GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 4, 2023

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

RE: License #: AH330405755
Investigation #: 2024A1021011
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

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 #:	2024A1021011
Complaint Receipt Date:	10/31/2023
Investigation Initiation Date:	11/01/2023
Report Due Date:	12/30/2023
Licensee Name:	Red Cedar Senior Living Holdings, LLC
Licensee Address:	150 East Broad Street Columbus, OH 43215
Licensee Telephone #:	(614) 221-1818
Administrator:	Abi 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:	04/07/2023
Expiration Date:	04/06/2024
Capacity:	155
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility unsupervised.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/31/2023	Special Investigation Intake 2024A1021011
11/01/2023	Special Investigation Initiated - Letter referral sent to APS
11/02/2023	Inspection Completed On-site
11/03/2023	Contact - Telephone call made interviewed SP4
11/13/2023	Contact-Documents Received Received additional facility documents
12/04/2023	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 A left the facility unsupervised.

INVESTIGATION:

On 10/31/2023, the licensing department received a complaint with allegations Resident A left the building unsupervised. The complainant alleged Resident B also left the facility unsupervised in the same manner Resident A did.

On 11/01/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 11/02/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A resides in the memory care unit and tends to wander throughout the

facility. SP1 reported when Resident A exited the facility, the door alarm did alert caregivers and caregivers reported the door was secured. SP1 reported kitchen staff found Resident A outside and brought her back into the facility. SP1 reported following this incident, the door alarm is louder and at all shift change caregivers are to check the door alarms.

On 11/02/2023, I interviewed interim administrator Jenel Stoinski at the facility. Ms. Stoinski reported on the day Resident A eloped there was a new resident moving into the facility. Ms. Stoinski reported Resident A left the facility out the north side door, SP2 found Resident A outside, and brought Resident A back into the facility. Ms. Stoinski reported after this incident occurred, Resident A is now on hourly checks and at each shift change caregivers are to check the alarms on the doors. Ms. Stoinski reported there may have been an in-service for caregivers regarding door alarms, but she is not entirely sure as she was not at the facility when this incident occurred. Ms. Stoinski reviewed the quality improvement program documentation and did not find any documentation of any additional residents leaving the building unsupervised.

On 11/02/2023, I interviewed SP2 at the facility. SP2 reported she was leaving the facility for the day and when she got outside, she found Resident A by the north side hallway door near the dumpsters. SP2 reported she brought back Resident A back into facility. SP2 reported on the walkie-talkies she heard the alarm going off but that the door was secured.

On 11/02/2023, I interviewed SP3 by telephone. SP3 reported she was working in the assisted living unit when Resident A left the facility. SP3 reported she heard the door alarm go off three times and every time other staff members reported the door was secured. SP3 reported when she came back to the memory care unit, she was told Resident A was found outside. SP3 reported Resident A is now on hourly checks and at all shift change caregivers are to check the door alarm. SP3 reported Resident B has also left the building unsupervised.

On 11/02/2023, I interviewed SP5 by telephone. SP5 reported that she was working in memory care when Resident A left the facility. SP5 reported she went to the assisted living unit to set a pendent for a new resident. SP5 reported on her walkie talkie she heard the door alarm go off three times and asked each time if the door was secured. SP5 reported caregivers in the unit reported the door was secured. SP5 reported when she came back to the memory care unit, she was told that Resident A exited the building. SP5 reported a resident was moving in that day and was using that day so it is unclear if the door was secure or if the caregivers checked the door. SP5 reported caregivers are now to check the door alarm at every shift change. SP5 reported Resident B has also left the building unsupervised.

On 11/02/2023, I interviewed SP4 by telephone. SP4 reported that she was working in the memory care unit when Resident A exited the building. SP4 reported she is not certain if the door alarm went off. SP4 reported she is unsure how the door

works as she is a newer employee. SP4 reported Resident A was brought back into the facility by another staff member.

I reviewed *Door Check Compliance to be done by Med Tech* documentation sheet for October 2023. The sheet revealed the medication technician is to check the doors are locked and are alarms are working at the start of each shift. This documentation revealed it was not checked on 10/27 at 11:00pm, 10/29 at 7:00am, 10/29 at 3:00pm, 10/29 at 11:00pm, 10/30 at 11:00pm, and 11/02 at 7:00am.

I reviewed potential in-service titled *Exit Doors/Elopements* sign in sheet. The documentation revealed multiple different staff members in various departments attended the in-service. It is not entirely clear what the in-service educated employees on as the wellness director that provided the education is no longer with the company.

I reviewed observation notes for Resident A. The note read,

> *"10/24/2023: Resident reported to be retrieved from outside (near back mc exit door) by kitchen employe (SP2). (SP2) reported an incident to reception whom then reported incident to care staff. MC door resident exited from alerted walkies of opening 3x, reported by staff to be secure 3x prior to confirmed incident. WD, and ED notified. WD stated she would inform DPOA. Frequent checks of door security ordered by WD/ED."*

I reviewed observation notes for Resident B. The notes read,

> *"07/16/2023: Observed residents walker holding open the north hallway door, resident was found outside in the dumpster area trying to open the gate to get out. I re-directed resident back inside and she is doing a word search now sitting down. Residents daughter has not yet been in to see her today. Resident has been in courtyard for a walk as well. Will continue to keep her busy and monitor. Resident was found outside the north hallway door but still inside the white gated area. Resident was outside for less than 30 seconds until staff arrived after hearing door alarm and directed resident back inside.*
> *08/25/2023 0936: At approximately 0915 resident was observed in the MC court yard dumping out her coffee. Resident was then observed by (SP6) in the parking lot of red cedar lodge wandering around at approximately 0920. Caregiver was notified by front desk reception that resident had left the building. Immediately I ran out through the court yard doors through the unlatched gate and met the resident and escorted her back into the building back in the memory care unit.*
> *08/25/2023: 1124: Incident type elopement: resident was observed in the main parking lot by (SP6). Resident was last observed by (SP7) approx.. At 9:15am in the mc courtyard dumping coffee into landscaping. Resident was observed by security cameras exiting memory care main courtyard side door at approx. 9:13am wearing appropriate clothing no walker, proper fitting footwear, purse and*

coffee in hand. Resident dumped coffee into landscaping while ambulating to MC gate. Resident was observed exiting gat at approx. 9:14am. (SP7) then entered the main building entrance with resident at approx.. 9:20am. Resident was easily directed. Maintenance notified to change door code, activities will make a sign stating emergency door exit only for both side of gate, lock on MC main courtyard door, and daily checklist per shift that will include door checks daily per shift to check MC gate door is secure as well as all MC doors for audible alarms.
08/26: Nurse observed resident outside of the community, in the parking lot, trying to enter the parked vehicles."

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 documentation revealed on 07/16, 08/25, and 08/26, Resident B was able to exit the facility unsupervised. Following the elopements, staff members were to check the doors and the audible alarms. On 10/24, Resident A was able to exit the facility unsupervised. Following this incident, facility implement the corrective action of having the medication technician be responsible for ensuring compliance with the security of the doors and the audible alarms. Review of documentation revealed this compliance check is not completed consistently to ensure protection.

	The facility lacks an organized program of supervision and reasonable protective measures to keep the cognitively impaired resident population safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Inspection at the facility revealed the authorized representative Rose Siddle and the administrator Kelly Wriggelsworth were no longer with the facility. Ms. Siddle last day with the company was on 10/25/2023. On 11/07/2023, the licensee submitted required paperwork to appoint Jody Linton as the new authorized representative.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The facility did not provide written notice to the department within 5 business days of the changes with the authorized representative and administrator.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident A’s service plan read,

“safety checks 2 hour checks, redirection during periods of wandering, 1 person assist with showers, supervision required when leaving memory care unit as well as community, assistance to sign in and out of the facility. Reminders for meals, independent with ambulation.
Secured Community- As needed
Wander Assistance-Monitoring- As needed
Orientation Assistance- As needed
LOW risk for oversight and/or monitoring- As needed
Ambulation-Partially independent”

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A's service plan revealed inconsistencies in the service plan and the level of care the facility was to provide. Resident A has left the facility unsupervised and Resident A was identified in the service plan to wander. However, within the service plan, it does not define how staff are to assist Resident A with these behaviors only that it was on a "PRN need." In addition, Resident A was identified as independent with ambulation as well as partially independent.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of SP4 employee training record revealed on 10/04/23, SP4 participated in new employee training. The training consisted of human resource information, emergency disaster training, enrichment training, culinary training, and customer service training. SP4 record did not include any additional required training documentation.

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.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**

ANALYSIS:	Review of SP4 employee record revealed no record that SP4 completed required employee training.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of SP4 employee record revealed SP4 simply signed into new staff orientation training.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	Review of SP4 employee record revealed no record that SP4 was evaluated for competencies.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 11/30/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 12/04/2023

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