GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 18, 2020

Lauren Gowman
Linden Square Assisted Living
650 Woodland Drive East
Saline, MI 48176

RE: License #: AH810334704
Investigation #: 2021A0784006
Linden Square Assisted Living

Dear Mrs. Gowman:

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. 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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2021A0784006
Complaint Receipt Date:	11/20/2020
Investigation Initiation Date:	11/20/2020
Report Due Date:	01/19/2020
Licensee Name:	Linden Square Assisted Living, LLC
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Robert Kamp
Authorized Representative:	Lauren Gowman
Name of Facility:	Linden Square Assisted Living
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:	01/10/2020
Expiration Date:	01/09/2021
Capacity:	187
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly supervised	Yes
Additional Findings	Yes

III. METHODOLOGY

11/20/2020	Special Investigation Intake 2021A0784006
11/20/2020	Special Investigation Initiated - Telephone Contact attempted with complainant
11/20/2020	Contact - Telephone call made Interview conducted with Complainant
11/20/2020	Contact - Telephone call made Interview conducted with resident services coordinator Britney Cable
11/20/2020	Contact - Document Sent Investigative document request sent to Ms. Cable
11/20/2020	Contact - Document Received Investigative documents received by email from Ms. Cable
12/18/2020	Exit Conference – Telephone Conducted with authorized representative Lauren Gowman

ALLEGATION:

Resident A was not properly supervised

INVESTIGATION:

On 11/20/20, the department received this online complaint.

According to the complaint, on 11/12/20, Resident A walked out a fire escape door, circled around the building to the main entrance to come back inside. Resident A made an unsuccessful attempt to exit the building at least one previous time,

approximately 11/11/20. Resident A has since been moved to the secured memory care.

On 11/20/20, I interviewed Complainant by telephone. Complainant stated Resident A moved into the facility approximately two weeks ago. Complainant stated Resident A is known to be a person who wanders. Complainant stated the incident happened during the daytime on 11/11/20. Complainant stated Resident A was seen exit seeking with the attempt of exiting the building at least one time since his moving to the facility prior to 11/12/20.

On 11/20/20, I interviewed resident services coordinator Britney Cable by telephone. Ms. Cable stated that on 11/12/20, Resident A did exit the building through a door "at the end of the building" and came back through another door. Ms. Cable stated two staff on break in the parking lot did observe Resident A the entire time he was outside but that the care staff working inside the building were not aware that Resident A had exited the building. Ms. Cable stated Resident A has been at the facility since the beginning of October 2020 and was not known to be an exit seeker. Ms. Cable stated Resident A is a person who use to participate in triathlons and likes to walk around within the building. Ms. Cable stated that after exiting the building on 11/12, Resident A was moved to the secured memory care.

I reviewed Resident A's service plan provided by Ms. Cable. Under a section titled *Cannot Leave Building Unattended,* the plan reads "I must be accompanied by staff, family or friends when I Leave the building". Under a section titled Preventing Anxiety And Agitation, the plan reads, in part, "I have always been a very active man. When I don't have anything to do, I can become anxious and/or agitated".

I reviewed a facility notes titled *Observations* for Resident A. Notes entered on 11/10/20 read "Reported to PCP that resident continues to exhibit anxiety, restlessness, wandering and exit seeking behaviors. Writer requested referral to Seniors Wellness Group for med review and psych eval. No new orders receive at this time".

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.
For Reference: R 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a

	resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged Resident A did not have an adequate plan for his supervision when he exited the building. The investigation revealed Resident A did exit the building on 11/12/20 and that staff responsible for his care were not aware of his exit. While the administrator reported Resident A was not known to be an exit seeker, review of staff notes revealed Resident A was observed exit seeking on 11/10/20. Review of Resident A's service plan did not include any provisions for addressing exit seeking behavior. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Review of the facility licensing file revealed no incident report was submitted regarding Resident A's exit from the building on 11/12/20.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death

ANALYSIS:	The investigation revealed Resident A exited the building on 11/12/20 while responsible staff were not aware. Review of the facility licensing file revealed the facility did to report this incident to the department. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

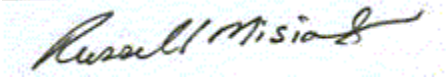
IV. RECOMMENDATION

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

12/15/20

Aaron Clum — Date
Licensing Staff

Approved By:



12/16/20

Russell B. Misiak — Date
Area Manager