GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

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

RE: License #:	AL030006860
Investigation #:	2024A0356056
	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,

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 #:	2024A0356056
Complaint Receipt Date:	09/03/2024
Investigation Initiation Date:	09/04/2024
Report Due Date:	11/02/2024
Licensee Name:	Leisure Living Management of Holland Inc.
Licensee Address:	21800 Haggerty Rd. Suite 115 Northville, MI 48167
Licensee Telephone #:	(616) 394-0302
Administrator:	Mistee Hondorp
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:	03/16/2023
Expiration Date:	03/15/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not administering Resident A's Parkinson medications as prescribed.	No
Resident medications are not documented properly as administered on the resident medication administration records (MARs).	Yes

III. METHODOLOGY

09/03/2024	Special Investigation Intake 2024A0356056
09/03/2024	APS Referral
09/04/2024	Special Investigation Initiated - Telephone Referral Source.
09/20/2024	Inspection Completed On-site
09/20/2024	Contact - Face to Face Ashley Kiss, RN, Brooklyn Muyskens, Resident Care Coordinator, Resident A.
09/20/2024	Contact - Document Received Facility documents received.
10/07/2024	Contact - Telephone call received Resident A.
10/08/2024	Contact - Face to Face Resident A, Ashley Kiss, Brooklyn Muyskens.
10/08/2024	Contact - Document Received Facility documents.
10/14/2024	Contact - Telephone call made Relative #1.
10/16/2024	Contact-Telephone call made Mistee Hondorp, administrator.
10/21/2024	Contact-Telephone call received

	Ms. Hondorp.
10/23/2024	Contact-Telephone call made DCW's Shanise Dawson and Arielle VanHuis.
10/30/2024	Exit conference-Mistee Hondorp as approved by Licensee Designee, Stephen Levy.

ALLEGATION: Staff are not administering Resident A's Parkinson medications as prescribed.

INVESTIGATION: On 09/03/2024, I received a LARA-BCHS (Bureau of Community Health Systems) online complaint. The complainant reported the facility makes medication errors.

On 09/04/2024, I interviewed Resident A via telephone. Resident A stated she moved into this facility on 03/09/2024 and has Parkinson's disease that require medications to be administered on time all the time. Resident A stated she is getting her medications an hour to two hours too late and these medications are sensitive to time and need to be administered on time. Resident A stated the Parkinson medications are Carbidopa Levodopa (Sinemet) and Amantadine. Resident A stated she is concerned about how these two medications are administered and stated the rest of her medications are administered as prescribed.

On 09/20/2024, I conducted an unannounced inspection at the facility and interviewed Ashley Kiss, RN (registered nurse) and Brooklyn Muyskens, Resident Care Coordinator in the office at the facility. Ms. Kiss stated Resident A's Parkinson medications, Carbidopa Levodopa and the booster Amantadine are scheduled to be administered within 15 minutes before or after the documented administration time and that is when staff are administering them, rather than the allotted "window period" of up to one hour before or one hour after the documented time per medication administration rules. Ms. Kiss stated Resident A often does not think staff gave her medications according to the prescription, but they do, and staff have been diligent in doing so.

On 09/20/2024, I interviewed Resident A in her room at the facility. Resident A stated that the administration of her medications has been better lately but overall, staff are not able to accommodate the 15 minutes before the administration times and/or the 15 minutes after. Resident A stated these Parkinson's medications are imperative to have at the correct time to keep symptoms of the disease controlled. Resident A stated all her other medications are administered as prescribed.

On 09/20/2024, I reviewed Resident A's MARs (medication administrator records) for the months of August and September 2024 to date. The August MAR documented the following:

- August 2024-Amantadine HCl Oral Tablet 100 MG, 1 tablet by mouth two time per day every day at 6:00a.m., 2: 00p.m. along with the Sinemet (Carbidopa/Levodopa). Additional notes, take one tablet twice daily at 6am and 2pm along with the Sinemet. Must be administered within 15 minutes of 6am and 2pm.
- August 2024-Amantadine HCl Oral Tablet was documented by staff initials as administered as prescribed except for 2 dates, 08/02/2024 at 2:00p.m. and 08/24/2024 at 6:00a.m. where there is a dash (-) in the box where staff initials should be documented.
- August 2024-Carbidopa/Levodopa Oral Tablet 25-100 MG, 1.5 tablet by mouth five times per day every day at 2:00a.m., 10:00a.m., 2:00p.m., 6:00p.m., 10:00p.m. Special instructions: Take 2 whole tablets from the bottle that has the whole tablets in it (do not use half tablets for this administration) within 15 minutes of 6am. Take 1.5 tablets within 15 minutes of 10am, 2pm, 6pm, 10pm, and 2am by mouth daily. Additional notes: Take 1.5 tablets (take 1 whole tablet and 1 half tablet) (These are in two separate bottles please check your dosing) within 15 minutes of 10 am, 2pm, 6pm, 10pm, and 2am by mouth daily.
- August 2024-Carbidopa/Levodopa Oral Tablet was documented by staff initials as administered as prescribed except for 11 dates, 08/2/2024, 2:00p.m. and 10:00p.m., 08/04/2024, 10:00p.m., 08/06/2024, 2:00a.m., 08/07/2024, 2:00a.m., 08/09/2024, 10:00p.m., 08/10/2024, 10:00p.m., 08/17/2024, 10:00p.m., 08/21/2024, 10:00p.m., 08/24/2024, 6:00a.m., 08/25/2024, 10:00p.m where there is a dash (-) in the box where staff initials should be documented.
- A review of the abbreviations does not include a dash (-) as an explanation.
- A review of the abbreviations included “REF” as an explanation of resident refusal.

On 10/08/2024, I conducted an unannounced inspection at the facility, and Resident A reported staff continue to administer her Parkinson’s medications untimely.

On 10/08/2024, I reviewed Resident A’s MARs for the months of September 2024 and October 2024 to date.

- September 2024 MAR for Amantadine HCl Oral Tablet and Carbidopa/Levodopa Oral Tablet is documented administered as prescribed by staff initials for each date except for 09/02/2024, 10:00p.m. administration is documented with staff initials and marked as “OTH.”
- October 2024 (to date) MAR for Amantadine HCl Oral Tablet and Carbidopa/Levodopa Oral Tablet is documented administered as prescribed by staff initials for each date and time (to date) except for 10/02/2024, 6:00p.m., 10:00p.m., 10/03/2024, 6:00p.m., 10:00p.m., 10/05/2024, 6:00p.m., and 10/06/2024, 10:00p.m., are documented with staff initials and marked as “OTH.”
- A review of the abbreviations includes an “OTH” as “other” but does not explain what that abbreviation means. In a follow-up conversation, Ms.

Hondorp and Ms. Kiss explained that “OTH” means other and in the instances documented above, the “OTH” is documented by staff on a paper MAR, that the electronic MAR system called Yardi was offline, and the medications were administered as prescribed.

On 10/14/2024, I interviewed Relative #1 via telephone. Relative #1 stated Parkinson medications are not medications that staff can administer late because Resident A would have trouble walking and talking if she does not have the medications on time. Relative #1 stated when Resident A first moved into the facility, the medications were prescribed to be administered every 4 hours. Staff at the facility reported they had an hour before or an hour after to administer the medications per medication administration rules but Relative #1 stated, with these medications it is imperative they are administered 4 hours apart as close to the time prescribed as possible as the medications are time dependent. Relative #1 stated Resident A’s primary care doctor and neurologist did not like the way the medications were being administered to Resident A in this facility as she was either underdosed or overdosed with her Parkinson medications depending on the time they were giving them to her. Relative #1 stated the doctors prescribed the Amantadine, Carbidopa and Levodopa medications be administered no more than 15 minutes before or 15 minutes after the scheduled time to ensure accurate levels remain in her system. Relative #1 stated ½ hour-1 hour off the prescribed time is too long of a gap between the administration of these medications. Relative #1 stated Resident A would never refuse any of her medications especially the Parkinson’s medications. Relative #1 stated the administration of Resident A’s Parkinson’s medications has been on ongoing issue but the remainder of Resident A’s medications are administered as prescribed.

On 10/16/2024, I interviewed Mistee Hondorp, Administrator via telephone. Ms. Hondorp stated the dashes (-) on the MAR means that Resident A refused the medications or that the system was down and staff had to chart in a different way such as on a paper MAR. Ms. Hondorp stated Resident A sometimes refuses the medications if staff try to administer them 15 minutes before the prescribed time and Resident A will tell staff it is too soon to take the medication. Ms. Hondorp stated it can be challenging to make sure Resident A’s Parkinson medications are being administered 15 minutes before or after the prescribed time when there are other events occurring at the facility such as a resident death or an incident that requires staffs’ undivided attention. Ms. Hondorp stated due to all the concerns they have had with the timing of Resident A’s medication administrations, they set up 2 med techs to go together to observe and administer Resident A’s medications within the ½ hour window (15 minutes before or 15 minutes after the prescribed time) to make sure the medications were being administered as prescribed. Ms. Hondorp stated they did this for 30 days and then went back to one staff administering medications.

On 10/21/2024, Ms. Hondorp called and stated she has reviewed staff’s daily logs and progress notes which is part of their Yardi MAR electronic system. Ms. Hondorp stated in those notes it is documented that all medications were given. The notes do

not document each medication individually, but the staff noted all medications were given each day for the date and time for the month of August where dash (-) marks appear on the MAR. In addition, the progress notes included the staff's names on the Yardi document. Ms. Hondorp stated the Yardi MAR documentation system times out (after the two-hour medication administration window has passed for most residents) and once the system times out, staff are not able to get back into the system to sign the MAR for a period of time. To make sure documentation is done, staff then document in the daily logs and progress notes that medications were passed.

On 10/21/2024, I received and reviewed the Yardi progress notes for all dates marked on the MAR with a dash (-) and for each date on the MAR with a dash (-) there is a progress note that has staff's name and an explanation that states "meds given," or "took all meds." Resident A's individual medications are not documented on the progress notes, but it is documented with a note stating Resident A took all medications with the time the medication was given.

On 10/23/2024, I interviewed DCW (direct care worker) Shanise Dawson. Ms. Dawson stated she works 1st shift at the facility and reported that Resident A gets her medications as prescribed. Ms. Dawson stated for a period of time, when she passed Resident A's Parkinson's medication, she had another staff observe the passing of the medications just to make sure it was completed on time. Ms. Dawson stated the medications were never passed beyond 10-15 minutes before or after the prescribed time. Ms. Dawson stated she has been through "a lot of training" to ensure proper medication administration.

On 10/23/2024, I interviewed DCW Arielle VanHuis via telephone. Ms. VanHuis stated she works 2nd shift full time at the facility. Ms. VanHuis stated Resident A always gets her Parkinson's medications within the allotted window of time, 15 minutes before or after the prescribed times on her shifts. Ms. VanHuis stated she also charts on the daily log/progress notes so any anomalies on the MAR should be documented on the daily charting log. Ms. VanHuis stated there are times she "times out" on the MAR and is not able to get back into the Yardi system to sign the MAR but she makes sure she documents that Resident A was given and took her medications on the Yardi progress note system. Ms. VanHuis stated Resident A is "absolutely" getting her medications as prescribed.

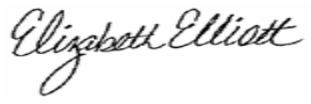
On 10/30/2024, I conducted an exit conference with Mistee Hondorp as approved by Licensee Designee, Stephen Levy. Ms. Hondorp stated staff worked hard at making sure Resident A's medications were administered as prescribed and on time and they will continue to do so. Ms. Hondorp stated she will provide staff with a refresher training and the MAR will be always documented appropriately or there will be a paper MAR to back-up staff signatures and administration times if the system goes down. Ms. Hondorp stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A and Relative #1 reported that Resident A's Parkinson's medications are not always administered at the time prescribed. Upon initial review of Resident A's medication administration records, it appeared that resident medication was not always administered as prescribed by the physician due to the absence of staff initials on some of the dates/times on the MARs. However, Ms. Kiss, Ms. Hondorp, Ms. Dawson and Ms. VanHuis report Resident A's medications are administered as prescribed. Ms. Hondorp, Ms. Kiss and Ms. VanHuis reported documentation of the medications is also done on the Yardi progress notes as a back-up to the MAR. Resident A and Relative #1 stated Resident A does receive her medications but the issue is the timeliness of the administration of the medications within the ½ hour window prescribed. A review of the Yardi progress notes documented Resident A's medications were administered by staff and the dates and time documented, corresponded with each date the dashes were noted on the MAR. Based on investigative findings, there is not a preponderance of evidence to indicate that staff are not administering resident medications as prescribed and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all the following provisions: (b) Complete an individual medication log that contains all the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Resident A's medication administration records show dates where there is a dash (-) where staff initials are required when a medication pass is completed. Ms. Kiss and Ms. Hondorp stated staff get locked out of the Yardi MAR system and document the administration of Resident A's medications on the progress notes. The progress notes document the time, date, staff name and explanation such as "meds given" and "took meds." However, the document does not individually document the medication, or the dosage nor are the staff initials entered at the time the medication is given because staff have been timed out of the Yardi system. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

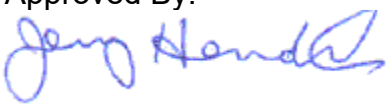
Upon receipt of an acceptable corrective action plan, I recommend the status of license remain unchanged.



10/30/2024

Elizabeth Elliott, Licensing Consultant Date

Approved By:



10/30/2024

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Jerry Hendrick, Area Manager Date