GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

Alexandra Allie
Linden Square Senior Care
650 Woodland Drive East
Saline, MI 48176

RE: License #: AH810334704
Investigation #: 2025A0784080
Linden Square Senior Care

Dear Alexandra Allie:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2025A0784080
Complaint Receipt Date:	08/27/2025
Investigation Initiation Date:	08/27/2025
Report Due Date:	10/26/2025
Licensee Name:	Linden Square Senior Care, LLC
Licensee Address:	7366 N Lincoln Ave Suite 304 Lincolnwood, IL 60712
Administrator/Authorized Representative:	Alexandra Allie
Name of Facility:	Linden Square Senior Care
Facility Address:	650 Woodland Drive East Saline, MI 48176
Facility Telephone #:	(734) 429-7600
Original Issuance Date:	06/21/2013
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	187
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care for Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

08/27/2025	Special Investigation Intake 2025A0784080
08/27/2025	Special Investigation Initiated - Telephone Attempted contact with complainant. Messge left requesting return call
08/28/2025	Contact - Telephone call made Interview with complainant
09/03/2025	Contact - Telephone call made Interview with Administrator Alexandra Allie and Staff 1
09/03/2025	Contact - Document Sent Investigative document/information request sent to staff 1 and Admin via email
09/04/2025	Contact - Document Received Investigative documents received via email
10/31/2025	Exit - Email Report sent

ALLEGATION:

Inadequate care for Resident A

INVESTIGATION:

On 8/27/2025, the department received this complaint.

According to the complaint, Resident A is a person who required assistance for transfers from staff as she was unable to walk or transfer on her own. On 8/04/2025, she received a mobile x-ray at the facility and was diagnosed with a fractured femur.

On 8/05/2025, Resident A was transferred to U of M hospital in order to have surgery for the fractured femur. On 8/06/2025, Resident A passed away during the attempted surgery. Upon her passing, an investigation was done to determine how Resident A may have obtained the fracture. It was discovered that, after reviewing facility hallway camera footage, on 7/24/2025 at approximately 12:45pm, a staff member wheeled Resident A into her room. Several minutes after this, two additional staff came to the room with all three staff leaving the room approximately 45 minutes later. After discussing this with facility administration, it was discovered that interviews with at least one staff member revealed Resident A had been dropped.

On 8/28/2025, I interviewed complainant by telephone. Complainant stated that Resident A had been expressing pain for several days prior to 8/04/2025. Complainant stated that prior to ultimately having Resident A receive the mobile x-ray on 8/04/2025, the facility did not report any falls or related issues that may have caused Resident A to have additional pain beyond what was normal for her. Complainant stated that due to Resident A's health decline, she was placed on hospice as of 7/30/2025. Complainant stated that hospice had visited with Resident A several times between 7/30/2025 and only treated Resident A's pain with medication. Complainant stated that due to Resident A's increased expression of pain, Resident A's family insisted she have a mobile x-ray. Complainant stated that when Resident A's family mentioned that Resident A appeared to be in increasing pain prior to 8/04/2025 for a few days, a staff member indicated it had been more than a few days related to an incident that happened on 7/24/2025. Complainant stated it was not until after Resident A was determined to have a fracture to her femur and subsequently sent to the hospital on 8/05/2025 that an investigation was done by the facility to determine if something happened to her.

On 8/29/2025, I received an email from complainant further summarizing the circumstances related to Resident A's injury and subsequent investigation into the matter. The email read, in part, "[Resident A] was a resident at Linden Square Assisted Living Facility for several years. She could not walk or stand on her own and required health aides to move her between bed and wheelchair and chair. On August 5, 2025, she was transferred by ambulance from Linden Square to UM Hospital after the results of a portable x-ray conducted the previous evening (August 4) revealed that she had a fractured femur. She died on August 6, 2025, at University of Michigan Hospital during surgery to repair the fractured femur. In the days following her death, the Medical Examiner requested and received clarifying information from Linden Square about this injury. Linden Square reviewed video tapes to determine that some incident happened on July 24, 2025, in her room. On Friday, August 8, [a family member] visited Linden Square to ask staff how a non-ambulatory resident paying for healthcare services including assisted transfer could have gotten a fracture. He was told about the investigation that they had started after they heard from the Medical Examiner. He was told that Linden Square's recorded videos from the hallway illustrate that on July 24, around 12:45pm, one aide wheeled mom in a wheelchair into her room. Several minutes later, 2 additional aides rushed

into the room. Sometime later (perhaps 45 minutes), all 3 aides left the room. [The family member] was told by Linden Square staff that they had interviewed one or more of the aides involved and had determined that my mother was dropped. No incident or record of a fall, drop, or abuse was ever reported. The Medical Examiner ultimately listed the cause of death on the certificate is “Complications of Left Distal Femur Fracture” and “Blunt Force Trauma to the Left Lower Extremity due to Unknown Causes” and the manner of death as “Accident”.

I reviewed resident A’s *CERTIFICAE OF DEATH* which read consistently with statements provided by complainant.

On 9/03/2025, I interviewed Staff 1 and administrator Allie Alexandra by telephone. Both were present via speaker phone. Administrator stated she was not present at the facility when the incident happened. Administrator stated the investigation into the matter was completed by staff 2 who she stated no longer works at the facility. Staff 1 stated that upon investigation, it was discovered that staff 3 had attempted to transfer Resident A from her walker to her bed as Resident A required staff assistance for transfers per her service plan. Staff 1 stated staff 3 did not admit to dropping Resident A during the transfer, but that two other staff, staff 4 and 5, were called to room to assist Resident A off the floor as Resident A ended up on the floor during the attempted transfer. Staff 1 stated staff 3 was terminated for the incident as well as for not reporting the incident. Staff 1 stated staff 6, the supervisor on duty at that time, reported that staff 3, 4 and 5 never reported any “code white” (internal facility code word for falls) with Resident A at that time. Staff 1 stated staff 3 reported Resident A did not fall but reportedly stopped supporting her own weight and became too heavy so Staff 3 reported lowering Resident A to the ground. Staff 1 stated staff 3 was a seasoned employee and should have known to notify supervision once the incident occurred. Staff 1 stated staff 3 had also been trained on how to conduct a proper transfer. Staff 1 stated that during the investigation into the matter, staff 4 and 5 were also asked to provide statements regarding the incident as they had been called to the room to assist.

I reviewed staff 3’s termination document titled Final Written Warning, provided by staff 1. The document was dated 8/05/2025 and read consistently with staff 1’s statements regarding the reason for staff 3’s termination.

I reviewed staff 3’s training documents, provided by staff 1. The documents read consistently with staff 1’s statements indicating staff 3 had been trained in proper transferring techniques which included having to demonstrate competency.

I reviewed Resident A’s service plan which read consistently with statements provided by staff 1 regarding Resident A’s need for assistance with transfers.

I reviewed written statements from staff 4 and 5, provided by staff 1, regarding the incident in question. Both statements read consistently with staff 1 statements regarding staff 4 and 5 being called to Resident A’s room to assist Resident A off the

floor into her bed. In staff 4's statement, he noted that staff 3 told him Resident A "went dead weight so I sat her on the floor". Staff 5 indicated she and staff 4 "were not aware [Resident A] had fallen. Regarding Resident A's leg pain, staff 5's statement read, in part, "while my trainee and I were changing the resident, they complained of leg pain" and staff 4's statement read, in part, "when we put her in bed she complained many times about her left leg being in pain as we moved her around for repositioning"

I reviewed a written statement from staff 6, provided by staff 1. Regarding the incident in question, staff 6's statement read, in part, "[Staff 5, 4, nor 3] said anything to me about the fall. Me and [staff 5] never even had a conversation. Nobody said the resident was complaining of pain even when they had her in her chair and stepped in [Resident A's room] or indicated that she was in pain. I WAS UNAWARE OF ANYTHING THAT HAPPENED".

I reviewed Facility Observation notes for Resident A dated between 7/20/2025 and 8/05/2025. No notes were entered for 7/22/2025 through 7/27/2025. Notes dated 7/28/2025 read "The left knee is swollen and tender to touch. The family is aware. There is slight bruising along the inner knee. She was given PRN pain medication and icepack to keep the swelling down". Notes dated 7/29/2025 read, "NAPROXEN 500 MG TABLET given to resident for pain in knee". Notes dated 7/30/2025 read "the writer was called to come to resident's room. The resident's left leg is painful and has some bruising. The hospice nurse assesses resident. The resident's POA was notified that the resident's leg was hurting". Notes dated 8/03/2025, time stamped at 2:45pm, read, in part, "Resident given 0.25 ml of morphine at 1:22pm witnessed by supervisor. The resident was having pain in her knee rated it a 10". Notes dated 8/03/2025, time stamped at 6:30pm read, "the left leg is still swollen and bruised, especially around her knee, and the resident is still complaining about pain. She was seen by hospice around 5pm tonight". Notes dated 8/05/2025, time stamped at 2:15pm read, in part, "on 8/05/2025 at 7:45am, the writer received a call from Optimal Hospice that resident's left femur was fractured". Notes dated 8/05/2025, time stamped at 5:30pm, read "At 915am on 8/05/2025, while reporting to DON what was happening with the resident, shift supervisor also stated that an aide [staff 5] mentioned a fall with this resident during her training. Shift supervisor told aide to write a statement and give to DON [Director of Nursing] immediately. DON then began an investigation as a fall was never reported. Upon receiving [staff 5's] statement, other staff members were involved and also asked to write statements and were also questioned by DON with ADON [Assistant Director of Nursing] present as a witness. After reviewing camera footage, obtaining witness statements and questioning all employees involved, it was determined that the resident was lowered to floor/sustained a fall that was unreported".

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.**
ANALYSIS:	The complaint alleged inadequate care was provided for Resident A after she had a fall during an apparent attempted transfer by staff. While evidence reviewed for the investigation and interviews with staff could not confirm if Resident A had a fall, it was revealed that Resident A did end up on the floor after an attempted transfer. Based upon statements provided by staff present after the incident, it was clear to the staff that Resident A was in pain as a result of ending up on the floor, which was never reported to supervision. Based on the findings, the allegation is substantiated. Additionally, it should be noted that while facility administration did take measures to address staff 3, no actions were taken to address the fact that both staff 4 and 5 even though they both reported that Resident A was reporting pain after the incident but neither of them reported this to supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, staff 1 and administrator both confirmed that no incident report was created related to the incident in question due to staff not reporting the incident. Both staff 1 and administrator agreed this was a lack of adherence to the facilities incident reporting policies.

I reviewed the facilities Incident Report Notification policy, provided by administrator, which read consistently with staff 1 and administrators statements regarding incident reporting. The policy read, in part, “an incident report should be completed for each occurrence regardless of injury”.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 10/22/2025

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 10/30/2025

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