GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Nozmi Elder
Cedar Woods Assisted Living
44401 I-94 S Service Dr
Belleville, MI 48111

RE: License #: AH820304947
Investigation #: 2025A0628021
Cedar Woods Assisted Living

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 responsible party 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) 335-5985.

Sincerely,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820304947
Investigation #:	2025A0628021
Complaint Receipt Date:	09/02/2025
Investigation Initiation Date:	09/08/2025
Report Due Date:	11/01/2025
Licensee Name:	Willow Commons, LLC
Licensee Address:	44401 I-94 S. Service Dr. Belleville, MI 48111
Licensee Telephone #:	(734) 699-2900
Administrator:	Robin Wojtowicz
Authorized Representative	Nozmi Elder
Name of Facility:	Cedar Woods Assisted Living
Facility Address:	44401 I-94 S Service Dr Belleville, MI 48111
Facility Telephone #:	(734) 699-2900
Original Issuance Date:	05/21/2010
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	210
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility lacked an organized program to provide protection, supervision and assistance to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

09/02/2025	Special Investigation Intake 2025A0628021
09/03/2025	Contact - Document Sent email sent to administrator requesting additional information
09/04/2025	Contact - Document Received email received with requested documentation
09/08/2025	Special Investigation Initiated - On Site
09/08/2025	Contact - Document Sent Email sent to the administrator requesting additional information
09/08/2025	Contact - Telephone call made Phone call made to complainant. The complainant asked me to send an email
09/08/2025	Contact - Document Sent Email sent to complainant requesting additional information
09/09/2025	Contact - Document Received Email received. The complainant is unable to provide the requested documentation at this time
09/17/2025	Contact - Telephone call made Phone call made to Van Buren fire department requesting additional documentation
09/17/2025	Contact - Document Sent Email sent to Van Buren fire department records department requesting additional documentation
09/17/2025	Contact - Document Received Email received with requested documentation

09/18/2025	Contact – Document Sent Email sent to administrator requesting additional documentation
09/19/2025	Contact – Document Received Email received with requested documentation
09/30/2025	Exit conference completed with Nozmi Elder and Robin Wojtowicz

ALLEGATION:

The facility lacked an organized program to provide protection, supervision and assistance to Resident A.

INVESTIGATION:

On 09/02/2025, the department received a complaint that read in part

> "*On the date listed above, my department was dispatched on a medical. Per our dispatch we were told the patient had fallen an hour prior to calling 911 and was unable to move her arms and legs. Upon our arrival we found the patient unattended, low oxygen levels and what seemed to be fall matts placed around her bed with no bed rails in place. Almost as if she had fallen out of bed multiple times. My team provided care and vitals improved. Patient stated she was in pain from hitting her head and also had an altered level on consciousness. Staff instead (sp?) she didn't, which I find hard to believe considering it was an unwitnessed fall. All of that being said I personally had to go and find a staff member to get more information. The staff member was very unprofessional, rude and even scalding (sp?) the patient. I found this call very disturbing and neglectful. I failed to get the care givers information, busy with patient care."*

On 09/08/2025, while onsite, I conducted an on-site inspection and interviewed Administrator Robin Wojtowicz and Employee #1. The administrator reported that Resident A had a fall on 08/26/2025 and was transported to the hospital. I reviewed the incident report for Resident A, dated 08/26/2025. The incident report stated the time of the fall for Resident A was 3:24pm, that EMS was called at 3:30pm and that EMS arrived at 3:40pm to transport Resident A to the ER. The chart notes dated 08/26/2025 state Resident A was sent to St. Joe's Hospital at 3:30pm. On 08/29/2025, the chart notes state that Resident A returned to the facility at 1:24pm.

While onsite, I interviewed Employee #2, who completed the incident report for Resident A on 08/26/2025. Employee #2 reported that Resident A did not have a fall. They reported that Resident A was yelling from their room, "Help. Help. Help." Employee #2 reported they heard this from the hallway and went to check on

Resident A. They reported that Resident A was complaining of numbness from their neck down. Employee #2 reported that Resident A did not have a fall. When reminded by the administrator, that the incident report stated Resident A had a fall, Employee #2 reported, “that must have been a different day”, but was unable to confirm what date Resident A fell. An incident report dated 08/24/2025, and completed by Employee #3, states Resident A had an unwitnessed fall at 5:13am and was sent to St. Joe’s Hospital at 5:40am.

Review of the Van Buren Fire Department run sheet for 08/26/2025 revealed it was time-stamped 8:51pm when the department was dispatched to Cedar Woods Assisted Living. The facility was unable to produce an incident report for 08/26/2025 at 8:50 PM, when the 911 call came into the Van Buren Fire Department.

Additionally, a review of the medication administration record revealed that melatonin was documented as given at bedtime on 08/26/2025, Lamotrigine was documented as given at 7:00pm, and Oxycodone was documented as given at 6:00pm. Per the facility’s medication administration policy, “The time listed on the medication sheet is when to pass the medication. You may give the medication up to one (1) hour before or one (1) hour after that time. EXAMPLE: Med time is 9am you have a window from 8am (one hr before) to 10am (one hr after). If the medication was not passed within that time, you must follow the Missed Medication Procedure. This is considered a medication error. Know what times medications are required for the residents you are working with by checking at the beginning of each shift you work.”

Review of the Activities of Daily Living (ADL) log for Resident A revealed that staff had signed off completing ADL care for Resident A on 08/26/2025 and 08/27/2025 during timeframes that chart notes and the incident report stated Resident A was hospitalized. Twenty-three ADL activities were charted as completed with Resident A during the timeframe Resident A was allegedly hospitalized, per the facilities own documentation.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all 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 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.**
For Reference: R 325. 1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Review of Resident A's service plan states Resident A is a low fall risk. However, Resident A's service plan also states she threatens to throw herself on the floor and has done so in the past. Additionally, Resident A's service plan states she is a one-person assist with transfers and ADL log states they require a two-person assist with transfers. Review of Resident A's ADL log revealed numerous ADL activities signed off as completed by staff in the facility during the timeframe that the facility documented that Resident A was hospitalized. Review of Resident A's medication administration record showed three medications signed off as given to Resident A after the facility documented Resident A had been sent to the hospital. Review of documentation provided by the Van Buren Fire department does not match the time of the incident on the facility incident report. Through interviews with staff members, review of documentation from the Van Buren Fire Department, review of facility documents, including the service plan for Resident A, chart notes, the facility incident report from 08/26/2025, Resident A's medication administration log and ADL log it is clear the home's documentation does not align, and staff statements do not match the incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/22/2025

Rebekah Looney
Licensing Staff

Date

Approved By:

_____

Andrea Moore Date
Area Manager