STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2025

Leigh McLeod
The Orchards at Canterbury Village
5601 Hatchery Road
Waterford, MI 48329

RE: License #: AH630380234
Investigation #: 2025A1019085

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630380234
Investigation #:	2025A1019085
Complaint Receipt Date:	09/02/2025
Investigation Initiation Date:	09/02/2025
Report Due Date:	11/02/2025
Licensee Name:	Canterbury Village MI Opco LLC
Licensee Address:	362 E Kennedy Blvd Lakewood, MI 08701
Administrator:	Jennifer Moore
Authorized Representative:	Leigh McLeod
Name of Facility:	The Orchards at Canterbury Village
Facility Address:	5601 Hatchery Road Waterford, MI 48329
Facility Telephone #:	(248) 674-9292
Original Issuance Date:	01/05/2018
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	32
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/02/2025	Special Investigation Intake 2025A1019085
09/02/2025	Special Investigation Initiated - Letter Licensee reported the incident to LARA on 8/26/25. Email correspondence ongoing.
09/02/2025	Contact - Document Sent Request for police report made to Waterford Police Department.
09/02/2025	Contact - Document Received Police report received.
09/08/2025	Inspection Completed BCAL Sub. Compliance

ALLEGATION: Resident A eloped from the facility.

INVESTIGATION:

On 9/2/25, the department received a complaint alleging that Resident A eloped from the facility. The complaint read that the elopement occurred on 8/25/25 and alleged that facility staff failed to call the police when they could not locate the resident. The complaint alleged that the resident had been missing for roughly four hours before being found. Due to the anonymous nature of the complaint, additional information could not be obtained.

Prior to receiving the complaint, the administrator Jennifer Moore reported the incident to the department. The administrator provided an incident report that read *"On 08/25/2025 at about 1710, [Resident A], a resident did an unauthorized leave from the facility through a window that had become unnoticeably loose due to natural wear and tears. The resident was quickly located and safely returned by staff within minutes. No injuries occurred."* The incident report read that Waterford Police Department was notified on 8/25/25 at 6:16pm.

On 9/2/25, a request was made for the police report. The police report read:

> *On 8/25/25 at approximately 1750 hours, [Officer 1] and 1, [Officer 2], were dispatched to [name redacted] in reference to a welfare check.*
>
> *Upon arrival, officers spoke with [Witness 1] and [Resident A]. [Witness 1] advised that one of the parents informed her that [Resident A] was walking near Airport Rd. and appeared confused. [Witness 1] remained with [Resident A] while officers were enroute. I spoke with [Resident A], who was unaware of where he was or what was going on. It appeared that [Resident A] had dementia and officers were asked dispatch to contact Canterbury on the Lake to see if [Resident A] was a resident there, due to the close proximity. Dispatch was only able to get ahold of the main building, who advised they did not have a resident there by that name.*
>
> *[Resident A] gave me his wallet, and I was able to find a card for a different senior care facility. I contacted them by phone, and they advised [Resident A] was a resident there until a week ago when he was transferred out by his family. The [sic] also advised that their records showed [Resident A] was not a resident at the Canterbury on the Lake memory care facility.*
>
> *At about this time, staff members from Canterbury on the Lake were driving by and saw [Resident A] with officers. They approached and initially advised they had been looking for [Resident A] since 1430. They checked the facility and the grounds and were unable to locate him, so they began driving around to find him. Their manager, Jennifer Moore, was enroute to speak with officers as well.*
>
> *When Jennifer arrived, she said [Resident A] had only been missing since approximately 1700 hours. Jennifer said she personally saw [Resident A] at 1645 hours before she left the facility, but he had been seen by other staff after that Jennifer advised their policy is to check the building and surrounding areas first, and when they aren't able to locate a resident, they contact the police.*
>
> *I was unable to establish a definitive time when [Resident A] left the facility. Staff advised [Resident A's] window and screen were open and removed and they believed he left through the window. Jennifer advised more safety precautions would be put in place to prevent this from happening with [Resident A] in the future. Resident A went with Jennifer and was returned to the facility without issue. APS was notified.*

In follow up correspondence with the administrator, she reported that staff last saw Resident A around 5:15pm and staff could not locate him during shift change around 6:00pm. The administrator reported that Resident A was located around 6:15pm and she personally escorted him back to the facility around 6:35pm. The administrator reported that Resident A was located about 0.4 miles away from the facility. The

administrator clarified that facility staff did not contact the police department but documented that the police were notified because they were on scene when the resident was found.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For reference R 325.1901	**(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.** **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(iv) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Resident A was able to elope from the secured memory care facility for an unknown amount of time. The incident report, police report and follow up with the administrator provide varying accounts of what occurred and how long Resident A was potentially unaccounted for. What is known is that Resident A was placed at great risk of harm while being outside of the facility unattended during this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(8) If an elopement occurs, staff shall conduct a search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall comply with subrule (7) of this rule and contact the local police authority.
ANALYSIS:	Resident A eloped from the facility on 8/25/25. Facility staff admit that they did not notify the police of the resident's disappearance, when the resident was not located after 30 minutes, despite documenting on the incident report that notification was provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 10/3/25, licensing staff received email correspondence from Employee 1 appointing her as the administrator of the facility. When questioned about the status of the authorized representative, Employee 1 reported that the person on file is no longer employed at the facility and her last day worked was 8/14/25. Prior to this correspondence, the department had not received notification of a change to this appointment. At the time of this report, paperwork has not been submitted to change the authorized representative appointment.

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 facility's former authorized representative ceased employment in August 2025. The licensee failed to provide timely notification of this change and has not submitted documentation appointing someone else to this role.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

09/15/2025

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/06/2025

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