



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Elisabeth Delaney
Legacy at Orchard Grove
71301 Orchard Crossing Ln
Romeo, MI 48065

RE: License #: AH500367780
Investigation #: 2025A0784071
Legacy at Orchard Grove

Dear Elisabeth Delaney:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Aaron Clum".

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH500367780
Investigation #:	2025A0784071
Complaint Receipt Date:	07/25/2025
Investigation Initiation Date:	07/28/2025
Report Due Date:	09/23/2025
Licensee Name:	Trilogy Healthcare of Romeo, LLC
Licensee Address:	303 N. Hurstbourne Pkwy. #200 Louisville, KY 40222
Licensee Telephone #:	(502) 412-5847
Administrator:	Elisabeth Delaney, Authorized Repr.
Authorized Representative/	
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?
Inadequate supervision for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

07/25/2025	Special Investigation Intake 2025A0784071
07/28/2025	Special Investigation Initiated - On Site
07/28/2025	Inspection Completed On-site
07/28/2025	Exit Conference Conducted with administrator

ALLEGATION:

Inadequate supervision for Resident A

INVESTIGATION:

On 7/25/2025, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, on 7/19/2025, Resident A was able to exit the facility, which is a secured memory care (MC), for several minutes. Resident A had been exiting seeking throughout the morning causing the alarm system to keep triggering. Staff working that morning were aware that the alarm went off before Resident A was able to get out of the building but did not intervene. Staff 1 and 2 first attempted to locate Resident A in the building before realizing she had exited outside. Staff 1 and 2 located Resident A behind the Independent living (IL) building on the same property.

On 7/28/2025, I interviewed staff 1 at the facility. Staff 1 confirmed she was working on the morning of 7/19/2025. Staff 1 stated that prior to exiting the building, Resident A had been exit seeking since 7am when staff 1 started her shift. Staff 1 stated that during the shift exchange that morning, third shift staff did not report any exit seeking by Resident A but stated she appeared very confused and had been asking why she

was at the facility and kept asking when she was going to go home. Staff 1 stated during the morning, Resident A was continually setting off the door alarm and staff had to keep intervening. Staff 1 stated that when Resident A was able to get out of the building, it was approximately 10:50am. Staff 1 stated she was in a room assisting a resident while staff 2 was in another room assisting another resident. Staff 1 stated staff 3, the supervisor on duty, was on the floor but apparently did not make it to the door in time, after Resident A set off the alarm, to keep Resident A from getting out. Staff 1 stated that when she came out from the resident room she was assisting in, she observed staff 3 coming in from the door Resident A exited from apparently having looked outside and not seeing Resident A. Staff 1 stated she and staff 2 then went to look for Resident A and found Resident A by the independent building located on the same property. Staff 1 stated Resident A had been out of the building for approximately two to five minutes before she was aware and that it took approximately two minutes to locate her. During the onsite, I had staff 1 walk me through the door Resident A exited from and to where she and staff 2 located Resident A. Before exiting the door, I tested the door alarm, and it took approximately 15 seconds of pressing on the door latch before the door opened. It took approximately two minutes to get from the MC building to the location where staff 1 and 2 found Resident A which was on the side of the independent building closest to the main road which was also a short distance from the road. Staff 1 stated that prior to Resident A getting out of the building, no additional measures were put in place or even discussed to provide extra supervision for Resident A. Staff 1 stated Resident A's son was contacted, after Resident A was found outside, and came to the facility to sit with Resident A and help to calm her down.

On 7/28/2025, I interviewed staff 4, a supervisor, at the facility. Staff 4 stated she was not working on the morning of 7/19/2025. Staff 4 stated she did not find out about Resident A getting out of the building until after it happened. Staff 4 stated it was her understanding that staff 1, 2 and 3 were working with Residents when Resident A exited the building. Staff 4 stated that when situations arise, such as a resident who is consistently exit seeking, staff have help available to them. Staff 4 stated there are other non-HFA buildings located on the campus and that a campus supervisor is always available to come to the building and assist if needed. Staff 4 stated a campus supervisor was available that morning. Staff 4 stated facility staff also used an app called *REDEAPP* which serves as a message board on which staff can notify any supervisor if additional assistance is needed. Staff 4 stated administrative staff receive these notifications even when they are not on duty and that, if necessary, they can coordinate to come to the building to assist. Staff 4 stated none of the staff working on the morning of 7/19/2025 contacted the campus supervisor or notified administration with the *REDEAPP* that they were having difficulties with Resident A or that additional support was needed.

On 7/28/2025, I interviewed administrator Elisabeth Delaney at the facility. Administrator provided statements consistent with those of staff 4. Administrator stated she was notified of the incident, after the fact, by administrative staff. Administrator stated she contacted staff 3 to discuss the situation. Administrator

stated staff 3 provided statements consistent with staff 1 in that staff 1 and 2 were in resident rooms at the time the door alarm went off. Administrator stated that staff 3 admitted to being on the floor down the hall at the nurse's desk when the alarm went off. Administrator stated that staff 3 reported that by the time she responded to the alarm, Resident A was already out of the building. Administrator stated that given the difficulty staff were apparently having that morning, staff should have contacted administration for additional assistance.

I reviewed written statements from staff 2 and 3, provided by administrator, which read consistently with staff 1's statements regarding the sequence of events on the morning of 7/19/2025

I reviewed Resident A's service plan, provided by administrator. Under a section titled Mood and Behaviors, the plan read, in part, "resident has exit seeking".

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:	The complaint indicated a lack of adequate supervision for Resident A when she was able to exit the secured facility on the morning of 7/19/2025. The investigation revealed that while Resident A had been exit seeking for several hours prior to getting out of the building, staff working that morning did not seek additional assistance to help supervise Resident A even though it was available to them. Review of Resident A's service plan revealed Resident A was a known exit seeker. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L. Clum

9/08/2025

Aaron Clum
Licensing Staff

Date

Approved By:

Andrea L. Moore

09/24/2025

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

Date