GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Alison VanRyckeghem
Livonia Assisted Living and Memory Care
34020 Plymouth Rd
Livonia, MI 48150

RE: License #: AH820402086
Investigation #: 2026A0627029
Livonia Assisted Living and Memory Care

Dear Ms. VanRyckeghem:

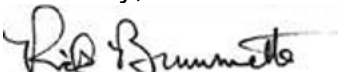
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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

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

I. IDENTIFYING INFORMATION

License #:	AH820402086
Investigation #:	2026A0627029
Complaint Receipt Date:	02/03/2026
Investigation Initiation Date:	03/06/2026
Report Due Date:	04/26/2026
Licensee Name:	Livonia Assisted Living and Memory Care LLC
Licensee Address:	34020 Plymouth Rd Livonia, MI 48150
Licensee Telephone #:	Unknown
Administrator:	Kerry High, Administrator
Authorized Representative/	Alison VanRyckeghem, Authorized Repr.
Name of Facility:	Livonia Assisted Living and Memory Care
Facility Address:	34020 Plymouth Rd Livonia, MI 48150
Facility Telephone #:	(734) 743-2300
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	88
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Orders stating the resident was to be supervised at meals were not followed by caregivers. Diet orders were not followed resulting in choking and aspiration.	Yes
Additional Findings	No

III. METHODOLOGY

02/03/2026	Special Investigation Intake 2026A0627029
03/06/2026	Special Investigation Initiated - On Site

ALLEGATION:

It was alleged that orders specifying the resident was to be supervised at meals were not followed by caregivers and diet orders were not followed resulting in the resident choking and aspirating her food.

INVESTIGATION:

On 2/3/26 the Bureau of Community and Health Systems received a complaint alleging that diet orders were not followed and that supervision orders were not followed for Resident A who died while eating lunch on 10/29/24.

On 3/6/26 I went onsite to investigate the allegations. I interviewed Executive Director Kerry High who reported that the facility has an 88-bed capacity with a current census of 26. ED reports that SP1 named in the complaint no longer works at the facility but does confirm that the hospice nurse who was on the unit at the time of Resident A's incident, does routinely work at the facility treating hospice patients on behalf of a community hospice program.

On 3/6/26, I reviewed employee record of SP1 the facility had archived. The record showed detailed training in HIPPA, Resident Rights, Mandatory Reporting, Privacy & Security policy, and was found eligible for employment in a background check.

On 3/6/26, I conducted an interview via telephone with Hospice Nurse 1 regarding the incident involving Resident A. She recalled that she was working in her hospice office on the Memory Care Unit and remembers hearing “fussing” of the caregivers feeding residents during lunch asking Resident A to “swallow her food” and telling Resident A to “slow down” her speed of eating. Resident A was feeding herself. Hospice Nurse 1 stated she then remembers looking up again a little while later and thinking that Resident A had fallen asleep. When staff tried to wake her up, Resident A did not awaken. Resident A had a “Do Not Resuscitate” order. Hospice Nurse 1 states she did not hear Resident A choking or struggling to breathe.

On 3/6/26, I reviewed the 6 month assessment for Resident A dated 7/18/24. The facility Assessment and Service plan had orders for supervised meals with thickened liquids to a honey consistency and a note stating, “Choking Risk: The Resident has a choking risk and requires close supervision during meals to ensure safe swallowing and prevent choking” (sic). Other orders present included weekly blood pressure checks, monthly pulse checks and monthly weight monitoring, all of which were monitored by the facility. Hospice had ordered Calmoseptine ointment to be applied to Resident A’s coccyx area. It was noted during an interview with SP2 that all staff have access to each resident’s information including diet and feeding orders through the facility’s Quick MAR system.

I inquired of the ED on 3/6/26 whether a meal record for the 10/29/24 meal Resident A had to confirm whether thickened liquids were included on her tray. ED replied that there was no documented record of what Resident A would have been served. I inquired about reviewing any incident reporting related to Resident A having an aspiration incident on 10/29/24. The ED reported that he could not find any documentation pertaining to this incident.

On 3/6/26, I reviewed the facilities policy titled: “Reporting of Accident, Incident, and Elopement 1. Resident care staff shall contact the administrator immediately and complete an incident report in the event of……. A. Death of a resident…..”

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The

	incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	Evidence shows the facility provided care for the resident as evidenced by detailed orders found in the 6-month assessment. However, record of the meal with thickened liquids on 10/29/24 could not be verified. The records failed also to document anything surrounding the Resident's aspiration incident during the noon meal. Facility staff failed to complete an incident report as specified by facility policy and Home for the Aged Licensing Rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend continuing the status of the license upon submission of an acceptable corrective action plan.

3/26/25

Rick Brummette Date
Licensing Staff

Approved By:

06/11/2026

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