GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2026

Cody Connally
Volante of Lake Orion
985 N Lapeer Rd
Orion, MI 48362

RE: License #: AH630400653
Investigation #: 2026A1027040
Volante of Lake Orion

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630400653
Investigation #:	2026A1027040
Complaint Receipt Date:	05/04/2026
Investigation Initiation Date:	05/05/2026
Report Due Date:	07/03/2026
Licensee Name:	Inspired Senior Living of Lake Orion MT, LLC
Licensee Address:	Suite 300 7047 E. Greenway Pkwy Scottsdale, AZ 85254
Licensee Telephone #:	(480) 748-4339
Authorized Representative/ Administrator:	Cody Connally
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents A and B's medications were not available for administration.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/04/2026	Special Investigation Intake 2026A1027040
05/05/2026	Special Investigation Initiated - Letter Email sent to complainant requesting additional information
05/05/2026	Contact - Document Received Email received from the complainant with additional information
05/10/2026	Contact - Document Received Email received from complainant with additional information
05/11/2026	Contact - Document Sent Email sent to complainant requesting additional information
05/11/2026	Contact - Document Received Email received from complainant with requested information
05/26/2026	Contact - Document Sent Follow up email sent to complainant
05/27/2026	Contact - Telephone call made Telephone interview conducted with Employee #1
05/27/2026	Contact - Document Sent Email sent to Employee #1
05/28/2026	Contact - Document Received Email received from Employee #1
05/29/2026	Contact - Telephone call made Telephone call to Trinity Hospice
05/29/2026	Contact - Document Sent Email sent to Trinity Hospice to request Resident A's records

05/30/2026	Contact - Document Received Email received from complainant with additional allegations
06/01/2026	Inspection Completed On-site
06/01/2026	Inspection Completed-BCAL Sub. Compliance
06/12/2026	Exit Conference Conducted via email with Cody Connally

ALLEGATION:

Residents A and B's medications were not available for administration.

INVESTIGATION:

On May 4, 2026, the Department received an allegation which read that the facility repeatedly failed to maintain residents' prescribed medications, particularly pain medications, on hand for timely administration. According to the complainant, this issue had been occurring weekly for approximately six months, including as recently as May 3, 2026. Resident A, who was receiving hospice services, reportedly experienced multiple instances in which medications were unavailable when due and were not administered as ordered by the physician and hospice team.

On May 5, 2026, email correspondence with the complainant confirmed Resident A's identity and expressed the complainant's concern that Resident A should not experience unnecessary pain due to medications not being in the building or not yet checked in. The complainant also reported that Resident B lived with Resident A at the facility.

On May 10, 2026, the complainant reported by email that Resident A had been evacuated to a sister facility due to a water main break and was expected to return within 7 to 10 days. The complainant stated they would notify the Department upon Resident A's return. At this time, Resident A was receiving services from Trinity Hospice, whose team was aware of medication availability concerns.

On May 27, 2026, I conducted a telephone interview with Employee #1 to verify Resident A's status. Employee #1 reported that Residents A and B were not evacuated and relocated because Resident A was receiving hospice services, and the home aimed to keep all hospice residents on-site during the evacuation. While some residents were temporarily evacuated due to concerns over possible water loss, the home never actually lost water, and residents returned within a few days.

Employee #1 stated that Resident A passed away at the home on hospice services, and Resident B remained at the facility with support from family and friends.

On May 28, 2026, Employee #1 email correspondence confirmed that Resident A moved into the home on December 31, 2023, and passed away on May 20, 2026.

On May 29, 2026, I conducted a telephone call with the clinical manager of Trinity Hospice Services and made a verbal request for documentation related to Resident A's medications. A follow-up email request for the hospice documentation was also submitted. However, the requested documentation has not yet been received.

On May 30, 2026, the complainant emailed, provided additional allegations reporting that Resident B had not received his Eliquis for three days.

On June 1, 2026, I conducted an on-site inspection and interviewed staff.

Employee #1 reported that the facility's pharmacy had ongoing delivery issues, including instances in which the pharmacy indicated that medications were delivered, but facility staff had not signed for them. He stated the facility planned to switch to a new pharmacy effective July 1, 2026.

Employee #2 confirmed that regularly prescribed medications were delivered by the pharmacy through cycle fills to refill all the medications. Employee #2 stated that she contacted the pharmacy on the preceding Friday to request a refill of Resident B's Eliquis.

While on-site, I compared Resident B's June 2026 medication administration record (MAR) with the medications in the medication cart and confirmed that all routinely prescribed medications, including Eliquis, were available for administration.

Resident A's face sheet aligned with the information previously provided by Employee #1 and identified Relative A1 as her emergency and primary contact.

A review of Resident A's MARs from February through May 2026 showed the following:

May 2026:

- Acetaminophen, scheduled every 8 hours at 6:00 AM, 2:00 PM, and 10:00 PM, was documented as unavailable for multiple doses between May 1 and May 18, 2026. However, during that same period, staff also documented administering the medication on seven separate occasions at various times.
- Ciprofloxacin, prescribed April 22, 2026, and discontinued May 4, 2026, with hospice verification the course ended April 26, 2026, was documented as administered on May 1 and May 2, 2026.

- Lorazepam, ordered as needed for anxiety, was documented as administered on May 14, 2026, for pain.

April 2026:

- Acetaminophen was documented as not available for the 2:00 PM dose on April 29, 2026, then recorded as administered at 10:00 PM, and again documented as not available for the 6:00 AM and 2:00 PM doses on April 30, 2026.
- Lorazepam, ordered as needed for anxiety, was administered on April 27, 2026, for shortness of breath.

March 2026:

- Acetaminophen was documented as not available for the 2:00 PM dose on March 17 and March 18, 2026, while other doses were recorded as administered.
- Vitamin D2, scheduled weekly on Mondays, was not available on March 2, 16, and 30, 2026, but was recorded as administered on March 9 and March 23, 2026.
- PRN medications Albuterol and Alprazolam did not specify a required reason for administration, resulting in staff documenting various reasons for administration of the medications.

February 2026:

- Asenapine, to be given daily at bedtime, was not available on February 10 and 13, 2026, but documented as administered on February 11 and 12, 2026.
- Vitamin D2 was not available on February 2 and 23, 2026, but was documented as administered on February 9 and 16, 2026.
- PRN medications Albuterol and Alprazolam again lacked required indications for administration, resulting in staff documenting various reasons for administration of the medications.

Review of Resident B's May 2026 MAR showed:

- Eliquis, ordered twice daily at 8:00 AM and 8:00 PM, was documented as not available from May 5 at 8:00 PM through May 12, 2026. However, staff documented that 8:00 PM doses were administered on May 8 and May 10–12, 2026. One staff member documented that an adverse reaction was the reason for not administering the May 12, 2026, for the 8:00 AM dose. Additionally, staff documented that the medication was not available on May 28, 2026, at 8:00 PM and May 29, 2026, at 8:00 AM.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	Review of Residents A and B's MARs showed multiple instances where medications were documented as not available for several scheduled doses. The MARs also reflected inconsistent documentation, with some staff recording medications as unavailable while others documented the same medications as administered. As a result, it could not be determined whether the medications were actually available or given. In addition, PRN medication orders did not include specific indications, making it unclear for staff to determine and document the appropriate reason for administration. Based on these findings, the allegation that medications for Residents A and B were not available for administration is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On May 27, 2026, a telephone interview with Employee #1 indicated that the previously appointed administrator and authorized representative was no longer employed at the home, and that he had been serving as the general manager for the past four weeks.

On the same date, the authorized representative and administrator appointment forms were emailed to Employee #1. These completed forms had not returned at the time the investigation was concluded.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of

	any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The home did not notify the Department within 5 days of a change in administrator and authorized representative; therefore, a violation was substantiated for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

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

06/05/2026

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Jessica Rogers Date
Licensing Staff

Approved By:

06/11/2026

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