GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 20, 2026

Lynn MacKenzie
Tridgeview Commons LLC
3520 Davenport Avenue
Saginaw, MI 48602

RE: License #: AL560419735
Investigation #: 2026A0360045
Tridgeview Commons MC

Dear Lynn MacKenzie:

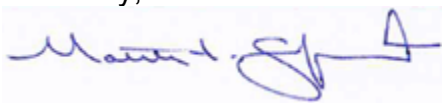
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (616) 356-0100.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
989-370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL560419735
Investigation #:	2026A0360045
Complaint Receipt Date:	06/26/2026
Investigation Initiation Date:	06/26/2026
Report Due Date:	07/26/2026
Licensee Name:	Tridgeview Commons LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 293-4621
Administrator:	Lynn MacKenzie
Licensee Designee:	Lynn MacKenzie
Name of Facility:	Tridgeview Commons MC
Facility Address:	4012 Waldo Ave. Midland, MI 48642
Facility Telephone #:	(989) 293-4621
Original Issuance Date:	01/23/2026
License Status:	REGULAR
Effective Date:	01/23/2026
Expiration Date:	07/22/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered severe injuries after being left unattended despite being a fall risk.	Yes

III. METHODOLOGY

06/26/2026	Special Investigation Intake 2026A0360045
06/26/2026	Special Investigation Initiated - Letter Relative A
07/07/2026	Contact - Telephone call received Relative A
07/16/2026	Inspection Completed On-site Licensee Designee Lynn McKenzie, Suenae Blankenship, Resident B
07/16/2026	Contact - Telephone call made DCS Kim Grice
07/16/2026	Contact - Telephone call made DCS Jule Guza
07/16/2026	Contact - Document Received Lynn Mackenzie
07/17/2026	Contact - Telephone call made Emily Hill American Home Hospice
07/17/2026	APS Referral
07/20/2026	Exit Conference

ALLEGATION:

Resident A suffered severe injuries after being left unattended despite being a fall risk.

INVESTIGATION:

On 6/26/26, I contacted Relative A by email letting him know that I was assigned the investigation.

On 7/7/26, I was contacted by Relative A who stated that Resident A had passed away on 6/29/26. Relative A stated that Resident A had been in the memory care unit at Tridgeview when she experienced a fall on 6/22/26 and broke her hip. Relative A stated that direct care staff named Kim and Jule were working when Resident A fell. He stated that Resident A has a history of fall risk and had another fall in October 2025. He stated that he was concerned about the lack of supervision when Resident A was toileted and left in the bathroom. He stated that he was told another resident from room 10 also fell and required hospitalization on the same night Resident A fell and he is concerned about the staffing.

On 7/16/26, I conducted an unannounced onsite inspection at the facility. The licensee designee Lynn MacKenzie stated that on 6/22/26 at about 5 a.m. Resident A was being toileted in her bathroom when it is suspected she had a seizure. She stated that Resident A does have a history of falls and has fall risk documented in her written assessment plan. She stated the direct care staff was giving Resident A privacy in the bathroom but was just outside the door. Ms. MacKenzie stated that staff immediately contacted herself, hospice, 911, and Relative A. Ms. MacKenzie stated that Resident A has a history of osteoporosis and stated she heard that Resident A ended up with a neck and pelvis fracture. Ms. MacKenzie provided me with the 6/22/26 staff schedule which showed direct care staff (DCS) Kim Grice and Jule Guza were working at the time. She stated there were sixteen residents in the memory care unit that morning with two staff for an 8 resident to 1 staff ratio. Ms. MacKenzie stated that another resident had fallen earlier that morning at about 1 a.m. She stated Resident B, who is also on hospice fell in her bedroom and required stiches to her face. Ms. MacKenzie then contacted direct care staff Suenae Blankenship and put her on speaker phone. Ms. Blankenship stated that when Resident A fell Ms. Grice immediately called Ms. MacKenzie, hospice, 911, and then Relative A. She stated there was no delay in the contact. Ms. Blankenship stated that Resident B had fallen at about 1 a.m. that same day and hospice was unable to respond to the facility immediately and advised the staff to contact 911 and have her transported to the hospital. Ms. MacKenzie stated she would email me Resident A and Resident B's incident report and written assessment plans as well as any medical documentation regarding the falls.

While at the facility, I observed Resident B in bed sleeping. She had a small dime sized cut on her left eyebrow where stiches had been. Ms. MacKenzie stated that Resident A had dementia and would not be able to be interviewed.

On 7/16/26, I contacted Ms. Grice. Ms. Grice stated that her co-worker Jule Guza had toileted Resident A at about 5 a.m. on 6/22/26. She stated that Ms. Guza came out of Resident A's bedroom and went into the laundry room when she heard a loud

thump from Resident A's bathroom. She stated Ms. Guza and herself ran into the bathroom and found Resident A on the floor convulsing and foaming at the mouth. Ms. Grice stated she reviewed her call log on her cell phone and that she called hospice who told her to wait to call 911 until they arrived at the facility, then she contacted Ms. MacKenzie, 911, and then Relative A. She stated that all calls happened within a few minutes. Ms. Grice stated that Resident A can have a shy bladder and likes privacy when toileting so even though she is a fall risk they will often step just outside the bathroom to allow for privacy, but that Ms. Guza should not have left the bathroom door and gone to the laundry room. Ms. Grice then described the fall from Resident B earlier in the night. She stated that at about 1 a.m. she and Ms. Guza heard a loud thump from Resident B's bedroom, and both ran into the room to discover that Resident B had fallen on the floor and had a cut on her face. She stated Resident B is also on hospice and she contacted hospice who stated they would not be able to immediately respond to the facility and to call 911 which she did. She stated that Resident B was transported to the hospital and received several stiches to her left eyebrow.

On 7/16/26, I contacted Ms. Guza. Ms. Guza stated just before 5 a.m. on 6/22/26 she got Resident A up and was getting her dressed and ready for the day. She stated she put Resident A on the toilet and that Resident A likes privacy, so she left her in the bathroom. She stated she checked Resident A's bed pad and decided to take her bedding across the hallway when she heard a loud thump from the bathroom. She stated herself and Ms. Grice both responded to the bathroom and found Resident A on the floor of the bath in what appeared to be having a seizure. She stated Ms. Grice contacted hospice, then Ms. MacKenzie, then Relative A. She stated that hospice told them not to call 911 immediately because Resident A had a DNR order in place until they arrived on scene. She stated that once hospice arrived, they requested that she contact an ambulance for transport to the hospital. Ms. Guza then described Resident B's fall earlier in the night which was consistent with Ms. Grice's interview.

On 7/16/26, I received documentation from Ms. MacKenzie that included the incident report, assessment plan, and after-care summaries from Resident A and B's hospitalizations. Resident A's plan documented that she had a history of falls and required two-person lift assist and total assistance to prevent falls. Regarding toileting it was documented that Resident A required "stand-by" assistance. The aftercare documentation indicated that Resident A had fractured her pelvis with a suspected fracture in her neck that would required follow up.

On 7/17/26, I contacted Emily Hill from American Home Hospice Services. Ms. Hill stated that they were contacted for two falls at the facility on 6/22/26. The first was for Resident B at about 1 a.m. in which they recommended the facility contacted 911 for transport to the hospital because staff was not available to immediately respond to the facility. She stated that they received another call just before 5 a.m. regarding Resident A having a suspected seizure while being toileted. Ms. Hill stated that due to Resident A having a DNR order in place they do not recommend that 911 be

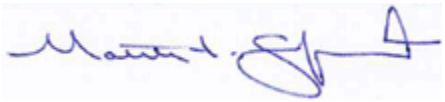
contacted until hospice staff get on site to assess the resident. She stated that when hospice staff arrived at the facility they recommended that Resident A be transported by ambulance to the hospital.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Interviews with Ms. MacKenzie, Ms. Blankenship, Ms. Grice, Ms. Guza, Ms. Hill, and Relative A revealed that Resident A had a history of falls that required stand by assistance while toileting. Resident A was left unsupervised in the bathroom and fell resulting in injuries and hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/20/26, I conducted an exit conference with Ms. MacKenzie who stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

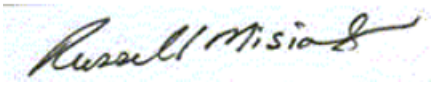
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



7/17/26

Matthew Soderquist Date
Licensing Consultant

Approved By:



7/17/26

Russell B. Misiak Date
Area Manager