GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2024

Kimberly Wozniak
River Oaks Senior Living
500 E University Dr
Rochester, MI 48307

RE: License #: AH630399620
Investigation #: 2024A0585076
River Oaks Senior Living

Dear Ms. Wozniak:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630399620
Investigation #:	2024A0585076
Complaint Receipt Date:	08/14/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	10/13/2024
Licensee Name:	Rochester Care Operations, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	Unknown
Administrator:	Andrea Flood
Authorized Representative:	Kimberly Wozniak
Name of Facility:	River Oaks Senior Living
Facility Address:	500 E University Dr Rochester, MI 48307
Facility Telephone #:	(248) 601-9000
Original Issuance Date:	01/01/2020
License Status:	REGULAR
Effective Date:	07/01/2024
Expiration Date:	07/31/2024
Capacity:	117
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

08/14/2024	Special Investigation Intake 2024A0585076
08/14/2024	Special Investigation Initiated - Telephone Contacted the complainant for additional information.
08/16/2024	Inspection Completed On-site Completed with observation, interview and record review.
08/16/2024	Inspection Completed-BCAL Sub. Compliance
08/29/2024	Contact – Document Sent Emailed administrator for additional information.
08/30/2024	Contact – Document Received Requested information received.
09/04/2024	Exit Conference. Conducted via email to authorized representative Kimberly Wozniak and administrator Andrea Flood.

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 8/14/2024, the department received this complaint through the BCAL online complaint system. The complaint alleged that Resident A eloped from the facility on 7/26/2024. The complaint alleged that Resident A walked .25 miles, fell and broke her hip.

On 8/14/2024, I interviewed the complainant by telephone. The complainant alleged that the facility called her informed her that Resident A walked out the front door at 5:49 p.m. using her walker, without assistance and undetected. The complainant said that this seems highly unlikely that Resident A would have had the physical and mental strength to manage the door on her own. She said that it more unlikely that she could have done so undetected.

On 8/16/2024, an onsite was completed at the facility. I interviewed the administrator Andrea Flood who stated that she was new and started working at the facility three days after Resident A eloped. She said that she was not really that familiar with the incident but from what she understood is that Resident A was not a flight risk. She said that a receptionist is usually at the front entry until 7:30 p.m. She said that it is her understanding that the video is no longer available.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that she was called by another staff who told her that the police came to the facility asking about Resident A. She said that Resident A was found walking on trial between 6:30/7:00. She said that residents are supposed to sign in and out of the facility. She said that staff didn't know that Resident A had left the building.

I interviewed Employee #2 at the facility. Employee #2 stated that she was on the second floor of the facility when the police came. She stated that Resident A has never eloped before and never went out by herself. Employee #2 stated that Resident A had her walker and went down the sidewalk, across the street, behind the library. She said that nobody knew she was gone. She explained that caregivers were throughout the building assisting other residents. Employee #2 stated that the receptionist is supposed to be at the front desk but sometimes they have to go deliver mail/packages and help escort residents.

I interviewed Employee #3 at the facility. Employee #3 stated, it was dinner time when Resident A eloped from the facility, and she was getting residents up. Employee #3 said that she did not know how long Resident A was gone. She said that they like for residents to sign in and out. She said that the alarm is usually put on after seven, but now they are on all the time since the incident.

On 8/30/2024, I interviewed Employee #4 by telephone. Employee #4 stated that he was on duty that evening working 2-7:30. Employee #4 said he had walked away to the Bristo and did not see Resident A leave out the door. Employee #4 stated that the doors were not locked and could easily be pushed open by pressing the handicap function. He said that he was shocked that Resident A could get out the door because she had never done that before. He said that Resident A is not strong and walk very slow but he believes that she could push a little and that's all it took for her to go out the door. He said she had difficulty walking.

Resident A's service plan read in part, "uses a walker to travel the assisted living neighborhood and while traveling please provide stand by assistance. Become familiar with my daily routine, check on her first thing in the am and 3-4 times a shift and attempt to anticipate and meet my daily needs. I am at risk for potential falls due to my decreased mobility. Observe me for any changes. Keep my routine consistent by providing me with designated care manager in order to ensure my routine and sense of security are maintained and to minimize my uncertainty and/or confusion. I am permitted outdoors with a team member with me. Do not allow me to sit outdoors unattended."

A review of facility document shows that on 7/26/2024, at 7:10 p.m., Resident A was found behind the library across the street. An individual at the library called police and stated that Resident A was on the sidewalk. They reported that the Resident A knew her name and age, date of birth and knew she lived closed by. The document revealed that the police contacted EMS and notified the facility. Vitals were taken at the scene and resident was transported to the hospital.

Staffing/sign in sheets was reviewed and there were no issues with the staffing on duty during the time of the incident.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

R 325.1901	**Definitions.**
	(p)"Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The service plan for Resident A indicated that staff is to keep her routine consistent by providing her with designated care manager in order to ensure that her routine and sense of security are maintained and to minimize my uncertainty and/or confusion. The plan also indicated that Resident A is permitted outdoors with a team member with her, and she is not allowed to sit outdoors unattended. On 07/26/2024, staff were unaware that Resident A had left the building, as the door alarm did not alert staff. Resident A went outside without staff and left the building. The facility has a sign out sheet that residents are supposed to sign when going in and out of the facility, but residents do not always sign out. Therefore, the facility did not assure the safety of Resident A as written in her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/03/2024

Brender Howard Date
Licensing Staff

Approved By:

09/03/2024

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