



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2026

Sondra Yantz
Charter Senior Living of Linden
5050 Amelia Earhart Dr
Linden, MI 48451

RE: License #: AH250409846
Investigation #: 2026A0585035
Charter Senior Living of Linden

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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250409846
Investigation #:	2026A0585035
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/15/2026
Report Due Date:	06/14/2026
Licensee Name:	Linden Senior Partners, LLC
Licensee Address:	Suite 800 9300 Shelbyville Rd Louisville, KY 40222
Licensee Telephone #:	(502) 423-0662
Authorized Representative/Administrator:	Sondra Yantz
Name of Facility:	Charter Senior Living of Linden
Facility Address:	5050 Amelia Earhart Dr Linden, MI 48451
Facility Telephone #:	(331) 472-2078
Original Issuance Date:	02/15/2024
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	104
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall, urinalysis was requested 3/18/26 but was not collected until 4/6/26.	Yes
There is no documentation on staff training.	No
Medication called to the wrong pharmacy.	Yes
Resident did not get out of bed and did not eat.	No
Additional Findings	No

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A0585035
04/15/2026	Special Investigation Initiated - Telephone Interviewed the complainant by telephone.
04/15/2026	Inspection Completed On-site Completed with observation, interview and record review.
04/15/2026	Inspection Completed-BCAL Sub. Compliance
04/16/2026	APS Referral Allegations referred to Adult Protective Services (APS)
05/21/2026	Exit Conference Conducted via email to Sondra Yantz.

ALLEGATION:

Resident A had a fall, and urinalysis was requested 3/18/26 but was not collected until 4/6/26.

INVESTIGATION:

On 04/15/2026, the licensing department received a complaint alleging that Resident A had a fall on 3/14/2026 and not sure if evaluation was completed. The complaint alleged a urinalysis was requested for Resident A, order was processed by the doctor. The complaint alleged that the urinalysis was not collected until the week of 4/6/2026 and it came back positive. The complaint alleges that it was four weeks before anything was done.

On 04/15/2026, a call was made to the complainant, and their statements were consistent with what was reported in the complaint. The complainant stated that she noticed that something was off with Resident A and requested that they do a urinalysis. The complainant said the facility could have collected the urine sample earlier. The complainant stated that she was on the phone with the doctor for two weeks and the order was still open. The complainant stated that she kept asking about the urinalysis and it finally came back positive on 04/13/2026. The complainant stated that Resident A treatment was delayed until 04/14/2026 when she received her first dose of antibiotics.

On 04/15/2026, onsite was conducted at the facility. I interviewed administrator Sondra Yantz at the facility. The administrator stated Resident A was incontinent and it is a challenge. She said they could have collected the urinalysis sooner. The administrator stated that Resident A had a fall, but they did not suspect a UTI and Resident A did not show any symptoms of a UTI. She said they told Resident A's family that they could not give Resident A an antibiotic and it had to be ordered. The administrator stated that they offered the POA to come for a care conference if they choose to after they updated the service plan. The administrator stated that if a resident has a fall, staff take vitals, do a complete assessment. She said they notify the nurse, the POA and the physician. She explained that if a resident falls and hits their head, they call 911.

The administrator shared a copy of a statement from Employee #1 that read in part:

"I have been asked to give a statement regarding [Resident A] conditions and he pet I may have played in it."

03/18/2026.....asked if UA (urinalysis) from 3/18/2026 was collected (Reminder: I was out of the State on 3/18/2026). I informed daughter that resident was receiving Motrin and I would look into the UA. I did tell her I thought it was negative but would follow up.

04/02/2026 and 04/03/2026 had staff attempt to collect a UA as lab had no knowledge of one being done.

04/04/2026 @ 4:38 pmdaughter texted Sondra and me requesting that Ibuprofen be stopped due to Gi upset and poor appetite. Also begged that we tell

resident that daughter says she has to get out of bed, go to meals, etc. Then thanked us for our assistance. Then asked if we ever found out if UA was completed. Told her I couldn't find results either and that we'd get one Monday.

04/06/2026 New urine sample sent out to lab.

04/06/2026 Email received from daughter asking about hospice services. Set up meeting for her on 4/7 @ 9:30 am

04/14/2026 email received from Dr.xxx's office stating UA was positive and antibiotic was called in to XXX.

Signed by Employee #1

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.
	<p>(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:</p> <p>(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.</p>

ANALYSIS:	<p>The complaint alleged Resident A had a fall, and urinalysis was requested 3/18/26 but was not collected until 4/6. Urinalysis came back as positive.</p> <p>The urinalysis was not completed in a timely manner and results showed that Resident A had a UTI.</p> <p>Therefore, the facility did not comply with this rule.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

There is no documentation on staff training.

INVESTIGATION:

The administrator stated that staff have training before caring for the residents. The administrator said new staff train three days on floor with lead. She said the first day the observe, second day new staff interact hands on with another staff and review documentation and on the third day, the trainer watch the new staff. She said on the fourth day staff do Relias training and the nurse do the final sign off to show competence.

During the onsite, I interviewed Employee #2 whose statements were consistent with the administrator regarding training. Employee #2 said that all staff is trained before they start working with the residents.

During the onsite, I interviewed Employee #3 whose statements were consistent with the administrator and Employee #2 regarding training.

Documentation showed that staff had training.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(6) The home shall establish and implement a staff training program based on the home's program statement, the

	<p>residents service plans, and the needs of employees, such as any of the following:</p> <ul style="list-style-type: none"> (a) Reporting requirements and documentation. (b) First aid and/or medication, if any. (c) Personal care. (d) Resident rights and responsibilities. (e) Safety and fire prevention. (f) Containment of infectious disease and standard precautions. (g) Medication administration, if applicable.
ANALYSIS:	<p>The complaint alleged there is no documentation on staff training.</p> <p>There is no evidence to support this claim.</p> <p>Therefore, this claim could not be substantiated.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medication was called to the wrong pharmacy.

INVESTIGATION:

The complaint alleged that Resident A’s medication was called to the wrong pharmacy.

The complainant said on 3/16/2026, a pain patch was prescribed for a recent fall and it was called to the wrong pharmacy. The complainant said it was a week before the pain patch was received. The complainant stated there was no follow up by the nurse when the new medication was ordered.

The administrator stated that they cannot call in a prescription, but the doctor has to. She said the doctor called the old pharmacy to order Resident A’s prescription. She said that after it was determined that Resident A did not get her medication, they called the doctor’s office to change the pharmacy. She said they got the medication the next day.

In a statement by Employee #1, she said:

“04/01/2026 @ 9:35 am, daughter texted that she spoke with xxx who was covering for doctor and asked about prescription for 600 mg Motrin to alternate with Tylenol.

Daughter did not know about the order and wanted to know if resident was receiving it....

04/14/2026 called XXX and asked if antibiotic was coming today. They stated that it was out for delivery today.

On 04/14/2026 @ 12:02 pm daughter texted and asked if antibiotic was delivered. I told her it would be delivered today, and the 1st dose would be given ASAP.”

Resident A service plan read, “Staff to coordinate with outside pharmacy as needed for resident’s medication needs.”

APPLICABLE RULE	
R 325.1932	Resident medication.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	The complaint alleged that medication was called to the wrong pharmacy. Resident A’s medication was called to the wrong pharmacy and therefore, she was not able to take it as prescribed. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident did not eat

INVESTIGATION:

The complainant stated that on 04/12/2026 they were informed by staff that Resident A did not get out of bed and did not eat on 4/11/2026. The complainant stated that staff did not contact her when Resident A refused to eat.

The administrator stated if they notice something odd, they contact the POA. She said there is nothing unusual about Resident A skipping meals. She said Resident A never comes out of her room during the day but will come down for supper.

During the onsite, I observed Resident A in her room. Resident A was well groomed. Employee #2 was in Resident A's room encouraging her to come out for lunch. Resident A refused to come out for lunch. Resident A told Employee #2 that she was not feeling well and didn't want to get up. She was sitting in her chair. Employee #2 told her that she would bring her some food.

APPLICABLE RULE	
R 325.1952	Meals and special diets.
	(1) A home shall offer 3 meals daily to be served to a regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	The complaint alleged Resident A did not eat. There is insufficient evidence to support this claim.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

Brender d. Howard

04/23/2026

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

05/21/2026

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

Date