GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 6, 2022

Stephen Levy
Leisure Living Management of Holland Inc.
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #: AL030016016
Investigation #: 2022A0467039
Addington Place of LakeSide Vista Friesland Haus

Dear Mr. Levy:

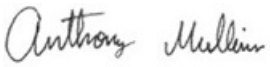
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030016016
Investigation #:	2022A0467039
Complaint Receipt Date:	04/06/2022
Investigation Initiation Date:	04/06/2022
Report Due Date:	06/05/2022
Licensee Name:	Leisure Living Management of Holland Inc.
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 394-0302
Administrator:	Stephen Levy
Licensee Designee:	Stephen Levy
Name of Facility:	Addington Place of LakeSide Vista Friesland Haus
Facility Address:	346 West 40th Street Holland, MI 49423
Facility Telephone #:	(616) 394-0302
Original Issuance Date:	03/15/1995
License Status:	REGULAR
Effective Date:	04/06/2020
Expiration Date:	04/05/2022
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 4/4/22, Resident A was found by staff with bruising to her hips, arms, and labia. It is unknown what happened to Resident A and there are concerns that Resident A's personal needs were not being met.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/06/2022	Special Investigation Intake 2022A0467039
04/06/2022	Special Investigation Initiated - Telephone
04/06/2022	APS Referral This complaint was received from APS
04/14/2022	Inspection Completed On-site
06/06/2022	An exit conference was completed with business office manager, Mistee Hondorp on behalf of Steve Levy, Licensee designee.

ALLEGATION: On 4/4/22, Resident A was found by staff with bruising to her hips, arms, and to her labia. It is unknown what happened to Resident A and there are concerns that Resident A's personal needs were not being met.

INVESTIGATION: On 4/6/22, I received a denied Adult Protective Services (APS) complaint from the BCAL online complaint system. The complaint stated that on 4/4/22, Resident A was found by staff with bruising to her hips, arms, and to her labia. As a result, Resident A was transported to the hospital and was not alert or oriented. It was reported that Resident A was in septic shock and it is unknown what happened to her.

On 4/6/22, I spoke to Jenna Borgia, social worker at the hospital. Ms. Borgia confirmed that Resident A arrived at the hospital on 4/4/22 due to bruising to her arms, hips, and labia. Ms. Borgia also confirmed that Resident A has septic shock. Ms. Borgia stated that Resident A is more alert today but her prognosis is still to be determined. Resident A has low blood pressure and a temperature of 97.5 degrees Fahrenheit. Ms. Borgia stated that Resident A will be observed and monitored for another day prior to doctors determining the next course of action. Ms. Borgia stated that Resident A will not return to the same adult foster care facility as her daughter is looking for placement elsewhere. Ms. Borgia stated Resident A has been involved with Kindred Hospice since January 2022 and will remain in service with them.

Ms. Borgia stated that she has not spoken directly to staff at the adult foster care facility regarding Resident A. Instead, she has received a report from a nurse within the hospital that Resident A has a history of falls and was given morphine recently. It was also relayed to Ms. Borgia that the ambulance personnel gave Resident A Narcan due to her presentation, anticipating that she may have received too much morphine while at the facility. Resident A's daughter is reportedly her Power of Attorney/Healthcare advocate, but Ms. Borgia stated she has not received documentation to confirm this yet. Ms. Borgia stated that the call for an ambulance was received on 4/4/22 at 1:26 pm, the ambulance arrived at the facility at 2:14pm and Resident A was transported to the hospital at 2:18 pm. I explained to Ms. Borgia that I will follow-up with her tomorrow for an updated prognosis for Resident A.

I reviewed an email from Abby Wierenga, Detective Bureau assistant at Holland Police department. The email included an investigation report, case number 2022-04040034 from Detective Maat, the assigned detective to the case. The report indicates that on 4/6/22, Detective Maat spoke to Resident A's daughter and the communication is summarized below.

Resident A's daughter provided Detective Maat with an update on Resident A's condition at his request. Resident A's daughter told Detective Maat that Resident A arrived at Zeeland Hospital with "a low heart rate, dehydrated, an infection on her arm that turned sepsis, and high levels of morphine in her system." Due to Resident A having bruising on her inner thigh and having a bruised and swollen labium, Resilience conducted a sexual assault exam at Zeeland Hospital. Resident A has been in ICU since 4/5/22 before being moved to a standard room. Resident A's daughter's opinion is that she will recover from what has happened. Resident A's daughter did not think that her mother would be able to recall what happened to her.

Resident A's daughter explained to Detective Maat that she moved Resident A into the memory care unit at Addington Place in January 2022. Resident A's daughter sought the assistance of Kindred Hospice Care on January 13, 2022 because of her mother's "age and advancement of Alzheimer's Disease."

Resident A's daughter explained to Detective Maat that, at first, Resident A's overall health improved upon admission to Addington Place. However, in the weeks following, Resident A's daughter said there have been no less than 12 incidents in which her mother has fallen. Per Resident A's daughter, these falls have caused bruising all throughout her body, including face, and lacerations in different areas. Two of these falls were severe enough to require a hospital visit. While Resident A does have Alzheimer's, she was able to have conversation, walk with the assistance of walker, and eat without assistance but began noticing a decline in these areas around the beginning of March. Resident A's daughter said that approximately 4-6 weeks ago, she received a call from Emma Evans explaining that Resident A had taken a bad fall. X-Rays were done on-site, and no fractures were found, despite the severe pain that Resident A was experiencing. Resident A's daughter said she is not

sure of Ms. Evans title at Addington Place but understands her to be one of the head nurses responsible to oversee and directs the individual care of the residents. Resident A's daughter noticed last week that her mother "seemed to be sleepier, her memory was noticeably worse, she could not find the words to say, had difficulty feeding herself, and was no longer able to walk with a walker, being confined to a wheelchair."

On 4/7/22, I spoke to Ms. Borgia via phone. Ms. Borgia informed me that Resident A is doing better today and was able to switch from IV medication to oral medication. Ms. Borgia stated that Resident A's nurse stated that she is "chatting", but her statements are not making sense and she is not responding directly to the questions she's being asked. Ms. Borgia described Resident A as being "in and out of it." Ms. Borgia stated that Resident A will likely be discharged from the hospital tomorrow or Saturday to Riley's Grove AFC in Zeeland or The Inn at Freedom Village in Holland.

On 4/8/22, I reviewed the police report #2022-04040034 from the Holland Department of Public safety. In the report, Officer Wolters documented that Resident A's daughter told him that Hospice visited her mother on 4/1/22 and she did not have any noticeable injuries. Resident A's daughter recalled receiving a call on Saturday afternoon (4/2/22) from staff member Nysa Sutton. Ms. Sutton reportedly told Resident A's daughter that her mother had several bruises that were found while Ms. Sutton was changing her. Therefore, it is believed that Resident A bruises appeared between 4/1/22 and 4/2/22. A friend of Resident A's daughter went to visit her on Saturday (4/2/22) afternoon and noticed the bruising. Resident A's daughter's friend told officer Wolters that Resident A did not have bed guards and she spoke with staff about this because she was concerned that Resident A might be falling out of bed. Staff told the friend of Resident A's daughter that bed guards were not prescribed by a doctor and therefore, they could not be put on her bed. The friend of Resident A's daughter was also reportedly concerned about her bed alarm being unplugged, which would sound off if she was out of bed. Operations Manager, Traci Scott informed Officer Wolters that staff members Roberta Evans, Twanya Sheard, and Carolyn O'Bryant worked Friday night (4/1/22) in the memory care unit where Resident A resided.

On 4/11/22, I spoke to staff at Holland Department of Public safety. Staff informed me that case #2022-04040034 was assigned to detective Joel Maat and she transferred the call. Introductions were made with Detective Maat. He informed me that he is waiting to obtain medical records from Resident A's daughter prior to interviewing staff members at the facility. Detective Maat stated that there was some significant bruising on Resident A's leg that went unexplained, which led to a rape kit being completed. As of this conversation, the results of the rape kit have not been received. Detective Maat is requesting medical records from the facility. To avoid impeding on the criminal investigation, I will postpone interviewing staff members. However, I will obtain any medical records and provide Detective Maat with a copy.

On 4/14/22, I received a voicemail from Detective Maat stating that he received a follow-up email from Resident A's daughter indicating that she (Resident A) passed away on Tuesday evening, 4/12/22 and there was no indication in the email whether anything that happened to her at Addington was the direct cause of her death.

On 4/14/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to Mistee Hondorp, business office manager and Emma Evans, resident care manager. I requested contact information for staff Roberta Evans, Twanya Sheard, and Carolyn O'Bryant as they were all reportedly working at the facility on the night in question. Ms. Hondorp provided me with an additional name of Martin Montoya, who was also working on the night in question. Ms. Hondorp provided me with cell phone numbers for all four staff members. I then requested any incident reports or documentation regarding any known injuries or falls for Resident A from March 1st through the time she was discharged to the hospital, as well as a list of all employees who would have provided care to Resident A in the month of March.

Ms. Hondorp stated that Resident A had sepsis from an infection in her elbow, per Resident A's daughter. Ms. Hondorp stated that Resident A was a known fall risk and had bed and chair alarms. Despite this, Resident A would try to walk through the facility without using any assistive devices. Ms. Hondorp stated that Resident A has "diagnoses" that could cause her to bruise more easily. I reviewed Resident A's diagnoses, which are as follows: anxiety, atherosclerosis of the aorta (disorder), Cardiovascular disease, NOS, Dementia, depression, hyperlipidemia, hypertension, hypothyroidism, osteoporosis, and osteoarthritis. Ms. Hondorp stated that bruising can happen in between Resident A's thighs if she falls on her side. Ms. Hondorp also stated that the facility has a doll weighing approximately 8 pounds that Resident A would bounce on her lap all the time. Ms. Hondorp stated that there are so many "what if's" as to what could have caused Resident A's bruising. Resident care manager, Ms. Evans stated that 3/22/22 was the last known fall for Resident A and 3/24/22 is when the bruises were reported by a 3rd shift staff member.

On 4/14/22, I reviewed all of the documentation I received from the facility thus far, which is summarized below:

On 3/22/22, there was an incident report completed for an unwitnessed fall for Resident A. The incident report indicated that Resident A was found on the floor next to her wheelchair by room 15. The incident report indicated that a head injury occurred by checking off a box that says "head" for site of injury. However, there were no further details related to this documented head injury. The "initial" incident reporter was Lindsay Harris and the report was entered by Holly Harper. On 3/24/22, there was a staff note entered by Jennifer Koy stating, "noticed bruising on cm buttocks, and inner thighs. Perform safety check. On 4/2/22, two notes were entered by Roberta Evans stating, "Swollen arm" and "bruising on lower L leg and R hip and leg." On 4/3/22, an incident report was completed for Resident A stating that she was sent to the ER for EVAL per hospice. It also stated that Resident A had a swollen arm painful to touch with bruising on both legs. It was noted that Resident A

was “confused/disoriented.” This incident report was completed by Roberta Evans. On 4/4/22, a staff note was entered by Roberta Evans stating, “Resident was sent out per hospice for her right arm being swollen with a lot of pain. She also has bruising on both legs and right hip.”

On 4/18/22, I received a call from Detective Maat. We discussed the information obtained throughout the investigation thus far, including some inconsistencies in documentation from 3/22 and missing forms. I agreed to reach out to the facility for a body check form that was reportedly completed by Jessica Harwood with Hospice on 3/31/22 when she observed the injuries on Resident A.

On 4/18/22, I emailed Ms. Evans and Ms. Hondorp requesting a body checklist form that was reportedly completed by hospice aide, Jessica Harwood on 3/31/22 when she observed bruising on Resident A. Ms. Evans did not provide the body checklist form that was completed by hospice.

On 5/3/22, I made an unannounced onsite inspection to the facility. Upon arrival, I spoke to staff member Roberta Evans. Ms. Evans stated that she has worked at the facility for nearly nine years and recalled working with Resident A. In particular, she recalled working on 4/1/22 from 6:45 am until 7:00 pm. The staff schedule was reviewed and confirmed this. Ms. Evans stated on the day in question, she observed Resident A with a bruise on the back of her leg but was unable to recall which leg. Ms. Evans stated that the hospice aide, Jessica Harwood told her that Resident A’s bruises were ~~spreading~~. Ms. Evans stated that at the time, there was no mention of Resident A falling. Ms. Evans questioned this because Resident A was capable of standing up and walking on her own, with or without assistive devices although she was always encouraged to use them. Ms. Evans stated that when she left the facility, Resident A was alert and sitting in her chair as she stated she didn’t want to go to bed that early. Although the police report from Holland PD mentions that Ms. Evans worked 3rd shift the night that Resident A supposedly obtained the bruises, Ms. Evans was adamant that she did not work 3rd shift. As noted above, the staff schedule confirmed that Ms. Evans worked from 6:45 am to 7:00 pm on 4/1/22.

Ms. Evans was unable to recall the exact date, but she stated that she was in the bathroom with Resident A while hospice bathed her. During this time, Ms. Evans stated that she didn’t see any other bruises on Resident A but she did notice her right arm was swelling. Ms. Evans denied any knowledge as to how this would have occurred. Ms. Evans stated that she has witnessed Resident A walk several times without her assistive devices and knows that she was a fall risk. Ms. Evans denied witnessing her colleagues hit, push, or assault Resident A during her time at the facility.

After speaking to Ms. Evans, I spoke to staff member Twanya Sheard. Per the staff schedule, Ms. Sheard worked at the facility on 4/1/22 from 6:45 am until 5:00 pm. Ms. Sheard stated that Resident A was usually awake and out of bed prior to her arrival in the morning. Ms. Sheard stated that the only time Resident A would still be

in bed when she arrived for her shift is if she had hip pain/spasm, which was occasional. Ms. Sheard was asked if she recalled seeing any bruises on Resident A while working at the facility on 4/1/22. Ms. Sheard stated, “honestly, she (Resident A) always had bruising.” Ms. Sheard stated that Resident A would always stand up from her wheelchair and walk around, leading to her having witnessed and unwitnessed falls. Ms. Sheard stated that sometimes, Resident A was able to get herself up from her fall. There were other times that she required assistance to get back up in her wheelchair, depending on how she was feeling that day. Ms. Sheard was adamant that she told Resident A often to use her wheelchair. However, Resident A refused and walked without any assistive devices.

Although Ms. Sheard stated that Resident A always had bruises, she was unable to recall if she had any bruises when she saw her on 4/1/22. When Ms. Sheard did see bruises on Resident A, she stated that the bruises would be purple in color, or she would have skin tears from scrapping her arms. Ms. Sheard stated that other staff members at the facility stated that Resident A had unwitnessed falls, including rolling out of bed or mobilizing herself without her wheelchair. Ms. Sheard did not have any knowledge related to Resident A having a swollen arm or bruises on her legs. Ms. Sheard stated that Resident A was usually in a good mood when alert. However, when she was in pain, she would be “ornery”. Ms. Sheard denied witnessing any of her colleagues push, hit, or assault Resident A during her time at the facility.

On 5/4/22, I spoke to staff member Martin Montoya via phone. Mr. Montoya did not specifically recall working at the facility on 4/1/22. However, he did recall working with Resident A when she was in the facility. Per the staff schedule, Mr. Montoya worked at the facility on 4/1/22 from 10:45 pm until 7:15 am by himself. I asked Mr. Montoya to share with me what he recalled about Resident A. Mr. Montoya stated that Resident A would get up from her wheelchair often and walk around. Mr. Montoya stated that he would tell Resident A to stay in her wheelchair. However, she refused and walked around without any assistive devices. Mr. Montoya stated in an attempt to get Resident A to stay in her wheelchair, he would use the wheelchair break. Despite this, Resident A continued to get up and walk around the facility.

Although Resident A refused to use her wheelchair at times, Mr. Montoya denied witnessing her fall at any time. Mr. Montoya stated he was aware that Resident A had falls on other shifts and when he returned for his next shift, he noticed the bruises on her arms and behind her back. Mr. Montoya stated that Resident A’s bruises were “always in the same spot.” Mr. Montoya was unable to give a specific time frame as to when he witnessed bruises on Resident A. Mr. Montoya was asked if Resident A needed assistance with transfers. Mr. Montoya stated that he has transferred Resident A to her bed and she would get out of her bed on her own. Mr. Montoya stated Resident A’s bed did not have any bedrails. Mr. Montoya stated that Resident A was able to go to the bathroom on her own. Mr. Montoya denied witnessing any of his colleagues hit, push, or assault Resident A during her time at the facility.

On 5/4/22, I spoke to Carolyn O'Bryant via phone. Ms. O'Bryant recalled working at the facility on 4/1/22 from 3:00 pm to 7:00 pm. The staff scheduled confirmed this as well. On the day in question, Ms. O'Bryant stated that Resident A appeared to be in a good mood, but she was also "antsy." Ms. O'Bryant stated that Resident A never told her what she was antsy about, but she does recall Resident A talking about having a car outside waiting for her and that she would be going home. During her 4-hour shift, Ms. O'Bryant stated that she assisted Resident A to the bathroom twice. After being wheeled to the bathroom, Resident A was able to stand up and transfer to the toilet herself both times. The first time was around 4:00 pm and the second time was between 6:00pm-6:15pm. Ms. O'Bryant recalls seeing bruises on Resident A's legs and below her knees. In addition to this, Ms. O'Bryant stated that she recalls Resident A's legs being swollen with fluid. Ms. O'Bryant stated that Resident A did not make any mention of her bruises or being in pain. Ms. O'Bryant noted that the bruises she observed on Resident A appeared old. She denied witnessing any bruises to Resident A's elbow. Ms. O'Bryant denied witnessing any of her colleagues hit, push, or assault Resident A during her time at the facility.

On 5/5/22, I received additional incident reports for Resident A during her time at the facility. All of the incident reports summarizing Resident A's falls (listed below) indicate that Resident A's daughter was notified of them. The individual incident reports are summarized below:

1/15/22: unwitnessed fall. Resident A was found on the floor with her back against the wall with some bruising on her lower back. Resident A was reminded to use her pull cord.

1/20/22: unwitnessed fall. Resident A had an unwitnessed fall that resulted in her getting a knot on her back and a skin tare on her right wrist, elbow, and leg. The incident report indicated Resident A had a head injury as well but did not discuss this in the narrative of the report. Resident A was assisted off the floor and her daughter and on-call nursing were notified.

2/1/22: unwitnessed fall. Resident A was found on the floor outside of room 12. No injuries were documented.

2/7/22: witnessed fall. Resident A got out of her wheelchair and lost her balance. Resident A was caught by activities staff member and lowered to the floor. There was no known bruising at this time. Resident A vitals were checked and her family and the nurse was notified.

2/17/22: witnessed fall. Resident A got up from her wheelchair and lost her balance. No injuries from the fall. Hospice was notified and were reportedly planning to order a posey alarm for her wheelchair.

2/18/22: witnessed fall. Resident A was walking prior to falling. No injury was documented.

2/20/22: unwitnessed fall with injury. Resident A fell out of her wheelchair and has a scrape on her forehead.

2/24/22: altercation between resident and staff. Resident A was calling staff names and hitting them. No injuries reported.

2/28/22: unwitnessed fall. Resident A tried to get herself out of bed and slid down to the floor. No injuries reported.

3/14/22: unwitnessed fall. Resident A had a “fall gash” on her right eye and skin tear on right elbow.

3/15/22: unwitnessed fall. Staff found Resident A on the floor in Pod 1 dining room yelling for help. Resident A was assessed and found 2 large skin tears on right arm near elbow. Resident A was placed on 30-minute checks and staff laid her down in bed. Resident A complained of right hip pain.

On 5/24/22, I spoke to Resident A’s daughter via phone. She stated that she believed her mother died due to the lack of care provided by Addington Place. Resident A’s daughter also stated that her mother was abused, referring to the several marks and bruises that were observed on her body by Addington Place staff, Kindred Hospice staff, and Zeeland Hospital staff. Resident A’s daughter stated that her mother had a rape kit performed while at Zeeland hospital due to having a bruised Labia and bruising on her inner legs and buttocks. Resident A’s daughter stated that “there is no way to explain the symmetry of the bruising” on her mother’s legs and labia. Resident A’s daughter expressed her opinion that there is no way her mother’s bruises could have been caused by falls.

I explained to Resident A’s daughter that the rape kit results have not yet been received and will likely not be received prior to the conclusion of the investigation. However, if the results later confirm that her mother was in fact raped, an additional licensing investigation will be conducted.

Resident A’s daughter stated that after her mother’s fall on 3/24/22, her mother asked her to go to the bathroom. Resident A’s daughter assisted her mother to the bathroom. While in there, “my mother literally put her hand in her rectum” in an attempt to remove feces from it. Resident A’s daughter stated that she informed hospice and Addington Place staff of this and requested their help. Although Resident A’s daughter informed Addington Place of this concern, she recalled there being a day that she came to visit her mother and noticed that her mother’s hands were covered in feces while sitting at the dining table. Resident A’s daughter reportedly wrote Addington staff an email regarding this concern.

Resident A’s daughter stated that she was notified of most falls her mother had but does not think she was informed of all her falls. Resident A’s daughter stated that her mother had four “severe” falls during her time at Addington Place. On 1/20/22,

her mother reportedly had a severe fall. After this fall, she was “prescribed” a wheelchair and a bed alarm. Despite having these items, Resident A’s daughter stated that her mother’s bed and wheelchair alarm were never used, which led to her mother having several unwitnessed falls. Resident A’s daughter recalled being at the facility and noting that her mother’s alarms were not in use.

Resident A’s daughter stated that her mother had a verbal altercation with Emma Evans and Ms. Evans would not let it go. This altercation reportedly involved Resident A’s mother referring to Ms. Evans by a derogatory name. Resident A’s daughter stated, “I tripped over myself apologizing for my mom” and remained adamant that her mother’s comments weren’t personal. Resident A’s daughter stated she believes her mother’s care faltered after this incident.

Resident A’s daughter stated an autopsy was not completed for her mother but “my mom died as a result of this.” Resident A’s daughter stated that on 3/24/22, her mother ended up with “massive wound” on her elbow and the facility did not keep it clean. On Saturday, 4/2/22, when she got a call from Ms. Sutton, she thought her mother had a broken arm because her arm was really swollen. She stated her mother was in septic shock and that she got sepsis because bacteria got into the wound due to facility staff not cleaning it properly.

On 5/24/22, I spoke to Molly Bosworth, RN for Kindred Hospice. Ms. Bosworth stated that she saw Resident A once a week and as needed until she discharged from Addington Place. Ms. Bosworth was asked if she had any concerns regarding the care Resident A received at the facility. Ms. Bosworth stated that she was concerned when Resident A was struggling with constipation. Ms. Bosworth stated that Hospice put things into place, such as putting Resident A on Senna medication and increased the dose to help Resident A with the constipation. Ms. Bosworth stated that staff at Addington Place staff were not giving Resident A her suppositories and they weren’t tracking her bowel movements. Ms. Bosworth stated that the facility not tracking the bowel movements was not uncommon in AFC homes as opposed to skilled nursing. However, due to Resident A being constipated, this led to her “starting to dig herself out,” meaning removing feces with her hands. As a result, Resident A would have stool under her nails after doing so. Ms. Bosworth stated that she observed stool under Resident A’s nails herself and as a result, she soaked her hands, cleaned them, and even painted her nails. Ms. Bosworth stated that she spoke to staff Emma Evans, Roberta Evans, and Ms. Sheard about this. Ms. Bosworth stated that Resident A’s daughter had the same concern with feces being under her mother’s nails. Ms. Bosworth stated that there were a couple of weeks where things were “rough” at Addington regarding this situation.

Ms. Bosworth stated that the weekend prior to Resident A going to the hospital, hospice staff received a call from the facility due to swelling in Resident A’s arm and bruises on her body. Ms. Bosworth stated that when Resident A was sent to the hospital, it was determined that she had bursitis, which is swelling/inflammation. Ms. Bosworth stated that Resident A had a scab on her arm and the hospital physician’s

theory was that “the infection could have come through a breakthrough in her skin.” Ms. Bosworth stated that she believes the bursitis led to Resident A becoming septic. Ms. Bosworth stated that the infection Resident A had caused her condition to decline further. I asked Ms. Bosworth if she believed Resident A’s infection was related to a lack of care by staff at the facility. Ms. Bosworth did not provide a direct answer to my question. However, she stated the only time Resident A received baths is when the hospice aide bathed her twice a week. I asked Ms. Bosworth if Kindred Hospice instructed staff at the facility not to bathe Resident A since the hospice aid was doing it twice a week and she stated no. Ms. Bosworth stated that the facility was supposed to continue providing day-to-day care for Resident A in between times that Hospice was providing care, such as bathing, grooming, toileting, etc.

I asked Ms. Bosworth if staff at the facility kept her updated/informed regarding Resident A’s care. Ms. Bosworth stated that she would typically find out about issues “after the fact”. Ms. Bosworth stated that it was frustrating when she would ask the facility medication tech for an update on Resident A and their response would be; “I haven’t been here” or “I don’t typically work here.” This led to Ms. Bosworth having to do an assessment on Resident A and “piecing things together” herself. If Ms. Bosworth was unable to get needed information from the medication tech, she would ask Emma Evans, Roberta Evans, or occasionally the Director of Nursing.

Ms. Bosworth stated that she observed Resident A on 4/4/22 and noticed that her condition had changed drastically. Due to this, Ms. Bosworth let Dr. Phillips know and he agreed that Resident A needed to go to the ER. Ms. Bosworth called Resident A’s daughter and informed her of this, and she agreed with sending her mother to the hospital. I asked Ms. Bosworth if she felt that Resident A should have been sent to the emergency room sooner. Ms. Bosworth stated she couldn’t speak to that because she did not physically see her until 4/4/22. Ms. Bosworth stated “I feel this facility needs help. It needs a plan of correction in place to provide adequate care for everyone.”

On 5/26/22, I spoke to Mary Semyn, on-call RN for Kindred Hospice. Ms. Semyn has been employed by Kindred Hospice for the past three years and she has been a nurse for the past 35 years. Due to being the on-call nurse, Ms. Semyn did not have scheduled days to care for Resident A. Instead, she would provide care for Resident A when called in by staff to do so. Ms. Semyn stated that Resident A started to fall a lot and become more confused in the middle of the night. Ms. Semyn stated that she was called into Addington Place approximately two or three times between 2:00 am and 3:00 am due to reported falls for Resident A. Ms. Semyn stated that she would arrive to the facility approximately 40 minutes later and Resident A would be asleep. While at the facility with Resident A, Ms. Semyn stated that her job was to ensure that Resident A had not hit her head during the fall, make sure she was able to move all of her extremities, and to make sure her diaper was clean. Ms. Semyn confirmed that this was completed during each of her visits with Resident A. Ms. Semyn stated that she didn’t think Resident A’s daughter realized how frail her mom was at times.

I asked Ms. Semyn, on-call RN for Kindred Hospice if she has any concerns regarding the care that Addington staff members provided to Resident A and she stated she does not. Ms. Semyn stated that she was provided with updates regarding Resident A when the medication tech called her. Ms. Semyn acknowledged that it seemed as if she had to repeat a lot of the same safety trainings with staff, which included bed alarms, checking on residents more often, etc. Ms. Semyn stated that she thinks Resident A had a bed alarm but she does not recall if she ever noticed it disconnected or not working properly. Ms. Semyn stated that if she had observed any issues with this, she would have made staff aware of it.

On 06/06/22, I conducted an exit conference with Mistee Hondorp, business office manager on behalf of license designee, Stephen Levy. Ms. Hondorp was informed of the investigative findings and agreed to complete a 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:	Staff Roberta Evans, Carolyn O'Bryant, Twanya Sheard, and Martin Montoya were all interviewed due to working on 4/1/22. Each of these staff members denied observing their colleagues hit, push, or assault Resident A during her time at the facility. Incident reports involving Resident A indicated that she had more than ten falls during her stay at the facility from January 2022 to April 2022. Some of the falls were witnessed but most of them were unwitnessed. Resident A's daughter stated that she observed feces under her mother's nails while visiting her. Ms. Bosworth (Kindred Hospice RN) also confirmed that she observed feces under Resident A's nails during a visit. Ms. Bosworth stated that Hospice started Resident A on Senna medication and increased the dose. Despite this, staff at Addington Place were not giving her suppositories, which caused her to "dig herself out," referring to removing the feces with her hand. Ms. Bosworth stated that Resident A had a scab on her arm and the physician at the hospital thought the infection could have come through a breakthrough in her skin. Ms. Bosworth stated that she believes the bursitis led to Resident A becoming septic,

	and the infection caused her condition to decline further. Ms. Bosworth stated that the only time Resident A received baths is when the hospice aide bathed her twice a week. Based on the information provided by Resident A's daughter and Ms. Bosworth, there is a preponderance of evidence to support the allegation that Resident A's personal needs were not met. It should be noted that A rape kit was completed on Resident A prior to her passing. As of the completion of this investigation, the results are still pending.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, I requested a copy of Resident A's Assessment Plan and Health Care Appraisal. I was provided with a copy of the Health Care Appraisal via email. However, Ms. Evans and Ms. Hondorp were unable to locate Resident A's Assessment Plan, which is a required document for licensing.

On 06/06/222, I conducted an exit conference with Mistee Hondorp, business office manager on behalf of license designee, Stephen Levy. I informed Ms. Hondorp of the investigative findings and she agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The assessment plan is required to be completed at the time of admission for all residents. Ms. Evans and Ms. Hondorp were unable to locate a copy of Resident A's assessment plan throughout the duration of this investigation. Therefore, a preponderance of evidence exists to indicate a rule violation.

CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION: While investigating the allegation listed above, it was brought to my attention that there was concern regarding Resident A not receiving her Levothyroxine medication consistently.

On 4/11/22, I spoke to staff at Holland Department of Public safety. Staff informed me that case #2022-04040034 was assigned to detective Joel Maat and she transferred the call. Detective Maat stated that he was informed that Resident A only received her thyroid medication five times in the month of March. Detective Maat is requesting medical records from the facility. He is also requesting to know if the staff members that were dispensing medications are qualified to do so. I agreed to obtain medical records and provide Detective Maat with a copy.

On 4/14/22, I made an unannounced onsite inspection to the facility. Upon arrival, I spoke to Mistee Hondorp, business office manager and Emma Evans, resident care manager. Due to there being reported concerns of Resident A not receiving her thyroid medication (Levothyroxine) during the month of March, I observed Resident A's electronic MAR, which indicated that she was given her medication on one day (3/31/22) during March and four days in April prior to going to the hospital. Ms. Evans stated that when Resident A moved into the facility, she was using a different pharmacy than what the facility uses. The resident or the Power of Attorney (POA) has to sign a form giving the facility consent to use their pharmacy in order for the medications to be sent to the facility. Ms. Evans stated that Resident A's daughter refused to sign the form, indicating that her lawyer advised her not to sign it. Ms. Evans stated that Resident A's hospice nurse, "Molly" contacted their pharmacy and asked if they could put the medications in "Profile Only," to have it displayed in their system. I asked Ms. Evans to explain what "profile only" means. Ms. Evans stated that profile only means that the facility is not responsible for getting medications to the facility or refilling them once they run out. It essentially clears the facility from responsibility. Ms. Evans reiterated that this was due to Resident A's daughter refusing to sign-off on this. Ms. Evans stated that once the medication is listed in the system, staff at the facility were able to administer the medication, which they did, starting on 3/31/22 due to Resident A being on hospice. Per Ms. Evans, Resident A moved into the facility on 1/15/22 and signed on to hospice her second day. It should also be noted that Resident A's Levothyroxine was originally prescribed by her PCP. Ms. Evans stated that their pharmacy needed a script from the doctor but never received it.

On 4/18/22, I received a call from Detective Maat. I agreed to reach out to the facility in an attempt to gather Resident A's electronic and handwritten MAR from the date of her admission until the date she was transported to the hospital.
On 4/18/22, I emailed Ms. Evans and Ms. Hondorp requesting Resident A's electronic MAR from the date of her admission (January 2022 through February 2022), and any handwritten MARs from the date of her admission through April 4th.

On the same day, I reviewed all Resident A's electronic MARs from January through April, as well as the handwritten MARs during the same time frame. Per the electronic MAR, Resident A did not receive her Levothyroxine in January or February. In March, she received the medication on 3/31 and in April she received the medication from 4/1-4/4. Per the handwritten MAR, Resident A received her Levothyroxine on 3/5, 3/6, 3/18-3/20, 3/26, and 3/29. There were two pages of handwritten MARs that were confusing as it was not clear as to which month the medication was given. Based on how the MARs were sent to me, it appears that Resident A received her Levothyroxine in January from 1/16-1/23, 1/28-1/29 and not at all during the month of February. Due to the MARs being unclear, I called Ms. Evans to ask if she could provide clarification. Ms. Evans stated that she believed the handwritten MARs reflect the medications being administered sometime between February and March. Ms. Evans stated that the handwritten MAR was only supposed to be used for three days. However, staff continued to use it longer. The facility did not document on both the handwritten and electronic MARS during January through March the reason(s) why the medication was not given to Resident A.

I reviewed an email from Abby Wierenga, Detective Bureau assistant at Holland Police department. The email included an investigation report, case number 2022-04040034 from Detective Maat, the assigned detective to the case. The report indicates that on 4/18/22, Detective Maat spoke with Molly Bosworth, Kindred Hospice RN and she identified herself as Resident A's primary nurse. The contact between Detective Maat and Ms. Bosworth is summarized below:

Detective Maat asked Ms. Bosworth about Resident A's Levothyroxine medication. Ms. Bosworth recalled the medicine being prescribed prior to Resident A being admitted into Hospice and Addington Place. Ms. Bosworth also recalled there being a problem with Resident A getting the medication on a regular basis, stating that she (Resident A) received the medication "sporadically" throughout her stay. Detective Maat asked Ms. Bosworth if she had seen the medication charts kept by Addington Place. Ms. Bosworth stated that she saw both a digital and handwritten chart. Ms. Bosworth stated that the handwritten chart she saw showed that Resident A received her Levothyroxine inconsistently and not daily as prescribed.

Detective Maat asked Ms. Bosworth if she knew why Resident A was not being given the medication. Ms. Bosworth stated that Levothyroxine is not a medication that is covered by Hospice so it would have to be received from the pharmacy Addington Place uses or Resident A's daughter would have to get it from her own pharmacy. Ms. Bosworth understood from Resident A's daughter that she did not want to use Addington Place's pharmacy because of potential financial responsibility should there ever be an outstanding balance. However, she also knew that Resident A's daughter was providing Addington Place with the medication to give to Resident A. Detective Maat asked Ms. Bosworth about potential side effects from not taking the Levothyroxine and she stated you could expect to see increased tiredness,

lethargy, and heart complications. Ms. Bosworth's opinion was that the more concerning problem was the bursitis that Resident A was being treated for.

On 5/3/22, I made an unannounced onsite investigation to the facility. I spoke to staff member Twanya Sheard. Ms. Sheard was asked if she was responsible for providing Resident A with her medications. In particular, her Levothyroxine. Ms. Sheard stated that this medication was scheduled to be given to Resident A at 6:00 am. Ms. Sheard's shifts does not start until 6:45 am. Therefore, 3rd shift was responsible for providing Ms. Sheard with her Levothyroxine. Ms. Sheard was adamant that she gave Resident A all her medications that were scheduled during her shift.

Ms. Sheard acknowledged that there was an issue with staff being able to give Resident A medications. Ms. Sheard stated that the delay was due to Resident A's daughter not wanting the facility to give her medication and also her daughter didn't sign documents to allow the facility to give Resident A her medicine. Ms. Sheard stated that when Resident A signed onto hospice, staff at Addington were able to give her the medications she was prescribed. Even after signing onto hospice, Ms. Sheard shared that Resident A wasn't getting her Levothyroxine medication consistently. As mentioned above, Resident A's Levothyroxine medication was scheduled at 6:00 am. Ms. Sheard stated that there were multiple times that she came into work and noticed that 3rd shift never gave Resident A her Levothyroxine as scheduled. Ms. Sheard stated that this was due to the facility not having a med tech on staff. Ms. Sheard stated that the facility has more than enough med techs on 3rd shift now.

On 5/24/22, I spoke to Resident A's daughter via phone. Resident A's daughter expressed her belief that her mother died due to Addington Place not giving her the prescribed Synthroid medication (Levothyroxine), which can cause confusion and dizziness. Resident A's daughter stated that her mother had a "bad" fall on 3/24/22. Resident A's daughter stated that she thought staff were giving her mother Norco due to her cognitive issues she was having. This prompted Resident A's daughter to ask staff member Nysa Sutton to show her, her mother's MAR, which is when she noticed that Ms. Sutton was the only one signing off on giving her mother her Synthroid medication. Resident A's daughter asked Ms. Sutton why no other staff were providing her mother with her Synthroid medication and Ms. Sutton reportedly stated, "I don't know." Resident A's daughter stated that her mother's thyroid levels were high "sky high" when she arrived at the hospital on 4/4/22. Prior to not receiving her Synthroid medication, Resident A's daughter stated that her mother could do things on her own such as feeding herself. After finding out that the facility was not giving her mother her Synthroid medication, Resident A's daughter stated that it took her four days to get her mother back on the medication. Resident A's daughter stated that the medication was at the facility, so she is unsure why staff didn't give it to her as scheduled. Resident A's daughter reportedly asked Ms. Emma Evans about why her mother has not received her medication and Ms. Evans stated that she did not know why either.

On 06/06/22, I conducted an exit conference with Mistee Hondorp, business office manager on behalf of license designee, Stephen Levy. I informed Ms. Hondorp of the investigative findings and she agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Ms. Sheard stated that Resident A wasn't getting her Levothyroxine medication consistently. I reviewed Resident A's electronic and handwritten MARs and confirmed this. Resident A's Levothyroxine medication was scheduled at 6:00 am. Ms.

	Sheard stated that there were multiple times that she came into work and noticed that 3rd shift had not given Resident A her Levothyroxine as scheduled. Resident A's MARs do not indicate why she wasn't given the medication on certain days or if she refused them. Resident A's daughter confirmed that she did not use Addington Place's pharmacy. However, she stated that she gave her mother's medication to the staff at Addington Place, and she is unsure why she wasn't getting it. Hospice nurse Ms. Bosworth confirmed that Resident A's daughter gave Addington Place staff Levothyroxine to give to Resident A as prescribed. However, Resident A was only getting the medication sporadically. Therefore, a preponderance of evidence exists to support a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention that there were concerns regarding staff member Martin Montoya's working eligibility and his lack of training as a direct care worker.

On 5/24/2022, I spoke to Resident A's daughter via phone. Resident A's daughter stated that hospice nurse, Mary Semyn came to Saugatuck to see her. Ms. Semyn told her that she and other hospice staff noticed a staff member named Martin Montoya had worked at Addington Place for several years and was always on the night shift alone. Resident A's daughter stated that Ms. Semyn and Ms. Bosworth were concerned that Mr. Montoya was in the memory care unit alone although he's not "certified" to care for memory care patients. In fact, Resident A's daughter stated that she was told that Mr. Montoya is a janitor as opposed to a direct care worker. Resident A's daughter stated that Ms. Semyn had told Mr. Montoya that she was going to see her mother and other residents. Mr. Montoya reportedly responded by saying, "no, you don't need to see her. I already tucked her into bed." Resident A's daughter stated that Ms. Semyn believed that Mr. Montoya was deterring hospice staff from checking in on her mother and other residents.

Resident A's daughter stated she brought this concern to Detective Maat with Holland PD after she was encouraged to do so by Ms. Semyn. I notified Resident A's daughter that I had interviewed Mr. Montoya due to him being the only staff member that worked 3rd shift on the night of 4/1/22, which is when it is thought her mother's injuries occurred. I explained that prior to interviewing Mr. Montoya, I had no knowledge of him reportedly telling hospice staff not to check on residents, including Resident A.

On 5/26/22, I spoke to Mary Semyn, on-call RN for Kindred Hospice. Ms. Semyn stated that she observed Mr. Montoya in a direct care role with residents after he told her that he has worked at the facility for 30 years as a janitor. Ms. Semyn confirmed that Mr. Montoya told her that he already took care of residents' needs, including Resident A and that she did not need to check on them. Despite this, Ms. Semyn stated that she completed her own checks on residents. Based on being told from Mr. Montoya that he was a janitor, Ms. Semyn was concerned about Mr. Montoya not being trained to do the job.

On 5/26/22, I sent Business Office Manager, Mistee Hondorp an email requesting documents to confirm Mr. Montoya's employment and training within the facility. On 5/27/22, Ms. Hondorp sent me the following documents for Mr. Montoya: background check, ID card, verification of training in the areas of first aid, safety/fire prevention, residents rights, personal care, supervision, and protection, prevention and containment of communicable disease, verification of TB test, and a signed statement by his doctor attesting to the physician's knowledge of his physical health. The only document that Ms. Hondorp was unable to provide was proof that Mr. Montoya had completed his CPR training. Ms. Hondorp stated that Mr. Montoya's latest CPR certificate is expired.

On 06/06/22, I conducted an exit conference with Mistee Hondorp, business office manager on behalf of license designee, Stephen Levy. I informed Ms. Hondorp of the investigative findings and she agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(c) Cardiopulmonary resuscitation.**
ANALYSIS:	I received verification of all requested licensing documents for Mr. Montoya, except for a valid CPR certificate. Ms. Hondorp stated that Mr. Montoya's CPR certificate has expired. Therefore, there is a preponderance of evidence to support a violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention that there are not enough staff working in the facility on third shift to adequately meet the needs of residents.

On 5/26/22, I spoke to Mary Semyn, on-call RN for Kindred Hospice. Ms. Semyn stated that during 3rd shift, staff coverage was “sparse”. Ms. Semyn stated that there have been occasions when only one person was working when she arrived at the facility and she would have to wait outside for an unknown period of time to be let into the facility. Ms. Semyn stated that there were other times where the med tech would call her to tell her that a resident had fallen and when she arrived at the facility, the staff member that was providing care for Resident A or other residents had no knowledge of the fall. Ms. Semyn stated that things were “discombobulated.”

On 5/31/22, I spoke to Mistee Hondorp via phone. She confirmed that on 4/1/22, the facility had 16 residents and staff member Martin Montoya worked 3rd shift by himself. Ms. Hondorp stated that the facility has one resident, Resident B that requires a two-person assist and she has been at the facility for years. I explained to Ms. Hondorp that when a facility has a resident that requires a two-person assist, there must be a minimum of two staff members working at all times to address that resident’s needs, regardless of the time of day. Ms. Hondorp stated that she understands.

On 06/06/22, I conducted an exit conference with Mistee Hondorp, business office manager on behalf of license designee, Stephen Levy. I informed Ms. Hondorp of the investigative findings and she agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(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.
ANALYSIS:	Ms. Hondorp confirmed that Resident B requires a two-person assist and on 4/1/22, Mr. Montoya was the only staff member working 3rd shift. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

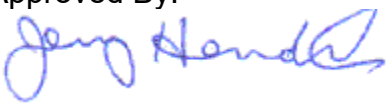
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.

Anthony Mullins

06/06/2022

Anthony Mullins, Licensing Consultant Date

Approved By:



06/06/2022

_____

Jerry Hendrick, Area Manager Date