GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2024

Paul Wyman
Retirement Living Mgmt. of Mason LLC
1845 Birmingham SE
Lowell, MI 19331

RE: License #: AL330299047
Investigation #: 2024A0007043
Green Acres Retirement Living

Dear Paul Wyman:

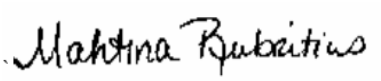
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330299047
Investigation #:	2024A0007043
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/26/2024
Report Due Date:	11/22/2024
Licensee Name:	Retirement Living Mgmt. of Mason LLC
Licensee Address:	1845 Birmingham SE Lowell, MI 19331
Licensee Telephone #:	(616) 897-8000
Administrator:	Erin Droscha
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres Retirement Living
Facility Address:	1025 E. Ash St. Mason, MI 48854
Facility Telephone #:	(517) 676-1484
Original Issuance Date:	08/18/2009
License Status:	REGULAR
Effective Date:	03/25/2024
Expiration Date:	03/24/2026
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake - 2024A0007043
09/23/2024	APS Referral Received.
09/24/2024	Contact - Telephone call made to Citizen #1. Message left. I requested a returned phone call.
09/26/2024	Special Investigation Initiated - On Site- Unannounced Face to face contact with Erin Droscha, Administrator, Katie Steadman, Staff, Office staff, and Resident A.
10/08/2024	Contact - Document Received - Copy of Discharge Notice 30 Day Notice to Terminate Tenancy.
10/11/2024	Contact - Telephone call received from Amber Fry, Regional Consultant. Discussion.
10/14/2024	Contact - Telephone call received from Michelle Hardman, Adult Protective Services. Case discussion.
10/14/2024	Contact - Document Received - Copy of Letter.
10/22/2024	Contact - Telephone call received from Amber Fry, Regional Consultant.
10/22/2024	Contact - Document Received - Email from Michelle Hardman, APS Worker.
10/23/2024	Contact - Telephone call made to Amber Fry, Regional Consultant. No answer. Message left.
10/23/2024	Contact - Telephone call made, and email sent to Michelle Hardman, APS Worker.
10/24/2024	Contact - Telephone call received from Michelle Hardman, APS Worker. Discussion.

10/24/2024	Contact - Telephone call received - Message from Amber Fry, Regional Consultant.
11/14/2024	Contact - Telephone call made and email to Michelle Hardman, APS Worker. Status update requested.
11/14/2024	Contact - Document Received - Email from Michelle Hardman, APS Worker. Status update regarding Resident A provided.
11/20/2024	Contact - Telephone call made to Amber Fry, Regional Consultant.
11/20/2024	Contact – Telephone call made to Paul Wyman, Licensee Designee. Message left. I requested a returned phone call to conduct the exit conference.
11/20/2024	Exit Conference conducted with Paul Wyman, Licensee Designee.

ALLEGATIONS: Resident A eloped from the facility.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the additional information was noted:

> "[Resident A] is a Caucasian female in her 80's and lives at Greenacres assisted living facility. [Resident A's] diagnoses are unknown. On 09/19/2024, [Resident A] seemed confused and disoriented. [Resident A] was seen walking down the sidewalk away from Greenacres. [Resident A] got about half a mile down the road and seemed exhausted. It took [Resident A] an hour to walk a block, so she was gone from the facility at least a couple hours. [Resident] A was taken back to the facility, and staff stated that [Resident A] was a ward of the state and that she could check herself out at any time and were not concerned that she had left the facility."

On September 26, 2024, I conducted an unannounced on-site investigation and made face to face contact with Erin Droscha, Administrator, Katie Steadman, Staff, office staff, and Resident A.

Erin Droscha and other office staff members informed me they have been working to address the issues going on with Resident A, and they care about her wellbeing. Prior to her residing in this facility, Resident A was observed walking around town pushing a baby stroller. Erin Droscha informed me that Resident A was her own person, she has no friends or family, and she moved into the facility in July 2024.

According to Erin Droscha, Resident A sometimes goes into behaviors, she has delusions that someone is trying to attack her, and she was recently diagnosed with a bipolar disorder and schizophrenia.

I inquired about Resident A leaving the facility. Erin Droscha informed me that their protocol is for residents sign out when they leave the building. In addition, that on September 22, 2024, Resident A left the facility at 3:00 a.m. and went into the community. Erin Droscha was not sure if Resident A signed out at that time. Staff (either Jennifer Johnson or Dee Dee Ryan) notified her that Resident A had left. According to Erin Droscha, when Resident A was in a behavior or a mood, it was “a lost cause” to try to intervene. Two hours went by, and staff went to look for Resident A around 5:30 a.m. The police were already looking for her as well. Erin Droscha stated that she looked around at parks and in the community attempting to locate Resident A. Erin Droscha returned to the facility and looked for Resident A, and the police brought her back around 7:00 a.m. Erin Droscha spoke with Resident A and “she was in her mood.” Resident A stated that she didn’t want to live there and that she didn’t want to be bothered. A short while later staff notified Erin Droscha that Resident A was leaving again. Resident A was observed by someone on Columbia Road, heading out of town; this was approximately a half a mile away. That is when a lady, Individual #1, picked her up and brought her back to the facility. Individual #1 asked Resident A if she wanted a ride. This was the same lady that brought Resident A back before. Erin Droscha stated that she was not sure if Individual #1 spoke to staff when she dropped Resident A off. Erin Droscha expressed concerns as she felt like their hands were tied, they struggled to keep Resident A safe, and she questioned if this was the best placement for her. According to Erin Droscha, Resident A left again, after being brought back by Individual #1. Katie Steadman, staff, found Resident A, helped her, and took her to the local farmers market for three hours. Erin Droscha stated that Adult Protective Services has been called, they’ve tried to get help, and they have tried to get Resident A into a guardianship, without success. A family member was located in North Carolina, but they’re not interested in caring for Resident A.

During the interview with Katie Steadman, she stated that Dee Dee Ryan called her on Sunday, September 22, 2024, at 4:28 a.m. and said Resident A left at 3:00 a.m. Katie Steadman instructed staff to contact law enforcement because nothing was open at 3:00 a.m. The police located Resident A and brought her back to the facility around 7:00 a.m. While Resident A was in the facility, staff tried to administer her medications, but she would not take them. Katie Steadman headed back to the facility to assist with medication administration. Staff stated that Resident A would not take her medications, and she was already leaving the facility again. When Katie Steadman arrived at the facility, Resident A was located on the ground, in the front facility, in the parking lot. Resident A had gotten herself up from the ground and she was telling Katie Steadman to get her out of this town. Katie Steadman took Resident A to the market until noon, and that calmed Resident A down. Resident A took her medications when she returned to the facility.

I reviewed the Resident Sign In/Out Sheet and noted that on September 19, 2024, at 4:43 p.m. Resident A signed out and the return time was blank. On September 22, 2024, Resident A's name was listed, and it was noted that Resident A left at 3:10 a.m. and returned at 7:15 a.m. Resident A was then signed out again from 8:42 a.m. to 10:00 a.m. On this same date, Resident A's name was listed as leaving the facility at 10:08 a.m. and returning at noon.

While at the facility, I interviewed Resident A. When Erin Droscha first told Resident A that someone wanted to speak with her, Resident A, shouted from behind her closed bedroom door that she wanted to be left alone; however, shortly thereafter, Resident A opened the door and was willing to talk. Once on the topic, she stated that she tries to go for a walk daily, but she didn't recall going for a walk at 3:00 a.m. Resident A did not provide any additional information regarding her walks in the community.

During the on-site investigation, I spoke to Erin Droscha and inquired if Resident A was able to move about independently in the community and she provided me with a copy of the *Level of Care Assessment Plan* for Resident A, most recently signed by Erin Droscha and Resident A on September 11, 2024.

In relevant part, the following information was noted in the assessment plan:

- Question #1: Uses public transportation system or drives car (moves independently in community), and the "No" box was checked.
- Question #4: May drive own car, but question safety, and the answer was "Yes."
- Question #5, Requires customized handicapped vehicle for transportation or requires supportive person to be with him or her, the box "No" was checked.
- There was also a comment included noting "doesn't have car sold it/likes to walk places."

I discussed my concerns with Erin Droscha regarding question #1 as it notes that Resident A cannot move about independently in the community. Erin Droscha informed that she was referring to transportation and Resident A driving and referenced her comment. We discussed that the questions on document may need to be separated or better explained.

During this investigation, I received and reviewed the 30-Day Notice to Terminate Tenancy, dated October 7, 2024. It was noted that Resident A was being provided with the 30-Day Notice to Terminate Tenancy due to the facilities' inability to safely care for Resident A's needs, as well as a lack of payment. It was requested that Resident A leave the premises before or by November 6, 2024.

On October 11, 2024, I spoke with Amber Fry, Regional Consultant, regarding the discharge notice being issued as the facility staff could not keep Resident A safe and she had not paid rent. According to Amber Fry, a referral agency had located a secured unit for Resident A to relocate to. Amber Fry informed me that she would

have Erin Droscha send me the contact information for the referral agency. According to Amber Fry, Michelle Hardman from APS was now involved and they were informed that because Resident A had been deemed incompetent, Resident A could not sign a new lease agreement. Amber Fry expressed concerns and stated that they wanted to keep Resident A safe.

On October 14, 2024, I spoke to Michelle Hardman, Adult Protective Services. She stated that Resident A was given a 30-day discharge notice. In addition, that a doctor had deemed that Resident A did not have the capacity to make her own decisions. Michelle Hardman informed facility management that it was unwise to discharge Resident A, given her lack of capacity. In addition, that the new facility Resident A toured was not a higher level of care, and they would likely experience the same challenges. Michelle Hardman informed me that she would be filing for a guardianship hearing. In the meantime, the facility staff would be required to keep Resident A safe. We discussed options and possible resources to protect Resident A, if she insisted on leaving the facility unsupervised, which also included contacting law enforcement for an assessment if Resident A was in a behavior and additional assessments and intervention was necessary. Michelle Hardman agreed to forward me a copy of the letter that addressed Resident A's capacity.

During this investigation, I reviewed the letter authored by Dr. R. Hansen, MD, dated August 29, 2024. It was noted that Resident A was a patient and receiving services through Careline Physician's Services; and that medical records indicated that Resident A did not have the "mental capacity to make independent legal, medical or financial decisions on her own." In addition, that she was diagnosed with a Mild neurocognitive behavior disorder and paranoid schizophrenia. It was of Dr. R. Hansens' clinical opinion that Resident A's power of attorney documents for both property and health should now be in effect. Further that, by reason of mental incapacity Resident A could not manage her own estate, enter into a binding agreement, or understand that a contract is being made and its general nature.

On October 24, 2024, I spoke to Michelle Hardman, Adult Protective Services. We discussed Resident A being issued the discharge notice, and I explained that licensing does not make recommendations for placement; however, I did explain the options, which included the licensee having the ability to issue a discharge notice if they could not provide the care that Resident A required (Note: Per licensing rules, in certain situations, there were additional steps that must be followed prior to a resident being relocated). Michelle Hardman informed Amber Fry of the consequences based on the decisions they decided to make regarding this matter. In addition, that based on the letter authored by Dr. R Hansen, MD, Resident A lacked capacity to make decisions, including entering into a contractual housing agreement or deciding to move. Michelle Hardman filed for guardianship and there is a hearing scheduled in December. Michelle Hardman informed me that she would follow up with Amber Fry and let her know that they're responsible to keep Resident A safe until the guardianship hearing, and after that, the guardian can find an

alternative placement. Michelle Hardman would also discuss ways they could keep Resident A safe pending the guardianship hearing.

On October 24, 2024, I received a message from Amber Fry, Regional Consultant. She informed that she spoke with Michelle Hardman from Adult Protective Services, and they understood their obligations to keep and protect Resident A.

On November 14, 2024, Michelle Hardman informed me that Resident A was currently in the GEMS unit at McLaren, and she has a pending guardianship and conservatorship hearing scheduled for December 12, 2024. It was her understanding Resident A would remain at McLaren until the hearing.

On November 20, 2024, I spoke to Amber Fry, Regional Consultant. The conclusion of the investigation was discussed. Amber Fry stated that they were misled by the placing agency and the hospital regarding Resident A's condition when she was admitted into the home and then they were stuck dealing with the situation. In addition, that their doctor was the one who diagnosed Resident A. She expressed disappointment regarding the conclusion of the investigation and recommendations.

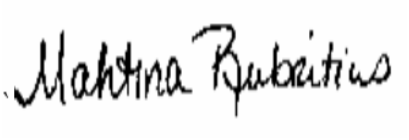
On November 20, 2024, I conducted the exit conference with Paul Wyman, Licensee Designee. I discussed the investigation, the conclusion, and my recommendations. Paul Wyman stated that they dealt with this situation for a while and experienced difficulties with getting any assistance from Adult Protective Services. I informed him that I would be requesting a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Erin Droscha informed me that Resident A was her own person, she has no friends or family, and she moved into the facility in July 2024. In addition, that Resident A sometimes goes into behaviors, she has delusions that someone is trying to attack her, and she was recently diagnosed with a bipolar disorder and schizophrenia. According to Erin Droscha, their protocol is for residents sign out when they leave the building. In addition, that on September 22, 2024, Resident A left the facility at 3:00 a.m. and went into the community. Resident A was located by the police and returned to the facility. I reviewed the *Level of Care Assessment Plan* for Resident A, and the following was noted for Question #1 and Question #4: Question #1: Uses public transportation system or drives car (moves independently in community), and the "No" box was checked. Question #4: May drive own car, but question safety, and the answer was "Yes." There was a comment included noting "doesn't have car sold it/likes to walk places." Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the amount of supervision and protection that Resident A required was not provided; as Resident A moved about independently, in the community without staff supervision, after Dr. R. Hansen, MD determined on August 29, 2024, that Resident A was diagnosed with a Mild neurocognitive behavior disorder and paranoid schizophrenia. Further that Resident A did not have the "mental capacity to make independent legal, medical or financial decisions on her own."
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



11/20/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

11/20/2024

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Dawn N. Timm Date
Area Manager