GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2025

David Fennell
118 Belleview Dr.
Ionia, MI 48846

RE: License #: AF340280762
Investigation #: 2025A0466013
Belleview AFC

Dear Mr. Fennell:

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 feel free to 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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AF340280762
Investigation #:	2025A0466013
Complaint Receipt Date:	12/23/2024
Investigation Initiation Date:	12/23/2024
Report Due Date:	02/21/2025
Licensee Name:	David Fennell
Licensee Address:	118 Belleview Dr. Ionia, MI 48846
Licensee Telephone #:	(616) 527-9927
Administrator:	N/A
Name of Facility:	Belleview AFC
Facility Address:	118 Belleview Drive Ionia, MI 48846
Facility Telephone #:	(616) 527-9927
Original Issuance Date:	03/10/2006
License Status:	REGULAR
Effective Date:	11/12/2024
Expiration Date:	11/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Issac Heynig and Xavion Liek live in the basement of the facility and they both are disruptive and make the residents feel unsafe.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/23/2024	Special Investigation Intake 2025A0466013.
12/23/2024	Special Investigation Initiated – Telephone call Complainant interviewed.
12/23/2024	Contact - Telephone call made to assigned licensing consultant Amanda Blasius interviewed.
01/16/2025	Inspection Completed On-site.
01/17/2025	Contact - Document Sent BCAL 1326A-NFP sent to licensee David Fennell for members of household.
01/22/2025	Contact - Telephone call received licensee David Fennell contacted about instructions for BCAL 1326 NFP.
02/03/2025	Contact- Document sent- FOIA Request.
02/04/2025	Contact- Telephone call to Resident A's case manager Andrea Nagurski interviewed.
02/05/2025	Contact- Telephone call made to Ionia Dispatch left a message for an office to contact me.
02/05/2025	Contact- Telephone call recevied from Trooper Lynch interviewed.
02/05/2025	Contact- Telephone call to licensee David Fennell interviewed.
02/06/2025	Contact- Document recevied BCAL 1326 NFP for Issac Heynig and Xavion Liek.
02/06/2025	Contact- Document sent to abucholtz@ioniacounty.org about FOIA request.
02/12/2025	Exit conference with licensee David Fennell.

ALLEGATION: Issac Heynig and Xavion Liek live in the basement of the facility and they both are disruptive and make the residents feel unsafe.

INVESTIGATION:
On 12/23/2024, Complainant reported that about two months ago, both Xavion Like and Issac Heynig entered the facility and were intoxicated, “caused a scene”, upset residents and made them feel unsafe. Complainant reported household member Xavion Liek drinks alcohol every day and then makes a “huge scene” in and out of the facility. Complainant reported police have been at the facility many times for Xavion Liek. Complainant reported that Xavion Liek was taking gabapentin, which he is not prescribed.

On 0/16/2025, I conducted an unannounced investigation and I interviewed responsible person Sherry Betz who was on duty at the facility. Responsible person Betz reported that there has been police involvement at the facility because of Xavion Liek. Responsible person Betz reported that residents have discussed with her being woken up due to Xavion Liek and Issac Heying being loud and yelling and reported being scared and afraid. Responsible person Betz reported that none of the residents are prescribed gabapentin and she has no knowledge if Xavion Liek takes gabapentin and/or if it is prescribed to him. Responsible person Betz reported one resident has moved out due to these conditions and she knows that Resident A wants to move out also due in part because of disruptive behavior from these two household members. Responsible person Betz reported that Resident A is the only verbal resident currently living at the facility.

Resident A reported that Issac Heying and Xavion Liek bring people over and they are yelling and screaming at night. Resident A reported that she goes to bed at 10 pm and that she has been woken up several times by Issac Heying and Xavion Liek’s loud behavior which is very scary and upsetting. Resident A reported that she is afraid to leave her bedroom at night because she is afraid that there will be yelling and screaming. Resident A reported that when there is yelling and screaming, she just stays quiet in her bedroom. Resident A reported that licensee David Fennell tries to intervene with Issac Heying and Xavion Liek but it does not always calm things down. Resident A reported that her roommate, Resident B is often woken up and upset by this also. Resident A reported that when these situations occur licensee David Fennell does not check on the residents to see if they are okay. Resident A reported that she does not know if licensee David Fennell is aware that the residents are all up because he does not check on them. Resident A reported that she has asked her case manager to move her to another facility because of the stress that this is causing her and the plan to find another living arrangement is in motion.

On 02/04/2024 I interievewed case manager Andrea Nagurski who reported that Resident A just moved out of the facility because she was upset about Issac Heying

and Xavion Liek bringing people over and them yelling and screaming at night with police involvement. Case manager Nagurski reported that she recently moved another resident out of this same facility prior to Resident A leaving per the resident's request due to similar reports.

On 02/05/2025, I interviewed Trooper Lynch who reported that there has been police involvement at 118 Belleview Drive Ionia, MI 48846 due to Issac Heying and Xavion Leik's behavior. Trooper Lynch stated both household members live in the basement of the facility. Trooper Lynch reported that the most recent police involvement was in in November 2024 for a possible assault which was a verbal dispute involving Xavion Liek and Sandra Fennell. Trooper Lynch reported that Xavion Liek was intoxicated and belligerent at the time of the police intervention. Trooper Lynch reported that in September 2024 the police were called to the facility to do a welfare check on Xavion Liek for him huffing a can of dust cleaner. Trooper Lynch reported that the police are "familiar with" both Xavion Liek and Issac Heying because of responding to the facility for calls of assistance as well as issues in the community.

On 02/05/2025, I interviewed licensee David Fennell who reported that he was asleep and was not involved in the dispute that took place between his wife Sandra Fennell and Xavion Liek in November 2024. Licensee David Fennell confirmed that both Issac Heynig and Xavion Liek live in the facility as members of household. Licensee David Fennell reported Xavion Liek was intoxicated and that Xavion Liek and Sandra Fennell were yelling at each other. Licensee David Fennell reported that he did not check on the residents after this incident nor did anyone else check on the residents that he was aware of during or after this incident occurred as he stated he assumed the residents were asleep. Licensee David Fennell reported that no other responsible person was on duty at that time. Licensee David Fennell reported that responsible person Sherry Betz typically only works during the day or when he is not home.

I interviewed responsible person Betz for a second time and she reported that Sandra Fennell told her about the night that the police were called to the facility in November 2024. Responsible person Betz reported that Sandra Fennell told her that Xavion Liek called Sandra Fennell a "bitch" while he was intoxicated and that according to Sandra Fennell they were yelling at each other. Responsible person Betz reported that Sandra Fennell told her that she was up all night and did not sleep well because she was upset about the night before and the interaction with Xavion Liek. Responsible person Betz reported that Sandra Fennell never told her who called the police but Sandra Fennell told her that the police were at the house intervening between Sandra Fennell and Xavion Liek.

I interviewed Sandra Fennell who reported that she called the police in November 2024 because she and Xavion Liek were yelling at each other while he was intoxicated. Sandra Fennell reported that both Issac Heynig and Xavion Liek live in the basement of the facility. Sandra Fennell reported that she told Xavion Liek that he needed to get a job and that there was no drinking in the facility. Sandra Fennell

admitted to being angry with Xavion Liek and reported that they were yelling at each other in her living area of the facility and not by the residents. Sandra Fennell reported Xavion Liek has no place else to live and he is friends with her grandson, Issac Heynig. Sandra Fennell reported that she is not aware of any medications that Xavion Liek may take or may be prescribed. Sandra Fennell reported that although Xavion Liek still does not have a job, he has not caused any problems since.

On 02/06/2025, licensee David Fennell submitted BCAL 1326 NFP for Issac Heynig and Xavion Like which were processed and approved for both individuals to be members of household.

I made a FOIA request on 02/03/2025 to Ionia County and sent a follow up email on 02/06/2025 and as of the writing of this report I have not received any requested documentation.

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(1) A licensee, responsible person, and a member of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	Resident A, responsible person Betz and case manager Nagurski reported that Issac Heying and Xavion Liek bring people over and they are yelling and screaming at night. Resident A, responsible person Betz and case manager Nagurski reported Resident A has been woken up at night several times by Issac Heying and Xavion Liek which they described as upsetting and scary leading to Resident A's relocation to another facility. I confirmed that another resident moved due to this disruptive behavior by both household members. Issac Heying and Xavion Liek negatively impacted Resident A's mental health and quality of her care due to intoxication, loud behavior, and police intervention. Therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 0/16/2025, I conducted an unannounced investigation and I observed the medication cabinet was unlocked and the key to the cabinet in the lock. I observed multiple pharmacy prescribed resident medications on top of the medication cabinet that were unsecured. I observed a small refrigerator used to store resident

prescription medication that required refrigeration that was not locked. Additionally, some of the medications in the refrigerator were taken out of the pharmacy prescribed container, were not labeled and I could not determine what the name of the medication was nor to whom it was prescribed.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific 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. **(5) Prescription medication shall be kept in the original pharmacy-supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.**
ANALYSIS:	At the time of the unannounced investigation the medication cabinet was unlocked with additional prescription medications unsecured on top of the cabinet and not placed in a locked cabinet or drawer as required. All resident medications that required refrigeration were stored in an unsecured refrigerator. Additionally, some medications in the refrigerator were taken out of the original pharmacy prescribed container and were not individually labeled therefore there was no way to determine what the name of the medication was, what the dosage was or to whom it was prescribed therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 0/16/2025, I conducted an unannounced investigation and I reviewed the medication administration records (MAR) for Resident A, Resident B, Resident C and Resident D.

- Resident A's MAR was printed on 12/19/2024 and stated, "charting for Thurs 01/02/2025-Sat 02/01/2025." All three pages were completely blank.
- Resident B's MAR was printed on 12/11/2024 and stated "charting for Wed 12/11/2024-Friday 1/10/2025. All three pages were initialed through day 10, the rest of the month on all three pages was left blank.

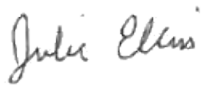
- Resident C's MAR was printed on 12/19/2024 and stated "charting for Wed 1/01/2024-Friday 1/31/2025. All three pages were initialed through day 10, the rest of the month on all three pages was left blank.
- Resident D's MAR was printed on 12/19/2024 and stated "charting for Wed 1/01/2024-Wed 12/31/2025. All three pages were initialed through day 10, the rest of the month on all three pages was left blank.

I reviewed the pharmacy prescribed medications which were bubble packaged and compared the medications to the MAR, I was not able to determine if medications were being administered as prescribed. The medications were filled on various dates and the administering date did not line up on the bubble pack.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Medication administration records for Resident A, Resident B, Resident C and Resident D were not being routinely completed when medication was being administered therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



2/11/2025

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Julie Elkins Date
Licensing Consultant

Approved By:

02/12/2025

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Dawn N. Timm Date
Area Manager