GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2025

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

RE: License #: AL030006859
Investigation #: 2025A0464018
Addington Place of LakeSide Vista Rotterdam 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,

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 #:	AL030006859
Investigation #:	2025A0464018
Complaint Receipt Date:	01/09/2025
Investigation Initiation Date:	01/09/2025
Report Due Date:	03/10/2025
Licensee Name:	Leisure Living Management of Holland Inc.
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 394-0302
Administrator:	Mistee Hondorp
Licensee Designee:	Stephen Levy
Name of Facility:	Addington Place of LakeSide Vista Rotterdam Haus
Facility Address:	340 West 40th Street Holland, MI 49423
Facility Telephone #:	(616) 394-0302
Original Issuance Date:	12/12/1988
License Status:	REGULAR
Effective Date:	04/04/2024
Expiration Date:	04/03/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Jaqaues Burt became physically aggressive towards Resident A.	Yes

III. METHODOLOGY

01/09/2025	Special Investigation Intake 2025A0464018
01/09/2025	APS Referral
01/09/2025	Special Investigation Initiated - Telephone Micheal McClellan, Allegan County APS
01/09/2025	Contact-Document received Facility Records
03/07/2025	Contact-Telephone call made Jaqaues Burt, Staff
03/07/2025	Contact-Telephone call received Michael McClellan, Allegan County APS
03/07/2025	Inspection Completed-Onsite Mistee Hondorp, Administrator
03/10/2025	Exit Conference Stephen Levy, Licensee Designee

ALLEGATION: Staff Jaqaues Burt became physically aggressive towards Resident A.

INVESTIGATION: On 01/09/2025, I received a complaint alleging on 12/22/2024 staff Jaqaues Burt was physically “rough” with Resident A while providing care. More specifically, it was alleged that while dressing Resident A, Ms. Burt pinned Resident A’s arms down on the bed and was throwing him around.

On 01/09/2025, I spoke to Allegan County Adult Protective Services (APS) worker, Michael McClellan to coordinate the investigation. Mr. McClellan stated he interviewed Resident A at the hospital with a Holland Police Officer. Mr. McClellan stated Resident A reported on 12/22/2024, he needed staff assistance with transferring from his bed to his chair. Ms. Burt was not happy about having to help Resident A. Resident A informed Mr. McClellan that Ms. Burt grabbed him by the wrists and pulled him up. She then roughly placed him in his wheelchair. Resident

A reported he sustained bruises on his wrists from the incident. Mr. McClellan reported he photographed the bruises on Resident A's wrists and would send me copies of the images. Mr. McClellan reported the facility immediately suspended Ms. Burt's employment while the investigation was conducted.

On 01/09/2025, I received and reviewed the photographs of Resident A's injuries. Resident A sustained bruises on both of his wrists. The bruising resembled what appeared to be grab marks.

On 03/07/2025, I attempted to contact Ms. Burt, requesting a return phone call.

On 03/07/2025, I spoke to Mr. McClellan by telephone. Mr. McClellan reported APS substantiated Ms. Burt for abuse towards Resident A. Mr. McClellan stated the facility terminated Ms. Burt's employment.

On 03/07/2025, I completed an unannounced, onsite inspection at the facility. I interviewed facility administrator, Mistee Hondorp. Ms. Hondorp reported that when she learned of the allegations, Ms. Burt was immediately suspended. Since then, Ms. Burt's employment was terminated.

On 03/10/2025, I completed an exit conference with licensee designee, Stephen Levy. He was informed of the investigation findings and recommendations. Mr. Levy reported a corrective action plan would be submitted to licensing.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 01/09/2025, a complaint was received alleging staff Jaqaues Burt was physically aggressive towards Resident A. Adult Protective Services (APS) interviewed Resident A. Resident A reported that Ms. Burt assisted him with transferring from his bed to his wheelchair on 12/22/2024. Resident A reported Ms. Burt was too "rough" with him, which caused bruising on his wrists. APS photographed the injuries and sent them to licensing. APS substantiated Ms. Burt for physical abuse towards Resident A.

	On 03/07/2025, an onsite inspection was completed at the facility. Facility administrator, Mistee Hondorp was interviewed and reported Ms. Burt's employment has been terminated. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Burt was physically aggressive towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

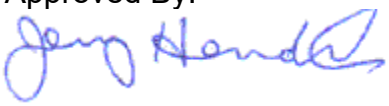
IV. RECOMMENDATION

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

03/10/2025

Megan Aukerman Date
Licensing Consultant

Approved By:



03/10/2025

Jerry Hendrick Date
Area Manager