



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 23, 2026

Leone Swanberg  
5329 McCords  
Alto, MI 49302

RE: License #: AM410008670  
Investigation #: 2026A0467018  
Swanberg AFC - Springwood

Dear Mrs. Swanberg:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

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**

<b>License #:</b>	AM410008670
<b>Investigation #:</b>	2026A0467018
<b>Complaint Receipt Date:</b>	03/10/2026
<b>Investigation Initiation Date:</b>	03/11/2026
<b>Report Due Date:</b>	05/09/2026
<b>Licensee Name:</b>	Leone Swanberg
<b>Licensee Address:</b>	5329 McCords Alto, MI 49302
<b>Licensee Telephone #:</b>	(616) 893-6613
<b>Administrator:</b>	Ben Visel
<b>Licensee Designee:</b>	Leone Swanberg
<b>Name of Facility:</b>	Swanberg AFC - Springwood
<b>Facility Address:</b>	1158 Springwood Drive SE Kentwood, MI 49508-6055
<b>Facility Telephone #:</b>	(616) 532-0356
<b>Original Issuance Date:</b>	08/01/1979
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/15/2024
<b>Expiration Date:</b>	10/14/2026
<b>Capacity:</b>	12
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
On 3/7/26, staff member Renee Partee slapped Resident A during a behavioral episode.	No
On 3/7/26, Resident A was recorded without her consent during a behavioral episode.	Yes
Additional Findings	Yes

## III. METHODOLOGY

03/10/2026	Special Investigation Intake 2026A0467018
03/11/2026	APS Referral Recipient Rights Officer Ashton Byrne confirmed that Kent County APS is currently involved
03/11/2026	Special Investigation Initiated - On Site There were no staff and residents at the home.
03/12/2026	Inspection completed – On site
03/16/2026	Contact – telephone call made to Resident A’s guardian, Daphne Welton.
03/16/2026	Contact – Face to Face with Resident A
03/16/2026	Contact – telephone call made to Breanna Burrows with N180
03/16/2026	Contact – telephone call made to Marie Steffens with N180
03/16/2026	Contact – telephone call made to Laura Ruhl.
03/18/2026	Exit conference with AFC administrator, Ben Visel.

**ALLEGATION:** On 3/7/26, staff member Renee Partee slapped Resident A during a behavioral episode.

**INVESTIGATION:** On 3/10/26, I received a complaint from Kent County Recipient Rights Officer Ashton Bryne. The complaint alleged that on 3/7/26, Resident A had a behavioral episode involving hallucinations and physical aggression. Resident A was reportedly sent to the hospital and returned home the same night. During the incident, it was alleged that staff member Renee Partee slapped Resident A in the face.

On 3/12/26, I conducted an unannounced onsite investigation at home. Live-in manager Neeva James allowed entry into the home and staff member Renee Partee was present and agreed to be interviewed.

Ms. Partee confirmed that Resident A had a behavioral episode on 3/7/26 involving physical aggression toward her and two other residents. She explained that Resident A became upset when her sister did not arrive as planned and began “rocking back and forth.” Ms. Partee stated that she attempted to redirect Resident A by suggesting they watch a movie downstairs, but Resident A refused and scratched Ms. Partee’s arm. Ms. Partee reported that she held Resident A’s arms in the air to prevent further injury. She stated that two other residents approached during the incident, and Resident A pushed one and struck another. Ms. Partee contacted 911, and two police officers responded to the home. Resident A was subsequently transported to Metro Health hospital by ambulance and returned later that night. Resident A and the other two residents involved in the incident were not available for interview during my onsite visit due to being on outings.

Ms. Partee shared that two nights prior, Resident A’s sister asked her why she slapped Resident A. Ms. Partee denied ever slapping or hitting Resident A during the incident or at any other time. Ms. Partee reported that while police were onsite during Resident A’s behavioral episode on 3/7/26, they spoke to Resident A and she reportedly denied having any concerns with Ms. Partee and described her as being “nice.”

On 3/16/26, I spoke to live-in staff member Neeva James via phone. Ms. James stated that she was not home during Resident A’s behavioral episode on 3/7/26. She reported that she believed the incident may have occurred due to Resident A’s sister not arriving at the home as originally planned. Ms. James stated that during the episode, Ms. Partee called her to report that Resident A had become aggressive, first toward Ms. Partee and then toward two residents. According to Ms. James, she instructed Ms. Partee to call 911. She stated that police responded to the home and had Resident A transported to the hospital via ambulance.

Although Ms. James was not present during the physical altercation, she denied having any knowledge of Ms. Partee hitting or assaulting Resident A or any other resident. Ms. James stated that she informed Resident A’s sister that she had a ring camera in the living area and would check it to see whether the incident had been recorded. Ms. James reported that “nothing was showing up” on the camera, and she therefore had nothing to show Resident A’s sister.

On 3/16/26, I spoke to Resident A’s guardian, Daphne Welton via phone and we agreed to meet at a restaurant located at 44<sup>th</sup> street and Division to discuss case allegations. Introductions were made with all parties and Resident A agreed to be interviewed. Due to Resident A’s history of trauma involving men, her sister remained present to support her during the interview.

Resident A confirmed her demographic information and stated that she has lived at the AFC home “for a long time.” When asked about the incident that resulted in police involvement, Resident A stated that Ms. Partee hit her in the face because she did not want to go downstairs. She reported the incident occurred in the front room of the home, which is the designated living area of live-in manager Neeva James. Resident A stated that she grabbed Ms. Partee in response to being hit and used her hand to show that she was hit on the right side of her face by Ms. Partee. She denied having any marks or bruises from the incident, and no visible marks or bruises were observed during the interview. Resident A reported that no other individuals witnessed the slap. She also stated that after she grabbed Ms. Partee, she hit two of her peers when they entered the room, despite acknowledging that they had not done anything to her. Resident A reported that she continues to feel safe in the home and has not seen Ms. Partee since the incident.

Mrs. Welton stated she believes Resident A’s explanation as to what occurred because she has consistently repeated the same version of the events. She expressed concern that Ms. Partee remained in the home after the incident and was only removed once the incident was made known to others outside the home.

On 3/18/26, I conducted an exit conference with administrator, Ben Visel. He was informed of the investigative findings and denied having any questions.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following:</b> <b>(a) Use any form of punishment.</b>
<b>ANALYSIS:</b>	Resident A reported that she was slapped in the face by Ms. Partee. Ms. Partee denied the allegation against her. There were no witnesses to the incident and no marks or bruises on Resident A’s face. Therefore, there is not a preponderance of evidence to support this applicable licensing rule.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** On 3/7/26, Resident A was recorded without her consent during a behavioral episode.

**INVESTIGATION:** On 3/10/26, I received a complaint from Kent County Recipient Rights Officer Ashton Bryne. The complaint alleged that during Resident A’s behavioral episode on 3/7/26, staff member Renee Partee recorded Resident A with a cell phone without consent. It was also alleged that live-in manager Neeva James

is aware of the recording and she had a Ring Camera being used in her designated area of the home.

On 3/12/26, I conducted an unannounced onsite investigation at the home. Live-in manager Neeva James allowed entry into the home. Present in the home with her was her colleague, Renee Partee, who agreed to be interviewed.

During the interview, Ms. Partee was adamant that she did not record Resident A at any point during the behavioral episode on 3/7/26. She stated that although Resident A's sister and guardian, Daphne Welton asked her to record the incident, she refused. Ms. Partee denied showing any recordings to Ms. James, explaining that there were never any recordings on her phone to begin with.

Ms. Partee reported that approximately one week prior to the 3/7/26 incident, she informed Ms. James that staff were not allowed to record in the home. She explained that Resident A's behavioral episode occurred in the front living room, which is Ms. James' personal space. According to Ms. Partee, she was unaware that the Ring camera was in the room until after the incident had already occurred. She added that if she knew about the camera, she would not have allowed Resident A to enter the area. Ms. Partee also stated that she does not believe the Ring camera works, indicating that Ms. James uses it primarily as a deterrent because her personal belongings have been stolen in the past.

Administrator Ben Visel arrived at the home while I was interviewing Ms. Partee. Mr. Visel stated that he had no prior knowledge of a Ring camera being used in Ms. James' living area. He agreed that the camera was an invasion of the residents' privacy as it records both video and audio. Mr. Visel confirmed that he would ensure the camera is removed immediately.

Before leaving the home for a scheduled resident appointment, Ms. James spoke with me briefly in her designated area at the front of the house. In the area I observed a Ring camera positioned next to the TV and facing the entryway. Ms. James acknowledged the device, stating that she believed it was acceptable because it was located in her personal space. I explained that despite this being her personal area, a resident gained access to it and was recorded without consent. Ms. James stated that she did not personally bring Resident A into her personal space, however, the issue remained that a resident was on camera without consent. Ms. James then stated that she does not use the camera and does not have access to it because her daughter set it up. I tested the device by pressing the button on it and confirmed that the camera was working/recording. Ms. James was informed that the camera needed to be removed immediately, and she was receptive to this.

On 3/16/26, I spoke to live-in manager Neeva James via phone regarding her knowledge of Ms. Partee recording Resident A without consent. Ms. James stated that Resident A's sister asked her to record Resident A's next behavioral outburst because she had not personally witnessed them. Ms. James relayed this request to

Ms. Partee, who then stated that staff are not allowed to record residents. Ms. James initially reported that Ms. Partee had a voice recording of Resident A “going on and on,” which she claimed was made at the sister’s request. Moments later, Ms. James contradicted this by stating that Ms. Partee did not have any recording and that she only heard Resident A’s behavior while she was on the phone with Ms. Partee. When asked for clarification, Ms. James again changed her story, stating that she went home on 3/7/26 and heard Resident A having a behavioral episode, although she did not see it. Throughout this conversation, Ms. James’ explanation as to what occurred was inconsistent and disorganized, despite multiple attempts to redirect her.

On 3/16/26, I spoke with Resident A’s guardian, Daphne Welton via phone and we agreed to meet at a restaurant located at 44<sup>th</sup> street and Division to discuss the allegations. During the meeting, Resident A denied any knowledge of the AFC staff recording her without consent.

Mrs. Welton reported that she and Ms. James exchanged text messages regarding an alleged recording of Resident A’s behavioral episode. Mrs. Welton provided screenshots of these conversations. According to the messages, at 1:27pm on 3/7/26, Ms. James informed Mrs. Welton that Resident A had a “screaming episodes” yesterday and this evening and staff had recorded a video for Mrs. Welton to review. At 6:13pm, Mrs. Welton asked Ms. James to send her the video. At 7:15pm, Ms. James stated the video was too long to send and she requested that Mrs. Welton set up a time to view it, as it was on Ms. Partee’s phone. Despite this, Ms. James never followed through.

After concluding the meeting with Resident A and her family on 3/16/26, I called Ms. James to get clarification regarding discrepancies between her prior statements and text messages provided by Mrs. Welton. I was unable to leave a voicemail because her mailbox was not set up. I attempted to call her again on 3/18/26, but she didn’t answer. As of the conclusion of this investigation, Ms. James has not returned my calls.

On 3/18/26, I conducted an exit conference with administrator Ben Visel. He was informed of the investigative findings, which were that live-in manager Neeva James and relief staff member Renee Partee provided inconsistent explanations as to what occurred when compared to text message conversations between Mrs. Welton and Ms. James. Mr. Visel is aware that a corrective action plan is due within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b>

	<b>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</b>
<b>ANALYSIS:</b>	Ms. James had a Ring camera in her designated area of the home. During a behavioral episode, Resident A was in the area and was recorded by the camera without her consent. Both Ms. Partee and Ms. James denied that Resident A had been recorded with a phone. However, text messages provided by Resident A's guardian show that on 3/7/26, Ms. James informed the guardian that Ms. Partee had a recording on her phone. The messages contradict the statements made by Ms. James and Ms. Partee. Therefore, there is a preponderance of evidence to support this applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:** While investigating the allegations listed above, Resident A's guardian, Daphne Welton informed me that on or around February 24<sup>th</sup>, Resident A and others were left unsupervised at the home. This was reportedly observed by a case worker that went to the home to see their client.

On 3/16/26, I spoke to Resident A's supports coordinator, Breanna Burrows. Ms. Burrows confirmed that her colleague, case manager Marie Steffen observed Resident A and others at the home without staff supervision.

On 3/16/26, I spoke to Ms. Steffen via phone and she confirmed that she went to the home on 2/23/26 to meet with her client, Resident B. When she arrived, an unknown resident allowed entry into the home. Ms. Steffen stated that she went downstairs to Resident B's room and noticed that she was not there. Ms. Steffen stated that Resident B shares a room with Resident A, and Resident A was observed sitting in her room. Ms. Steffen stated that she walked through the house calling for staff and no one answered.

Ms. Steffen stated that Resident B's grandmother, Laura Ruhl arrived at the home and she allowed her in the home. The two of them sat at the dining room table for 10 minutes before live-in staff member Neeva James walked into the house with Resident B. Ms. Steffen stated that Resident B was carrying a soda, so it was evident that Ms. James and Resident B went to a store or gas station to get that while leaving other residents at the home. Ms. Steffen provided me with Resident B's grandmother's contact information to confirm this incident.

On 3/16/26, I spoke to Resident B's grandmother, Laura Ruhl via phone. Ms. Ruhl confirmed that on 2/23/26, she went to the home and was let in by Resident B's case manager, Marie Steffens. Ms. Ruhl did not see other residents in the home because they had already returned to their room by the time she arrived. She also did not see any staff members in the house when she first arrived. However, Ms. Ruhl confirmed that she witnessed her granddaughter (Resident B) and live-in staff member Neeva James arrive at the home together after sitting at the dining room table with Marie Steffens for some time.

On 3/16/26, I called Ms. James to discuss this. I was unable to leave a voicemail due to not having her voice mailbox set up. I also called her again on 3/18/26 but she did not answer. As of the conclusion of this report, Ms. James has not returned my call.

On 03/18/26, I conducted an exit conference with administrator, Ben Visel. He was informed of the investigative findings and expressed concern about who allowed the case manager in the home on 2/23/26 and if staff were in the home. Mr. Visel shared that he spoke to a few different people, including staff member Renee Partee and some of the residents, and he received different stories as to what occurred. I explained to Mr. Visel that based on the disclosure from Resident B's case manager and grandmother, it was enough to support a citation of this rule. Mr. Visel agreed to complete a CAP within 15 days of receipt of this report. Mr. Visel stated that he is in the process of hiring a new live-in manager to replace Ms. James and Ms. Partee will not work in the home moving forward.

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirements.</b>
	<p><b>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:</b></p> <p><b>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</b></p> <p><b>(b) 12 residents for small group and family homes.</b></p>
<b>ANALYSIS:</b>	Resident B's case manager confirmed that Resident A and two other residents were in the home without staff on 2/23/26. Resident B's grandmother confirmed that when she arrived at the home on 2/23/26, she did not see any staff inside the home until her granddaughter and Ms. James arrived minutes after she was in the home. Therefore, there is a preponderance of

	evidence to support this applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Anthony Mullins*

03/23/2026

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Anthony Mullins  
Licensing Consultant

Date

Approved By:

*Jerry Hendrick*

03/23/2026

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Jerry Hendrick  
Area Manager

Date