GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

Leone Swanberg
5329 McCords
Alto, MI 49302

RE: License #: AM410016238
Investigation #: 2023A0467006
Swanberg - Countryside AFC

Dear Mrs. Swanberg:

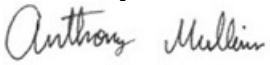
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0467006
Complaint Receipt Date:	10/21/2022
Investigation Initiation Date:	10/21/2022
Report Due Date:	12/20/2022
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?
Staff are not addressing Resident A's needs, including scheduling a podiatrist appointment, completing labs, and picking up his hearing aids.	Yes

III. METHODOLOGY

10/21/2022	Special Investigation Intake 2023A0467006.
10/21/2022	Special Investigation Initiated - Telephone Complainant.
10/21/2022	Resident A's medical records received via email from the complainant.
10/24/2022	APS Referral – Spoke to Emily Graves with Kent County APS.
10/26/2022	Inspection Completed On-site.
11/07/2022	Exit conference completed with the administrator, Ben Visel on behalf of the licensee designee, Leone Swanberg.

ALLEGATION: Staff are not addressing Resident A's needs, including scheduling a podiatrist appointment, completing labs, and picking up his hearing aids.

INVESTIGATION: On 10/21/22, I received a BCAL online complaint stating that Resident A's psychiatrist, Dr. Aaron Plattner has been asking the AFC home manager to arrange for Resident A to see a podiatrist since January 2022, obtain new hearing aids since June 2022, and obtain labs since August 2022. Resident A has been complaining of foot pain since January 2022 and has not been evaluated by a podiatrist yet. In July 2022, Resident A had his ENT appointment. His hearing aids have been available for pickup since the beginning of August 2022 and staff have been unable to take him to get his hearing aids. There is ongoing concern with the Visel homes that staff are neglecting taking clients to medical appointments, cancelling last minute due to staffing, and delaying their medical care. On 10/21/22, I spoke to the complainant via phone.

The complainant confirmed the allegations and agreed to send me a copy of a progress note from Resident A's psychiatrist from 10/19/22 to confirm the allegations. She also stated that Resident A's nurse followed-up with Recipient Rights regarding their concerns as it relates to this complaint. The complainant was

unaware if a rights officer has been assigned the case.
On 10/21/22, I received an email from the complainant that contained medical records from Resident A's psychiatrist, Dr. Plattner between January 2022 through October 2022. The medical records are summarized below:

On 1/5/22, Resident A met with his psychiatrist, Dr. Plattner. During the visit, it was noted that, '(Resident A) complained of his foot hurting, this was reviewed with staff, they will try to get a podiatrist appointment and address his pain which seems to be under his toenail.' There were no other concerns discussed during this appointment.

On 3/30/22, Resident A met with Dr. Plattner for a medication review. There were concerns regarding Resident A continuing to nap throughout the day. Dr. Plattner discussed tapering his medication and monitoring how he does with a slow taper. Resident A told Dr. Plattner that everything is going well for him. Dr. Plattner documented, 'the podiatrist will be contacted regarding his toe pain.'

On 5/24/22, Resident A was seen by Dr. Plattner for a medication review. Dr. Plattner stated that Resident A has been doing well overall, which is his baseline. Dr. Plattner also stated, 'he (Resident A) was supposed to be seen by a podiatrist, this has been delayed, hopefully he will be able to see a podiatrist soon.' Dr. Plattner requested that Resident A come in for his next appointment so that he can obtain vitals and meet with Resident A in person as opposed to over the computer.

On 8/24/22, Dr. Plattner met with Resident A for a medication review. Resident A continues to take a lot of naps. Resident A's supports coordinator and Dr. Plattner believe that it would be helpful for Resident A to have more activities at the home during the day. Live-in staff member, Ms. Shipley agrees with this but lists limitations in the services the home can provide and that residents need to take advantage of the options that are available. The medication review also mentioned a continued request for podiatry consult, labs to sent, and for Resident A's hearing aids to be fitted and used by his next appointment.

On 10/19/22, Resident A was seen by Dr. Plattner in person. At the time of the visit, 'no labs have been received.' The medical record stated, 'we printed labs and sent Lyle upstairs for labs given the numerous times we have requested labs without any labs obtained. Further, despite multiple requests for a podiatry appointment, this has not been completed either.' Dr. Plattner stated that it was difficult to engage with Resident A during his appointment due to not receiving his hearing aids. Dr. Plattner stated, 'I certainly understand that different homes have difficulty with hiring additional staff, but the fact that he (Resident A) still does not have hearing aids is of grave concern as I'm concerned that (Resident A) is rather bored and under stimulated at the home in which he largely is sitting the majority of the day taking naps.'

On 10/24/22, I spoke to Kent County APS worker, Emily Graves. Ms. Graves stated that the house manager, Ms. Shipley is "frustrated and doing the best she can". Ms.

Graves stated that Ms. Shipley did not admit to missing appointments for Resident A. Ms. Graves spoke to Resident A's guardian and the guardian reportedly stated that she has more issues with the supports coordinator than she does with Ms. Shipley and the AFC home as she does not understand limitations that the AFC home has. Ms. Graves stated that all the appointments with Resident A's psychiatrist are via telehealth. Ms. Graves stated that Ms. Shipley acknowledged that Resident A's hearing aids weren't picked up when they first arrived in August, but they were picked up on 10/19/22. Ms. Graves stated that Resident A's guardian shared that he constantly loses his hearing aid or refuses to wear them, so she was not in a rush for the AFC staff to pick them up. Ms. Graves informed me that Ms. Shipley is currently on vacation and Mr. Visel is working at the home until she returns.

Ms. Graves stated that Ms. Shipley told her that Resident A has not complained of foot pain. Ms. Graves interviewed Resident A during her visit and he stated that he's happy and denied any concerns with his needs being met. Due to the guardian and Resident A denying any concerns, Ms. Graves does not plan to substantiate her complaint.

On 10/26/22, I made an unannounced onsite investigation to the facility. Upon arrival, the facility administrator, Ben Visel answered the door and allowed entry into the home. Mr. Visel confirmed that live-in staff member, Kaliee Shipley is currently on vacation for a week. Therefore, he is working at the home until she returns. Mr. Visel and I discussed case allegations at the dining room table.

Mr. Visel acknowledged that he was aware of aware of Resident A's lab order not being completed. However, Mr. Visel stated that Resident A has since completed his labs on 10/19/22 after his appointment with his psychiatrist. Regarding a podiatrist appointment, Mr. Visel had no knowledge of Resident A needing to be seen by a podiatrist. Mr. Visel stated that Resident A has not complained of foot pain to him, Ms. Shipley, or his PCP. Mr. Visel also stated that Resident A met with his psychiatrist, Dr. Plattner virtually and Dr. Plattner never examined his feet. Mr. Visel stated that there was never a referral made to a podiatrist.

I discussed concerns of Resident A's hearing aids being available for pick-up since August 2022 and staff being unable to pick them up. Mr. Visel confirmed that the facility is having **"**staffing issues**"**, which is why no one has been able to pick-up Resident A's hearing aids. Mr. Visel stated that he has not had supplemental staff for a few months now. Mr. Visel stated that he personally took Resident A to pick-up his hearing aids last week Thursday (10/20/22). Mr. Visel stated that Resident A needed to be present to pick-up the hearing aids because he needed to have them fitted. Otherwise, Mr. Visel would have been able to pick-up the hearing aids sooner. To address the staffing issue, Mr. Visel plans to try hiring people, which is what he has been working on for the last few months. Mr. Visel will also fill-in for his staff when able. Mr. Visel plans to follow-up with N-180's contract manager, Tony Maniscalco in an attempt to have Network 180's staff and his staff work together on addressing any concerns or issues that may arise.

Mr. Visel was adamant that Resident A has not had any cancelled appointments. Mr. Visel stated that Ms. Shipley would call and asked for a virtual appointment for Resident A but she never cancelled them. Mr. Visel stated that Resident A works with Harmony Cares, which was previously known as Visiting Physicians Association (VPA) and they come to the home to see him.

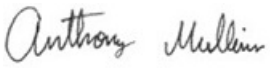
On 11/07/2022, I conducted an exit conference with the facility administrator, Ben Visel via email. He was informed of the investigative findings and agreed to complete a corrective action plan. He denied having any questions and stated that he has already spoken to live-in staff member, Ms. Shipley about better communication with him about resident's lab orders and appointments due to not having extra staff at this time.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Resident A's medical records were reviewed, indicating that his psychiatrist requested that he be seen by a podiatrist since January 2022 after complaining of foot pain, which has not occurred. Medical records also indicated that Resident A's hearing aids were ready to be picked up in August 2022 and as of his 10/19/22 psychiatry appointment, staff at the AFC home had yet to pick them up. Resident A's psychiatrist also requested that labs be completed in August, and this did not occur until the physician sent him for labs during his 10/19/22 appointment. Mr. Visel acknowledged that Resident A's labs were not completed when requested and that his hearing aids were not picked up until 10/20/22, although they have been available since August 2022. Mr. Visel stated that a referral was not made to a podiatrist for Resident A and he never complained of foot pain to the AFC staff or his PCP. Resident A was not interviewed due to being away from the home at the time of my onsite investigation. Based on the information provided in Resident A's medical records and the disclosure from Mr. Visel of not completing labs and picking up

	Resident A's hearing aids until 10/20/22, 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.



11/07/2022

Anthony Mullins Date
Licensing Consultant

Approved By:

11/07/2022

Jerry Hendrick Date
Area Manager