



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 4, 2025

Angela Hall  
Golden Years Personal Care Home LLC  
PO Box 5088  
N. Muskegon, MI 49445

RE: License #: AM610282328  
Investigation #: 2025A0009031  
Golden Years Personal Care Home

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

Sincerely,

A handwritten signature in cursive script that reads "Adam Robarge".

Adam Robarge, Licensing Consultant  
Bureau of Community and Health Systems  
Suite 11  
701 S. Elmwood  
Traverse City, MI 49684  
(231) 350-0939

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM610282328
<b>Investigation #:</b>	2025A0009031
<b>Complaint Receipt Date:</b>	08/14/2025
<b>Investigation Initiation Date:</b>	08/15/2025
<b>Report Due Date:</b>	09/13/2025
<b>Licensee Name:</b>	Golden Years Personal Care Home LLC
<b>Licensee Address:</b>	PO Box 5088 N. Muskegon, MI 49445
<b>Licensee Telephone #:</b>	(231) 788-2160
<b>Administrator:</b>	Angela Hall
<b>Licensee Designee:</b>	Angela Hall
<b>Name of Facility:</b>	Golden Years Personal Care Home
<b>Facility Address:</b>	6274 MacArthur Road Muskegon, MI 49442-9421
<b>Facility Telephone #:</b>	(231) 788-2160
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/10/2024
<b>Expiration Date:</b>	08/09/2026
<b>Capacity:</b>	12
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS & AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A left the facility unbeknownst to staff and fell several blocks away. He sustained a head injury prompting emergency personnel to respond to the scene. The staff on duty at the facility did not know Resident A was absent until emergency personnel arrived to tell her.	Yes
The home is inadequately staffed.	No

**III. METHODOLOGY**

08/14/2025	Special Investigation Intake 2025A0009031
08/14/2025	APS Referral
08/15/2025	Special Investigation Initiated - On Site Interview with Resident A, licensee designee Angela Hall, administrative assistant Alyssa Katzenbach and supervisor Stephanie Arnold
08/19/2025	Contact – Documents (emails with attachments) received from licensee designee Angela Hall
08/25/2025	Contact – Documents received and sent (Teams messaging) with adult protective services worker Kenneth Beckman
09/03/2025	Contact – Telephone call made to former direct care worker Breana Jones
09/04/2025	Exit conference with licensee designee Angela Hall

**ALLEGATION:** Resident A left the facility unbeknownst to staff and fell several blocks away. He sustained a head injury prompting emergency personnel to respond to the scene. The staff on duty at the facility did not know Resident A was absent until emergency personnel arrived to tell her.

**INVESTIGATION:** I conducted a site visit at the Golden Years Personal Care Home on August 15, 2025. Licensee designee Angela Hall was present at the time of my visit. She told me that this was the first time that Resident A had “wandered”. About a month ago, he had been found in the grassy area in front of the home but it wasn’t as if he was having a problem, he was just out there walking around. I asked about

the recent incident of Resident A leaving the facility unbeknownst to staff and falling. She confirmed that happened and that the staff on duty did not know he had left until emergency personnel showed up to tell her. The staff then went down the road to check on Resident A. Ms. Hall said that she was upset that the staff had left all the other residents alone at that point. She said that they do have a system in place to alert staff when a door to the outside is opened but it was not active at the time. She said that they are using it at all times now. Ms. Hall said that she has also purchased a "mat alarm" that sounds when someone steps on the area in front of the inside of the door.

I spoke with Resident A at the time of my visit. I noted a bandage on his head and a scraped knee. He said that he has three staples in his head now. Resident A said that he was walking down to the lake to talk to someone. The person he was meeting is "just a friend who is helping me find another place to live." It was a friend he met "on-line". Resident A said that he did tell the staff person working that he was leaving. He couldn't remember who was working at the time. He said it was "4:00 or 5:00 in the afternoon" when he left. He said that he did have his walker with him. Resident A said that he gets "real dizzy" when he tries to walk a long way. I asked him if he gets confused at times. He replied that he didn't think so but that his daughter says he gets confused. He and she are not getting along right now and he asked that I not speak with her about what happened.

I then spoke with Angela Hall with her administrative assistant, Alyssa Katzenbach. They reported that Resident A was last seen on video footage the night he got hurt at 8:24 p.m. They saw him on the footage sitting at the dining room table getting his medication and having a snack. They do not see him leave the home but do see a fire truck going by on the road at 8:50 p.m. and a law enforcement officer arrives at the facility at 8:58 p.m. The staff person working at the time was Breana Jones. She was working alone. She said that she was caring for other residents when it happened. I asked about Resident A experiencing confusion. They said that he did have some medication issues which made his blood pressure low. He did have confusion at that time. Ms. Katzenbach said that Resident A has been the victim of scams. He has sent money to people and believed that they were coming to pick him up. She said that Resident A's cognition is declining and some days he seems confused and other days he seems fine. Ms. Katzenbach said that one day he was out in the yard and was talking about "going to the other building" across the street. She had to show him that there was no other building across the street, only woods. Ms. Katzenbach said that she thought Resident A might be having some "Sundowners" (a type of dementia). She said that she has worked the midnight shift when he gets up in the middle of the night thinking it is breakfast time.

I then spoke with supervisor Stephanie Arnold. She said that she had been "on-call" when direct care worker Breana Jones called to tell her what had happened to Resident A. Ms. Arnold said that she could hear people in the background and Ms. Jones acknowledged that she was down the road where Resident A had fallen. Ms. Arnold said that she told her that she needed to get back to the facility since the

other residents could not be alone. She acknowledged that she had not known that Resident A had left. Ms. Arnold said that after her conversation with her, she called another worker to go to the facility to “relieve” Ms. Jones.

I spoke with former direct care worker Breana Jones by telephone on September 3, 2025. She said that she was in the process of getting residents ready for bed when Resident A left the facility unbeknownst to her. There were 11 residents present that night. Resident A was sitting with another resident at the table and then he was laying on the couch as she checked on them between caring for other residents. She had changed a resident, checked on them and then was changing another resident when Resident A left. The resident who she was changing has dementia and is sometimes difficult to change. She was walking to the laundry room to drop off her clothing that were wet when emergency personnel came to the door. They asked her if Resident A lived there. She said yes and had not known he was missing. She left with him to where Resident A had fallen. He was in the back of an ambulance by that time. He had fallen half-way down a hill on the way to the lake, which is not far from the facility. I told her that I had noted the hill on the road towards the lake during my visit. She said that she went back to the facility as soon as she saw he was being cared for. Nothing like that had happened before. She has not known Resident A to want to leave although he had made some statements indicating that he was confused before. Ms. Jones said that she thinks an alarm system would have prevented the incident and said that she had talked to both the supervisor and administrative assistant about the need for one. She said that she thought if she would have had some warning that Resident A was attempting to leave, he would not have gotten far.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	It is confirmed through this investigation that Resident A’s personal needs, including protection and safety, were not attended to at all times when he was able to leave the facility unbeknownst to staff and was hurt as a result.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:** The home is inadequately staffed.

**INVESTIGATION:** I asked licensee designee Angela Hall about the fact that there was only one staff on-duty at the time Resident A left the facility. It happened at

bedtime as the staff was getting residents ready for bed. She said that she didn't think there needed to be a second staff person present during that shift. Ms. Hall said that the residents are all "pretty calm". She said that there are only two with any dementia, with Resident A only beginning to show signs of being confused in the evening. The other person who has dementia has never wandered before and does not seem to have that inclination. I asked Ms. Hall if she would provide me with the residents' Resident Care Agreements (BCAL-3266) and Assessment Plans (BCAL-3265). She also asked if I would like copies of their Daily Care Plans, which she showed me is a checklist that staff use to document individual care that is provided to each resident on each shift. I replied that she could provide those as well.

Administrative assistant Alyssa Katzenbach reported that everyone there does need some assistance at bedtime but that some of their needs are fairly simple. Some of them need assistance getting into bed and some need to be changed before bed. Others only need to be checked on and covered up.

I received Teams messages from adult protective services worker Kenneth Beckman. He reported that Resident A eloping from the building was not normal for him. Mr. Beckman said that Resident A's physician thought it was now appropriate for Resident A to have a guardian assigned to him. Mr. Beckman would be assisting with that.

I spoke with former direct care worker Breana Jones by telephone on September 3, 2025. She said that she had been working by herself on second shift for more than a month during her employment at the facility. She said that she had been doing "perfectly fine" working by herself during that time until the night that Resident A left without her knowing. Ms. Jones had not known he might do that. She said that he had shown some confusion like asking where his mother and father's room was or saying something about going to work with his father. She had not known him to try to leave. The other resident with dementia does not try to leave. She said that she was always very busy during her shift and was always going from one resident to another. She would help each resident before bedtime in some fashion, but some needed more care than others. Two require assistance with "sit-to-stand" lifts, five needed changing before bed, one needed a catheter change but that didn't take long. There were six residents in wheelchairs although some of them could move themselves. None of the residents ever needed two staff at once for transfer or personal care. She would take some down to the bathroom before bed to use the bathroom. A few of them liked to have assistance with brushing their teeth. After she was done with nightly medication administration and nighttime snacks, she would start getting each ready for bed one at a time. This took a while but it was doable. She was also expected to clean and do chores, which was a lot especially when staff during the shifts before her had not done what they were supposed to do. Ms. Jones said that she had been in communication with some current staff at the facility who said that there are now two staff on both first shift and second shifts since her time there.

I reviewed the resident care agreements, written assessments and daily care plans that were provided. For the second shift, several daily care needs were listed for each resident such as: transferring, locomotion, redirection due to behavior issues, intensive supervision, physical therapy, assist with dressing, toileting after meals and assist with personal hygiene. Several of the written assessments indicated that residents needed “Assist” or “Assist as needed” with hygiene or other personal care. There was nothing in the documentation that indicated that any of the residents needed two direct care staff at once.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>
<b>ANALYSIS:</b>	<p>Evidence was not discovered through this investigation which would clearly indicate the licensee had insufficient direct care staff on duty at all times for the supervision, personal care and protection of the residents and to provide the services specified in their resident care agreements and assessment plans.</p> <p>The direct care worker on-duty the night that Resident A left said that she had been “perfectly fine” doing everything herself up to the night that Resident A left. She had been busy but thought that it was doable for her to perform all the tasks before and during bedtime. There was nothing in the residents’ written assessments or resident care agreements that would indicate that any of the staff would need two staff on-hand or that all of them together were too much for one staff during second shift.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

An exit conference was conducted with licensee designee Angela Hall by telephone on September 04, 2025. She was told of the findings of the investigation and given the opportunity to ask questions. Ms. Hall reported that she has added a second direct care worker until 5 p.m. on weekdays and until 3 p.m. on weekends. She has also added a second direct care worker from 7 p.m. until 11 p.m. to help with bedtime. They continue to use the door alarm and door mat alarm to assist staff with knowing when someone comes in or out of the facility.

**IV. RECOMMENDATION**

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



09/04/2025

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Adam Robarge  
Licensing Consultant

Date

Approved By:



09/04/2025

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Jerry Hendrick  
Area Manager

Date