GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

Nirmal Kesavan
Legacy at Orchard Grove
71301 Orchard Crossing Ln
Romeo, MI 48065

RE: License #: AH500367780
Investigation #: 2026A0628028
Legacy at Orchard Grove

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 (April 24, 2026) 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,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500367780
Investigation #:	2026A0628028
Complaint Receipt Date:	02/12/2026
Investigation Initiation Date:	02/17/2026
Report Due Date:	04/11/2026
Licensee Name:	Trilogy Healthcare of Romeo, LLC
Licensee Address:	#200, 303 N. Hurstbourne Pkwy. Louisville, KY 40222
Licensee Telephone #:	(502) 412-5847
Administrator:	Dana Best
Authorized Representative:	Nirmal Kesavan
Name of Facility:	Legacy at Orchard Grove
Facility Address:	71301 Orchard Crossing Ln Romeo, MI 48065
Facility Telephone #:	(586) 372-4899
Original Issuance Date:	03/14/2017
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	35
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home is discharging Resident A without just cause.	No
The home does not follow the service plan of Resident A.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. 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.

The complainant identified some concerns that were previously investigated in the report 2026A0628008, in which the findings were submitted to the home on 02/16/2026.

III. METHODOLOGY

02/12/2026	Special Investigation Intake 2026A0628028
02/16/2026	Contact - Document Sent
02/16/2026	Contact - Document Received email received from administrator with requested documents.
02/17/2026	Investigation initiated -Remotely
04/09/2026	Exit Conference conducted with Nirmal Kesavan

ALLEGATION: The home is discharging Resident A without just cause.

INVESTIGATION:

On 02/12/2026, the department received a complaint that the home was conducting a retaliatory and procedurally defective 30-day discharge of Resident A. The complaint alleges that the 30-day notice was signed by the home on 02/05/2026, but did not arrive via mail, to the complainant until 02/10/2026. The complaint alleges that the notice has a discharge date of 03/07/2026, less than 30 days from receipt of the notice. Additionally, the complaint alleges that the discharge is in retaliation to a complaint investigation completed by the Long-Term Care State Licensing Section at

this home. The complaint alleges that the discharge paperwork only states "communication with DPOA" as the reason for discharge.

On 02/16/2026, I requested, and received, a copy of the discharge notice from the home. Review of the document reveals it is dated 02/05/2026. Additionally, there are numerous reasons for discharge noted, including:

- Communication requirements that exceed standard practice
- Refusal to participate in necessary interdisciplinary care meetings
- Impediment to timely and efficient care coordination
- Undo strain of staff causing inequitable care for all residents
- Inability to establish a practical, safe, and sustainable ongoing plan

Upon review of email correspondence provided by the complainant, Relative A1 declined to participate in multidisciplinary meetings regarding the care coordination of Resident A. Relative A1 stated that she is not declining communication or collaboration, but she is declining a group meeting format as that is inappropriate for her. Additionally, Relative A1 states that, "written communication has become the necessary and appropriate format, especially when clarity, accuracy, and documentation are required". She states she is fully open to written communication.

Communication from the executive director of the home, in these same emails, states, "the group meeting was to establish an alternative communication plan that allows us to continue collaborating effectively while meeting the needs of both your family and our care team as well as to ensure that everyone is on the same page." He also states that the home will not be able to continue to manage all care coordination exclusively through email. Additionally, he states that the volume of weekly communication from the complainant is not sustainable for the staff while working to provide high-quality care across the campus.

Through correspondence with the executive director on 03/12/2026, which is more than 30 days after the notice received by Relative A1, it was reported that Resident A continues to reside at the home as a discharge location is realized.

On 04/06/2026, the complainant provided an updated timeline of events. Documentation was reviewed as applicable to this investigation.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(11) In accordance with MCL 333.20201(3)(e), a home's discharge policy shall specify that a home for the aged

	resident may be transferred or discharged for any of the following reasons: **(a) Medical reasons.** **(b) His or her welfare or that of other residents.** **(c) For nonpayment of his or her stay.** **(d) Transfer or discharge sought by resident or authorized representative.**
ANALYSIS:	Through review of documents, it appears that the home provided various reasons for the discharge, including the welfare of other residents due to staff spending so much time with Resident A, per Relative A1's care requests, and staff utilizing a significant amount of time to respond in writing to all written communication requests. Additionally, only giving the option of written communication puts Resident A at risk when care decisions need to be made promptly. Furthermore, Resident A has been permitted to stay at the home beyond receipt of the 30-day discharge notice. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The home does not follow the service plan of Resident A.

INVESTIGATION:

On 02/12/2026, the department received a complaint that alleged the home does not follow Resident A's service plan regarding sleeping at night. The complaint alleges that the home allows Resident A to sleep in the common area overnight instead of sleeping in her own room.

Documents reviewed include Resident A's recent service plan, nursing notes from the staff regarding Resident A's sleeping location, and a log provided by Relative A1 regarding the dates Resident A was not sleeping in her room at night.
Per the log provided, there were 10 dates from 12/15/2025-02/01/2026 where the resident did not sleep in her room and was assumed to have slept in the common area. Additionally, there were six dates when Resident A either left the room during the night and did not return or was out of the room overnight until returning to her room during the early morning hours. These dates were noted through ring footage observed by Relative A1 from a camera in Resident A's room.

The service plan for Resident A, updated 12/09/2025 states

"DPOA HS request

1. Default sleep location: (Resident A) sleeps in her room each night. She should only remain in the common area overnight if she clearly communicates that preference herself at that time.
2. Return to room: if (Resident A) is out of her room overnight, staff should make gentle re-approach attempts and offer assistance back to bed in a calm, dementia-appropriate manner."

Staff nursing notes from the time frame of 12/01/2025-01/31/2026 reveal only two entries regarding Resident A not sleeping in her room. On 12/08/2025, an entry states that Resident A refused to go to bed x3. Resident A stated when she was ready to go to bed she would. On 01/17/2026, an entry states Resident A refuses to go to bed. She was agitated, cursing, and striking out at staff.

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:	Through reviewing documents there is no documentation from staff noting that they encouraged Resident A to sleep in her room on any but one of the nights where Resident A was reportedly not in her room overnight. It cannot be determined if staff was following the service plan for Resident A that states "*Return to room: if (Resident A) is out of her room overnight, staff should make gentle re-approach attempts and offer assistance back to bed in a calm, dementia-appropriate manner."* as there is lack of documentation to support this was being done. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Rebekah Looney 03/16/2026
Rebekah Looney Date
Licensing Staff

Approved By:

04/07/2026

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