alleged it was later learned that the facility did not know the whereabouts of Resident A and that Resident A was found at a nearby hotel.

On 07/17/2025, the licensing department received another complaint with similar allegations.

On 07/21/2025, I interviewed facility administrator Patricia Laugavitz at the facility. The administrator reported on 06/23/2025, Resident A did leave the facility but was always within the eyesight of caregivers. The administrator reported Resident A went to the exit doors, the alarm sounded, and the doors unlocked. The administrator reported Resident A was able to be coaxed back into the facility. The administrator reported Resident A's family was then immediately contacted to inform them of this incident. The administrator reported caregivers are trained and have been re-trained

in ensuring the doors are secure. The administrator was unable to produce documentation of said training.

On 07/21/2025, I interviewed SP5 at the facility. SP5 reported a resident was moving out of the facility and the exit doors were propped open. SP5 reported Resident A left the facility and started to walk across the parking lot and to the hotel. SP5 reported Resident A did not want to return to the facility. SP5 reported Resident A was followed by caregivers during this entire time. SP5 reported Resident A was eventually able to be convinced to return to the facility. SP5 reported Resident A's family was notified of the incident.

On 07/21/2025, I interviewed staff person 1 (SP1) at the facility. SP1 reported there were two elopements on 06/23/2025. SP1 reported she was clocked out for the day and was leaving the facility when an outside vendor reported they observed a resident leaving the facility with a purple walker. SP1 reported this was Resident B who resides in the assisted living unit. SP1 reported Resident B was brought back into the facility. SP1 reported the second shift then completed a head count and could not locate Resident A. SP1 reported caregivers searched the entire inside of the memory care unit and still could not locate Resident A. SP1 reported caregivers started searching the parking lots and various other outside locations for Resident A. SP1 reported the nearby hotel contacted the facility because there was a resident that was found in the hotel hallway. SP1 reported caregivers responded to the hotel, found Resident A, and brought Resident A back to the facility. SP1 reported it was very hot on this day and Resident A was wearing a fleece jacket and had a blanket. SP1 reported Resident A appeared to be fatigued and confused when Resident A was found. SP1 reported Resident A was uncounted for approximately 10-15 minutes. SP1 reported the service door was not alarmed as it was not re-set from the day prior to this incident. SP1 reported that the medication technician is to ensure the doors are alarmed and locked at each shift change. SP1 reported that the medication technicians have not been properly trained on the door alarms and how to re-set them.

On 07/21/2025, I interviewed SP3 at the facility. SP3 reported on she was on the fifth floor and observed a resident in the parking lot. SP3 reported that caregivers went outside and brought this resident, who is Resident B, back inside the facility. SP3 reported soon afterwards, SP2 reported that Resident A was unable to be located. SP3 reported caregivers then started to search outside the facility for Resident A. SP3 reported the receptionist at the facility received a phone call from a local hotel inquiring if the facility had a missing resident. SP3 reported caregivers went to the hotel and brought Resident A back to the facility. SP3 reported it was very hot outside and when Resident A was found she appeared to be fatigued and confused.

On 07/21/2025, I interviewed SP4 at the facility. SP4 reported she may have received a telephone call from the hotel on 06/23/2025 for a resident but she is uncertain if this did occur.

On 07/21/2025, I viewed facility camera footage of the exit doors at the facility. The footage showed on 06/23/2025, Resident B was able to exit the facility at approximately 3:16pm. The camera footage showed Resident A exited the facility at approximately 3:14pm. The footage revealed no caregivers were with the residents when they exited the facility.

On 07/23/2025, I conducted a video conference with authorized representative Jody Linton and SP6. The authorized representative and SP6 reported after my onsite visit that a thorough investigation was completed due to the inconsistences in information gathered during in my interviews. The authorized representative and SP6 reported there now has been additional training and education provided to the facility on incident reporting, investigating, and documentation. The authorized representative and SP6 reported that new policies and procedures have also been put in place.

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

"06/23/2025: Resident held door over 15 seconds, door released, alarm sounded, resident exited building, movers observed resident walking into parking lot, at that time staff went to assist with resident, resident did not immediately want to return into community, staff assisted resident indoors, FVS WNL, resident offered water and refused. Staff to provide frequent checks on resident.

06/23/2025: This nurse and ED spoke with resident's daughter, POA regarding incident.

06/25/2025: Received a phone call from resident's daughter inquiring about the incident that occurred on 6/23/25. Informed her that I was not present in the building at time of the incident, but had received a full report from staff. Explained that staff maintained visual supervision of the resident throughout the event and assisted her in returning to the building as promptly as possible. The resident was initially resistant but responded to redirection and re-entered the building safely. Upon return, VSS, resident was in good spirits and displaying no signs of distress."

I reviewed Resident B's facility observation notes. The notes read,

05/21/2025: At 8:45pm resident got on the service elevator with writer. Resident was confused and trying to get off in the back service hallway behind (memory care). Talking about going to the lobby to get help contacting her sons. Writer redirected resident to her room. Please make sure checks are being done on resident as she would have gotten outside if I wouldn't have already been on the elevator.

06/14/2025: This resident went down the service elevator and ended up coming into (memory care). I escorted her to the lobby and had the receptionist call for a CG on AL to come and get her and take her back to her room.

06/21/2025: Resident observed walking around the block-escorted inside by writer. Noted to take multiple breaks from fatigue d/t weather being 91 degrees. WD notified.

06/23/2025: Resident is exit seeking, resident was attempting to go for a walk outdoors with 90-degree weather, staff stayed with resident and continued resident to come indoors, resident finally agreed to come back indoors. Family notified.

06/24/2025: Resident continues to exit seek, resident is not safe to be leaving the building due to current mental status. Staff provided 1:1 for resident's safety, family notified and Care Patrol 1:1 discussed."

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:	The facility lacked an organized plan of protection as evidenced by Resident A and Resident B were both able to exit the building unsupervised. During the investigation into this complaint, the facility completed an internal investigation into the details of the events 06/23/2025. On 07/22/2025, the facility submitted a corrective action plan to prevent future recurrence of these events, including resident elopement. The corrective action plan has been reviewed and accepted to correct this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite on Monday July 21st, 2025, I observed the exterior doors from the memory care unit to the parking lot. There were two exterior doors that exited from the memory care unit to a fenced exterior courtyard. In this courtyard there were two dumpsters and other trash items. This courtyard had gates that were open and were not secure. In addition, the fencing unit was broken at two separate areas. The broken areas were wide enough to allow a resident to leave this area and gain access to a busy parking lot and various other businesses.

The administrator reported the fence has been broken since she started at the facility in January 2025. The administrator reported that the facility submitted their request to the corporate office for a vendor to fix the fence. The administrator reported that the gates are opened when the trash is removed on Thursday and maintenance is to secure the gates afterwards.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations conducted revealed the facility has had broken exterior fence since January 2025. By having this broken fence, it allows cognitively impaired residents to easily gain access to a busy parking lot and various other businesses. On 07/22/2025, the facility submitted a corrective action plan to prevent future recurrence of these events, including resident elopement. The corrective action plan has been reviewed and accepted to correct this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received. I recommend no change in the status of the license.

07/24/2025

_____

Kimberly Horst — Date
Licensing Staff

Approved By:

07/31/2025

_____

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