GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Justin Wray
The Indigo at Lansing
1634 Lake Lansing Road
Lansing, MI 48912

RE: License #: AH330386131
Investigation #: 2025A1028085
The Indigo at Lansing

Dear Justin Wray:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH330386131
Investigation #:	2025A1028085
Complaint Receipt Date:	09/05/2025
Investigation Initiation Date:	09/08/2025
Report Due Date:	11/05/2025
Licensee Name:	Jaybird LSE Lan03 LLC
Licensee Address:	P.O. Box 2229 Rancho Santa Fe, CA 92067
Licensee Telephone #:	Unknown
Administrator:	Malik Davis
Authorized Representative:	Justin Wray
Name of Facility:	The Indigo at Lansing
Facility Address:	1634 Lake Lansing Road Lansing, MI 48912
Facility Telephone #:	(517) 507-3303
Original Issuance Date:	11/30/2018
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	66
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was found soaked with urine on multiple occasions during the past 2 months.	Yes
Additional Findings	No

III. METHODOLOGY

09/05/2025	Special Investigation Intake 2025A1028085
09/08/2025	Special Investigation Initiated - Letter
09/08/2025	APS Referral
09/09/2025	Contact - Face to Face Interviewed the facility administrator at the facility.
09/09/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
09/09/2025	Contact - Face to Face Interviewed Employee 2 at the facility.
09/09/2025	Contact - Face to Face Interviewed Employee 3 at the facility.
09/09/2025	Contact - Face to Face Interviewed Resident A at the facility.
09/09/2025	Contact - Document Received Received requested documentation from the facility administrator.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Resident A was found soaked with urine on multiple occasions during the past 2 months.

INVESTIGATION:

On 9/5/2025, the Bureau received the allegations through the online complaint system.

On 9/9/2025, I interviewed the facility administrator who reported Resident A has heavy bladder incontinence requiring multiple changes of clothing and bedding daily. The administrator reported Resident A's family has not notified [them] of any concerns, but there was an incident last week in which [they] were notified by staff that Resident A's family member had found Resident A's sheets soiled with urine. Staff immediately changed Resident A's sheets, and the administrator followed up behind staff to ensure the sheets were changed. The administrator reported Resident A's family have not expressed any concerns to [them] yet, but Resident A will be moving out of the facility on 9/22/2025. The administrator reported staff assist Resident A throughout the day with incontinence care, but staff do not document incontinence incidents or Resident A's refusals of assistance with incontinence care. The administrator reported Resident A refuses assistance from staff often due to privacy and dignity concerns and is not consistent with use of the call-light either. The administrator reported Resident A often becomes embarrassed when an incontinence incident occurs and will attempt to change [their] own clothing and/or bedding. Staff use reapproach techniques, redirection, and/or distraction techniques to encourage and assist with care when Resident A refuses. However, Resident A's recliner continues to have a urine smell even though it has been professionally cleaned. The administrator reported Resident A and the family refuse to remove the recliner from the room, so staff try to clean it as often as possible. The administrator provided me with the requested documentation for my review.

On 9/9/2025, I interviewed Employee 1 at the facility who confirmed Resident A has heavy bladder incontinence and that staff regularly check on Resident A to ensure care, but Resident A does refuse staff assistance. Employee 1 confirmed staff use reapproach techniques, redirection, and/or distraction techniques when Resident A refuses assistance with care, but staff do not specifically document incontinence care. Employee 1 reported third shift staff change Resident A's sheets almost daily due to Resident A's heavy bladder incontinence. Resident A's bed is stripped and the mattress, which has a vinyl protection cover, is cleaned and sanitized as well. Resident A can become upset intermittently when staff change the bedding but will often comply after reapproaching to allow staff to change bedding. Employee 1 reported there is a urine smell in Resident A's room due to Resident A's recliner. The recliner has been professionally cleaned, but Resident A will not allow staff to remove the recliner from the room despite the smell. Employee 1 confirmed knowledge of Resident A being found in urine soaked clothing the prior week and that staff addressed the incident immediately.

On 9/9/2025, I interviewed Employee 2 at the facility who confirmed Resident A requires increased assistance due to heavy bladder incontinence and that Resident A can refuse care due to privacy and dignity concerns. Resident A is inconsistent

with the use of the call-light as well. Employee 2 reported Resident A will incur a incontinence accident and will not alert staff and/or refuse staff assistance. Staff use reapproach techniques, redirection, and/or distraction techniques with Resident A during refusals of care. Employee 2 confirmed that staff do not specifically document incontinence care or the changing of Resident A's clothing or bedding due to an incontinence incident. Employee 2 also confirmed that there is a light urine smell in Resident A's room due to Resident A's continued refusal to remove [their] recliner. Employee 2 was unsure if the recliner had been professionally cleaned, but reported staff try to keep it as clean as possible.

On 9/9/2025, I interviewed Employee 3 at the facility whose statement was consistent with the administrator's statement, Employee 1's statement, and Employee 2's statement.

On 9/9/2025, when interviewing Resident A, [they] demonstrated intermittent confusion about staff assistance with room cleaning, changing of linens, and assistance with incontinence care. During the interview, a urine smell was also detected in the room. It could not be determined if the urine smell was from the recliner or Resident A's bed. A pile of soiled laundry was also noted in Resident A's closet during the room observation.

On 9/15/2025, I reviewed the requested documentation which revealed the following:

- Resident A requires one person assistance with bathing, dressing, and toileting; and set-up with grooming.
- Resident A is on a toileting check for *early AM, AM, Noon, PM, bedtime, and 3rd shift to ensure [Resident A] is clean, dry, and [their] brief is changed if needed. Staff to report any issues to supervisor.*
- *Skin checks are performed twice weekly during showering. Staff to report any skin concerns to supervisor.*
- The facility manages all meals, laundry, housekeeping, and medication for Resident A.
- *Housekeeping staff to clean room weekly. Care staff to tidy room and empty trash every shift.*
- *Laundry staff to provide service weekly and as needed for soiled/wet items. Care staff to rinse any soiled/wet items in hopper for laundry. Laundry staff to provide service weekly and as needed for soiled/wet items.* Resident A's scheduled laundry day is Thursday.
- There is no documentation to support Resident A's refusals of incontinence care. There is no documentation to support Resident A's linens and bedding are changed almost daily during third shift due to incontinence incidents.

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.
ANALYSIS:	It was alleged that Resident A was found soaked with urine on multiple occasions during the past 2 months. Interviews, onsite investigation, and review of documentation reveal that while staff interviews were consistent about Resident A having heavy urine incontinence and refusing assistance with incontinence care, there was no evidence found during the investigation or within the provided documentation to support this. While it was reported by staff that third shift staff changed Resident A's linens almost daily due to Resident A's incontinence incidents, there was no evidence found during the investigation or within the provided documentation to support this. Due to the lack of documentation in Resident A's record, it cannot be determined if staff appropriately assisted Resident A during incontinence incidents and/or in accordance with the service plan, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

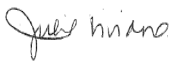
On 9/9/2025, it was alleged during the onsite investigation that the facility was short-staffed. Due to this allegation, I reviewed the working staff schedules from August 2025 to September 2025 with the facility administrator. The facility administrator reported there are currently 24 residents total in the facility and three staff are assigned to each shift. The facility administrator reported there are on-call staff, agency staff, and management to fill a call-in to prevent a short shift. Employee 3 filled a call-in at the time of the onsite investigation to prevent a short shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	It was alleged during the onsite investigation that the facility was short staffed. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility currently demonstrates an appropriate number of staff to resident ratio to meet resident needs. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.



9/15/2025

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Julie Viviano Date
Licensing Staff

Approved By:

09/30/2025

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