GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2026

Jessica Pathfinder
Trilogy Healthcare of Livingston, LLC
Suite 200
303 N. Hurstbourne Pkwy
Louisville, KY 40222-5185

RE: License #: AH470395495
Investigation #: 2026A1035029
The Legacy at Howell

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 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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470395495
Investigation #:	2026A1035029
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/10/2026
Report Due Date:	05/08/2026
Licensee Name:	Trilogy Healthcare of Livingston, LLC
Licensee Address:	Suite 200 303 N. Hurstbourne Pkwy Louisville, KY 40222-5185
Licensee Telephone #:	(502) 412-5847
Administrator/ Authorized Representative:	Jessica Pathfinder
Name of Facility:	The Legacy at Howell
Facility Address:	1550 Byron Road Howell, MI 48855
Facility Telephone #:	(517) 552-9323
Original Issuance Date:	10/29/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	35
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility was unable to meet Resident A care needs. Resident A was evicted without notice.	Yes
Additional Findings	No

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A1035029
03/10/2026	Special Investigation Initiated - Telephone
03/17/2026	Contact: Document Request
03/17/2026	Contact: Documents Received
04/15/2026	Inspection Complete. BCAL Sub-Compliance
04/15/2026	Exit Conference

ALLEGATION:

The facility was unable to meet Resident A care needs. Resident A was evicted without notice.

INVESTIGATION:

On March 9, 2026, the Department received a complaint through the online complaint system which read:

> "Resident was receiving inadequate care. Facility evicted resident due to being unable to care for resident properly. Resident had no place to go when evicted."

On March 10, 2026, a phone interview was conducted with the complainant. The complainant states Resident A has a diagnosis of dementia and at times has becomes agitated and hard to redirect. The complainant states Resident A became combative with staff during morning care. The facility held a conference to discuss the incident. Resident A was sent to the hospital during this time for further evaluation. The incident was written up at this time family was informed if they were unable to manage Resident A's behavior they would have to issue a 30-day discharge notice. The complainant states Resident A hit another resident on the

back of head. After this event the facility stated he needs to be discharged immediately. Family moved Resident A out promptly with the intent of Resident A to reside with family until a more suitable placement was established.

On March 17, 2026, an email was sent to the facility Administrator Jessica Pathfinder requesting incident reports, progress notes, service plan, resident contract, and 30-day discharge notice.

On March 17, 2026, the facility provided requested information. The Administrator stated “A 30-day notice was issued on 1/9/26; however, the family elected to proceed with discharge on 1/22/26. As a result, the original 30-day notice was rendered void.”

The following was obtained through record review:

- December 30, 2025, Resident A moved into the facility.
- January 5, 2026, Resident A attempted to choke a staff member while “toileting” resident. Resident A stated he was going to “kill” her for touching his brief. Resident A was sent to hospital for further evaluation. Hospital contacted the facility informing them Resident A will be treated for an urinary tract infection.
- January 9, 2026, Resident A had an altercation with a staff member, where he “kicked the aide in the head during am care” incident occurring at 06:30 a.m. Resident A was sent to the hospital for further evaluation related to behaviors. A conference was scheduled with Resident A’s family, Executive Director (ED), Director of Health Services (DHS), and Wellness Director (WD) on January 9, 2026, to discuss Resident A’s behaviors and a potential 30-day discharge notice if the facility was unable to meet Resident A’s needs. The facilities corporate directive was to have an assigned 1:1 sitter with Resident A during wake hours or send Resident A to inpatient psychiatric facility until stabilized. A 1:1 sitter had been initiated.
- January 14, 2026, Resident A continues to be restless but redirectable according to progress notes.
- January 15, 2026, Resident A had medication adjustment where staff document had effective.
- January 22, 2026, notes indicated that Resident A “knuckled punched” a Resident while entering the dining area for no reason. January 22, 2026, 12:15 p.m. note states “Resident A will be discharged immediately due to incident and continued behaviors that are unpredictable.” Family arrived at 15:00 p.m. to pick up Resident A per facility request. At time of discharge, progress notes indicate the facility offered to send Resident A to inpatient psychiatric facility or VA hospital family declined. Facility referred family to “placement Services.”

On March 9, 2026, an email was sent to the Administrator requesting additional information related to a written 30-day discharge notice and an immediate discharge notice.

On March 10, 2026, the Administrator responded stating “we initially gave the 30-day to wife, then family elected to proceed with discharge on 1/22/26 after event. We were going to issue another notice, but family came and got him instead to discharge- we did not make them leave.”

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **(b) A substantial risk or an occurrence of the destruction of property.** **(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident:** **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.**

ANALYSIS:	Facility did not follow discharge requirements when the 30-day discharge was discussed on 1/9/2026, a written notice was not provided. Additionally, the facility did not follow all steps stated in rule 325.1922 (15) and (16), as written notice was not provided when the less than 30-day discharge was effectuated 1/22/2026. Based on information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/08/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

04/15/2026

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