GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Deana Wright
Volante of Chesterfield
29891 23 Mile Road
New Baltimore, MI 48047

RE: License #: AH500397098
Investigation #: 2025A0784072
Volante of Chesterfield

Dear Deana Wright:

Attached is the Special Investigation Report for the above-mentioned 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. 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,

Aaron L 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 #:	AH500397098
Investigation #:	2025A0784072
Complaint Receipt Date:	07/28/2025
Investigation Initiation Date:	07/30/2025
Report Due Date:	09/26/2025
Licensee Name:	Inspired Senior Living of Chesterfield MT, LLC
Licensee Address:	7047 E. Greenway Pkwy Suite 300 Scottsdale, AZ 85254
Licensee Telephone #:	(480) 748-4339
Administrator:	Dolanda Scott
Authorized Representative:	Deana Wright
Name of Facility:	Volante of Chesterfield
Facility Address:	29891 23 Mile Road New Baltimore, MI 48047
Facility Telephone #:	(586) 422-1600
Original Issuance Date:	01/14/2019
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision for Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

07/28/2025	Special Investigation Intake 2025A0784072
07/30/2025	Special Investigation Initiated - On Site
07/30/2025	Inspection Completed On-site
07/30/2025	Exit Conference Conducted with administrator

ALLEGATION:

Inadequate supervision for Resident A

INVESTIGATION:

On 7/29/2025, the department received this complaint from adult protective services (APS) centralized intake. Information on the complaint indicated the complaint was received by APS from an anonymous source so APS denied the complaint for investigation.

According to the complaint, a resident recently fell and broke his hip due to the lack of supervision. Staff did not conduct regular safety checks for the resident, so it is unknown how long he was on the floor after having fallen before staff found him.

On 7/30/2025, I interviewed administrator Dolanda Scott at the facility. Administrator confirmed Resident A had a fall sometime in the morning of 7/23/2025. Administrator stated Resident A was found by staff at approximately 7:15am that morning on the floor of his bathroom while staff was conducting morning rounds. Administrator stated Resident A was a person who was independent for transfers but was expected to try to contact staff for assistance with using the bathroom. Administrator stated Resident A has a call pendent which he did not use and appears to have attempted to use the restroom on his own when he fell. Administrator stated it was unknown the last time staff checked on Resident A. Administrator stated the general

expectation is for staff to conduct rounds every two hours to check on residents. Administrator stated Resident A was sent to the hospital and is having surgery on his hip.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The complaint alleged inadequate supervision when a resident was discovered, after an unknown amount of time, to have fallen. The investigation revealed Resident A had a fall in his bathroom on the morning of 7/23/2025 and was discovered by staff at approximately 7:15am. Resident A was taken to the hospital and found to have a break in his hip. While administrator reported staff are supposed to conduct regular two-hour safety checks for residents, administrator stated "we don't know when he was last check on" prior to being discovered by staff. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's service plan, provided by administrator. The plan included sections for *Need*, *Goal* and *Action*. Under *Need* title *Fall Potentia*l, the *Goal* read "Resident will maintain and/or maximize current level of functioning with fall potential", while the *Action* section was left blank with no instructions included. Under the Need *Toileting*, the *Goal* read "Resident will maintain and/or maximize current level of functioning with toileting", while the *Action* section read "Adult pullup/protective underwear". This section did not include any instructions or indications regarding Resident A's need for assistance with toileting. The plans "effective date" indicated it was last updated on 3/06/2025.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A's service plan revealed the plan did not include adequate information necessary for his care. Additionally, even though Resident A recently had a major incident that would certainly adjust his needs, review of his service plan revealed it had not been updated for several months. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

It is recommended that the status of the license remains unchanged.

Aaron L Clum 9/10/2025

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 09/24/2025

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