



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2026

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

RE: License #:	AL030006860
Investigation #:	2026A0356050
Addington Place of Lakeside Vista Amsterdam 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. If 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 "Elizabeth Elliott". The signature is written in dark ink and is positioned below the word "Sincerely,".

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030006860
Investigation #:	2026A0356050
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/14/2026
Report Due Date:	09/12/2026
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:	03/16/2025
Expiration Date:	03/15/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident B's medications were administered to Resident A.	Yes
Staff are not trained prior to caring for residents.	No
Additional Finding	Yes

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A0356050
07/14/2026	Special Investigation Initiated - Telephone Natasha Grew, LARA, Licensing Consultant.
07/24/2026	Contact - Telephone call made Relative #1
07/28/2026	Inspection Completed On-site
07/28/2026	Contact - Face to Face Eric Rash, executive director, Resident A, Resident B.
07/28/2026	Contact - Face to Face Review resident MARs (medication records).
07/28/2026	Contact - Document Received Resident A and B's MARs (medication administration records). IR (incident report)
08/17/2026	Contact-Document Received Complaint received
08/18/2026	Contact-Telephone call made Staff, Emma Morgan, interview
08/27/2026	Contact-Document Received Staff training records reviewed
09/04/2026	Contact-Telephone call made DCW Melissa Schmall
09/08/2026	Exit-Steve Levy, Licensee Designee.

ALLEGATION: Resident B's medications were administered to Resident A.

INVESTIGATION: On 07/14/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that a resident was given someone else's medication.

On 07/24/2026, I interviewed Relative #1 via telephone. Relative #1 stated Resident A was given 6 medications that were not hers. Relative #1 stated Resident A called her and said, "they gave me the wrong meds." Relative #1 stated Resident A had just moved into the facility on 06/29/2026 and was there for approximately 4 days, and had a stroke on 07/02/2026. Resident A went to the hospital for a week and once back at the facility on 07/09/2026, Resident A's evening medications were administered and Resident A took the medications. Relative #1 stated when staff came into her room to administer a breathing treatment Resident A said that she did not have a breathing treatment and called saying she had just taken the wrong medications. Relative #1 stated the facility med tech told her (Relative #1) it was busy, he gave Resident B's medications to another staff and asked that staff to give the medications to Resident B. Relative #1 stated instead of giving Resident B's medications to Resident B, the staff person gave Resident B's medications to Resident A. Relative #1 stated she had staff call an ambulance and send Resident A to the hospital where she was evaluated and returned to the facility.

On 07/28/2026, I conducted an unannounced inspection at the facility and interviewed Eric Rash, administrator. Mr. Rash stated DCW/med tech, Jordan Hicks popped Resident B's medications and instructed DCW (direct care worker) Yesenia Molina to go to Resident B's room to administer the medications. However, Ms. Molina went into Resident A's room and gave her the medications, which she ingested. Mr. Rash stated only Resident A received the wrong medications. Mr. Rash stated Resident A went to the hospital where she was evaluated and monitored with no ill effects. Mr. Rash stated Mr. Hicks was pulled off the med cart, a corrective measure put in place, and Mr. Hicks is currently going through re-training on the administration of resident medications. Mr. Rash stated this incident occurred on 07/13/2026 as documented in the IR (incident report) and not on 07/09/2026 as reported by Relative #1.

On 07/28/2026, I interviewed Resident A in her room at the facility. Resident A stated a female staff (Ms. Molina) came in her room and gave her pills. She took the pills, then Ms. Molina came in with a nebulizer and attempted to give her the nebulizer treatment. Resident A stated that is when she told staff that she did not have a nebulizer treatment and refused to take it. Resident A stated, "I guess I caught that first." Resident A stated Mr. Hicks came into her room and told her they gave her the wrong pills, she "wiggled her uvula" and was able to spit up two pills. Resident A stated staff called Relative #1 who instructed them to call an ambulance, and she (Resident A) went to the hospital, was monitored and then returned to the facility. Resident A stated she has "no clue" how that happened. Resident A stated the following day, Mr. Hicks came into her room and apologized.

On 07/28/2026, I interviewed Resident B in her room at the facility. Resident B stated staff did not administer the wrong medications to her.

On 07/28/2026, I reviewed the IR dated 07/13/2026, written by Jamal Jackson and signed on 07/14/2026. The IR documented the following information, *'Med tech assigned to hall instructed another Med Tech to pass meds to a resident they were instructed to pass to room 34 but went to room 36. Staff passed meds to resident before realizing they were given to the wrong resident. Staff asked resident to spit out any meds that she could to prevent her from swallowing all of them. Corrective action was given and the employee was pulled from the med cart for further training.'*

On 07/28/2026, I reviewed Resident A's MAR (medication administration records) for the month of July 2026. On 07/13/2026, Resident A's evening medications were Acetaminophen 500MG tab, take two tablets by mouth every eight hours for pain, to be administered at 10:00p.m., marked by Mr. Hicks as 'OOF' which stands for, 'out of facility.'

I reviewed Resident B's MAR and the evening (8:00p.m.) medications administered to Resident A were as follows:

- Atorvastatin Tab 10MG, take one tablet by mouth once daily.
- Breyna AER 80/4.5 MCG/ACT Inhalation Aerosol, Inhale two puffs by mouth twice daily. Resident A reported she did not take this treatment, she refused and stated she knew she did not have an inhaler.
- Eliquis Tab 5MG, take one tablet by mouth twice daily.
- Gabapentin Cap 300MG, oral capsule, take two capsules by mouth twice daily.
- Metformin Tab 500MG, oral tablet, take one tablet by mouth twice daily.
- Myrebetriq Tab 50MG, oral tablet, extended release 24-hour, take one tablet by mouth at bedtime.
- Senna-5 Tab 8.6 50MG, oral tablet, take one tablet by mouth twice daily.

All the medications were marked as administered and signed on the MAR by 'JH1' which is DCW, Jordan Hicks.

On 08/27/2026, I reviewed medication administration training documents for Mr. Hicks dated 06/17/2026. The training certificate documented that Mr. Hicks attended education and passed a written exam covering the following, 'six rights of medication, medication considerations, storage, and labels, medication pass procedures, medication administration techniques, eMAR/MAR documentation, narcotic receiving and documentation, pharmacy specific processes.'

On 09/04/2026, I conducted an exit conference with Licensee Designee, Stephen Levy via email. Mr. Levy did not provide any additional information to this allegation, analysis, or conclusion of this applicable rule.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	The complainant reported that a resident was given someone else's medication. Based on my investigative findings, on 07/13/2026 the evening medications for Resident B were erroneously administered to Resident A who ingested the medications. Resident A was transported to the hospital for evaluation and returned to the facility. A violation of this applicable rule is established.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff are not trained prior to caring for residents.

INVESTIGATION: On 08/17/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that new staff are not trained prior to caring for residents at the facility. After a review of this complaint with Licensing Consultant Natasha Grew, we added this complaint to the existing complaint.

On 08/18/2026, I interviewed DCW (former) Emma Morgan. Ms. Morgan stated she was hired and training to be a med tech, 1st shift, 7:00a.m.-3:00p.m. with Melissa Schmall, DCW. Ms. Morgan stated she is a certified nurse aid. Her first day was 08/15/2026 and she worked the entire shift with Ms. Schmall learning resident medications. On 08/16/2026, Ms. Morgan stated she worked at 7:00a.m. again, with Ms. Schmall but ended up leaving the shift at 8:30a.m. and quit. Ms. Morgan stated Ms. Schmall wanted her to work as an aid, taking care of the residents on 08/16/2026, by herself and she (Ms. Morgan) did not have the knowledge of the residents or experience to care for the residents herself. Ms. Morgan stated she had not been shown or read about any of the residents or how to care for them. Ms. Morgan explained that Ms. Schmall was administering medications on 08/16/2026 and asked her (Ms. Morgan) to go into the residents' room and check on them, make sure they were ok and see if they needed anything. Ms. Morgan stated she checked on the residents. Everyone was fine and none of the residents needed anything but if they had, she would not have known what to do. Ms. Morgan stated Ms. Schmall was working with her on this date, and she was not alone but Ms. Schmall was working on medications and sent her on her own to check on residents. Ms. Morgan stated she left the facility, tried to call the on-call scheduler Haile Pacholka, emailed the manager, Eric Rash and no one responded.

On 08/24/2026, I interviewed Mr. Rash via telephone. Mr. Rash stated they were in the process of fully training Ms. Morgan but she only worked one full day and an hour the following day and so they were unable to fully train Ms. Morgan. Mr. Rash stated Ms. Morgan was not left alone to care for the residents and was not sent out on her own to care for the residents. Mr. Rash stated Ms. Schmall was working with Ms. Morgan and providing on the job training.

On 08/27/2026, I received and reviewed Relias training records for Ms. Morgan dated 08/13/2026-08/14/2026. Ms. Morgan's training records documented many of the required training courses as completed.

On 08/27/2026, I received and reviewed training records for DCW's Bonnie Stogsdill, Deja Scout, Jenna Doornbos, Litzy Medina, Jane Pershing, Melissa Schmall, De'Zhanae Johnson, Brianna Moore, Sierra Hauch, Briana Crawford, and Aeysha Armijo. The staff are documented as trained.

On 09/04/2026, I interviewed Ms. Schmall via telephone. Ms. Schmall stated she had worked at the facility for over two years and on 08/15/2026 she worked with Ms. Morgan, training her on resident medications. Ms. Schmall stated she reviewed the computer system and went through resident books and other facility information with Ms. Morgan. Ms. Schmall stated on 08/16/2026 it was a hectic day because the Wi-Fi was down, so she (Ms. Schmall) asked Ms. Morgan to check on the residents to see if they needed any water or coffee while she took care of the medications and attempted to get the phones and computers working. Ms. Schmall stated she never requested that Ms. Morgan take care of the residents on her own and she never put Ms. Morgan on the floor to work on her own. Ms. Schmall stated Ms. Morgan said she was not going to do that, even though she (Ms. Schmall) never asked Ms. Morgan to provide any resident care or to work on her own. Ms. Schmall stated then Ms. Morgan left 2 hours into her second shift. Ms. Schmall stated she is fully trained, she takes refresher training "constantly" and that was the same plan for Ms. Morgan, but she only worked one full shift and a short part of another before she walked off the job so training could not be completed.

On 09/04/2026, I conducted an exit conference with Licensee Designee, Stephen Levy via email. Mr. Levy did not provide any additional information to this allegation, analysis, or conclusion of this applicable rule.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	(5) 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 trained and competent in all of the following areas before performing assigned tasks independently: (a) Reporting requirements.

	(b) First aid. (c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases including recognizing signs of illness. (h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner. (i) Nutrition and special diets.
ANALYSIS:	The complainant reported that new staff are not trained prior to caring for residents at the facility. Based on investigative findings, DCWs at the facility are trained and Ms. Morgan was being trained but only worked one full shift and two hours into a second shift and was not fully trained when she ended her employment. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 07/28/2026, I conducted an inspection at the facility and interviewed Mr. Rash. Mr. Rash stated on 07/13/2026 during the evening medication administration pass, Mr. Hicks gave Resident B's medications to Ms. Molina to administer to Resident B.

On 07/28/2026, I interviewed Resident A who stated a female DCW (Ms. Molina) administered the medications to her and then Mr. Hicks came into her room and told her she had been administered the wrong medications.

On 07/28/2026, I reviewed the MAR for the 07/13/2026 evening medication administration for Resident B. Mr. Hicks signed the MAR as the staff that administered the medications to Resident A.

On 09/04/2026, I conducted an exit conference with Licensee Designee, Stephen Levy via email. Mr. Levy did not provide any additional information to this allegation, analysis, or conclusion of this applicable rule.

APPLICABLE RULE	
R 400.675	Resident medications.

	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (v) Initials of the individual who administered the medication at the time given.
ANALYSIS:	Mr. Hicks signed the MAR as the direct care worker who administered Resident B's evening medications on 07/13/2026. However, investigative findings show that Mr. Hicks gave Resident B's medications to Ms. Molina and Ms. Molina administered the medications to Resident A erroneously. A violation of this applicable rule is established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



09/08/2026

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



09/09/2026

Jerry Hendrick
Area Manager

Date