GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2025

David Fennell
118 Belleview Dr.
Ionia, MI 48846

RE: License #: AF340280762
Investigation #: 2025A0622054
Belleview AFC

Dear Mr. Fennell:

Attached is the Special Investigation Report for the above referenced facility. Due to the number and severity of the quality of care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 335-5985.

Sincerely,

Amanda Blasius, 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

I. IDENTIFYING INFORMATION

License #:	AF340280762
Investigation #:	2025A0622054
Complaint Receipt Date:	07/17/2025
Investigation Initiation Date:	07/21/2025
Report Due Date:	09/15/2025
Licensee Name:	David Fennell
Licensee Address:	118 Belleview Dr. Ionia, MI 48846
Licensee Telephone #:	(616) 527-9927
Administrator:	N/A
Licensee Designee:	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(S)

	Violation Established?
Resident A was observed experiencing a low oxygen reading that was not monitored and prescribed oxygen was not provided. Staff smoke in the home which poses serious safety risks.	Yes
Medications are unsecured.	Yes
David Fennell is no longer able to care for residents due to symptoms of dementia.	No
Additional Findings	Yes

III. METHODOLOGY

07/17/2025	Special Investigation Intake 2025A0622054
07/21/2025	Special Investigation Initiated - On Site
07/21/2025	Contact - Telephone call made to Resident A's doctor.
07/23/2025	APS referral made. Assigned on 7/24 to Carol Dryer.
07/24/2025	Mail and email sent to licensee David Fennell requesting medical clearance form be completed by 8/25/25.
07/24/2025	Telephone call received from Resident A's doctor.
07/24/2025	Telephone call received from Jessica Gardner, Reliance program caseworker and adult protective services worker, Carole Dreyer.
08/06/2025	Telephone call made to Guardian A1.
08/06/2025	Telephone call received from Reliance program manager Vicki Holmes.
08/07/2025	Telephone call to licensee, David Fennell.
08/14/2025	Email contact with Reliance caseworker, Jessica Gardner.
08/26/2025	Phone call to licensee, David Fennell, direct care worker, Sherry Betz, Harmony Cares Nurse Becca Bouch and Reliance Case worker, Jessica Gardner.
8/28/2025	Onsite investigation
09/03/2025	Contact- Telephone call to Mandy Fennell.

09/09/2025	Exit Conference with licensee, David Fennell

ALLEGATION: Resident A was observed experiencing a low oxygen reading that was not monitored and prescribed oxygen was not provided. Staff smoke in the home which poses serious safety risks.

INVESTIGATION:
On 07/17/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, a medical assistant was at Belleview AFC on 07/16/25 to visit Resident A for a routine visit. The complaint stated that she took Resident A's oxygen level and it was low measuring in the mid 80's, but she has an oxygen tank in her room and is supposed to be using it. According to the complaint, when Complainant asked staff working about Resident A's oxygen use, staff stated Resident A's oxygen is used only as needed and staff did not know the signs or symptoms to determine if Resident A's oxygen level was low.

On 07/21/2025, I completed an unannounced onsite investigation to Belleview AFC. During the unannounced onsite investigation, I reviewed Resident A's file and interviewed licensee, David Fennell and responsible person, Sandra Fennell. I could not interview Resident A as Resident A had been admitted to the hospital and had yet to be discharged at the time of my unannounced onsite investigation.

Licensee David Fennell reported that Resident A was experiencing severe diarrhea, and her medications were not helping control it. He stated that she went to the hospital four days ago (approximate date 7/17/25) and should be discharged within a day. Licensee David Fennell stated that Resident A's doctor was at the facility and called the ambulance for Resident A due to her condition at the time of the physician visit. Mr. Fennell reported that he checks Resident A's oxygen level twice a day, in the morning and night, by using a pulse oximeter and if it measures below 86% blood oxygen saturation, he will put her oxygen on. Mr. Fennell was able to show me a pulse oximeter within the home that he uses to measure Resident A's blood oxygen saturation level. Mr. Fennell was unable to provide documentation of how he documents her oxygen levels after taking them. Mr. Fennell reported neither he nor any other staff keep oxygen on Resident A at all times and only use it as needed. Mr. Fennell confirmed that household members and residents smoke within the home. During the unannounced onsite investigation on 07/21/25, I observed Resident B and household member, and licensee's adult child, Mandy Fennell smoking within the home.

On 07/21/2025, I viewed Resident A's file and viewed documentation from Harmony Cares, dated 7/16/25. The documentation was a *Care Plan Summary* from Dr. John Duhn's visit on 7/16/25. The following was documented on the *Care Plan Summary*:

"Skin breakdown/pressure injury. Report skin breakdown or pressure injury related to immobility to care team.

Orders Placed today:

- ***Black stool:*** *concern for upper GI bleeding and this needs to be evaluated today at the hospital. I suggest Corewell Hospital. Staff were calling to set up transportation as we were leaving.*
- ***Chronic Respiratory failure:*** *use oxygen 24 hours a day. No smoking of Tabacco or marijuana in the home at any time.*
- ***Hypoxemia:*** *Chronic and stable. No changes in treatment at this time. Usually Hypoxic and off oxygen when we arrive.*
- ***Incontinence of feces:*** *Chronic and stable. No changes in treatment at this time. Worsening. She may have a worsening spine issue that is making incontinence worse.*
- ***Pressure injury of sacral region of back stage II:*** *Chronic and stable. No changes in treatment at this time. Continue home health wound care."*

On 07/23/2025, I interviewed Resident A's doctor, Dr. Duhn via phone. Dr. Duhn reported that there has been clear physician orders regarding Resident A's oxygen use for a long time and Resident A should have been on oxygen at all times. Dr. Duhn reported that himself and other nurses from Harmony Cares have discussed with Mr. Fennell the importance of not smoking within the home for a long time yet there continues to be smoking within the home. Dr. Duhn reported that he spoke with Mr. Fennell on 7/16/25 and asked how he was checking Resident A's oxygen and he was unable to explain his process or show Dr. Duhn a pulse oximeter. Dr. Duhn reported that he feels they are neglecting Resident A as she is not placed on oxygen as ordered and Resident A continues to have bed sores from not getting her out of bed and/or being re-positioned regularly. Dr. Duhn reported that he feels both caregivers, David Fennell and Sandra Fennell, appear to have dementia.

On 07/23/2025, an adult protective services referral was made.

On 07/23/2025, I interviewed Guardian A1 via phone. She reported that she was aware of the concerns regarding the care being provided to Resident A and was working with Jessica Gardner from Reliance on finding a different placement. Guardian A1 stated that Resident A was discharged from the hospital and is back at Belleview AFC.

On 07/24/2025, I interviewed Reliance case manager, Jessica Gardner via phone. She reported that she was in the home on 07/23/2025 and the household members were still smoking in the home, despite the orders from Resident A's doctor. Ms. Gardner reported Resident A returned from the hospital to Belleview AFC. Ms. Gardner stated that she was informed by responsible person/direct care worker, Sherry Betz that the home owners plan to keep smoking in the home, despite the doctor's order not to smoke in the home. Ms. Gardner reported that she has concerns that Resident A is left in bed for 24 hours. She explained that she has

been told that Resident A is put to bed around 7/8pm and not checked on the rest of the night. Ms. Gardner reported that she is concerned that David Fennell is not reviewing any orders or documentation coming from Resident A's doctor or hospital personnel. Ms. Gardner reported that she has tried to educate David Fennell regarding her concerns and has also tried to educate direct care worker Sherry Betz on the care needed for Resident A.

On 07/24/2025, I interviewed adult protective services worker, Carole Dreyer via phone. She reported that she was assigned the complaint and visited Belleview AFC on 07/24/2025. She reported that when she arrived, Dr. Duhn from Harmony Cares was visiting Resident A. Ms. Dreyer stated that Resident A was dehydrated, did not look well and Dr. Duhn was recommending that Resident A go back to the hospital. Ms. Dreyer stated that during her visit to Belleview AFC, Resident A's blood oxygen saturation measured 83% and Ms. Dreyer stated she observed that Resident A was not connected to oxygen when she arrived at the home at 2pm. Ms. Dreyer reported that David Fennell told her that Resident A was off her oxygen because he fed her lunch, but it was 2pm during her visit which was well past a typical lunch time. Ms. Dreyer reported that household members were still smoking within the home during her visit. Ms. Dreyer reported that she also discussed with David Fennell the importance of Resident A being on her oxygen 24 hours a day and not smoking any substances within the home. Ms. Dreyer stated that if the guardian is not willing to move Resident A from Belleview AFC, she will be recommending that the court file a petition to obtain guardianship and move Resident A.

On 07/24/2025, I interviewed Reliance Program Manager, Vicki Holmes via phone. Ms. Holmes reported that Belleview AFC has been on probation with their company since May, 2025 due to not being compliant with their signed contract to provide care and services to residents. Ms. Holmes reported that currently Reliance is not referring any new residents for placement, as they have been waiting over 50 days for Belleview AFC licensee David Fennell and responsible person Sandy Fennell to come into compliance. Ms. Holmes stated that David Fennell struggles to remember to call Reliance regarding any resident concerns or to report needed information or Sandra Fennell will call multiple times a day and repeat the same items or ask the same questions. Ms. Holmes reported that Belleview AFC, including licensee David Fennell and responsible person Sandy Fennell, has not been documenting any services provided or submitting required logs to Reliance. Ms. Holmes also stated that they did not have any documentation or a criminal history clearance for a previous employee either.

On 08/06/2025, I interviewed Guardian A1 via phone. Guardian A1 stated that recently Resident A was sent back to the hospital because she was dehydrated and had a urinary tract infection. Guardian A1 reported that a Care Link nurse called her and said Resident A needed to be sent back to the hospital right away. Guardian A1 reported that she is concerned about the care licensee David Fennell and other staff are providing for Resident A as Guardian A1 understands Sandra Fennell now has dementia. Guardian A1 stated that when she visited Resident A in the home after

her recent hospital stay, she was still not on her oxygen and was told that she keeps pulling it out. Guardian A1 explained also observing household members smoking in the back closed in porch off from the dining room. Guardian A1 reported that she decided not to send Resident A back to Belleview AFC after her second hospital stay rather Resident A was admitted to a nursing home.

On 08/06/2025, I received a phone call from Reliance program manager, Vicki Holmes. She reported that Reliance has made the decision to not renew the MI Choice Waiver contract with Belleview AFC. She provided written documentation which stated the following:
"Reliance CCP received and reviewed the Corrective Action Plan (CAP) submitted. It was noted to be incomplete missing the following items required:

- *Policies for: feedback/evaluation, reporting abuse/neglect exploitation/critical incidence.*
- *Workers Comp/unemployment insurance.*
- *Orientation plan for employees.*
- *Annual in-service training plan for employees.*
- *SAM/OIG check (plan and copies of current checks) for all employees.*
- *Job descriptions for employees.*
- *Plan to ensure terminations records are maintained.*
- *Submission of signed/dated monthly care logs for June (and now July)*
- *Background check for B.H. or written notification indicating this staff is no longer employed.*

The contract with Belleview AFC was signed on 9/1/2023 and therefore the contract is set to expire 9/1/2025."

On 08/26/2025, I interviewed Becca Bosch, Harmony Cares Nurse via phone. Ms. Bosch reported that she was brought in to treat Resident A's wounds. Ms. Bosch stated that she would visit Resident A at Belleview AFC and "she was never really on her oxygen despite multiple conversations and reminders" to licensee David Fennell, responsible person Sandra Fennell and responsible person/direct care worker Sherry Betz. Ms. Bosch reported that Resident A had many wounds on her bottom, as they were putting her to bed early and she would sit in urine and fecal matter for eight hours. Ms. Bosch reported that if she came to visit Resident A earlier in the day before 12pm, Resident A would still be in bed and soaked with urine through her brief, clothes and onto her bed. Ms. Bosch stated that the care provided to Resident A has gotten worse over the last six months. Ms. Bosch stated that Resident A needs a Hoyer lift and she was only out of bed for a few hours in the middle of the day and sometimes had dinner in bed. She explained that Harmony Cares has been treating Resident A's wounds since the end of December 2024 by providing treatment at least once a week. Ms. Bosch stated Resident A has wounds on her bottom and then also had a wound on her upper back due to sitting in urine from her bottom to up to her shoulders. Ms. Bosch reported that the staff at Belleview AFC continued to use rubber underpants over her brief even though Ms. Bosch continued to educate them to stop using the rubber

underpants over Resident A's incontinence brief as it keeps the moisture locked in. Ms. Bosch reported that she attempted to educate licensee David Fennell and Sandra Fennell on the need for Resident A to be changed during the middle of the night, throughout the day and not to use rubber underpants over her briefs. Ms. Bosch reported that Resident A's wounds were not clearing up or making much progress from the care being provided in the AFC home. Ms. Bosch reported that she saw Resident A the day before she was re-admitted to the hospital and she appeared pale, lethargic, sleepy and had severe swelling to her arms. Ms. Bosch reported that Resident A's wounds should have healed in a normal amount of time if the home was complaint with getting Resident A out of bed, changing Resident A's incontinence brief every few hours and using the prescribed creams.

On 08/26/2025, I interviewed responsible person/direct care worker (DCW) Sherry Betz via phone. DCW Betz reported that she works four days a week, Wednesday, Thursday, Friday and Saturday from 9am-6/7pm. DCW Betz stated that David Fennell has been told many times that Resident A needs her oxygen on at all times but continues to not comply with this physician's order. DCW Betz explained that she is not sure why Mr. Fennell would not keep the oxygen on and stated that maybe he is "just lazy or it cost too much to run it 24/7." DCW Betz reported that everyone in the house continued to smoke in the home after they were told to stop several times by Resident A's physician and Reliance case managers and caregivers. DCW Betz stated she observed responsible person Sandra Fennell walk into Resident A's room while smoking and care for Resident A with a lit cigarette and Resident A's oxygen running. DCW Betz reported that Resident A is put to bed around 6 or 7pm and then left in bed all night without being changed until she arrived for her shift at 9am. She explained that David Fennell will not change female residents, including Resident A, as he does not feel it's right and Sandra Fennell is not strong enough to lift and turn Resident A to change her. DCW Betz reported that every morning she arrives for work, Resident A is fully soaked through her brief, clothes and bedding. She explained that Resident A's bottom is always red and her skin is always breaking down. DCW Betz stated that she would make progress on her wounds while she worked the four days and then when she returned the following week, her skin would be breaking down again. DCW Betz reported that she has informed David and Sandra Fennell that Resident A needs to be changed at night and she also observed nurse Becca Bosch tell them the importance of changing Resident A in the middle of the night. DCW Betz reported that she is not sure who assisted Resident A with changing and personal care on her off days, but assumes it was responsible person, Sandra Fennell, licensee David Fennell or their adult daughter, Mandy Fennell.

On 08/26/2025, I requested visit note reports and physician orders from Harmony Cares regarding Resident A's wound care. On 8/28/2025, I received orders and visit note reports from Harmony Cares which included an order dated 2/11/25 from Resident A's physician Dr. Duhn which stated, in part, the following:

> *"Two new pressure ulcers to right upper back, unstageable deep tissue but does have a pinhole opening with tan thin drainage. Swollen under*

deep tissue injury. Seems like it's fluid filled, but not blister. 4.5cm X4cm X0CM."

"Wound care two times a week by nurse using asceptic technique. Clean with wound spray, gauze, pat dry, cover and secure with adhesive form dressing."

"New open stage 2 pressure ulcer. 1.5cm X 2.7cm X0.2cm to upper left buttocks, wound care two times pers week by nurse and PRN for soiled dressing. Clean with wound spray, gauze, pat dry, cover and secure with adhesive form dressing."

"SN frequency change to 2W5, then resume previous frequency due to new increased amount of wounds."

"Patient was soiled and still in bed at 11pm today. Soiled and in bed at last week's visit at 1pm."

I received and reviewed another physician order from 4/15/25 from Dr. Duhn was received which stated, in part, the following:

"A verbal order stated that for skilled nurse to perform/teach wound care to patients pressure injuries around her anus, using aseptic technique, cleanse with wound cleanser, pat dry with gauze. Apply triad paste to the wound base and covered with gauze or ABD. Check patient every two hours for incontinence and reapplication of triad paste if necessary."

I received and reviewed treatment documentation, in part, as follows:

- *On 2/8/25, a nurse provided wound care to two wounds, numbers 7 and 8 on buttocks.*
- *On 2/11/25, a nurse provided care to four wounds, numbers 7, 8, 10 all on buttocks. Number 9 is located on the right shoulder. A note was made that a caregiver expressed concerns regarding lack of care at times and requested a joint instruction with owner of AFC home.*
- *On 2/13/25, a nurse provided care to four wounds, numbers 7 and 10 on buttock, number 9 on the right shoulder and number 11 on the upper thigh. Comments from visit:*

"Education to homeowners husband and wife [David Fennell and Sandy Fennell] regarding extreme importance of keeping skin clean and dry. Checking brief every two hours and changing if soiled or wet. Repositioning at least every two hours and ensuring that she is up in her wheelchair for 1-2 hours, at least 1-2 times a day. Husband and wife both repeated back to me the importance of increased need for frequent position changes and keeping skin dry at all times. They both acknowledged that her skin is fragile and easily breaks down with any stool or urine and that any extended period of time in one position will cause the skin breakdown. Both husband and wife homeowners stated

they would increase the frequency of position changes and brief checks and changes."

- *On 03/03/25, a nurse provided care to three wounds, number 7 and 10 on her buttocks and number 9 on her right shoulder.*
- *On 04/14/2025, a nurse provided care to three wounds, numbers 10 on her buttocks, number 12 multiple on her anus and number 9 on her right shoulder.*
- *On 04/23/25, a nurse provided care to three wounds, numbers 12 on her anus, 9 on her right shoulders and number 13 on her left upper buttocks.*
- *On 05/20/2025, a nurse provided wound care to two wounds, numbers 12 on her anus and number 9 on her right shoulder.*
- *On 06/03/2025, a nurse provided wound care to two wounds, numbers 9 on right shoulder and number 12 on anus.*
- *On 06/11/2025, a nurse provided wound care to two wounds, numbers 9 on right shoulder and number 12 on anus. Comments from visit: "Education provided to staff regarding incontinence care and importance of keeping wound stool off patients skin."*
- *On 07/01/2025, a nurse provided wound care to one wound, number 12. Comments from visit: "Patients pressure injury to right upper back is no longer red and has fully healed. Patient continues to have loose, sticky stools. Physician notified and staff educated to give Imodium every 2-3 hour, but no more than 8 within 24 hours per physicians recommendation. Patient recertified to be seen once a week for nine weeks or until wound heals."*
- *On 07/06/2025, a nurse provided wound care to one wound, number 12 on her anus. Number 9 on her shoulder has healed at this time.*
- *On 07/09/2025, a nurse provided wound care to one wound, number 12 on her anus. Comments from visit: "Patient shows increased signs of pain during wound care today. Patient was started on a probiotic to see if this helps decrease her loose stools. Caregivers report giving approximately 6 Imodium per day. Education provided regarding the ability to use up to 8 Imodium per day for continued loose stools."*
- *On 07/15/2025, a nurse provided wound care to one wound, number 12 on her anus. Comments from visit: "Wound assessment and skilled dressing change completed around patients anus using aseptic technique. Patient has increased indications of pain today and increased surface area of red open tissue. Patient was obtained and sent to wound specialist and physician. Vital signs are within normal limits today. Patient continues to have loose stool, but the facility is only providing 6 Imodium per day despite education and order set indicating giving 8 Imodium per day."*
- *On 07/23/2025, a nurse provided wound care to two wounds, numbers 12 on her anus and 14 on her heel. Comments from visit: "Patient was sent to the hospital because she was experiencing continued dark loose stools. Patient had a colonoscopy which showed no signs of a bleed. Patient was discovered to have pneumonia from a chest x-ray and antibiotics were prescribed. Patient had a indwelling urinary catheter placed at the hospital to help with wound prevention. Patient was discovered to have stool sitting up between her labia, but there is no*

drainage to the broken down area at this time. Patient has bogginess noted to her left heel which could indicate deep tissue injury. Education provided to caregivers regarding management of area around anus and left heel. Patient has increased swelling to her right upper extremity and continues to have contractions to her left upper extremity."

On 08/28/2025, I completed a second unannounced onsite investigation to Belleview AFC. During the investigation, I interviewed Resident B in person. She reported that she smokes cigarettes, and she was never made to go outside and smoke. Resident B reported that she has observed adult household member, Mandy Fennell to also smoke marijuana in the home. Resident B stated that she has observed licensee David Fennell and Sandra Fennell to continue to smoke cigarettes on the second level of the home.

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.

ANALYSIS:	Based upon interviews and documents reviewed, I found that licensee David Fennell did not follow Resident A's physician orders and recommendations of in-home health care providers. On 07/16/25, Resident A's physician, Dr. Duhn, provided licensee David Fennell with a physician order to have all household members stop smoking cigarettes and marijuana within the home. Despite this physician's order, licensee David Fennell confirmed during my unannounced onsite investigation at the facility on 07/21/25 that he continues to allow household members and residents to smoke in the facility. Further, on 07/21/25, I observed Resident B, smoking inside the facility despite this physician's order. Also on 07/24/25, adult protective services worker Carole Dreyer observed household members smoking inside the facility. Responsible person Sherry Betz and Resident B also reported that household members continued to smoke cigarettes and marijuana within the home and were never made to go outside to smoke. Household member and resident smoking all occurs while in the area of an in use oxygen machine creating a clear danger to all. On 7/16/25, an additional order was given from Dr. Duhn for Resident A to use oxygen 24 hours a day. Prior to this order, licensee David Fennell stated he was measuring Resident A's blood oxygen saturation level twice daily but did not have any physician order instructing him to do so nor was there any physician order listing a lowest approved blood oxygen saturation level for Resident A before turning on Resident A's oxygen. During Dr. Duhn's 07/16/2025 evaluation of Resident A, licensee David Fennell could not explain how he monitored Resident A's blood oxygen saturation level nor could David Fennell produce the pulse oximeter he was using. Also, on 07/24/25, adult protective service worker Carole Dreyer observed that Resident A was not using oxygen as ordered. Responsible Person Betz also stated she often observes Resident A without her oxygen and that David Fennell has been directed multiple times by Resident A's medical providers for Resident A's oxygen to be in use at all times. Licensee David Fennell has consistently not provided Resident A with continual oxygen use as ordered by Resident A's physician. Lastly, Resident A started receiving wound care from Harmony Cares medical staff on 2/11/25 twice per week for four wounds located on her shoulder, buttocks and anus. Harmony Cares medical staff provided directions and orders to licensee David Fennell and responsible person Sandra Fennell on 2/13/25, that ordered: Resident A to be checked and changed every two

	hours, repositioned every two hours, and gotten out of bed at least two times a day to assist with wound healing. On 02/13/25, Harmony Cares medical staff noted Resident A had a new wound develop on her upper thigh. On 04/23/25 and 05/20/25 additional new wounds were noted on Resident A's anus area and upper buttock respectively. On 06/11/25, Harmony Cares Medical staff provided wound education again to licensee and responsible persons. On 07/23/25 prior to Resident A's first hospitalization, Harmony Cares Medical staff noted, in part, the following: "Patient [Resident A] was discovered to have stool sitting up between her labia, but there is no drainage to the broken down area at this time. Patient [Resident A] has bogginess noted to her left heel which could indicate deep tissue injury. Education provided to caregivers regarding management of area around anus and left heel. Patient [Resident A] has increased swelling to her right upper extremity and continues to have contractions to her left upper extremity." Upon review of multiple Harmony Cares Medical staff notes about wound care for Resident A, David and Sandra Fennell were not consistently changing Resident A every two hours nor repositioning her every two hours as directed despite re-educated multiple times by medical personnel. Many of Resident A's wounds did not heal and new wounds developed from February 2025 until August 2025 as licensee David Fennell and responsible persons Sandy Fennell and Sherry Betz did not follow physician care instructions and continued to use a rubber pant liner over Resident A's incontinence brief even though they were directed multiple times to stop doing this as it negatively affected wound healing. Resident A was also observed soaked with urine from her buttocks to her shoulders on multiple occasions by staff members and medical providers. Based on the above information, licensee David Fennell chose not to follow physician orders pertaining to Resident A's care as he continued to allow smoking in the facility, did not provide Resident A with continuous oxygen, did not check and/or change Resident A's incontinence brief every two hours, did not re-position Resident A as directed and did not get Resident A out of bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Medications are unsecured.

INVESTIGATION:
On 07/17/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, the medications in the home are unsecured. This complaint came through as anonymous, and no additional details were provided.

On 07/21/2025, I completed an unannounced onsite investigation to Belleview AFC. Upon arriving to the home, I asked to see the resident medications. Licensee David Fennell pulled open the medication cabinet without using a key or unlocking the cabinet in any other manner. Mr. Fennell stated the medication cabinet was not locked because this facility is a family home and no one accesses them. Mr. Fennell showed me the location of the keys which were sitting on top of the medication cabinet. I informed Mr. Fennell that the rules require a family home to also lock medications and he stated that the rules are becoming too strict regarding medications.

On 07/21/2025, during my unannounced onsite investigation, I viewed Resident A's bedroom. On a shelf within her bedroom were 13 different bottles of prescribed creams and over the counter creams. Mr. Fennell and responsible person Sandra Fennell were informed that the prescribed and over the counter creams also need to be locked.

On 08/28/2025, I completed a second unannounced onsite investigation to Belleview AFC. During the unannounced onsite investigation, the medication cabinet was observed to be unlocked again. Licensee David Fennell reported that he only locks the medication cabinet at nighttime. Licensee David Fennell was informed again that the medication cabinet needs to be locked at all times.

On 08/28/2025, I interviewed Resident B in person. She reported that she receives her medications at the table and she has observed other residents leave their medication at the table and the medication was left unattended on the table for the day.

On 2/12/25 *Special Investigation Report* #2025A0466013 cited a rule violation of Rule R. 400.1418 (5). Special Investigation Report #2025A0466013 noted 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. The report also stated all resident medications that required refrigeration were stored in an unsecured refrigerator. The corrective action plan dated 3/5/25 and signed by licensee, David Fennell, stated "medication cabinet remains locked except when dispensing. Lock installed on refrigerator on the porch." The CAP stated this will be maintained by "checked all day."

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(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 investigation, I observed the medication cabinet unlocked upon arrival for both unannounced investigations on 07/21/25 and 08/28/25. I also observed prescribed and over the counter creams to be unlocked within Resident A's bedroom on 07/21/25. Licensee David Fennell also reported that he only locks the medication cabinet at night. Despite documenting on a corrective action plan dated 02/27/2025 and signed by licensee David Fennell that he would lock the medication cabinet and complete daily inspections to assure the medication cabinet was locked, the medication cabinet remained unlocked on two separate unannounced investigations.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A0466013 and CAP DATED 2/27/2025.**

ALLEGATION: Licensee David Fennell is no longer able to care for residents due to symptoms of dementia.

INVESTIGATION:
Throughout interviews with Reliance case manager, Jessica Gardner, Reliance contract coordinator, Vicki Holmes, Harmony Cares nurse Becca Bosch, all three shared concerns regarding licensee David Fennell having a decline cognitively and being able to care for the residents within Belleview AFC. Based upon my in-person interactions with David Fennell and phone calls with David Fennell, I noted that licensee David Fennell did not recall previous licensing corrective action plan requirements that he had written and agreed to incorporate, could not locate paperwork from previous licensing investigations and was unable to provide a consistent timeline for the care provided to Resident A. One example occurred while I was interviewing licensee David Fennell in person 7/21/25, David Fennell reported Resident A's doctor had not been there that month to evaluate Resident A but then later in the conversation stated Resident A's doctor was the one who sent her to the hospital on 07/16/25 after noting concerns while evaluating Resident A in the facility. A *BCHS 3704 AFC Medical Clearance* was requested for licensee, David Fennell and a copy was provided to him via mail and email on 07/24/2025. A phone call to David Fennell occurred on 8/7/25 to determine if he received the medical clearance. He reported that he has and was going to the doctor on 8/8/25. On 08/26/2025, I followed up with David Fennell regarding his medical clearance, as it had not been received yet. Mr. Fennell reported that the doctor was supposed to fax the form to me. Mr. Fennell was informed that it has not been received yet and he stated that he

would fax the form to me and he took my fax number. On 08/28/2025, when I completed my unannounced second onsite investigation, I had not received Mr. Fennell's completed medical clearance. During the unannounced onsite investigation on 8/28/25, Mr. Fennell provided a copy to me.

According to licensee David Fennell's *BCHS 3704 AFC Medical Clearance,* his doctor, Dr. Hoogmoed reported that David Fennell has no known physical/mental condition or health problems that exists that would limit the ability to work with or around dependent adults.

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:	Although concerns regarding licensee David Fennell's cognitive decline were noted and episodes of confusion and forgetfulness were observed, licensee David Fennell's physician did not document any concerns.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/21/2025, I completed an unannounced onsite investigation to Belleview AFC. Upon arriving to the home, I saw another person in the home who was introduced to me as their daughter, Mandy Fennell. Adult household member, Sandy Fennell reported that Mandy Fennell is not an employee. I observed Resident B and Mandy Fennell smoking in a small room off from the dining room. Licensee David Fennell did not identify his daughter as an adult household member. I reviewed the AFC file and noted no request had been received from licensee David Fennell to add Mandy Fennell as a household member nor had Mandy Fennell completed a criminal history record clearance prior to living in the home as required.

On 08/25/2025, during a phone interview with Becca Bouch, nurse for Harmony Cares, she reported that she smelled marijuana in the home and observed adult household member, Mandy Fennell, smoking marijuana and cigarettes during some of her home visits. Ms. Bouch reported that she observed Mandy Fennell working as a direct care worker and that Mandy Fennell was also sharing a bedroom with Resident C. Ms. Bouch stated that Mandy Fennell had been there for several months as an adult household member.

On 08/25/2025, I interviewed direct care worker, Sherry Betz via phone. She reported that Mandy Fennell is living in the home and smokes marijuana and cigarettes in the home around residents. DCW Betz stated that Mandy Fennell was not supposed to live in the home very long but has been there for months. DCW Betz reported Mandy Fennell was sharing a bedroom with Resident C but has now moved into another bedroom with Resident D. DCW Betz reported that Mandy Fennell was working as a direct care worker for some time, without any criminal history clearance or training. DCW Betz stated that Mandy Fennell now has an additional job but could be assisting the residents when she is gone.

Based on the statements of DCW Betz and nurse Becca Bousch, I reviewed the Michigan Workforce Background Check website to determine if Mandy Fennell had been fingerprinted as an employee. There was a record of Mandy Fennell being employed until 12/13/2010 at which time licensee David Fennell changed her status to “no longer employed.” There was no current fingerprint clearance for Mandy Fennell documented in the Michigan Workforce Background Check website.

On 08/25/2025, I spoke with licensee David Fennell via phone. He confirmed that his daughter, Mandy Fennell was currently living in room number 1 and sharing the bedroom with another adult household member, Saundra Hoffman. He stated that she was not going to be there long, therefore he did not complete a criminal history clearance for her as an adult household member as required. David Fennell also stated that she was sharing a bedroom with one of his other daughters, B.J, also known as Saundra Hoffman. David Fennell reported that she was not a resident and he would need to submit an adult household member clearance for her also. David Fennell reported that Mandy Fennell has been living in the home since March 2025 and Saundra Hoffman has been there a few weeks.

On 08/25/2025, I had email contact with Reliance Caseworker, Jessica Gardner. She reported that Sandra Fennell told her on 4/17/25, that Mandy Fennell was living in the home, as she had to move out of her apartment. Sandy Fennell also reported to Jessica Gardner, that Mandy Fennell was sharing a bedroom with Resident C. Ms. Gardner reported that she observed Mandy Fennell providing care to residents on 07/14/25 and 07/23/25.

On 08/28/2025, I completed an unannounced onsite investigation to Belleview AFC. I observed adult household member, Mandy Fennell, sleeping in the first resident bedroom. According to licensee, David Fennell and responsible person Sandra Fennell, Mandy Fennell is sharing the resident bedroom with another adult household member, Saundra Hoffman. During my unannounced onsite investigation, David Fennell reported that Ms. Hoffman was an adult household member as well, however Sandra Fennell and DCW Sherry Betz reported that she is a resident. Ms. Hoffman was not present at the home to be interviewed. At the time of my unannounced onsite investigation, Saundra Hoffman had not been approved as a resident nor an adult household member. Sandra Fennell reported that she is the legal guardian for her daughter, Saundra Hoffman.

On 08/28/2025, I interviewed Resident B in person. She reported that Mandy Fennell has lived at the home for months and previously she was sharing a bedroom with another resident, but recently they moved that resident into her room. Resident B reported that she has observed Mandy Fennell smoke cigarettes in the home, smoke marijuana in the home and drink alcohol to the point where she was stumbling around the house. Resident B explained that she was not sure what she was drinking, but it is a small bottle and is clear. Resident B reported that Mandy Fennell “is on the hard stuff.” Resident B reported that this morning on 8/28/25, she heard Mandy Fennell and Sandra Fennell yelling at each other. She heard Sandra Fennell yell at Mandy “This is my house and you get out.” Resident B reported that she heard the doors slamming also.

On 08/28/2025, I interviewed David Fennell and Sandra Fennell. Mr. Fennell reported that Mandy Fennell was not supposed to stay for a long period at the house and that is why he has not cleared her. Mr. Fennell reported that he was going to ask her to move out within a month. Mr. Fennell was informed that he was still required to complete a criminal history clearance for Mandy Fennell. Mr. Fennell and Sandra Fennell confirmed the argument between Sandra Fennell and Mandy Fennell on the morning of 8/28/25. Sandra Fennell stated that it began over Mandy Fennell wanting to lock her door and that they were yelling back and forth at each other. Mr. Fennell and Sandra Fennell both denied Mandy Fennell provided any care for residents like an employee. They also both denied Mandy Fennell using marijuana and drinking in the home. David Fennell reported that Mandy Fennell was sharing a bedroom with Resident C for some time, before they were informed that she cannot share the same bedroom with a resident. Currently, Mandy Fennell is sharing a bedroom with another person who has been identified as a resident by Sandra Fennell and direct care worker, Sherry Betz but as an adult household member by David Fennell. David Fennell and Sandra Fennell both denied Mandy Fennell providing care to residents within the home.

On 08/28/2025, I interviewed Guardian B1 via phone. She reported that she has observed Mandy Fennell living in the home. Guardian B1 stated that she does feel that Mandy Fennell causes conflict in the home with DCW Sherry Betz and with Mr. Fennell and Sandra Fennell. Guardian B1 stated that she has not observed Mandy Fennell use marijuana or alcohol in the AFC home. Guardian B1 reported that she had asked a nurse who was a caregiver at Belleview and she was told that Mandy Fennell was a caregiver. Guardian B1 stated that she expressed concerns to the nurse because she knew that Mandy Fennell was not cleared or trained to be an AFC caregiver.

During the unannounced onsite investigation on 7/21/25, Mr. Fennell was unable to remember the checklist created for his corrective action plan signed on 6/26/25, nor could he provide a copy of the checklist for clearing a responsible person hired for employment.

On 09/03/2025, I interviewed Mandy Fennell via phone. She confirmed that she lives at the home and stated that she helps her parents out as needed with the residents. Mandy Fennell gave the examples of “helping them to the bathroom or getting them a glass of water.” Mandy Fennell denied receiving payment for helping and stated that she used to stay alone with the residents, but no longer provides when her parents are gone from the home.

On 2/12/25 *Special Investigation Report* #2025A0466013 cited a rule violation of R 400.1405 (1). The analysis section of the report stated adult 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.

On 05/09/2025, Special investigation report #2025A1033033 cited a rule violations of R 400.1405 (3), The analysis section of the report stated Ms. Houserman has been working in the capacity of a Responsible Person with the residents of the facility and has not completed a Michigan Workforce Background Check Consent & Disclosure form, nor completed the fingerprinting process for the Michigan Workforce Background Check. Special investigation report #2025A1033033 cited a rule violations R 400.1405 (2). The analysis section of the report stated based upon the interview conducted with Mr. Fennell, it can be concluded that he does not have current documentation from a physician attesting to the health status of Ms. Houserman. Mr. Fennell reported that Ms. Houserman does function in the capacity of a Responsible Person at the facility. Special investigation report #2025A1033033 cited a rule violations of R 400.1405 (3)The analysis section of the report stated Based upon the interview conducted with Mr. Fennell, it can be concluded that Mr. Fennell does not have current documentation demonstrating that Ms. Houserman has tested negative for tuberculosis within the past three years.

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:	Based on interviews and lack of documentation, it was determined that licensee, David Fennell has not cleared his daughter, Mandy Fennell or Saundra Hoffman as adult household members, therefore I am unable to determine if adding them to the household would negatively affect the health of a resident. Based upon interviews with direct care worker, Sherry Betz, Resident B and Harmony Cares nurse, Becca Bouch, all three observed Mandy Fennell to use marijuana within the home. Additionally, Resident B, David Fennell and Sandra Fennell confirmed an argument and slamming of doors between Mandy Fennell and Sandra Fennell on the morning of 8/28/25, which occurred in front of residents. Licensee David Fennell also reported that he has allowed Mandy Fennell to share a bedroom with residents. Due to Mandy Fennell's loud arguments with other adult household members and use of marijuana within the home it was found that she is negatively affecting the quality of care provided to the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A0466013 and CAP DATED 2/27/2025.**

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.

ANALYSIS:	Based upon interviews with Reliance case manager, Jessica Gardner, Guardian B1, direct care worker, Sherry Betz and Harmony Cares nurse Becca Bosch all confirmed that they have observed Mandy Fennell providing care to residents at Belleview AFC. Mandy Fennell confirmed that she was assisting with providing care to the residents at Belleview during a phone interview on 9/3/25. David Fennell denied this claim, but was unable to provide any documentation confirming that Mandy Fennell free from communicable tuberculosis. Upon review of previous special investigation, #2025A1033033, Mr. Fennell has not been following is signed corrective action plan dated 6/26/25, which states “Moving forward, Mr. Fennell will assure responsible persons hired have a completed negative TB test within the past 3 years. Mr. Fennell will create a checklist for items required for employment of a responsible persons and follow this checklist.”
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033033 and CAP DATED 06/26/25]**

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(2) A licensee shall have on file with the department a statement signed by a licensed physician or his or her designee with regard to his or her knowledge of the physical health of the licensee and each responsible person. The statement shall be signed within 6 months before the issuance of a license and at any other time requested by the department.

ANALYSIS:	Based upon interviews with Reliance case manager, Jessica Gardner, Guardian B1, direct care worker, Sherry Betz and Harmony Cares nurse Becca Bosch all confirmed that they have observed Mandy Fennell providing care to residents at Belleview AFC. Mandy Fennell confirmed that she was assisting with providing care to the residents at Belleview during a phone interview on 9/3/25. David Fennell denied this claim, but was unable to provide any documentation from a signed licensed physician with regard to his or her knowledge of the physical health of Mandy Fennell. Upon review of previous special investigation, #2025A1033033, Mr. Fennell has not been following is signed corrective action plan dated 6/26/25, which states "Moving forward, Mr. Fennell will assure responsible persons hired have a completed physicians statement of good health. Mr. Fennell will create a checklist for items required for employment of a responsible persons and follow this checklist."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033033 and CAP DATED 06/26/25]**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant

	licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the adult foster care facility or staffing agency that has made a good-faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good-faith offer of independent contract to that applicant.

ANALYSIS:	Based upon interviews with Reliance case manager, Jessica Gardner, Guardian B1, direct care worker, Sherry Betz and Harmony Cares nurse Becca Bosch all confirmed that they have observed Mandy Fennell providing care to residents at Belleview AFC. Mandy Fennell confirmed that she was assisting with providing care to the residents at Belleview during a phone interview on 9/3/25. David Fennell denied this claim, but was unable to provide any documentation of a completed a *Michigan Workforce Background Check Consent & Disclosure* form for Mandy Fennell, nor completed the fingerprinting process for the *Michigan Workforce Background Check*. Upon review of previous special investigation, #2025A1033033, Mr. Fennell has not been following is signed corrective action plan dated 6/26/25, which states "Moving forward, Mr. Fennell will assure that any responsible person employed by the licensee will have a *Michigan Workforce Background* Check fingerprinting process completed within 30 days of employment. Mr. Fennell will create a checklist for items required for employment of a responsible persons and follow this checklist."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033033 and CAP DATED 06/26/25]**

INVESTIGATION:

On 07/21/2025, I completed an unannounced onsite investigation to Belleview. During the unannounced onsite investigation, I viewed *Medication Administration Record* for Resident A. The medication administration record for Resident A was only signed and recorded for July 1st- July 10th, 2025. Upon reviewing the care summary from Dr. Duhn on 7/16/25 and the medication administration record, it was found that there was no documentation of Resident A receiving the following prescribed medications, nor are they documented on Resident A's *Medication Administration Record.*

- Destin Rapid Relief 13% topical cream; apply topical thin film to left heel and sacrum BID until healed, cover with dressing. 11/1/23 started.
- Hydrocortisone .5% topical cream; apply topically to the affected area four times daily as directed. 2/19/25 started
- Nystatin 100,000 unit/gram topical cream; application, topical two times a day as needed to the affected area. 4/2/21 started.

On 2/12/25 *Special Investigation Report* #2025A0466013 cited a rule violation of Rule R. 400.1418(4)(a). The *analysis* section of this citation on the report noted that *medication administration records* (MAR) were not being routinely completed. The *corrective action plan* (CAP), dated 2/27/25, and signed by Mr. Fennell, stated that the *Corrective Action* to be taken is, "Initial MAR when dispensed."

On 5/9/2025 Special Investigation Report #2025A1033033 cited a rule violation of Rule R. 400.1418(4)(a). The analysis section of this citation on the report noted that no medications have been initialed as being dispensed for the dates 5/1/25 through 5/6/25 for any of the three residents. Furthermore, Resident C's insulin medication was not initialed as being administered a single time on the MAR dated 4/1/25 – 4/30/25, even though the coinciding blood glucose log identified at least 35 instances when Resident C should have had this medication administered due to high blood glucose readings. Therefore, a violation has been established at this time. The *corrective action plan* (CAP), dated 6/26/25, and signed by Mr. Fennell, stated that the *Corrective Action* to be taken is, "Mr. Fennell will conduct daily review of resident MARS to ensure medication administrations are being initialed as administered."

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:	Based upon review of Resident A's *Medication Administration Record* for July, 2025, it was found that Resident A's medications were not recorded for the following days: July 11th-21st. It was also found that there is no documentation of Resident A's prescribed topical creams being administered, nor were they documented on Resident A's medication administration record. Upon review of two previous special investigations, #2025A0466013 and #2025A1033033, Mr. Fennell has not been following is signed corrective action plans dated 2/27/25 and 6/26/25, which stated "Initial MAR when dispensed and Mr. Fennell will conduct daily review of resident MARS to ensure medication administrations are being initialed as administered."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A0466013 AND CAP DATED 2/27/25 and SIR#2025A1033033 and CAP DATED 06/26/25]**

IV. RECOMMENDATION

Due to the number and severity of quality of care violations cited in this report, I recommend revocation of the license.

09/09/2025

Amanda Blasius Date
Licensing Consultant

Approved By:

09/09/2025

Dawn N. Timm Date
Area Manager