GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 2, 2022

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

RE: License #: AL030006860
Investigation #: 2022A0464037
Addington Place of LakeSide Vista Amsterdam Haus

Dear Mr./Ms. 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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030006860
Investigation #:	2022A0464037
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/03/2022
Report Due Date:	07/03/2022
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 Amsterdam Haus
Facility Address:	340 West 40th Street Holland, MI 49423
Facility Telephone #:	(616) 394-0302
Original Issuance Date:	10/03/1988
License Status:	REGULAR
Effective Date:	03/16/2021
Expiration Date:	03/15/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/AGED

II. ALLEGATION(S)

	Violation Established?
Resident A contracted a urinary tract infection. Facility staff waited several days to obtain treatment for Resident A.	Yes

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A0464037
06/03/2022	Special Investigation Initiated - Telephone RS
06/06/2022	APS Referral
06/13/2022	Inspection Completed On-site Emma Evans (Nurse Manager), Mistee Hondorp (Administrator) & Resident A
06/13/2022	Contact-Document received Resident A's facility records
07/29/2022	Contact-Telephone call made RS
08/02/2022	Exit Conference Steven Levy, Licensee Designee

ALLEGATION: Resident A contracted a urinary tract infection. Facility staff waited several days to obtain treatment for Resident A.

INVESTIGATION: On 06/03/2022, I received an online BCAL complaint. The complaint alleged Resident A recently contracted a urinary tract infection (UTI). Resident A's condition rapidly declined physically and mentally. On 5/22/2022, the family of Resident A requested a urine screen to test for the UTI. The facility did not send a urine sample until 5/27/2022. Resident A was not put on antibiotics for a UTI until 05/29/2022.

On 06/03/2022, I left a message for the referral source, requesting a return phone call.

On 06/06/2022, I contacted Centralized Intake, Department of Health and Human Services (DHHS) and completed an Adult Protective Services (APS) referral per policy.

On 06/13/2022, I completed an unannounced, onsite inspection at the facility. I interviewed Mistee Hondorp (administrator) and Emma Evans (nurse manager). Both reported that on 05/22/2022, Resident A's daughter expressed concerns, informing them she thought Resident A had contracted an UTI, due to her confused state. Ms. Hondorp and Ms. Evans stated they thought Resident A's symptoms were due to her diagnosis of Dementia and the symptoms progressing. Ms. Evans stated she left for vacation and was informed by other staff that Resident A's family requested a urine sample. Ms. Evans stated she was not aware of the exact details but believes staff collected a urine sample from Resident A on May 23, 2022. The laboratory never came to pick up the sample. Staff did not follow-up until May 26, 2022. Staff collected a new urine sample from Resident A that was sent out that day. Ms. Evans reported the lab results were positive for an UTI, therefore an antibiotic was prescribed. Ms. Evans stated it was her understanding the family was still not happy and took her to the doctor on Monday, May 30, 2022. Resident A's physician then prescribed a different antibiotic.

I then made face-to-face contact with Resident A. An interview was not completed as Resident A was unable to answer questions regarding the allegation. Resident A was observed to be clean and appropriately dressed.

On 06/13/2022, I received and reviewed Resident A's facility records including Resident A's medication list. The list reflected Dr. Tim Conlon prescribed Resident A Bactrim 400-80 MG on 05/28/2022 to treat Resident A's UTI. Resident A's Medication Administration Record was reviewed and reflected Resident A was administered her first dose of Bactrim on the morning of 05/29/2022. There were no other medications listed that were prescribed to treat her UTI.

I then reviewed a note from staff, Camla Crevier stating a second urine sample was collected from Resident A on Friday, May 27th, 2022, due to the hospital not picking up the first collected urine sample. The on-call doctor was notified of the positive results on the same day and antibiotics were started on May 27, 2022.

On 08/02/2022, I completed an exit conference with licensee designee, Steve Levy. He was informed of the investigation findings and recommendations. A corrective action plan would be completed. Staff will ensure any collections go out to the laboratory in a timely mannor.

APPLICABLE RULE	
R 400.15310	**Resident health care.**

	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 06/03/2022, a complaint was received, alleging Resident A showed symptoms of a urinary tract infection on 05/22/2022. Facility staff did not seek medical treatment until 05/30/2022. Facility staff, Mistee Hondorp and Emma Evans both reported Resident A's daughter expressed concern regarding Resident A's condition and thought she may have a UTI. Both Ms. Hondorp and Ms. Evans stated staff collected a urine sample from Resident A on 05/23/2022, but failed to follow-up on whether the laboratory picked up the urine sample. Staff noticed the sample was never sent to the laboratory, therefore a new urine sample was collected and sent out on 05/27/2022. Medical records confirmed Resident A had a UTI and Resident A did not start medication to treat the UTI until 05/29/2022. Based on the investigative findings, there is sufficient evidence to support the findings that staff did not seek medical attention in an appropriate time frame.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action, I recommend that the licensing status remain unchanged.

Megan Aukerman, MSW

08/02/2022

Megan Aukerman — Date
Licensing Consultant

Approved By:

Jerry Hendrick

08/02/2022

Jerry Hendrick — Date
Area Manager