GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2025

Lance Davis
Volante of Lake Orion
985 N Lapeer Rd
Orion, MI 48362

RE: License #: AH630400653
Investigation #: 2025A1035084
Volante of Lake Orion

Dear Lance Davis:

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.

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 #:	AH630400653
Investigation #:	2025A1035084
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/20/2025
Report Due Date:	10/18/2025
Licensee Name:	Inspired Senior Living of Lake Orion MT, LLC
LicenseeAddress:	Suite 300 7047 E. Greenway Pkwy Scottsdale, AZ 85254
Licensee Telephone #:	(480) 748-4339
Administrator/ Authorized Representative:	Lance Davis
Name of Facility:	Volante of Lake Orion
Facility Address:	985 N Lapeer Rd Orion, MI 48362
Facility Telephone #:	(248) 977-6200
Original Issuance Date:	09/10/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are times the facility does not have med techs on the midnight shift. Residents are not receiving medications as ordered.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A1035084
08/20/2025	Special Investigation Initiated - Letter
09/30/2025	Contact - Face to Face
10/15/2025	Inspection Complete. BCAL Non-Compliance.
10/16/2025	Exit Conference.

ALLEGATION:

There are times the facility does not have med techs on the midnight shift. Residents are not receiving medications as ordered.

INVESTIGATION:

On August 19, 2025, the Department received a complaint through the online complaint system which read:

> "The building is left without a med tech on the night shift. Residents are going without their morning medications because there is no med tech to administer them. A resident requires pain medication every two hours, and going without the medication because there is no med tech. They fake the chart to reflect that the medications were given in the morning."

On September 30, 2025, an onsite investigation was conducted. While onsite I interviewed staff person (SP)1 who states the facility average daily census is 54 residents,16 of which reside on the memory care unit. Medications are typically scheduled for day shift and afternoon shift with approximately two residents requiring medication on the midnight shift. The facility staff with one caregiver and one med tech on the midnight shift.

While onsite I interviewed SP2 who states there is normally 1 med tech and 1 caregiver on the midnight shift. SP2 states it is challenging to meet the needs of the residents and pass medications with only 2 care staff for the amount of residents within the facility.

While onsite, I interviewed SP3 who states there have been times where midnight did not have a med tech assigned with previous management. SP3 states new management has been hiring and training all caregivers on medication administration.

On October 13, 2025, a phone interview was conducted with SP4 who states there is always a med tech on the midnight shift. In the event the med tech calls off, a manager will come in and pass medications. SP4 states the new management team is working on getting more care givers cross trained as med tech.

Through record review Resident A did not receive scheduled Hydromorphone multiple times though out the midnight shift on 8/14/25 and 8/16/2025. Resident B had multiple missed doses or not charted medications throughout the months of August and September.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Through record review of Resident A and Resident B MAR, there were multiple missed administration of medication throughout the months of August and September.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

There is insufficient staff on the midnight shift to meet the needs of the residents.

INVESTIGATION:

On September 30, 2025, an onsite investigation was conducted. While onsite, I interviewed staff person (SP)1 who states the facility average daily census is 54 residents, 16 of which reside on the memory care unit. SP1 states that the facility staffing goals are 2 med techs and 2 caregivers for assisted living and 1 med tech and 1 caregiver for memory care on days and afternoons shifts. For the night shift, 1 med

tech 1 caregiver for the entire building on midnight shift. SP1 reports there are no residents requiring two-person assistance within the community.

While onsite, I interviewed SP2 who states there is normally 1 med tech and 1 caregiver on the midnight shift. SP2 states it is challenging to meet the needs of the residents with 2 care staff for the number of residents within the facility. SP2 states it is expected that there is always one caregiver in memory care at all times. SP2 states there are three residents within the community that require two person assistance. SP2 states there are long wait time first thing in the morning related to staffing and residents needing to use the restroom and get up for the day.

While onsite, I interviewed SP3 who states new management has been hiring and training all caregivers on medication administration.

On October 13, 2025, a phone interview was conducted with SP4 who states there are approximately 4-5 residents who require two-person assistance within the home. SP4 states she has worked the midnight shift a few times and felt that two staff members are enough staff to meet the needs of the residents.

On October 13, 2025, SP1 was asked how staff breaks are covered when there are only two staff members working. SP1 stated “They relieve each other so there is someone in Memory care at all times.”

The med tech and caregiver midnight schedule August 18, 2025, through September 29, 2025, the home has three spots available to schedule two care givers and one med tech. Eighteen shifts throughout the time in review had two persons scheduled to provide care for 54 residents throughout the midnight shift.

On October 13, 2025, the facility provided additional requested information. Resident C and Resident D service plan indicated they required two-person assistance.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Through record review and staff interviews, the facility is staffing with two staff members on the midnight shift to provide care for an average daily census of 54 residents divided between assisted living and memory care units. The memory care unit requires one staff member to always remain within the unit. Staff members interviewed provided that there are longer wait times in the morning related to only having two staff members working and residents' needs being higher due to assistance with activities of daily living upon awakening. The facility practice of only having two staff members working on the midnight shift, with one staff member relieving the other staff member for breaks, results in the assisted living unit having no staff present during breaks. Additionally, there are residents that require two-person assistance and with only two staff on midnight shift, with one staff always needing to be present in the memory care unit, this care is not feasible to be completed. For these reasons, the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/13/2025

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

Approved By:

10/15/2025

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