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 #: 2022A1027098
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 #:	2022A1027098
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/21/2022
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
Additional Findings	No

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A1027098
09/21/2022	Special Investigation Initiated - Letter Email sent to medical records requesting resident census
10/14/2022	Inspection Completed On-site
10/20/2022	Contact - Telephone call made Telephone interview conducted with clinical coordinator. Follow up documentation requested by email
10/20/2022	Contact – Document Received Email received from clinical coordinator with requested documentation
10/21/2022	Inspection Completed – BCAL Sub. Compliance
11/18/2022	Exit Conference Conducted by telephone with authorized representative Lauren Gowman

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 9/21/2022, the department received a complaint through the online complaint system which read Resident A reported she was left in wet/soiled clothing for over an hour in her wheelchair on 9/12/2022 after returning from physical therapy. The complainant did not provide contact information.

On 10/14/2022, I conducted an on-site inspection at the facility. I interviewed the facility nurse who stated Resident A required staff assistance to utilize the bathroom. The facility nurse stated staff had not documented any notes regarding Resident A's wet/soiled clothing for 9/12/2022. Additionally, the facility nurse stated the call light response log was not always accurate because call pendants did not always turn off.

While on-site, I interviewed Resident A who stated she was a functional quadriplegic. Resident A stated she administered her own medications but required a one person assist to transfer from her bed to the electric wheelchair and the toilet, as well as required assistance with her showers which were Wednesdays and Saturdays. Resident A stated on 9/12/2022, she had two afternoon therapy appointments in which the area on aging transportation bus picked her up later in the evening around 7:15 PM. Resident A stated that evening she pressed her call pendant to summon for assistance upon arrival to her apartment but waited over an hour before staff arrived and wet herself because she could not hold it. Additionally, Resident A stated on 9/8/20222, she pressed her call pendent at 7:00 AM and did not receive assistance until after 10:00 AM. Resident A stated she texted her son, who called the facility to request for staff to assist her. I observed Resident A's text message to her son dated 9/8/2022 at 9:57 AM which read in part that she had laid in bed since 7:00 AM with the call light on and provided him the phone number to facility. Resident A stated she was in bed until after breakfast service was completed which was 9:00 AM, so her first meal of the day was lunch. Resident A stated there had been other times when she had not received assistance getting out of bed and missed breakfast service. Resident A stated she liked to received assistance with getting out of bed and toileting around 8:00 AM. Resident A stated she would then go to breakfast service around 8:30 AM in which she brought her meals back to her room to eat due to her immunocompromised status. Resident A stated she relayed her concerns with the administrator, clinical coordinator and other staff who apologized. Resident A stated she was concerned about staff not responding to call lights in which could have required a medical emergency, thus always keeps her phone with her.

On 10/20/2022, I conducted a telephone interview with the clinical coordinator who stated Resident A had expressed concerns regarding getting up in the morning to attend breakfast. The clinical coordinator stated she offered to assist Resident A in the mornings and had assisted for a short period of time but could not continue every day. The clinical coordinator stated staff were provided Resident A's appointment schedule so they could assist her with care timely for her to be ready. The clinical coordinator stated staff were expected to document in the task administration log every shift. The clinical coordinator stated staff usually documented the time in which they were on the computer documenting, not necessarily the time the task was completed since they completed tasks for multiple residents.

I reviewed Resident A's face sheet which read she admitted to the facility on 4/15/2022 and Relative A1 was her emergency contact.

I reviewed Resident A's service plan which read she was a one-person full assistance for transferring to the wheelchair and toilet, peri-care, dressing and showering. The plan read Resident A was independent with mobility in her electric wheelchair. The plan read Resident A administers her own medications in which there was a physician order, and she completed the medication self-administration competency test. The plan read Resident A was independent with eating and received a regular diet with no restrictions.

I reviewed Resident A's admission contract dated 4/15/2022 and signed by Resident A which read consistent her service plan.

I reviewed Resident A's task administration record for September 2022 which read consistent with her service plan. The task report read consistent with Resident A's statements for 9/12/2022 which read she was out of the facility for evening care and her meal. The task report read staff were to ensure Resident A received the appropriate diet and liquid consistency for each meal. The task report was left blank on one or meals on the following dates 9/4/2022 through 9/6/2022, 9/11/2022, 9/14/2022, 9/19/2022, 9/20/2022, 9/23/2022 through 9/25/2022, 9/27/2022, 9/28/2022, and 9/30/2022. The task report was left blank on the following shower dates 9/14/2022, 9/21/2022, 9/24/2022, and 9/29/2022.

I reviewed Resident A's call light response log for 9/12/2022 and 9/8/2022. The log dated 9/12/2022 read Resident A initiated her call pendant at 9:14 AM and response time was 10:21 AM, 1 hour 7 minutes. The log dated 9/12/2022 read Resident A initiated her call pendant at 7:50 PM and response time was 8:35 PM, 45 minutes. The log dated 9/8/2022 read Resident A initiated her call pendant at 7:02 AM and response time was 9:55 AM, 2 hours 53 minutes.

APPLICABLE RULE	
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 325.1901	**Definitions.**

	(16) "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:	Resident A's statements along with review of her records revealed she required one person assist for transfers and care. Additionally, Resident A's statements were consistent with call light response log. Review of the task log report revealed numerous blank spaces in which it could not identified if a task was completed or not. Based on the above information, the facility lacked ensuring Resident A's safety and protection as well as care consistent with contract and her service plan, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION 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

Contingent upon receipt of an acceptable corrective action plan, 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