GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 24, 2024

Leone Swanberg
5329 McCords
Alto, MI 49302

RE: License #: AM410016238
Investigation #: 2024A0467040
Swanberg - Countryside AFC

Dear Ms. Swanberg:

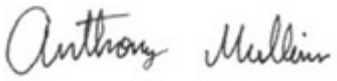
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AM410016238
Investigation #:	2024A0467040
Complaint Receipt Date:	06/04/2024
Investigation Initiation Date:	06/04/2024
Report Due Date:	08/03/2024
Licensee Name:	Leone Swanberg
Licensee Address:	5329 McCords Alto, MI 49302
Licensee Telephone #:	(616) 893-6613
Administrator:	Ben Visel
Licensee Designee:	Leone Swanberg
Name of Facility:	Swanberg - Countryside AFC
Facility Address:	6575 Whitneyville Road Alto, MI 49302
Facility Telephone #:	(616) 868-6003
Original Issuance Date:	03/10/1995
License Status:	REGULAR
Effective Date:	03/06/2024
Expiration Date:	03/05/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medications during the first week of June.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/04/2024	Special Investigation Intake 2024A0467040
06/04/2024	Special Investigation Initiated - Telephone Spoke to the complainant via phone
06/06/2024	Inspection Completed On-site
06/24/2024	APS Referral
06/24/2024	Exit conference completed with the administrator, Ben Visel on behalf of the designee.

ALLEGATION: Resident A did not receive his medications during the first week of June.

INVESTIGATION: On 6/4/24, I received a BCAL online complaint stating that Resident A's PRN (as needed) medications were disposed of prior to obtaining a new prescription. The complaint also stated that Resident A's mother had to refill his PRN medications.

On 6/4/24, I spoke to the complainant via phone. The complainant stated that the PRN medication that was disposed of was Xanax. The complainant stated that she believes the medication was disposed of due to it expiring. The complainant stated that other medications were also expired and disposed of, prior to the facility obtaining new ones. The complainant stated that Resident A's vitamins are supposed to be given daily but confirmed that he has missed scheduled doses.

On 6/6/24, I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff member Kailee Shipley answered the door and allowed entry into the home and agreed to discuss case allegations. Ms. Shipley stated that Resident A is away from the home at work, which he attends Monday through Thursday from 7:30 am to 4:00 pm. Ms. Shipley confirmed that due to having an upcoming inspection scheduled, she looked through the residents' medications to make sure none were expired. While doing so, she noticed that Resident A had some expired medications, which she disposed of appropriately. Ms. Shipley added that Resident A is

prescribed a multivitamin and Claritin, both of which he missed scheduled doses for approximately 1 week.

Ms. Shipley stated that Resident A's mother provides his over-the-counter medications, and she was asked to switch them to the pharmacy to obtain all his medications from the same place, which has not occurred. Despite this, Ms. Shipley is aware that as the live-in staff member, she is responsible for ensuring that Resident A's medications are readily available in the home to be administered as prescribed.

When asked about Resident A's Xanax medication, Ms. Shipley confirmed that she disposed of his expired Xanax medication in coffee grounds like she did with his other expired medications. Per Ms. Shipley, Resident A's Xanax is PRN and he rarely takes it. Ms. Shipley acknowledged that she "dropped the ball" by not disposing of Resident A's expired medication in a timely manner, in addition to Resident A not receiving his multivitamin and Claritin as prescribed.

On 06/24/24, I conducted an exit conference with Ben Visel, administrator. He was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Shipley confirmed that Resident A did not receive his Multivitamin and Claritin as prescribed for approximately one week. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I requested to review Resident A's Medication Administration Record (MAR) for the month of June. Resident A's MAR was not initialed for any of his medications through June 6th, which is a licensing requirement. Ms. Shipley stated that her laptop was broken due to falling down the stairs and she was unable to gain access to the electronic MAR system. Ms. Shipley stated that her laptop is now fixed, and she needs to update the MAR immediately. Ms. Shipley stated that she never relayed this concern to Mr. Visel although she should have. Despite the MAR not being initialed, Ms. Shipley

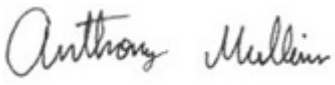
was adamant that Resident A and other residents are receiving their medications as scheduled.

On 06/24/24, I conducted an exit conference with Ben Visel, administrator of the facility. He was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report. Mr. Visel shared that he has already addressed this issue with Ms. Shipley, as she was reeducated on completing paper MARS if there's an issue with the electronic MAR system.

APPLICABLE RULE	
R 400.14312	**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 of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of 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 MAR was not initialed for any of his medications between June 1st and June 6th. Therefore, 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.



06/24/2024

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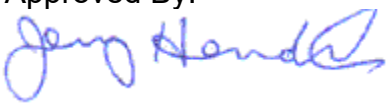
Anthony Mullins Date
Licensing Consultant

Approved By:



06/24/2024

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Jerry Hendrick Date
Area Manager