GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30, 2022

Leone Swanberg
5329 McCords
Alto, MI 49302

RE: License #: AM410016238
Investigation #: 2022A0467058
Swanberg - Countryside AFC

Dear Ms. Swanberg:

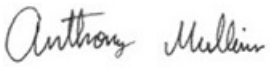
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:	2022A0467058
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/16/2022
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:	03/06/2022
Expiration Date:	03/05/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Live-in staff member, Kailee Shipley searched through residents' belongings without their consent.	Yes

III. METHODOLOGY

08/17/2022	Special Investigation Intake 2022A0467058
08/17/2022	Special Investigation Initiated - On Site
08/30/2022	Exit conference completed with the administrator, Ben Visel on behalf of Leone Swanberg.

ALLEGATION: Live-in staff member, Kailee Shipley searched through residents' belongings without their consent.

INVESTIGATION: On 8/17/22, I received a BCAL online complaint stating that live-in staff, Kailee Shipley searched through residents' belongings without their consent in an attempt to locate medications that were not accounted for during dispensing. The medications were reportedly located on the floor near the medication cart, which is in Ms. Shipley's living quarters in the basement. Ms. Shipley reportedly made the residents sit at the kitchen table while she searched through their belongings.

On 8/17/22, I made an unannounced onsite investigation to the home. Upon arrival, I spoke to Ms. Shipley in her office. Ms. Shipley confirmed that approximately one week ago, she made residents sit at the kitchen table while she searched through their belongings without their consent. While attempting to pass medications for Resident A, Ms. Shipley could not find Resident A's medication. As a result of not being able to find Resident A's medication, Ms. Shipley stated that she searched through the trash can and cabinets first. Ms. Shipley stated that she exhausted all options prior to searching the residents' belongings. Ms. Shipley stated that she has been told by the administrator, Ben Visel that if she has reason to believe medications are being stolen, she is able to check the residents' belongings. I explained to Ms. Shipley that the information that was relayed to her is incorrect and that she needs to have consent from the residents to search through their belongings. Ms. Shipley stated that she understands.

I asked Ms. Shipley how it would be possible for residents to steal medications if they are locked away in a cabinet on the main floor, as well as a cabinet in the basement that residents don't have access to. Ms. Shipley stated that residents have told her that they have made their way to the basement without her knowing

although they are not allowed in the basement. Ms. Shipley questioned if a resident was able to sneak in the basement and obtain access to her keys. However, this did not occur. Instead, Ms. Shipley stated that she found the medication in the locked cabinet in the basement, stating that she accidentally took the medication back downstairs. Ms. Shipley shared that even if the residents were to gain access to the basement of the home, she never leaves the medication cabinets unlocked.

Ms. Shipley shared with me that on 8/14/22, Resident A did not receive his Buspirone medication due to the medication rolling under the refrigerator after she attempted to open it. Ms. Shipley stated that she searched under the refrigerator and was unable to locate the medication. Ms. Shipley showed me Resident A's MAR, which documented that the medication was not given. Ms. Shipley was thanked for her time as this interview concluded.

After speaking to Ms. Shipley, I attempted to speak to Resident A. Resident A was away from the home at the time of the visit and was unable to be interviewed. I then spoke to Resident B on the front porch. Resident B recalled Ms. Shipley searching through his personal belongings without his consent. He did not know a specific date but recalls the incident occurring on a Sunday. Resident B stated that Ms. Shipley told him and other residents, "don't leave the table. I am going to search everyone's room." Resident B stated that Ms. Shipley did not find the medications in the rooms. Resident B stated that Ms. Shipley told everyone that she found the medications downstairs, which is part of the home that he and other residents do not have access to. Resident B stated that he was confused about Ms. Shipley searching his room for medications when he and other residents don't have access to them. Except for this incident, Resident B stated that things are going well in the home**.**

Prior to ending the interview, Resident B stated that Ms. Shipley is opening residents' medication packages too fast. Resident B expanded on this by stating that Resident A lost a medication under the fridge due to Ms. Shipley opening the package too fast. He did not have further information to add.

After speaking to Resident B, I spoke to Resident C on the front porch. Resident C confirmed that he and other residents recently had their personal belongings searched by Ms. Shipley without their consent. Resident C believed this incident occurred approximately a couple of weeks prior. Resident C stated that Ms. Shipley "just did it. She never asked us." Resident C stated that he told Ms. Shipley to check downstairs and that's where she was able to locate the medication. Resident C stated that he and other residents are not allowed in the basement. Therefore, neither of them would have access to the medication.

Resident C added that Ms. Shipley needs to be careful when opening medications. Resident C stated that Ms. Shipley pushes the medications out of the package and "they pop on the floor and she leaves it there." Resident C stated that he always finds pills on the floor from Ms. Shipley leaving them there. Resident C was thanked

for his time and this interview concluded. It should be noted that I observed the floor in the dining room and kitchen of the home and did not see any pills on the floor.

On 8/29/22, I made an unannounced visit to the home. I observed the kitchen and dining room floor again and did not observe any pills unattended to. Ms. Shipley denied leaving pills on the floor if they fallout while opening them. I asked Ms. Shipley to show me how she passes medication to residents. While opening the medication packages, Ms. Shipley used her hands to catch the medication. I explained to Ms. Shipley that it may be beneficial to use a different technique when opening medications to prevent them from falling on the floor, such as opening the pill packages with a cup underneath to prevent the medication from falling on the floor.

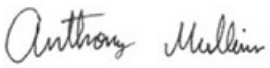
On 8/30/22, I conducted an exit conference with the administrator, Ben Visel. He was informed of the investigative findings and agreed to complete a corrective action plan. I also informed Mr. Visel of his staff utilizing better practices when opening medications to prevent them from going on the floor. Mr. Visel stated that he understands and plans to implement this change with Ms. Shipley when he returns to the home on Thursday.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Ms. Shipley confirmed that she searched through the residents belongings without their consent in attempt to locate medication that she left locked in a cabinet in the basement. Resident B and C stated that they do not have access to the basement and therefore, unable to gain access to their medication. Resident B and C both confirmed that Ms. Shipley searched through their personal belongings without their consent. Based on the information provided, a preponderance of evidence exist to support the allegation.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

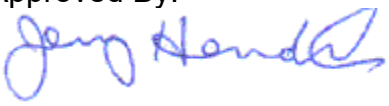
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



08/30/2022

Anthony Mullins — Date
Licensing Consultant

Approved By:



08/30/2022

Jerry Hendrick — Date
Area Manager