GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 10, 2023

Benjamin Visel
Visel AFC, Inc.
6565 Whitneyville Ave. SE
Alto, MI 49302

RE: License #: AM410401224
Investigation #: 2023A0467053
Visel Hilltop AFC

Dear Mr. Visel:

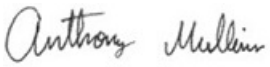
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AM410401224
Investigation #:	2023A0467053
Complaint Receipt Date:	08/03/2023
Investigation Initiation Date:	08/03/2023
Report Due Date:	10/02/2023
Licensee Name:	Visel AFC, Inc.
Licensee Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Licensee Telephone #:	(616) 893-6613
Administrator:	Benjamin Visel
Licensee Designee:	Benjamin Visel
Name of Facility:	Visel Hilltop AFC
Facility Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Facility Telephone #:	(616) 868-7478
Original Issuance Date:	06/25/2020
License Status:	REGULAR
Effective Date:	12/25/2022
Expiration Date:	12/24/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving personal care as specified in her assessment plan.	Yes

III. METHODOLOGY

08/03/2023	Special Investigation Intake 2023A0467053
08/03/2023	Special Investigation Initiated - Telephone
08/03/2023	Inspection Completed On-site
08/03/2023	APS Referral Sent via email.
08/09/2023	Inspection Completed On-site
08/09/2023	Exit conference with Owner/designee, Ben Visel.

ALLEGATION: Resident A is not receiving personal care as specified in her assessment plan.

INVESTIGATION: On 8/3/23, I received a complaint from Recipient Rights Officer, Michelle Richardson. The complaint alleged that Resident A is not receiving adequate personal care as her toenails have not been cut for an extended period of time. A picture of Resident A's toenails were attached to the complaint, which clearly showed her toenails curled under her feet and discolored. The current condition of Resident A's toenails make it obvious that they have not been trimmed in many months.

On 8/3/23, I spoke to Recipient Rights Officer, Michelle Richardson. Mrs. Richardson and I agreed to meet at the home at 2:30 pm to conduct a joint investigation.

On 8/3/23, Mrs. Richardson and I made an unannounced onsite investigation at the facility. Upon arrival, AFC home manager, Elizabeth Nolan answered the door and allowed entry into the home. Minutes later, AFC owner/designee, Ben Visel arrived at the home. Ms. Nolan stated that Resident A is away at Hope Network's Day Program. Ms. Nolan informed me that Resident A is deaf and non-verbal. Ms. Nolan was asked about Resident A's toenails and the personal care she's supposed to receive by staff. Ms. Nolan has been employed as the live-in house manager since

June 5th, 2023 and stated that she had no knowledge of Resident A's toenails being in their current state until she was informed by staff at Hope Network yesterday. Ms. Nolan stated that she planned to address the issue with Resident A yesterday, but she got busy with paperwork and other needs around the facility and forgot. I showed Ms. Nolan and Mr. Visel a picture of Resident A's feet that was received from the complainant. Both stated they did not know that her toenails were in the condition that was shown in the picture. Ms. Nolan stated "not really" when asked if Resident A requires assistance with her personal hygiene. Ms. Nolan stated that she is typically the only staff member working but she occasionally has help from a relief staff member.

Mr. Visel stated that he is unsure if Resident A requires assistance with her toenails. He did share that she requires "cues" with showering. Per Mr. Visel, Resident A can gesture and point at things to communicate pain or some of her needs. Mr. Visel stated that Resident A gets in the shower by herself because she is "private". Mr. Visel stated that Resident A will close the door and tell staff to get out. Ms. Nolan confirmed this as well. Mr. Visel stated that Resident A receives assistance addressing all her care needs. However, the current condition of her feet/toenails prove otherwise.

I reviewed Resident A's assessment plan. The assessment plan was signed on 12/9/22 by Resident A's guardian and 12/12/22 by Mr. Visel. The assessment plan clearly indicates that Resident A needs assistance with grooming. Specifically, the assessment plan states that AFC staff are to, "groom nails, reminders for oral care, brush hair if having difficulty". It also states, "AFC staff puts shoes and socks on for her, reminders/help adjusting for modesty." Despite this being in the assessment plan, AFC staff have not groomed Resident A's nails, which has caused her toenails to overgrow to the point that they are curling under her feet. Resident A's toenails are so bad that she will likely need to be seen by a podiatrist to address this concern. Resident A's health care appraisal was reviewed as well. The appraisal was signed by the doctor on 12/27/22. The health care appraisal does not list or mention any concerns related to Resident A's feet or toenails.

On 8/9/23, I made an unannounced onsite visit at the facility. Upon arrival, AFC home manager, Ms. Nolan allowed entry into the home and assisted me to Resident A's room. As previously noted, Resident A is deaf and non-verbal. However, Resident A was able to acknowledge me by waving. Ms. Nolan stated that Resident A is scheduled for her podiatrist appointment on Monday, 8/14 with Dr. Solon at Grand Rapids Podiatry. This was the first available appointment. Resident A allowed Ms. Nolan to remove her socks to view her toenails. Resident A's toenails were still curled to the side and discolored. However, I could tell that they had been partially trimmed from the original picture that I received from the complainant. Pictures were taken of Resident A's toenails. Ms. Nolan stated that Mr. Visel bought a pedicure/manicure drill set, which allowed her to "drill them down" this past Friday. Due to the condition of her toenails, it was agreed that Resident A would still greatly

benefit from her now scheduled appointment with a podiatrist. Ms. Nolan was thanked for her time as this home visit concluded.

On 08/09/2023, I conducted an exit conference the owner/designee, Ben Visel. He was informed of the investigative findings and made aware of the recommendation for the facility to be placed on a provisional license.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's toenails were observed to be curled under her feet and discolored. Live-in home manager, Ms. Nolan has been employed at the facility since June 5th 2023, and stated that she was not aware that she needed to address concerns with Resident A's toe nails. Resident A's assessment plan was reviewed and clearly indicates that AFC staff are responsible for grooming her nails and putting on her socks and shoes. Based on the information obtained through this investigation, it is apparent that Resident A has not had her toenails groomed for several months, resulting in her toenails being in the current condition and needing to be seeing by a podiatrist. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

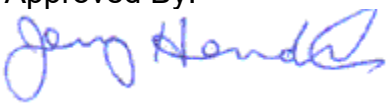
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended for the above-cited quality of care violation.

Anthony Mullins 08/10/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



08/10/2023

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Jerry Hendrick Date
Area Manager