



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2026

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

RE: License #: AL330314460
Investigation #: 2026A0007015
Green Acres Mason

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,

A handwritten signature in cursive script that reads "Mahtina Rubritius".

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 #:	AL330314460
Investigation #:	2026A0007015
Complaint Receipt Date:	02/17/2026
Investigation Initiation Date:	02/18/2026
Report Due Date:	04/18/2026
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 Mason
Facility Address:	1027 E. Ash Street Mason, MI 48854
Facility Telephone #:	(517) 676-1484
Original Issuance Date:	02/16/2012
License Status:	REGULAR
Effective Date:	07/28/2024
Expiration Date:	07/27/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On February 14, 2026, Resident A eloped from the facility. Resident A was found at the party store, half of a mile away from the facility, without her walker.	Yes

III. METHODOLOGY

02/17/2026	Special Investigation Intake - 2026A0007015
02/17/2026	Contact - Telephone call made to Relative A1.
02/18/2026	Special Investigation Initiated - On Site - Unannounced - Face to face contact with Erin Droscha, Administrator, Katie Steadman, Resident Care Coordinator, Resident A, other residents and staff.
03/18/2026	Contact - Face to Face contact with Erin Droscha, Administrator. Discussion.
04/08/2026	Contact - Telephone call made to Vabian Ford, message left. I requested a returned phone call.
04/08/2026	Contact - Telephone call made to the facility. Follow up questions for Erin Droscha and Katie Steadman.
04/08/2026	Contact - Telephone call made to Family Member B1. Message left. I requested a return phone call.
04/08/2026	Contact - Telephone call received from and to Vabian Ford. Interview.
04/08/2026	APS Referral made.
04/09/2026	Contact – Telephone call made to Paul Wyman, Licensee Designee. I requested a return phone call to conduct the exit conference.
04/09/2026	Contact – Document Sent – Email to Paul Wyman, Licensee Designee, regarding the exit conference.
04/09/2026	Contact - Telephone call received from Family Member B1. Interview.

04/14/2026	Contact - Telephone call Paul Wyman, Licensee Designee, to conduct the exit conference. Message left regarding the established violation.
------------	---

ALLEGATION: On February 14, 2026, Resident A eloped from the facility. Resident A was found at the party store, half of a mile away from the facility, without her walker.

INVESTIGATION:

As a part of this investigation, I called and spoke with Relative A1, regarding Resident A. Relative A1 stated that Resident A is 89 years of age and she has blindness in one eye. Resident A may utilize a walker in the facility. Relative A1 stated that on February 14, 2026, she received a call from Relative A2, who stated Resident A was missing and the facility staff did not know where she was located. There are issues with staffing shortages on the weekends. The police were contacted and they were looking for Resident A. The staff were also looking for Resident A and called a staff member (name unknown), at home, who went looking for Resident A. Resident A was found at a party store, east of the facility, which meant that Resident A had to cross the road to get there. Relative A1 stated that Resident A was wearing a sweater (not a coat), and it was unknown if she was checked for hyperthermia. It was unknown how long Resident A was missing from the facility and how she was able to leave. A person found Resident A at the party store and took her back to the facility. On Sunday (2/15/2026), Relative A2 went to the facility to check on Resident A.

On February 18, 2026, I conducted an unannounced on-site investigation and made face to face contact with Erin Droscha, Administrator. She stated on February 14, 2026, between 4:00 – 4:30 p.m., Mallory Syren, Med. Tech/DCW, notified on-call that Resident A was missing. Diane Peltier was on-call, and she contacted Erin Droscha to notify her that Resident A had eloped, and they were looking for her. Erin Droscha then contacted Katie Steadman, Resident Care Coordinator. Management staff arrived at the facility to assist in looking for Resident A. I was informed that Employee #1 does not live too far from the facility. Employee #1's mother (Family Member #1) was at the facility visiting her father, Resident C. Family Member #1 heard about what was going on and she contacted Employee #1. Employee #1 arrived before management staff.

Katie Steadman, Resident Care Coordinator then joined the interview. Katie Steadman stated that Employee #1 told her that she had located Resident A. Katie Steadman then updated Erin Droscha, as she was enroute. Erin Droscha and Katie Steadman informed me that Resident A was located at the corner store (Store #1) about 0.4 miles away from the facility. Resident A was wearing a sweater, slacks, and shoes. According to the staff, she was not harmed. Staff notified the police and Resident A's family member. I inquired about the police incident number, but it was

unknown at that time of the interview. Erin Droscha agreed to send me a copy of the incident report.

During the interview, Katie Steadman stated that Resident A was gone for maybe 15 to 20 minutes. She stated there are no cameras, the doors have alarms, which were functioning. When entering the facility, visitors can push the handicap assistance button, on the outside of the facility, to open the door. Katie Steadman stated they think Resident A went out after a resident's family member entered the facility. Staff conducted checks around 4:00 p.m. and sometime shortly after, they discovered that a family member (Family Member B1) of another resident (Resident B) told the kitchen staff, Vabian Ford, "By the way, [Resident A] went out the door about ten minutes ago." This alarmed Vabian Ford, and he went and told Mallory Syren, Med. Tech/ DCW and Tami Conaty, DCW. It was noted that it was possible that the alarm did not go off because the door was opened and Resident A left after someone was either entering or exiting the building.

We discussed the staffing and Erin Droscha described scheduling staff for the shifts as follows: 6:00 a.m. to 2:00 p.m. direct care worker, 7:00 a.m. to 3:00 p.m. med tech, 2:00 p.m. to 10:00 p.m. direct care worker, 3:00 p.m. to 11:00 p.m. med tech, 10:00 p.m. to 6:00 a.m. 3rd shift direct care worker, 11:00 p.m. to 7:00 a.m. med tech. Erin Droscha stated there were three staff on shift the day of the incident. She stated that Tami Conaty, DCW, Mallory Syren, Med. Tech/ DCW, and Vabian Ford (kitchen staff) were on duty.

Katie Steadman informed me that Resident A has a walker, but she does not use it. The walker is not prescribed, and it was brought in by her family. The walker is kept in her closet and is not utilized.

While at the facility, I also attempted to interview Resident A. Before the interview, staff assisted, walking along the side of Resident A, and stood by until she was comfortably seated in the office chair. Resident A was not utilizing a walker. Resident A was observed to be clean. Resident A appeared to be in good mood, she smiled, and she chatted about her family. When attempting to ask questions regarding the incident, Resident A responded with answers unrelated to the questions. Resident A did not provide any information to confirm or refute the allegations.

I reviewed the *Incident Report (IR)*, authored by Mallory Syren, Med. Tech/DCW, dated February 14, 2026, and following information was noted:

The incident occurred on February 14, 2026, at 4:30 p.m. It was documented that the staff assigned were Mallory Syren and Tami Conaty. It was documented on the IR that Employee #1 was an employee and visiting. Mallory Syren documented that Resident A was last seen around 4:00 p.m. for checks and she was observed sitting on the bench in front of the pharmacy (inside the facility). Both staff were assisting another resident when Vabian Ford told them that a family member of another resident told him she saw [Resident A] "outside the

window” about “fifteen minutes ago.” Mallory Syren documented that she, her co-workers (Tami Conaty, Vabian Ford, Nevaeh Quinn-Salas and Tyler Mankey), and some family members searched inside and outside of the building. Resident A was not located, and 911 was contacted for a search. Resident A’s family and on-call staff were also notified. Employee #1 searched the neighborhood nearby and found Resident A at the corner store, which was located around the corner from the facility. Employee #1 brought Resident A back to the facility at 4:42 p.m., at which time 911 and the family were notified. Resident A’s vitals were taken, and her blood pressure was 130/90, pulse was 114, oxygen levels were 97%, and her temperature was 97.5 degrees Fahrenheit, upon return. It was also documented in the report that the staff members did not recall any alarms showing up or going off for any of the doors.

The actions and corrective measures included contacting 911, on-call, and family, taking Resident A’s vitals and monitoring Resident A closely after the elopement. They also changed to hourly checks with a question for staff to answer regarding the location of the resident. It was also noted that many visitors were entering and leaving the building, possibly with the code to the door.

During this investigation, I reviewed the *Care Plan* for Resident A, dated 2/18/2026. It was noted that she had other diagnoses, but specifically, that she was diagnosed with Alzheimer’s Disease with late onset, Dementia “in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety,” and unspecified glaucoma. It was also noted that wellness checks would be completed every hour for Resident A.

I reviewed the *Health Care Appraisal* for Resident A, dated August 27, 2025, and it was noted that she is fully ambulatory.

On March 18, 2026, I made face-to-face contact with Erin Droscha, Administrator, while completing a different inspection. She informed me that they made changes to safeguard the residents. They disabled the handicap assistance button on the outside of the facility, to prevent residents from wandering out of the door after someone has entered the building. A key code is now required for people to enter or exit the building. They also changed the codes to the door.

On April 8, 2026, I spoke with Erin Droscha and Katie Steadman as I had some follow-up questions. It was noted in the incident report that other staff assisted and looked for Resident A. I inquired if the other staff left residents in the other building unattended. Erin Droscha stated that they had extra staff on duty. In addition, the staff contacted the other building to determine if Resident A was seen in that building. According to Erin Droscha, the assigned direct care staff did not leave the facility. Tyler Mankey and Vabian Ford were kitchen staff, and it wasn’t during a mealtime, so they were the staff outside looking for Resident A. We also discussed how Resident A may have left the facility and that she may have left after someone either entered or exited the building. Erin Droscha also stated there was a lapse on

the door, meaning that when it was closed, there was about ten seconds before the lock would engage. That has now been changed, and the door immediately locks once it closes.

On April 8, 2026, I conducted an interview with Vabian Ford. He reported to have the role as cook in the facility. On the day of the incident, he stated that he and a co-worker were in the kitchen and they were prepping for dinner, which would be served around 5:30 p.m. He stated there were guests standing by the door waiting to leave (they needed the code to exit the building). He stated that the kitchen staff will assist and open the doors for guest if the assigned direct care staff are busy assisting other residents. He stated that the guest had been waiting in the dining area and they knocked on the kitchen door for assistance. He entered the code, assisting them out of the building. He did not recall the resident's name, but her daughter was there visiting. The daughter told him that she saw Resident A outside of the window. This had occurred about 15 minutes prior. He then went down the hall looking for the staff who were assisting a resident. He informed them of the information. He and Tyler Mankey went outside attempting to locate Resident A. They did not see Resident A on the property. The staff in the other building were also informed. The staff were on the phone contacting administration and the authorities. Employee #1 was also notified, and he observed her driving around in the neighborhood, looking for Resident A. He spoke with Employee #1 and then they split up again, continuing to search for the resident. He went back to the facility to see if there was any new information and that is when he was told that Employee #1 had located Resident A. I inquired about the weather that day and Vabian Ford stated it was kind of nice, but there was a lot of snow on the ground. He stated he was outside without a coat during the search but was very concerned about Resident A, given her age, diagnoses, and all the snow.

On April 9, 2026, I interviewed Family Member B1. She informed me that on the day in question, she was sitting in her mother's (Resident B) room visiting. She looked out the window and saw Resident A walking down the sidewalk. She stated, "I don't think she's supposed to be out there. I better say something." It was not very long before Family Member B1 got up and went looking around for direct care staff; however, she could not find them, so she knocked on the kitchen door. Family Member B1 informed the worker that she had just seen Resident A walking down the sidewalk. Family Member B1 stated that she walked around looking for Resident A but did not see her; no one could find Resident A. After the incident, everything was a big secret. She eventually learned that Resident A had been located. I inquired if Resident A was utilizing a walker and she stated she was not. She stated that Resident A is ambulatory, a fast walker, and gets around quickly. Family Member B1 stated that the facility staff changed the security system right away, then they changed it again. Family Member B1 informed me that they quickly addressed the issue and security matters, so it does not happen again.

On April 14, 2026, I called and attempted to contact Paul Wyman, Licensee Designee, to conduct the exit conference; however, I was still unable to reach him. I

left a message to inform him that the allegations regarding Resident A wandering away from the facility were substantiated, and to give me a call if he had any questions.

Regarding Resident A's walker, it's recommended that technical assistance be provided regarding assistive devices remaining in the facility that are not prescribed. It's understandable that family members will bring in assistive devices and other items they believe would be helpful. While it was reported that Resident A did not use the walker and it's not prescribed by a doctor; it's recommended that it be removed from her room or returned to the family.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with facility staff, the resident and a family member, a family member visiting the facility, and review of pertinent documentation, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A, who is diagnosed with Alzheimer's, Dementia, and other health challenges, was not protected and kept safe; as on February 14, 2026, in the afternoon, she wandered away from the AFC memory care facility, she was not wearing a winter coat, and was found at the store, located around the corner from the facility. Resident A, being in the community without staff, exposed her to a great risk of harm.
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.

Mahtina Rubritius

4/9/2026

Mahtina Rubritius
Licensing Consultant

Date

Approved By:

Dawn Timm

04/10/2026

Dawn N. Timm
Area Manager

Date