GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 22, 2024

Paul Wyman
Retirement Living Management of Alpena LLC
1845 Birmingham SE
Lowell, MI 49331

RE: License #: AL040306253
Investigation #: 2024A0360026
Turning Brook III

Dear Mr. Wyman:

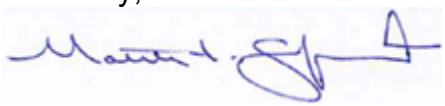
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 616-356-0100.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL040306253
Investigation #:	2024A0360026
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/22/2024
Licensee Name:	Retirement Living Management of Alpena LLC
Licensee Address:	1845 Birmingham SE Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Kristin Roznowski
Licensee Designee:	Paul Wyman
Name of Facility:	Turning Brook III
Facility Address:	400 Oxbow Dr. Alpena, MI 49707
Facility Telephone #:	(989) 354-4200
Original Issuance Date:	08/30/2010
License Status:	REGULAR
Effective Date:	02/27/2023
Expiration Date:	02/26/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident eloped and staff did not contact law enforcement within 30 minutes.	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A0360026
09/25/2024	Special Investigation Initiated - Letter APS Elizabeth Hinska
09/25/2024	APS Referral
09/26/2024	Inspection Completed On-site Administrator Kristin Roznowski
09/26/2024	Contact - Face to Face Resident A, RN Lori Kaye
09/30/2024	Contact - Document Received Kristin Roznowski
11/14/2024	Contact - Telephone call made DCS Angelina San Andreas
11/14/2024	Contact - Telephone call made DCS Sarah Broers
11/14/2024	Contact - Telephone call made Relative A
11/22/2024	Exit Conference

ALLEGATION:

Resident eloped and staff did not contact law enforcement within 30 minutes.

INVESTIGATION:

On 9/26/24, I conducted an unannounced onsite inspection at the facility. The administrator, Kristin Roznowski stated Resident A had no history of elopement. She stated Resident A is in the memory care unit. She stated on 9/21/24 her staff observed Resident A at the activity station around 4 p.m. Ms. Roznowski stated that around 4:30 p.m. another resident's family came to the facility to visit, and they think Resident A may have eloped when that relative left. She stated she did not know who the relative was that came to visit. Ms. Roznowski stated that while direct care staff (DCS) Sarah Broers was getting ready for dinner at about 5:10 p.m. she noticed that Resident A was missing. Ms. Roznowski stated that Ms. Broers and DCS Valerie Lord-Tomaszewski started looking for Resident A. She stated Ms. Lord-Tomaszewski contacted the facility nurse Lori Kaye who suggested to look in the other buildings on the property. Ms. Roznowski stated Ms. Lord-Tomaszewski while looking in another building asked another direct care staff, Angelina San Andreas to contact 911. Ms. Roznowski stated she estimated that Ms. San Andreas called 911 at about 5:20-5:25 p.m. but that she would contact the 911 dispatch center and request the specific time of the call. Ms. Roznowski stated that Resident A was found in a ditch down the street from the facility by a passerby who called 911. Resident A was picked up by an ambulance and taken to the hospital where she was diagnosed with a fractured toe and released back to the facility. Ms. Roznowski provided me with the incident report detailing the elopement as well as written statements from DCS Sara Broers, DCS Valerie Lord-Tomaszewski, and DCS Bernadette Idalski. Ms. Roznowski also provided me with Resident A's written assessment plan dated 7/10/24. While at the facility, I also interviewed Kathy Onweller, the regional consultant for Turning Brook. Ms. Onweller stated it was Turning Brook's policy to contact law enforcement within 15 minutes of an elopement.

On 9/26/24, While at the facility, I interviewed Resident A. Resident A was not oriented to time or place. Resident A stated she could not remember leaving the facility or how she hurt her foot.

On 9/26/24, While at the facility, I interviewed the facility nurse Lori Kaye. Ms. Kaye stated she received a call from the staff at about 5:15 p.m. that Resident A had eloped. She stated that Resident A had no elopement history. She stated that she recommended staff to search the other buildings and then contact 911.

On 9/30/2024, I received an email from the administrator Kristin Roznowski. Ms. Roznowski stated that she was able to speak with someone at the 911 dispatch center. She stated 911 received a General Medical 911 call at 5:36 p.m. from an individual who stated they seen a woman in the ditch at the area of Long Rapids Rd. and Brentwood. She stated 911 received a missing persons call from Turning Brook at 5:50 p.m. A google search revealed that the intersection of Long Rapids Rd. and Brentwood is approximately .5-1.25 miles from the facility depending on the direction of travel.

On 11/14/24, I contacted DCS Sara Broers by telephone. Ms. Broers stated she was working on 9/21/24 with two other staff. She stated she came into work at 3 p.m. and saw Resident A sitting in the facility with the other staff. She stated she was helping other Residents and heard a loud car come to the facility between 4:30 p.m. and 5 p.m. She stated that around 5 p.m. she was starting to get residents together for dinner and discovered that Resident A was missing. She stated she told both other staff working and all three of them searched the building for Resident A and could not find her. She stated Ms. Lord-Tomaszewski then called the nurse Lori Kaye who told her to search the other buildings and then contact 911. Ms. Broers stated Ms. Lord-Tomaszewski no longer works at the facility, and she believes she moved out of state.

On 11/14/24, I contacted DCS Angelina San Andreas. Ms. San Andreas stated Ms. Lord-Tomaszewski came into the building she was working in on 9/21/24 at sometime between 5 p.m. and 6 p.m. looking for Resident A. She stated they could not find Resident A in the building and that Ms. Lord-Tomaszewski asked her to contact 911. Ms. San Andreas stated she placed the 911 call at about 5:50 p.m. She stated when she called 911 that they placed her on hold for about 5-10 mins while 911 tried to get in contact with the ambulance who had picked up a person from the ditch to see if it was the same person.

On 11/14/24, I contacted Relative A by telephone. Relative A stated he was contacted on the day of the elopement. He stated Resident A must have eloped from the facility for much longer than one hour because she was picked up by ambulance almost 1.5 miles away from the facility. Relative A stated he would estimate that it would take at least 2-3 hours for Resident A to get to the location she was found based on her limited mobility. He stated she suffered a broken toe but was otherwise in good health. He stated other than the elopement the facility has provided very good care.

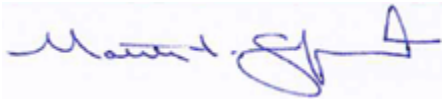
APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.

ANALYSIS:	Interviews with Ms. Roznowski, Ms. Kaye, Ms. Broers, Ms. San Andreas and Relative A revealed that law enforcement was not contacted within 30 minutes after the elopement occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/22/24 I conducted an exit conference with the administrator Kristin Roznowski. Ms. Roznowski stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

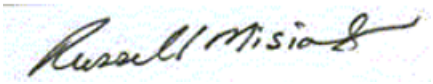
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



11/22/24

Matthew Soderquist — Date
Licensing Consultant

Approved By:



11/22/24

Russell B. Misiak — Date
Area Manager