GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

Paul Buchholz
Legacy Assisted Living
5025 Ann Arbor Rd.
Jackson, MI 49201

RE: License #: AH380299010
Legacy Assisted Living
5025 Ann Arbor Rd.
Jackson, MI 49201

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH380299010
Licensee Name:	Ganton Retirement Centers, Inc.
Licensee Address:	7925 Spring Arbor Rd. Spring Arbor, MI 49283
Licensee Telephone #:	(517) 750-0500
Authorized Representative:	Paul Buchholz
Administrator:	Paul Buchholz Jr.
Name of Facility:	Legacy Assisted Living
Facility Address:	5025 Ann Arbor Rd. Jackson, MI 49201
Facility Telephone #:	(517) 764-2000
Original Issuance Date:	05/12/2009
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 04/08/2026

Date of Bureau of Fire Services Inspection if applicable: 12/10/2025

Inspection Type: ☐ Interview and Observation ☐ Worksheet ☒ Combination

Date of Exit Conference: 04/08/2026

No. of staff interviewed and/or observed 15
No. of residents interviewed and/or observed 45
No. of others interviewed 0 Role N/A

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. The disaster plan was reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: CAP dated 9/18/2023 to Licensing Study Report (LSR) dated 9/7/2023: R 325.1932(2), R 325.1954
- Number of excluded employees followed up? On LSR - Zero, as verified in the workforce background check account on date of survey. N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 325.1932 **Resident's medications.**

(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.

Review of the March 2026 medication administration records (MARs) for Residents A, C, D, and E revealed multiple PRN (as-needed) medications prescribed for the same indications without clear administration parameters. For example, Resident A was prescribed Extra Strength Tylenol and Hydrocodone for pain; Resident C was prescribed Morphine and Tylenol for pain, as well as Haloperidol and Lorazepam for agitation; and Resident D was prescribed Morphine and Tylenol for pain. The physician orders did not provide guidance to staff on when to administer one medication over another or define the severity of symptoms warranting each medication. Similarly, Resident C's PRN medications for agitation lacked direction regarding when one medication should be used instead of the other.

Resident B was prescribed PRN Zolpidem for insomnia; however, staff documentation at times identified the reason for administration as restlessness and, in one instance, pain.

For Resident E, Lisinopril was prescribed to be administered once daily at 8:00 AM, with instructions to hold the medication if the systolic blood pressure was less than 120. Although staff documented his blood pressure and pulse, the medication was initialed as administered on March 18, 2026, and March 30, 2026, despite systolic readings below 120.

Additionally, Resident E was prescribed Carvedilol to be administered twice daily, with instructions to hold the medication if systolic blood pressure was less than 100 or heart rate was less than 70 beats per minute, with scheduled administration times of 8:30 AM and 5:00 PM. The MAR lacked documentation of blood pressure and heart rate at the time of administration; however, when compared to the vital signs recorded for the 8:00 AM Lisinopril dose, there were multiple instances where Carvedilol was administered contrary to the order parameters. For example, on March 1, 2026, the medication was administered when the resident's heart rate was 68, and on March 9, 2026, it was administered with a heart rate of 65. Additional instances occurred on March 11, 14, 15, 21, 23 through 27, and 29 through 31, when the resident's heart rate was below 70 and the medication was still initialed as administered. Furthermore, the MAR lacked documentation of a blood pressure and pulse for the 5:00 PM dose of Carvedilol.

REPEAT VIOLATION ESTABLISHED.

[For reference, see LSR dated 9/7/2023, CAP dated 9/18/2023.]

R 325.1970 Water supply systems.

(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

The water temperature measured 124.5 degrees Fahrenheit in room 143 and 129.6 degrees Fahrenheit in room 102.

VIOLATION ESTABLISHED.

R 325.1979 General maintenance and storage.

(3) Hazardous and toxic materials shall be stored in a safe manner.

In the memory care unit, several bottles of cleaning chemicals were observed stored under the dining room sink, including but not limited to Lysol water, Orange Force cleaner, Clorox wipes, and bug spray; these items were removed at the time of inspection.

VIOLATION ESTABLISHED.

IV. RECOMMENDATION

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

04/09/2026

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Date

Licensing Consultant