GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 23, 2025

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

RE: License #: AL030006860
Investigation #: 2025A0464012
Addington Place of LakeSide Vista Amsterdam Haus

Dear Mr. Levy:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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, MSW

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 #:	2025A0464012
Complaint Receipt Date:	12/03/2024
Investigation Initiation Date:	12/03/2024
Report Due Date:	02/01/2025
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:	Mistee Hondorp
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:	03/16/2023
Expiration Date:	03/15/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/AGED

II. ALLEGATION(S)

	Violation Established?
Staff are neglecting Resident A. Resident A had a urinary tract infection that went untreated.	No

III. METHODOLOGY

12/03/2024	Special Investigation Intake 2025A0464012
12/03/2024	APS Referral
12/03/2024	Special Investigation Initiated - Telephone Kathleen Woodworth, Allegan County APS
12/16/2024	Inspection Completed On-site Kathleen Woodworth (APS), Mistee Hondorp (Administrator), Shanise Dawson (Staff), and Resident A
12/17/2024	Contact-Document received Facility Records
01/23/2025	Exit Conference Stephen Levy, Licensee Designee

ALLEGATION: Staff are neglecting Resident A. Resident A had a urinary tract infection that went untreated.

INVESTIGATION: On 12/03/2024, I received a complaint from Adult Protective Services (APS), which alleged Resident A is physically handicapped and is 100% dependent on staff for her activities of daily living (ADL's). Resident A is not coherent and deemed incompetent. On 11/28/2024, Resident A was observed in bed and appeared to be very pale. Resident A's family requested that Resident A be sent out to the hospital. There was concern Resident A contracted a urinary tract infection that was left untreated.

On 12/03/2024, I spoke to Allegan County APS worker, Kathleen Woodworth to coordinate the investigation.

On 12/16/2024, Ms. Woodworth and I completed an unannounced onsite inspection at the facility. We interviewed facility administrator, Mistee Hondorp. She explained that Resident A suffers from dementia and her health was slowly declining. Resident A also has a metal rod in her leg, that causes leg pain. As a result,

Resident A was receiving palliative care through Wings of Hope. Mrs. Hondorp stated that on 11/27/2024, Resident A's Power of Attorney (POA) expressed concern regarding Resident A's health and suspected she had contracted a UTI. Mrs. Hondorp stated Resident A did not show any new signs of increased confusion or any changes in her daily routine but contacted Wings of Hope and collected a urine sample. On 11/28/2024, while the facility was awaiting lab results, Resident A's family requested Resident A be sent out to the hospital for evaluation. While at the hospital, Resident A suffered from a stroke. Mrs. Hondorp stated at no point did Resident A show any signs of a stroke.

Mrs. Woodworth and I then made face-to-face contact with Resident A. An interview was not conducted as Resident A presented as confused. Resident A was clean and appropriately dressed. No concerns were observed.

Mrs. Woodworth and I then interviewed staff, Shanise Dawson. Ms. Dawson stated she has routinely provided care for Resident A. Ms. Dawson stated Resident A is receiving palliative care and her health is slowly declining. She reported they did not notice any signs or symptoms of a stroke. Ms. Dawson stated the family did suspect Resident A had a UTI, but Resident A's urinalysis results were negative.

On 12/17/2024, I received and reviewed Resident A's facility records, specifically Resident A's Health Care Appraisal (HCA) which was signed and completed by nurse practitioner Chiauhi Neilly on 11/27/2024. The HCA reflects Resident A is diagnosed with chronic lymphocytic leukemia, dementia, osteoporosis, polyarthritis and urinary incontinence.

On 12/17/2024, I reviewed Resident A's facility progress notes. The notes reflected staff contacted Wings of Hope on 11/27/2024, to discuss the possibility that Resident A contracted a UTI. A urine sample was collected. The progress notes also reflect Resident A was sent out to the hospital on 11/28/2024 to be evaluated.

On 01/23/2025, I completed an exit conference with licensee designee, Stephen Levy. He was informed of the investigation findings and recommendations.

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 12/03/2024, a complaint was received alleging facility staff failed to address Resident A's urinary tract infection. On 12/16/2024, an unannounced, onsite inspection was completed at the facility. Staff Mistee Hondorp and Shanise

	Dawson reported Resident A suffered from declining health and was receiving palliative care services. Both denied witnessing any concerning symptoms; however, Resident A's Power of Attorney's request to have Resident A tested for a UTI and sent to the hospital was honored. Facility records reflected Resident A suffers from chronic lymphocytic leukemia, dementia, osteoporosis, polyarthritis and urinary incontinence. Resident A's progress notes reflected staff contacted Wings of Hope, collected a urine sample and sent Resident A to the hospital within an appropriate time frame. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff failed to obtain treatment for Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

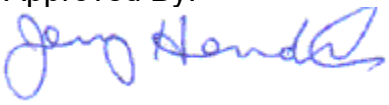
IV. RECOMMENDATION

I recommend that the licensing status remain unchanged.

01/23/2025

Megan Aukerman Date
Licensing Consultant

Approved By:



01/23/2025

Jerry Hendrick Date
Area Manager