GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2022

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

RE: License #: AH810334704
Investigation #: 2022A1027093
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 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2022A1027093
Complaint Receipt Date:	09/09/2022
Investigation Initiation Date:	09/12/2022
Report Due Date:	11/09/2022
Licensee Name:	Linden Square Assisted Living, LLC
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Jessica Richardson
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:	01/10/2022
Expiration Date:	01/09/2023
Capacity:	187
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed.	Yes
The facility lacked an organized program for resident protection.	No
Additional Findings	No

III. METHODOLOGY

09/09/2022	Special Investigation Intake 2022A1027093
09/12/2022	Special Investigation Initiated - Letter Email sent to APS central intake with new referral
09/12/2022	APS Referral Allegations referred to APS by email
10/14/2022	Inspection Completed On-site
10/20/2022	Contact - Telephone call made Telephone interview conducted with clinical coordinator
10/20/2022	Contact – Document Received Email received from clinical coordinator with information pertaining to investigation
10/21/2022	Inspection completed – BCAL Sub. Compliance
11/18/2022	Exit Conference Conducted by telephone with authorized representative Lauren Gowman

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 9/9/2022, the department received a complaint referred from the Attorney General's office. The complaint read Resident A went home with her family for a few

days. The complaint read Resident A's family administered her evening medications prior to her return to the facility. The complaint read Resident A's family requested the facility nurse and resident services coordinator place her medications on hold for that night since she had received them. The complaint read the "hold" was not removed for a two-week period and subsequently Resident A went to the hospital on 8/17/2022 for stroke like symptoms and high blood pressure. The complaint read it was believed Resident A went two weeks without medications for her blood pressure and blood thinner.

On 10/14/2022, I conducted an on-site inspection at the facility. I interviewed the facility nurse who stated on 7/25/2022 Resident A had tested positive for COVID-19 in which she went to the hospital then home with her family from 7/26/2022 through 8/5/2022. The nurse stated Resident A was hospitalized from 8/17/2022 through 8/26/2022 for stroke-like symptoms.

While on-site, I attempted to observe Resident A however memory care staff stated she was out of the facility for an appointment.

On 10/20/2022, I conducted a telephone interview with the clinical coordinator who stated there was not a note in the system as to why Resident A's medications were on hold 8/5/2022 through 8/17/2022. The clinical coordinator stated she would need to review Resident A's medical records and follow up.

On 10/20/2022, per email correspondence with the clinical coordinator, she could not locate any physician orders to hold Resident A's medications.

I reviewed Resident A's face sheet which read she admitted to the facility on 4/12/2022 and Relative A1 was her health care durable power of attorney (DPOA). The face sheet read Resident A was positive for COVID-19 on 7/25/2022 and quarantined until 8/9/2022.

I reviewed Resident A's service plan which read staff were to administer medications.

I reviewed Resident A's July and August 2022 medication administration records (MAR) which read consistent with the complaint. The July 2022 MAR read Resident A received Eliquis 5 mg one tablet by mouth twice daily and Carvedilol (Coreg) 25 mg one tablet twice a day from 7/1/2022 through 7/26/2022. The MAR read Resident A was hospitalized from 7/27/2022 through 7/30/2022, and with family on 7/31/2022.

The August 2022 MAR read Resident A was with family from 8/1/2022 through the morning of 8/5/2022. The MAR read on 8/5/2022 the evening doses of Coreg and Eliquis were held. The MAR read the medications Eliquis, and Coreg twice daily doses were on hold from 8/6/2022 through morning dose of 8/17/2022 until she was sent to the hospital that evening. The MAR read on 8/18/2022 Resident A was hospitalized through the morning of 8/19/2022. The MAR read Resident A received

her evening dose of Coreg on 10/19/2022. The MAR read on 10/20/2022 the Eliquis dose changed from 5 mg twice daily to 2.5 mg twice daily and Resident A received both doses of Eliquis, as well as Coreg. The MAR read for both Coreg and Eliquis Resident A refused morning doses on 8/21/2022, 8/22/2022, and 8/23/2022. The MAR read for both Coreg and Eliquis staff attempted the morning medication administration twice on 8/22/2022. The MAR read Resident A was hospitalized in the evening on 8/23/2022 through the morning of 8/26/2022. The MAR read Resident A received both doses of Coreg and Eliquis the evening of 8/26/2022 through 8/31/2022, however she refused both medications' morning doses on 8/29/2022.

I reviewed Resident A's observations notes dated 7/1/2022 through 8/31/2022 which read consistent with statements from the complaint, facility nurse and the face sheet. Note dated 7/25/2022 read Resident A was positive for COVID-19. Note dated 7/27/2022 read Resident A's family took her to the hospital for evaluation and treatment of COVID-19. Note dated 8/17/2022 read Resident A's daughter informed the facility of her high blood pressure readings and lethargy in which she wanted her sent to the emergency room. Note dated 8/18/2022 read Resident A admitted to the hospital and was positive for COVID-19. Notes dated 8/19/2022 read Resident A returned to the facility and there was a new prescription to decrease Eliquis from 5 mg to 2.5 mg. Note dated 8/23/2022 read Resident A was observed leaning to the right, nonverbal and unable to straightened in her wheelchair in which she was sent to the hospital. Notes dated 8/26/2022 read Resident A returned to the facility and possibly had a Transient Ischemic Attack (TIA).

I reviewed Resident A's hospital discharge summary dated 8/18/2022 to 8/19/2022 which read to continue all medications and changed the strength of Apixaban (Eliquis) to 2.5 mg twice daily.

APPLICABLE RULE	
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 records revealed she was prescribed medications Coreg for her blood pressure and Eliquis, a blood thinner. Review of Resident A's MAR revealed those medications were held from 8/6/2022 through 8/17/2022 in which facility staff were unable to provide a physician prescription with an order instructing the action to hold medications. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility lacked an organized program for resident protection.

INVESTIGATION:

On 9/9/2022, the department received a complaint referred from the Attorney General's office which read the resident service coordinator did not stop a resident's family member from coming into the building COVID positive.

On 10/14/2022, I conducted an on-site inspection at the facility. I interviewed the facility nurse who stated Resident A's daughter and son-in-law were in the facility in July 2022 visiting and were screened at the main entrance which included a screening questionnaire, obtaining a temperature and masking. The nurse stated she received a call from Resident A's daughter after visiting that she and her spouse tested positive for COVID-19. The nurse stated on 7/25/2022 Resident A had tested positive for COVID-19 in which she went to the hospital then home with her family from 7/26/2022 through 8/5/2022. The nurse stated they tested all memory care and assisted living residents, as well as all staff. The nurse stated some memory care residents and staff were positive with COVID-19. The nurse stated they attempted to keep staff consistent within the memory care unit to prevent further spread of COVID-19. The nurse stated the COVID-19 guidelines just changed in October 2022 in which the facility was following the updated guidelines currently.

On 10/20/2022, I conducted a telephone interview with the clinical coordinator whose statements were consistent with the nurse.

I reviewed the facility's COVID-19 mitigation operation manual in which read consistent with the facility's nurse statements.

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:	Staff attestations and review of the facility's policy revealed there was an organized program in place for visitor screening of COVID-19 upon entry. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/18/2022, I shared the findings of this report with authorized representative Lauren Gowman. Ms. Gowman verbalized understanding of the findings.

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

10/21/2022

Jessica Rogers — Date
Licensing Staff

Approved By:

11/17/2022

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