GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 31, 2026

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

RE: License #: AH330386131
Investigation #: 2026A1021026
The Indigo at Lansing

Dear Justin Wray:

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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330386131
Investigation #:	2026A1021026
Complaint Receipt Date:	02/25/2026
Investigation Initiation Date:	03/02/2026
Report Due Date:	04/27/2026
Licensee Name:	Jaybird LSE Lan03 LLC
Licensee Address:	P.O. Box 2229 Rancho Santa Fe, CA 92067
Licensee Telephone #:	(517) 507-3303
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	66
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employees smoke and drink while working.	No
Falls are not reported.	No
Facility does not have supplies.	No
Medication carts are not correct.	No
Resident laundry is not completed.	Yes
Additional Findings	No

III. METHODOLOGY

02/25/2026	Special Investigation Intake 2026A1021026
03/02/2026	Special Investigation Initiated - On Site
03/06/2026	Inspection Completed On-site
03/31/2026	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Employees smoke and drink while working.

INVESTIGATION:

On 02/25/2026, the licensing department received an anonymous complaint with allegations that employees smoke and drink while working. The complainant alleged that employees go to their car to drink and then go back to work.

On 03/03/2026, the licensing department received another complaint with workers sitting in their cars while they are to be inside the facility.

On 03/06/2026, I interviewed the administrator Malik Davis at the facility. The administrator reported that alcohol beverages were found in trash cans outside the facility. The administrator reported that it was found that third shift employees may have been drinking alcohol while on the job. The administrator reported that the employees were immediately terminated. The administrator reported that since those terminations occurred, alcoholic beverages have not been found. The administrator reported that employees receive a 30-minute break and employees can leave the facility for this break. The administrator reported that it has not been found that employees are taking a longer than 30-minute break or that employees are sitting in their cars while they are to be inside the facility.

On 03/06/2026, I interviewed staff person 1 (SP1) and SP2 at the facility. SP1 and SP2 both reported no concerns with employees smoking and drinking while working.

APPLICABLE RULE	
R 325.1923	**Employee's health.**
	(1) A person on duty in the home shall be in good health. The home shall develop and implement a communicable disease policy governing the assessment and baseline screening of employees. A record shall be maintained for each employee, which shall include results of baseline screening for communicable disease. Records of accidents or illnesses occurring while on duty that place others at risk shall be maintained in the employee's file.
ANALYSIS:	Interviews conducted revealed there was an isolated incident in which employees were found drinking while on the job. This issue was immediately addressed and does not appear to be a systemic issue throughout the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Falls are not reported.

INVESTIGATION:

The complainant alleged that falls are not reported. The complainant alleged that a resident was thrown in bed and there was a video of it.

The administrator reported no knowledge of a resident thrown in bed. The administrator reported one resident does have a nanny camera and this resident did fall, however, the resident was not thrown in bed. The administrator reported there

was an issue with an employee not completing an incident report and this employee was terminated. The administrator reported that if a resident falls, an incident report is completed, the appropriate parties are notified, and corrective measures are put into place. The administrator reported in February the facility may have had five falls.

SP1 and SP2 reported the facility does not have any frequent fall residents. SP1 and SP2 reported no knowledge of a resident being thrown into bed. SP1 and SP2 reported that if a resident does fall, incident reports are completed and appropriate corrective measures are implemented.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) Rule 24. (1) A home for the aged must implement and maintain a quality review program consistent with section 20175(8) of the act, MCL 333.20175, and the professional review function. The program is responsible for all of the following: **(a) Reviewing and evaluating incidents.** **(b) Identifying effective means to correct any deficient practice.** **(c) Ensuring resident safety and quality of care.** **(d) Improving procedures.**
ANALYSIS:	Interviews conducted revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility does not have supplies.

INVESTIGATION:

The complainant alleged that facility does not have briefs and they do not restock supplies.

SP3 reported that there are always supplies available to the caregivers to use. SP3 reported that management will order supplies at the end of each week. SP3 reported that if an outside provider, such as hospice, provides the briefs then management will contact the provider to order supplies. SP3 reported that supplies are typically kept in each resident room, but the facility has an overstock of supplies. SP3 reported that in the supply closet, there is a list that details who supplies the briefs

for each resident. SP3 reported that there are also gloves and other supplies available for the employees.

The administrator reported no concerns about supplies available. The administrator reported if there was an issue, the facility could go to the local pharmacy and buy additional supplies.

I observed the supply closet. I observed multiple boxes of briefs. I also observed other supplies such as gloves. I observed the list that detailed who provided the briefs for each resident.

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:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication carts are not correct.

INVESTIGATION:

The complainant alleged that medication carts are not correct.

SP1 reported that the facility recently changed pharmacies and medications are now packaged differently. SP1 reported that when this change occurred, the medication carts were cleaned out and re-organized. SP1 reported that the medication carts are clean, organized, and medications can be found. SP1 reported no concerns with medication carts.

The administrator reported that the facility completes a medication cart audit every Monday. The administrator reported that the facility completes training for medication technicians throughout the year to address any issues and to provide refresher training.

I observed the two medication carts at the facility. The medication carts were organized by the medication packets were arranged by each resident. The carts did

not have any medications not in packaging. There were no liquids that were spilled in the carts.

I reviewed Resident A and Resident B medication administration record (MAR) for February 2026. The review of MAR's revealed the medications were administered as ordered by the licensed health care professional.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(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:	Interviews conducted, observations made, and review of documentation revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident laundry is not completed.

INVESTIGATION:

The complainant alleged that residents do not have clothes and the laundry is not being done.

SP4 reported that the facility used to have a laundry aid but that was removed when the facility changed ownership. SP4 reported that second shift is to collect the laundry, third shift is to do the laundry, and first shift is to put away the laundry. SP4 reported that the laundry is typically not completed on a timely schedule. SP4 reported that there is a laundry schedule, but it is not certain if the schedule is followed. SP4 reported that it is difficult for first shift to do the laundry as it takes away from resident care. SP4 reported that residents do have clothes and there is an extra supply of clothes available to the residents, if needed.

The administrator reported that it was found that third shift was not completing the laundry tasks and re-education has been provided to the third shift. The administrator reported that the facility is re-doing the laundry schedule as the facility has had multiple new residents over the past few months.

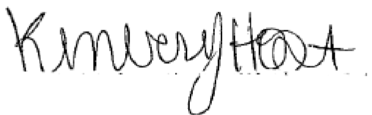
I observed the laundry room at the facility. There were multiple baskets of dirty laundry that were waiting to be washed. There were also clean clothes that were placed near dirty baskets of laundry which made it difficult to know which baskets were clean or dirty.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Interviews conducted and observations made revealed the facility was not completing resident laundry in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1975	**Laundry and linen requirements.**
	(1) A new construction, addition, major building change, or conversion after November 14, 1969 shall provide all of the following: **(a) A separate soiled linen storage room.** **(b) A separate clean linen storage room.** **(c) A separate laundry processing room with handwashing facilities in a home that processes its own linen.** **(d) Commercial laundry equipment with a capacity to meet the needs of residents in a home that processes its own linen.**
ANALYSIS:	Observations made revealed the facility was utilizing the laundry room as the soiled linen, clean linen, and processing room.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/12/2026

Kimberly Horst Date
Licensing Staff

Approved By:

03/30/2026

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