GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

Angela Hall
Hallstrom Castle Assisted Living, LLC
5638 Holton Rd
Twin Lake, MI 49457

RE: License #:	AL610395597
Investigation #:	2024A0356035
	Hallstrom Castle Assisted Living

Dear Ms. Hall:

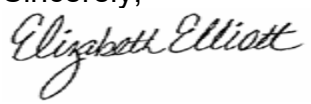
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610395597
Investigation #:	2024A0356035
Complaint Receipt Date:	05/07/2024
Investigation Initiation Date:	05/07/2024
Report Due Date:	07/06/2024
Licensee Name:	Hallstrom Castle Assisted Living, LLC
Licensee Address:	5638 Holton Rd Twin Lake, MI 49457
Licensee Telephone #:	(231) 828-4664
Administrator:	Angela Hall
Licensee Designee:	Angela Hall
Name of Facility:	Hallstrom Castle Assisted Living
Facility Address:	5638 Holton Rd Twin Lake, MI 49457
Facility Telephone #:	(231) 828-4664
Original Issuance Date:	03/09/2020
License Status:	REGULAR
Effective Date:	09/09/2022
Expiration Date:	09/08/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and staff did not know he had left.	Yes

III. METHODOLOGY

05/07/2024	Special Investigation Intake 2024A0356035
05/07/2024	Special Investigation Initiated - Telephone Tammy Kastelic, Reliance Community Care Partners.
05/16/2024	Contact - Telephone call made. Angela Hall, Licensee Designee.
05/23/2024	APS Referral Centralized Intake referral made.
05/23/2024	Contact - Telephone call made. Tammy Kastelic, Reliance Community Care Partners.
05/23/2024	Inspection Completed On-site Unannounced inspection at the facility.
05/23/2024	Contact - Face to Face Staff, Isaac Smith, Peggy Franz, Abigail Hall, Resident A.
05/28/2024	Contact - Document Received Ken Beckman, APS, DHHS, Muskegon County.
05/29/2024	Contact - Telephone call made. Relative #1.
05/30/2024	Exit conference, Angela Hall, Licensee Designee.

ALLEGATION: Resident A eloped from the facility and staff did not know he had left.

INVESTIGATION: On 05/07/2024, I received a telephone call and an email from Tammy Kastelic, Reliance Community Care Partners social worker. Ms. Kastelic reported she was made aware of an incident that occurred on 04/28/2024 at a local bar near this facility. On 04/28/2024, an elderly male (Resident A) entered the bar and ordered food and drink. Ms. Kastelic reported that Resident A was not able to

figure out how to pay his bill even though he had money in his wallet and a patron at the bar had to assist Resident A to pay his bill with his own money. Ms. Kastelic reported Resident A exited the bar but wandered around the area for some time before returning to the bar. He appeared very frail and confused. Ms. Kastelic reported Resident A told people at the bar that he lived near a church further down the road so a patron at the bar offered to drive Resident A home but was unable to locate any residence that Resident A could say was his house. Ms. Kastelic reported the bar patron returned to the bar and ultimately found a phone number in Resident A's wallet for his (Resident A's) son. Resident A's son informed the caller that Resident A lives at this facility, so the patron drove Resident A to Hallstrom Castle. Ms. Kastelic reported the bar patron and Resident A were able to go into the facility with no alarms or warning signals going off. Ms. Kastelic reported that the bar patron assisting the resident could not immediately locate any staff until noticing several staff sitting together in an area near the kitchen. Ms. Kastelic reported that the complainant stated staff expressed appreciation for bringing Resident A back but did not go to check on Resident A's well-being. Ken Beckman, Adult Protective Services Worker, Muskegon County Department of Health and Human Services was assigned to investigate.

On 05/16/2024, I interviewed Licensee Designee, Angela Hall via telephone. Ms. Hall acknowledged and confirmed that the information reported in the allegation did occur on 04/28/2024. Ms. Hall stated staff thought that after lunch on 04/28/2024, Resident A went back to his room to take a nap when instead he left the facility and made his way to the bar down the road and across M120, which admittedly is a very busy road. Ms. Hall stated there are alarms on the doors at the facility but Resident A "keeps turning them off." Ms. Hall stated staff did not realize Resident A was gone. Ms. Hall stated when the bar patron brought Resident A back, she came into the facility and began yelling and screaming at staff because no one greeted her at the door. Ms. Hall stated Resident A's assessment plan documents that Resident A can wander the grounds of the facility, go out of the facility in a vehicle or with family. Ms. Hall stated to prevent this from occurring in the future, they continue to alarm the door at the facility and a doorbell mat at the door that rings when stepped on to notify staff when anyone enters or exits the facility.

On 05/23/2024, I conducted an unannounced inspection at the facility and upon entry, a loud alarm rang continuously for several minutes until staff turned it off. I interviewed Resident A in his room and he stated he had no recollection of leaving the facility on 04/28/2024 and does not recall ordering food or anyone assisting him to pay for it. Resident A stated he does not recall anyone giving him a ride back to the facility. Resident A stated he is "in his 80's somewhere" and he always uses his walker to ambulate and walk around outside of the facility.

On 05/23/2024, I interviewed DCW (direct care workers) Peggy Franz who stated she was working on 04/28/2024 when Resident A left the facility. Ms. Franz stated after lunch, she saw Resident A go into his room which he usually takes a nap after lunch and that is what she thought he was doing. Ms. Franz stated there are 20

residents in the facility and she got busy getting medications ready for administration and did not check on Resident A or see him until the bar patron returned him to the facility. Ms. Franz stated she did not know that Resident A was gone. Ms. Franz stated Resident A can go out and walk around without staff supervision. Ms. Franz stated Casey Boucher was working in the kitchen and Rayven Roberts was providing care to residents on 04/28/2024 when Resident A left the facility. According to Ms. Franz, neither Ms. Boucher nor Ms. Roberts knew Resident A had left the facility.

On 05/23/2024, I interviewed DCW, Isaac Smith. Mr. Smith reported that he was not working on 04/28/2024 when Resident A left the facility and went to the bar. Mr. Smith stated Resident A "never" goes outside of the facility when he is working.

On 05/23/2024, I interviewed home manager, Abigail Hall at the facility. Ms. Hall acknowledged that on 04/28/2024, Resident A left the facility, walked down the long gravel drive to M120, crossed M120 and went further down the road to a bar. Ms. Hall acknowledged that staff at the facility did not know Resident A was gone. Ms. Hall stated Resident A has been living in the facility since 02/18/2021 and initially moved in with his wife, his wife died and then he had a friend in the facility who has died also so prior to these deaths, Resident A did not exit the facility or walk away. Ms. Hall stated the back yard of the facility is fenced in with a child lock on the gate that Resident A can open. Ms. Hall described Resident A as "sneaky and tricky". Ms. Hall stated a sign has been posted in the medication room to remind staff that Resident A cannot be outside without supervision and a door alarm and door mat alarm have been implemented to alert staff when anyone enters or exits the facility. Upon my exit from the facility, there was no alarm that sounded at all.

On 05/23/2024, I reviewed the assessment plan for AFC residents for Resident A. The assessment plan is dated 03/14/2024 and signed by Licensee Designee, Angela Hall and Relative #1. The assessment plan documented that Resident A is not able to move independently in the community with a description of, '*independent within Hallstrom grounds. Transportation done by family or company.'*

On 05/23/2024, I reviewed the Health Care Appraisal (HCA) for Resident A dated 02/07/2024 and signed by Kimberly Harper, NP (nurse practitioner). The HCA documented Resident A's diagnosis as, *'PVD (peripheral vascular disease), Vitamin D deficiency, dementia, impaired gait, impaired cognition, decreased hearing, lower extremity weakness.'*

On 05/29/2024, I interviewed Relative #1 via telephone. Relative #1 stated is it "very difficult" for Resident A to walk and he is surprised that he was able to walk as far as he did due to the difficulty he has ambulating. Relative #1 stated he "does not see this happening again." Relative #1 stated the bar patron was able to find his telephone number in Resident A's wallet and called him to find out where Resident A lived. Relative #1 stated he does not know how long Resident A was gone from the

facility and stated this has not happened in the past. Relative #1 stated Resident A should not be out of the facility and moving about independently in the community.

On 05/30/2024, I conducted an exit conference with Licensee Designee, Angela Hall. Ms. Hall agreed with the information, analysis, and conclusion of this applicable rule violation and stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complainant reported Resident A left the facility and walked to a bar, was confused, and could not find his way home requiring assistance from a bar patron. Ms. Hall, Ms. Abigail Hall, Ms. Franz acknowledged Resident A left the facility on 04/28/2024 and staff did not know he was gone. Relative #1 stated Resident A should not be independent in the community. Resident A's assessment plan documented Resident A is not able to be independent in the community. Based on investigative findings, staff failed to provide proper supervision, protection, and safety to Resident A on 04/28/2024 when he left the facility undetected by staff. Resident A walked down a long gravel driveway across a busy road using a walker and unsteady on his feet to a bar where he required assistance from a bar patron to get back to the facility. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

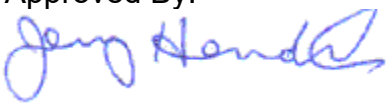
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain the same.

05/30/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:



05/30/2024

Jerry Hendrick Date
Area Manager