GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2022

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

RE: License #: AL030006862
Investigation #: 2022A0467033
Addington Place of LakeSide Vista Delph 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

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 #:	AL030006862
Investigation #:	2022A0467033
Complaint Receipt Date:	04/07/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/06/2022
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 Delph Haus
Facility Address:	344 West 40th Street Holland, MI 49423
Facility Telephone #:	(616) 394-0302
Original Issuance Date:	12/18/1989
License Status:	REGULAR
Effective Date:	02/05/2022
Expiration Date:	02/04/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 4/5/22, Resident A was observed by staff with bruises on her right arm. There is also a large bruise on her left hip. It is unknown where the bruises came from. There are concerns for physical abuse, but it is unknown who the perpetrator might be.	No
Additional Findings	Yes

III. METHODOLOGY

04/07/2022	Special Investigation Intake 2022A0467033
04/07/2022	Special Investigation Initiated - Telephone
04/07/2022	APS Referral – This complaint was received from APS.
05/06/2022	Exit conference completed with licensee designee, Stephen Levy.

ALLEGATION: On 4/5/22, Resident A was observed by staff with bruises on her right arm. There is also a large bruise on her left hip. It is unknown where the bruises came from. There are concerns for physical abuse, but it is unknown who the perpetrator might be.

INVESTIGATION: On 4/7/22, I received an Adult Protective Services (APS) complaint stating that Resident A was observed with bruises on her upper right arm, above her right elbow, and a fading bruise on her right elbow. It was also reported that Resident A had a large purple bruise on her left hip and it is unknown where the bruises came from. There are concerns of physical abuse by an unknown staff member.

On 4/7/22, I spoke to the complainant via phone and confirmed the allegation. The complainant stated that they spoke to the initial reporting source, and they stated although abuse was mentioned in the report, they denied stating that concern to centralized intake when making the complaint. The complainant stated that APS would be going to the facility today with law enforcement due to the complaint listing concerns of abuse.

On 4/7/22, I spoke to the assigned APS worker, Michael McClellan. He informed me that he is going to the facility today. During his visit, he agreed to request a copy of Resident A's assessment plan and healthcare appraisal and plans to send me a copy.

Below is a summary of the interview completed by Allegan County APS worker, Michael McClellan on 4/7/22 at the facility:

‘An unannounced visit was conducted with (Resident A) at Lakeside Vista Addington Place. APS was accompanied by Holland City Police Officer K. Reinink. The manager Camela Crevier was shocked to see APS with law enforcement regarding (Resident A). Ms. Crevier led APS and Law Enforcement to Building 2. (Resident A) was sitting for lunch when the investigators came. (Resident A) was willing to speak to APS and Law Enforcement in her room. (Resident A) was very confused. (Resident A) appeared to have poor circulation in her legs that appeared to be weeping. (Resident A) was asked if she has had any falls. (Resident A) stated, " No". (Resident A) was asked how staff were treating her at the home. (Resident A) stated, " I don't know what you’re saying". (Resident A) was asked if the worker could look at her arms for bruises. (Resident A) pulled her sleeve up on her right arm. The worker saw a small quarter sized greenish bruise just above her elbow. (Resident A) would not allow the worker to pull up her sleeve further nor her left arm sleeve. (Resident A) started reading the paper and would not answer any questions.

An interview was held with Courtney Hilderbrand who works with (Resident A). Ms. Hilderbrand stated that she is the main caregiver for (Resident A). Ms. Hilderbrand stated she has witnessed some of the bruising however does not know where it comes from. Ms. Hilderbrand stated (Resident A) should use her walker. However, she will ambulate without it and bumps into walls. Ms. Hilderbrand stated (Resident A) is listed as a fall risk. Ms. Hilderbrand stated she did report the hip bruise on Monday. However, she did not know the cause of the bruise. Ms. Hilderbrand stated Kindred at Home is the hospice agency working with (Resident A).

Ms. Hilderbrand stated that (Resident A) was just reinstated to hospice following her being taken off. Ms. Hilderbrand stated (Resident A) did try to leave the building yesterday. Ms. Hilderbrand was asked if she ever needs to help (Resident A) off the toilet or in the shower where she would have to grab her arms to help. Ms. Hilderbrand stated (Resident A) was very independent and did not really need assistance. Ms. Hilderbrand was asked if Resident A was very combative when staff were trying to help. Ms. Hilderbrand stated she does swing at staff sometimes. Ms. Hilderbrand stated she does not have too many issues with that on her shift. Officer K. Reinink was disinterested in the case. Officer K. Reinink was called out on an emergency call and stated he would write up a report.

An interview was held with Camila Crevier and Emma Evans. Ms. Crevier was informed the worker had allegations of elopement for (Resident A). Ms. Crevier was asked for the incident report. Ms. Evans stated (Resident A) is not in a locked unit and therefore, leaving the building was not considered elopement. Ms. Crevier and Ms. Evans stated they were looking into moving her to the locked memory care unit because elopement has been a recent issue. Ms. Evans stated that the daughter has been contacted regarding the bruises. Per Ms. Evans, it is unknown where the bruises came from on (Resident A) but they were documented. Ms. Evans stated there was no incident reports that needed to be filed as the situation did not result in treatment or hospitalization. Ms. Crevier and Ms. Evans were asked for (Resident A’s) Health Care Appraisal and Assessment Plan. Ms. Evans was asked to provide

at least 6 months of clinical notes for (Resident A). Ms. Crevier stated they were now documenting for skin care for (Resident A's) weeping legs. The Health Care Appraisal was signed on 10/15/2020 and listed that (Resident A) is confused, frail and a fall risk.

The six months of notes were valuable to the investigation. The main workers were Courtney Hilderbrand, Mackenzie Sluyter and CNA Holly Harper. On 04/05/2022, Ms. Hilderbrand noted that Hospice was bathing (Resident A) and found 3 bruises on her right arm. On 04/02/2022, Cindy Gately Medical tech saw a large purple bruise on her left hip. On 01/03/2022, a critical note was put in from Ms. Hilderbrand. "Reporting fall w/ Injury pt. fell in room and has an open wound around lt eye. Pt was sent to the hospital for evaluation." On 01/03/2022, another note was entered stating "Pt returned from hospital, pt does have stitches above lt eye and eye is starting to bruise, Pt is very tired and wants to sleep in recliner chair, med tech elevated legs while pt is in chair pt arrived with order to have DR. remove sutures in 5 days sent fax to DR. and also let on-call staff know." The notes indicate some combativeness from Resident A towards workers. Ms. Evans was asked about the help from Kindred Care Hospice. Ms. Evans stated they shower (Resident A) twice a week. Ms. Evans stated her staff rarely showers (Resident A) unless the need arises. Ms. Evans stated they are doing some wound care for her weeping legs. Ms. Evans was asked about Ms. Hilderbrand and Ms. Sluyter. Ms. Evans stated that Ms. Sluyter was let go due to substance use issues recently. Ms. Evans stated that Ms. Hilderbrand was a great asset to the team. Ms. Evans stated she had no concerns regarding Ms. Hilderbrand's care of (Resident A). Ms. Evans stated it was possible that (Resident A) is having falls and getting back up or bumping up against her walker or the wall.'

On 4/7/22, phone contact was made with Hospice Care Worker, Rachel Deridder. Ms. Deridder was asked about the allegation pertaining to Resident A. Ms. Deridder stated yesterday, she saw 3 bruises on her left arm and 3 bruises on the lower arms. Ms. Deridder stated the bruises did not have a definite shape (i.e. grab mark) however those bruises had to be reported to staff. Ms. Deridder stated Kindred Hospice staff bathe Resident A twice a week, but sometimes it's a battle to get her to bathe. Ms. Deridder stated Resident A allowed her to see the bruises on her left hip. The bruise did not appear to be deep from her observation and not swollen. Ms. Deridder stated that not knowing where the injury came from was concerning, but she did not necessarily believe it was from physical abuse. I asked Ms. Deridder if there were any issues with staff being inappropriate with Resident A and she denied witnessing any emotional abuse.

On 5/3/22, I conducted an onsite inspection to the facility. Upon arrival, I spoke to staff member Ms. Hilderbrand. She confirmed that Resident A is confused at baseline and assisted me to her room. Introductions were made with Ms. Hilderbrand. Resident A stated that she is doing "good." She was observed sitting in her recliner chair while watching TV. I did not observe any obvious signs of bruises. An interview was not attempted with Resident A due to her limited cognitive ability.

APS worker, Michael McClellan also attempted to interview Resident A on 4/7/22 with no success due to Resident A being confused.

On 05/06/2022, I conducted an exit conference with licensee designee, Stephen Levy. He was informed of the investigative findings and denied having any questions.

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:	APS worker, Michael McClellan conducted an onsite investigation to the facility on 4/7/22. An attempt was made to interview Resident A but this was unsuccessful. She did allow Mr. McClellan to view a small quarter sized greenish bruise just above her elbow. Resident A would not allow Mr. McClellan to pull up her sleeve to view any other potential injuries. Resident A's main caregiver, Ms. Hilderbrand confirmed that she noticed the bruising to Resident A but stated she was unaware of what caused the bruises. Ms. Hilderbrand stated that Resident A is a fall risk, and this was verified on her healthcare appraisal. Ms. Hilderbrand also stated that Resident A ambulated without her assistive device and bumped into walls. All interviewed parties were unable to explain how Resident A obtained her injuries and no one witnessed Resident A being abused. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's assessment plan, which was signed and dated on 11/30/20. This form is required to be updated at least annually.

On 05/06/22, I conducted an exit conference with licensee designee, Stephen Levy. He was informed of the investigative findings and 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:	Resident A's assessment plan was last signed on 11/30/20, which is nearly a year-and-a-half later than it should have been updated. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's healthcare appraisal, which was signed on 10/15/20. This form is required to be updated annually.

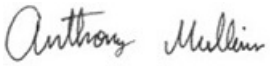
On 05/06/2022, I conducted an exit conference with licensee designee, Stephen Levy. He was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after

	admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A's healthcare appraisal was last signed on 10/15/20, which is more than a year-and-a-half later than it should have been updated. Therefore, a preponderance of evidence does exist to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

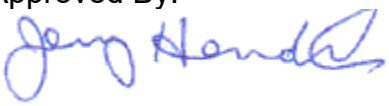
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



05/17/2022

Anthony Mullins — Date
Licensing Consultant

Approved By:



05/18/2022

Jerry Hendrick — Date
Area Manager