GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 13, 2026

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

RE: License #: AH630399620
Investigation #: 2026A0585047
River Oaks Senior Living

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 was required. On 07/10/2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

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 #:	2026A0585047
Complaint Receipt Date:	06/22/2026
Investigation Initiation Date:	06/23/2026
Report Due Date:	08/22/2026
Licensee Name:	Rochester Care Operations, LLC
Licensee Address:	144 940 Monroe Ave., NW Grand Rapids, MI 49503
Licensee Telephone #:	(248) 601-9000
Administrator:	Elizabeth Mahoney
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	117
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B left the facility.	Yes
Additional Findings	No

III. METHODOLOGY

06/22/2026	Special Investigation Intake 2026A0585047
06/23/2026	Special Investigation Initiated - On Site Interviewed administrator on site.
06/23/2026	Inspection Completed-BCAL Sub. Compliance
06/23/2026	Contact - Face to Face Attempt contact with witness. A card was left to call me.
07/14/2026	Exit Conference Conducted via email to authorized representative Kimberly Wozniak.

ALLEGATION:

Resident A and Resident B left the facility.

INVESTIGATION:

On 06/22/2026, the licensing department received a complaint from Adult Protective Services (APS) alleging Resident A left the facility with Resident B who both has diagnoses of dementia. The complaint alleges that at 6:00 am, during regular resident checks, facility staff realized that Resident A and Resident B were missing and called the police. The complaint alleges that Resident A and Resident B were found at a gas station that is about a quarter mile away from the facility. The complaint alleges that Resident A and Resident B were in the gas station for approximately three hours due to the rain and it was 57 degrees outside that morning.

On 06/23/2026, onsite was completed at the facility. I interviewed the administrator, Elizabeth Mahoney, who stated that they were notified at 4:40 am that two residents were unaccounted for and they started looking. She said that staff should have seen the residents around 2:00 a.m. She said that the memory care is a locked unit. She said that Resident A and Resident B are “pretty” cognitive. The administrator said that she believes Resident A knows the code to get out. She explained that

residents in memory care are monitored every two hours unless they are required to be monitored more frequently. She said the memory care is on the fourth floor of the facility. She said they have already put the corrective action plan in place. She said they have contacted the elevator company to make keys to get up and down on the elevator and they have added extra staff.

On 06/23/2026, I interviewed Employee #1 who stated that around 4:30 am, the supervisor notified her that they could not locate Resident A and Resident B. She said around 5:00 a.m. they notified the police. She said the police found Resident A and Resident B at the gas station.

On 06/23/2026, I went to the gas station which was approximately .2 miles away. I spoke to the manager, who stated the staff that I needed to speak to was not on shift. I left my business card with him to give to staff.

On 06/24/2026 and 07/01/2026, a call was made to the gas station to speak with the employee of the BP gas station. The employee who witnessed the incident was not there at the time. As of the date of this report, no return call has been received.

Resident A's service plan read, "Resident frequently wanders throughout the Memory Care unit, entering other residents' rooms and exhibiting exit-seeking behaviors. Staff are to conduct safety checks every 2 hours and use redirection technique as needed to discourage exit seeking and promote resident safety."

Resident B's service plan read, "Resident repeatedly verbalized a desire to return home and stated that she does not intend to remain at the facility. Due to confusion regarding place and timeframe, resident is at risk for wandering and/or exit seeking behaviors. Staff are to closely monitor for signs of wandering, exit seeking, or attempts to leave the facility. Increased safety checks have been initiated, and staff will continue to provide reassurance, redirection, and orientation as needed."

On 07/10/2026, the administrator and authorized representative submitted a corrective action plan which included:

- Staff education
- Every 2 hour checks and log initiated for identified residents
- Implemented a non-restrictive environmental modification by applying a bookshelf mural to the memory care elevator doors to reduce visual cues associated with exit-seeking behaviors. This intervention is intended to decrease resident fixation on the elevator while promoting engagement within the memory care environment.
- Weekly elopement risk assessment tool implantation for 4 weeks
- EMS educated on facility elopement protocol.

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.**
ANALYSIS:	The complaint alleged, Resident A and Resident B left the facility. Resident A and Resident B were able to get out the facility without staff knowing they were gone. Resident A was on two-hour checks, and it was reported that the last time Resident A and B was seen at approximately 9:00 pm – 10:00 pm. during shift change. Resident A and Resident B were found at a gas station by police at approximately 4:00 a.m. On 7/10/2026, the facility submitted a corrective plan which includes a new elevator with a code to get on and off. The facility also added additional staff for the protection of the residents. The facility has submitted a corrective action plan to ensure the safety of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

The facility has submitted a corrective action plan. I recommend no change in the status of the license.

07/13/2026

Brender Howard Date
Licensing Staff

Approved By:

07/13/2026

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