



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 20, 2026

Mark Sissell and Tara Sissell  
8180 19 Mile Rd.  
Sand Lake, MI 49343

RE: License #: AL410401172  
Investigation #: 2026A0579026  
Willow Grove

Dear Mark Sissell and Tara Sissell:

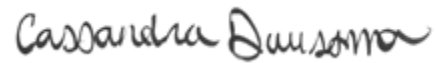
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0100.

Sincerely,

A handwritten signature in black ink that reads "Cassandra Duursma". The script is cursive and fluid.

Cassandra Duursma, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa, N.W., Unit 13  
Grand Rapids, MI 49503  
(269) 615-5050

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL410401172
<b>Investigation #:</b>	2026A0579026
<b>Complaint Receipt Date:</b>	03/12/2026
<b>Investigation Initiation Date:</b>	03/12/2026
<b>Report Due Date:</b>	05/11/2026
<b>Licensee Name:</b>	Mark Sissell and Tara Sissell
<b>Licensee Address:</b>	8180 19 Mile Rd. Sand Lake, MI 49343
<b>Licensee Telephone #:</b>	(616) 822-8756
<b>Administrator:</b>	Tara Sissell
<b>Licensee Designee:</b>	Mark Sissell
<b>Name of Facility:</b>	Willow Grove
<b>Facility Address:</b>	8180 19 Mile Rd. Sand Lake, MI 49343
<b>Facility Telephone #:</b>	(231) 747-2101
<b>Original Issuance Date:</b>	09/19/2025
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	09/19/2025
<b>Expiration Date:</b>	03/18/2026
<b>Capacity:</b>	17
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A and Resident B were given medication that they were not prescribed.	Yes
Mark Sissell discusses personal matters with Resident A and requires her to assist with the behaviors of other residents.	Yes

**III. METHODOLOGY**

03/12/2026	Special Investigation Intake 2026A0579026
03/12/2026	Special Investigation Initiated - Letter Complainant
03/12/2026	APS Referral
03/31/2026	Contact- Face to Face Resident A, Resident B, Tara Sissell (Administrator), and Mark Sissell (Licensee Designee)
04/20/2026	Exit Conference Tara Sissell, Administrator and Mark Sissell, Licensee Designee

**ALLEGATION: Resident A and Resident B were given medication that they were not prescribed.**

**INVESTIGATION:** On 3/12/26, I received this referral which alleged the previous week Resident A and Resident B were feeling nauseous and Mark Sissell (Licensee Designee) offered them his personal nausea medication and they took it. Resident A reported that Mr. Sissell told them not to tell anyone. Resident A reported this happened one time before but she refused the medication.

On 3/12/26, I confirmed receipt of the allegations with the complainant.

On 3/31/26, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Resident B, Mr. Sissell, and Tara Sissell (Administrator).

Resident A stated a few weeks ago she was feeling very unwell and nauseous, as was Resident B. She stated it was in the evening and Mr. Sissell was working. She stated Mr. Sissell gave her a medication that “starts with a z” that he reported was prescribed to him when he had kidney stones. I inquired if it was Zofran and Resident A said the medication was Zofran. She stated her only as-needed/PRN

medication is ibuprofen so she knew the medication is not something she is prescribed. She stated the medication did make her feel better but it “felt weird” taking a medication that was not hers.

Resident B stated a few weeks ago on a Saturday night, believed to be 3/7/26, she and Resident A were feeling very sick and nauseous. She stated she told Mr. Sissell she felt like she was going to vomit. She stated that Mr. Sissell brought a tablet to her that dissolved in her mouth. She stated she believed it was Alka-Selter. She stated she felt better shortly after and fell asleep. She stated she is not certain where the medication came from or if it was Mr. Sissell’s but she believes it is just an over-the-counter medication. She stated it is not a PRN medication prescribed to her as she had not had it before.

Mr. Sissell acknowledged he gave Resident A and Resident B a dissolvable Dramamine tablet when they were nauseous and vomiting a few weeks prior. He stated he understands neither resident is prescribed this medication but he did not believe there was a risk of harm since it is an over-the-counter medication and both residents appeared very unwell. He stated he discussed treatment options that a hospital would give the residents if needed, such a Zofran, and gave the example that he was prescribed Zofran for kidney stones. He stated he has not recently had a prescription for Zofran, there is none in the home, and he would not give residents his personal medication. He stated he understood that giving residents a medication they were not prescribed, even though it is over the counter, was likely a rule violation but he wanted the residents to feel better.

Consultation was provided with Mr. Sissell and Ms. Sissell, who joined the end of my conversation with Mr. Sissell, regarding obtaining orders for medications, including over the counter medications, to ensure the medications are cleared by a physician and it is confirmed that it does not interact with other prescription medications the residents take. They expressed understanding.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	Resident A, Resident B, and Mr. Sissell reported Mr. Sissell gave Resident A and Resident B a medication they were not prescribed to address their nausea and vomiting. Mr. Sissell and Resident B reported the medication was an over-the-counter medication.  Based on the interviews completed, there is sufficient evidence that Resident A and Resident B were given medication that was

	not ordered or directed by an appropriately licensed professional for their use.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Mark Sissell discusses personal matters with Resident A and requires her to assist with the behaviors of other residents.**

**INVESTIGATION:** On 3/12/26, I reviewed the referral which alleged Mr. Sissell requires Resident A to be a witness to the behavior of other residents in the home when they are having behaviors. Other residents will then direct their behavior and anger toward Resident A. Mr. Sissell also discusses his personal matters with Resident A.

Resident A stated previously Mr. Sissell and Ms. Sissell were requiring Resident A to watch them as they manage resident behaviors in the home. She stated Resident C has aggressive behavior and has made false allegations against Mr. Sissell. She stated due to this, when direct care workers (DCWs) are working alone, they ask Resident A to stand in the area to observe what happens. She stated once she was kicked by Resident C and Resident C will scream at her and call her names when she is present, which she does not like. She stated she is more cognizant than the other residents in the home so Mr. Sissell has asked her to be “his spy” and report what other residents are stating when DCWs are not around. She stated Mr. Sissell has asked her to observe other residents when they are on community outings as well, even though DCWs are present. She stated she recently discussed with Mr. Sissell and Ms. Sissell that she does not like supervising the other residents and they agreed they would not call her to assist anymore.

Resident A stated she also does not like that Mr. Sissell discusses his personal matters with her. She stated she knows that Mr. Sissell’s father was required to leave the home because he was assaulting others. She stated Mr. Sissell discusses his mother’s illness and requests that she prays for his mother. She stated Mr. Sissell discussed his child drinking alcohol in this home when he was 17 which occurred in their living area but did not involve residents so she did not need to know about it. She stated Mr. Sissell also discussed his frustration with the licensing process for the home and “things about” the previous licensing consultant for this home with her so she knows personal information about licensing consultants as well. She stated she does not want to know about these matters. She stated she does not want to make Mr. Sissell upset so she has not told him or Ms. Sissell that this behavior makes her uncomfortable. She stated she has told her case manager and may work with them to become comfortable stating she does not want to have these discussions anymore.

Resident B stated she does not participate with supervising other residents or reporting what they said to Mr. Sissell or Ms. Sissell. She stated Mr. Sissell does not

like to be alone with Resident C so he will ask other residents to be in the area to witness what occurs, which she understands. She stated he also asks other residents to report back to him what other residents are stating in the home. She stated she will “tell everyone everything” so she is not asked to report back what other residents say and she does not participate with witnessing resident behaviors, Resident A primarily does.

Mr. Sissell stated he faced false allegations from Resident C so if he is working alone, he will ask another resident to be present in the area to see what occurs until another DCW arrives. He stated the witnesses are not involved in the incident, they are only in the area and asked to witness what is happening. He stated Resident A recently told him she is uncomfortable with this so he will not be asking her anymore. He stated he may inquire about what residents are saying when DCWs are not present but he does not request that residents report back to him.

Mr. Sissell stated he does not intentionally discuss personal matters with Resident A. He stated that if Resident A discusses her feelings, he may give a personal example which relates, but he does not come to her to discuss his personal matters. He stated at times, residents ask if he is okay if they can tell a change in his demeanor, and he will be honest about what is bothering him. He stated the licensing process for this home took approximately six years and because it did impact residents, he did discuss the status of the license and his feelings about the process and previous consultant with the residents. He stated any discussion of these matters is a “mutual conversation” and not him initiating a conversation to discuss his personal matters. He stated if Resident A is not comfortable with these conversations, he will discontinue discussing these matters with her.

Ms. Sissell stated there are four DCWs in the home during resident awake hours and two DCWs overnight. She stated the home is so large that the DCWs are not always in the same area, especially in the evening when Mr. Sissell works. She stated due to this, DCWs will call each other on their cell phones for assistance but may not be able to respond immediately. She stated while the DCW is alone, they will ask a resident in the area to witness what is occurring from where they are to prevent false allegations. She stated the residents are kept out of being directly involved in the incident, are not in the immediate area, are protected from harm, and have not been impacted by resident aggressive behaviors. She stated she did not realize this was not appropriate.

Consultation was provided regarding respecting resident privacy, protecting residents, and only DCWs assisting with resident behaviors. Ms. Sissell expressed understanding and stated they will ensure that a DCW is called to the area immediately when a resident begins having behaviors.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>

	<b>A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>Resident A reported she is requested to be a witness to other resident behaviors to prevent false allegations against direct care workers. Ms. Sissell, Mr. Sissell, and Resident B confirmed this. Mr. Sissell reported Resident A advised she did not want to participate and this has since stopped.</p> <p>Resident A reported she does not like Mr. Sissell discussing personal or professional matters with her. Mr. Sissell reported he will discuss matters related to residents or relevant to the conversation with residents but will stop if Resident A is uncomfortable with this.</p> <p>Based on the interviews completed, there is sufficient evidence that residents are not treated with dignity and respect and protected and safe when they are asked to be witness to other resident behaviors or personal and professional matters of the licensee designee are discussed with them.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 4/20/26, I completed an exit conference with Ms. Sissell and Mr. Sissell who did not dispute my findings or recommendations.

#### IV. RECOMMENDATION

Contingent upon a receipt of an acceptable plan of corrective action, I recommend the status of the license remains the same.

*Cassandra Duursma*

04/20/2026

Cassandra Duursma  
Licensing Consultant

Date

Approved By:

*Jerry Hendrick*

04/20/2026

Jerry Hendrick  
Area Manager

Date