GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 12, 2022

Benjamin Visel
Visel AFC, Inc.
6565 Whitneyville Ave. SE
Alto, MI 49302

RE: License #: AM410401224
Investigation #: 2022A0467061
Visel Hilltop AFC

Dear Mr. Visel:

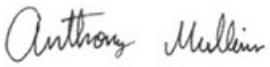
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	AM410401224
Investigation #:	2022A0467061
Complaint Receipt Date:	09/06/2022
Investigation Initiation Date:	09/06/2022
Report Due Date:	11/05/2022
Licensee Name:	Visel AFC, Inc.
Licensee Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Licensee Telephone #:	(616) 893-6613
Administrator:	Benjamin Visel
Licensee Designee:	Benjamin Visel
Name of Facility:	Visel Hilltop AFC
Facility Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Facility Telephone #:	(616) 868-7478
Original Issuance Date:	06/25/2020
License Status:	REGULAR
Effective Date:	12/25/2020
Expiration Date:	12/24/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Live-in staff member Cyndi Stevens is not addressing the residents' needs because she is "overwhelmed".	No
Cyndi Stevens was rude and disrespectful to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/06/2022	Special Investigation Intake 2022A0467061
09/06/2022	Special Investigation Initiated - Telephone Spoke to the complainant via phone.
09/06/2022	APS Referral Received the complaint from Adult Protective Services
09/07/2022	Contact - Telephone call made Spoke to the complainant to receive additional information.
09/07/2022	Inspection Completed On-site
09/12/2022	Exit conference completed with licensee designee, Ben Visel

ALLEGATION: Live-in staff member Cyndi Stevens is not addressing the residents' needs because she is "overwhelmed".

INVESTIGATION: On 9/6/22, I received a denied Adult Protective Services (APS) complaint through the BCAL online complaint system. The complaint alleges that residents care needs are not being addressed.

On 9/7/22, I made an unannounced onsite investigation to the facility. Upon arrival, M. Stevens greeted me in the driveway and allowed entry into the home to discuss the allegations. I explained to Ms. Stevens that I received allegations regarding the residents not having their needs met because she is overwhelmed. Ms. Stevens stated that when she agreed to take this job, she was told that her colleague, Amy Otto would be working alongside her for 20 hours a week. Ms. Stevens has been employed at the home for three months and this has not been the case for her. Ms. Stevens stated that Ms. Otto works anywhere from 10-20 hours per week when her schedule allows, which isn't helpful for her. Ms. Stevens stated that she doesn't get a break although she was told she would have one weekend off per month. Since starting her employment, Ms. Stevens stated that she has not had one night off and

if she takes a weekend off, she must pay $200 for a relief staff or Mr. Visel to stay at the home with the residents.

Ms. Stevens stated that she is doing her best and was adamant that all of the residents' needs are being met, including feeding, bathing, providing them with their medications, and making sure they attend their medical appointments. Ms. Stevens stated that she does not see an area that she can improve on as it relates to the resident care.

After speaking to Ms. Stevens, I interviewed Resident B, C, D, E and F. All five residents spoke highly of Ms. Stevens and confirmed that their needs are being met. Resident A was not interviewed due to being away from the home during the onsite inspection. Ms. Stevens provided me with copies of Resident B, C, D, E, and F's assessment plans, all of which were valid based on the dates signed. There were no major concerns noted for the residents. None of the assessment plans indicated any of the residents require more than one staff to assist them with transferring, ambulation, or any other support.

On 09/12/2022, I conducted an exit conference with licensee designee, Ben Visel. He was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Ms. Stevens was interviewed and stated that all residents' needs are being met. Resident B, C, D, E, and F were interviewed and all confirmed that their daily needs are being met in the home. I reviewed the assessment plans for each of the five residents and did not observe any concerns. Based on the information provided, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Live-in staff member Cyndi Stevens was rude and disrespectful to Resident A.

INVESTIGATION: On 9/6/22, I received a denied APS complaint through the BCAL online complaint system. The complaint alleged that live-in staff member, Cyndi Stevens is mean to Resident A and others by being rude and disrespectful. The complaint mentioned that Ms. Stevens locks the residents in the basement on the weekends until 8:00 am to give herself a break.

On 9/6/22, I spoke to the complainant via phone and she confirmed the allegations. The complainant stated that she was planning to work at the home with Ms. Stevens but decided not to based on how Ms. Stevens was treating the residents. The complainant stated that she saw enough to know that she would end up fighting Ms. Stevens based on her behavior towards the residents.

On 9/7/22, I spoke to the complainant via phone again. The complainant alleged that Ms. Stevens told her that she has a black whip that she snaps on the ground to scare the residents when they get out of control. The complainant did not observe the whip when she was recently in the home.

On 9/7/22, the complainant sent me a text message that included a video of Ms. Stevens being rude and disrespectful to an unknown resident. In the video, the unknown resident was crying and complaining to Ms. Stevens. Ms. Stevens could be heard saying, “I’ve heard enough, knock it off, I don’t want to hear all of that screaming and carrying on.” Ms. Stevens could also be heard telling the unknown resident that “you just need to calm down.”

On 9/7/22, I made an unannounced onsite investigation to the home. Upon arrival, I spoke to Ms. Stevens at the dining room table. I asked Ms. Stevens if she has ever recorded residents in the home while she was being verbally disrespectful to them and she stated no. I then played the video that I received from the complainant of Ms. Stevens recording a resident and making rude comments to her. Ms. Stevens then acknowledged that she wasn’t empathetic to Resident A in the recording and that this was an isolated incident. Ms. Stevens stated that she lost her patience the morning she made rude statements to Resident A and, “that was the meanest I’ve ever been in the house.” Ms. Stevens stated that she takes responsibility for the words she used towards Resident A in the video. Ms. Stevens stated that she would not have acted the way she did if she had a break. Mrs. Stevens stated that she hasn’t truly expressed how she feels to Mr. Visel as she doesn’t believe it would change anything. Ms. Stevens stated, “he knows I need help but he won’t get it.” Resident A was not interviewed due to being away from the home at the time of the onsite inspection.

I explained to Ms. Stevens that she is also being accused of locking residents in the basement on the weekends until 8:00 am to allow herself time to rest. Ms. Stevens stated, “that is a complete lie. I don’t lock them in the basement.” Ms. Stevens stated that the basement door does not have a lock on it. I observed the basement door and confirmed that it does not have a lock on it. Ms. Stevens added that during the week, she is in the kitchen at 6:00 am and serves breakfast at 6:30 am. On the

weekends, she is in the kitchen at 8:00 am and serves breakfast at 8:30 am. Ms. Stevens stated that Resident A had a history of waking up at 4:00 am to try to do her laundry and coming upstairs and awaking other residents by being too loud. Ms. Stevens stated that she told Resident A that she doesn't want her coming upstairs until the kitchen light is on to prevent her from interrupting the other residents' sleep. Ms. Stevens stated that Resident A and other residents know that if they do wake-up early, they can turn their TV on in the common area in the basement or engage in other activities until others wake-up. Regarding the allegation of Ms. Stevens using a whip to scare residents, Ms. Stevens adamantly denied this. Ms. Stevens stated that she doesn't even own a whip and all residents in the home would deny the allegation as well.

While at the home, I interviewed Residents B, C, D, E and F. All five residents denied being locked in the basement. They also denied any knowledge of Ms. Stevens having a whip or seeing her use a whip to scare residents. All five residents reported feeling safe with Ms. Stevens.

On 09/12/2022, I conducted an exit conference with the licensee designee, Ben Visel. He was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14305	**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:	I observed a video recording of Ms. Stevens making rude and disrespectful comments to Resident A. Ms. Stevens initially denied being rude to Resident A until she was made aware that I had a copy of the video. Ms. Stevens the admitted that she was not empathetic to Resident A when she made the rude statements. Based on the information provided, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention that Ms. Stevens recorded Resident A without her consent and sent the

video to the complainant. The complainant sent me a copy of the video, which showed Ms. Stevens recording Resident A and being rude and disrespectful.

While at the home on 9/7/22, I asked Ms. Stevens if she has ever recorded residents in the home and sent it to others via text message. Ms. Stevens initially denied doing this. After playing the video for her, Ms. Stevens admitted to recording Resident A approximately one week ago and sending it to two of her friends. Ms. Stevens acknowledged that she lied to me about recording the video and sending it to her friends because, “I know it is illegal. I know what I did was wrong.” Ms. Stevens stated that the owner/designee, Ben Visel is not aware of the incident. Ms. Stevens stated that she sent the video to her friends because she was exhausted due to not having time off. Ms. Stevens stated that she also recorded the video because she has been asking for help from friends to work in the home with her and she wanted them to see what she deals with by herself on a daily basis. Ms. Stevens stated that she takes full responsibility for recording and sending the video.

On 09/12/2022, I conducted an exit conference with licensee designee, Ben Visel. He was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	Ms. Stevens admitted to recording the video of Resident A without her consent and sending it to two of her friends. I observed this video after receiving a copy of it from the complainant. Resident A was not interviewed regarding this as she was away from the home during the onsite inspection. Based on the information provided, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

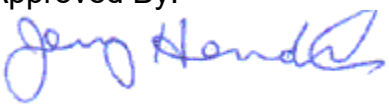
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.

Anthony Mullins

09/12/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



09/12/2022

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Jerry Hendrick Date
Area Manager