GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2024

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390016015
Investigation #: 2024A0581026
Fountain View Ret Vil 0f Port #2

Dear Connie Clauson:

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 feel free to 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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL390016015
Investigation #:	2024A0581026
Complaint Receipt Date:	07/10/2024
Investigation Initiation Date:	07/11/2024
Report Due Date:	09/08/2024
Licensee Name:	Leisure Living Mgt of Portage
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View Ret Vil 0f Port #2
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	08/01/1995
License Status:	REGULAR
Effective Date:	09/04/2022
Expiration Date:	09/03/2024
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION

	Violation Established?
On 07/09/2024, a direct care staff assaulted Resident A.	Yes

III. METHODOLOGY

07/10/2024	Special Investigation Intake 2024A0581026
07/10/2024	APS Referral- APS already received the allegations but denied investigating. No referral necessary.
07/11/2024	Contact – Telephone call made- Interview with Complainant.
07/11/2024	Special Investigation Initiated – Telephone call made. Interview with Relative A1
07/12/2024	Inspection Completed On-site- Interviewed staff and observed resident.
07/12/2024	Contact - Telephone call received- Received voicemail from facility's executive director, Brandy Aucunas.
07/12/2024	Contact - Telephone call made- Left voicemail for Ms. Aucunas.
07/12/2024	Contact - Document Sent- Email sent to Ms. Aucunas.
07/15/2024	Contact - Document Sent- Follow up email to Ms. Aucunas.
07/15/2024	Contact - Document Sent- Requested Portage police department report #: 24-21823
07/15/2024	Contact - Document Received- Received police report # 24-21823
07/15/2024	Contact - Document Received- Email from Ms. Aucunas.
07/16/2024	Contact - Telephone call made- Interview with direct care staff, Elaisha Burrell.
07/16/2024	Inspection Completed-BCAL Sub. Compliance
07/16/2024	Contact – Telephone call made - Left message with Transitions hospice nurse, Karen Golden.

07/16/2024	Contact – Telephone call received - Interview with Ms. Golden.
07/23/2024	Contact – Telephone call made- Contact with Ms. Golden.
07/26/2024	Inspection Completed On-site- Interview with Ms. Aucunas and direct care staff, Ms. Kellogg.
07/31/2024	Exit Conference with licensee designee, Connie Clauson, via email.

ALLEGATION: On 07/09/2024, a direct care staff assaulted Resident A.

INVESTIGATION: On 07/10/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged Resident A had been assaulted by a female direct care staff and subsequently had bruises on both arms and nail marks on her wrists. The complaint alleged there were other direct care staff who were present who assisted in getting the staff off Resident A. The complaint alleged the direct care staff who assaulted Resident A had been fired.

On 07/10/2024, I confirmed Adult Protective Services (APS) received the allegations, but APS denied assigning the complaint for investigation. Subsequently, no referral to APS was necessary.

On 07/11/2024, I interviewed Complainant whose statement to me was consistent with the allegations. Complainant stated facility staff contacted Relative A1 regarding the allegations.

On 07/11/2024, I interviewed Resident A's Power of Attorney (POA), Relative A1. Relative A1's statement to me was consistent with the allegations. Relative A1 stated he received a phone call from the facility's manager, Jessica [Unknown], at approximately 7 am who reported to him Resident A had diarrhea and it had gotten on her floor. Relative A1 stated it was reported to him a caregiver pushed Resident A on her couch, held her wrists and arms down and "jerked" her clothes off of her. Relative A1 stated the facility's supervisor, Brandy Aucunas, was also in the facility and heard Resident A screaming. Relative A1 stated Ms. Aucunas came into Resident A's bedroom at the end of the incident. Relative A1 stated Ms. Aucunas immediately fired the staff who was rough with Resident A.

Relative A1 stated he was unable to get to the facility to observe Resident A until the evening after the incident. He stated he observed bruises on Resident A's arms, hands, and wrists, as well as nail marks on the inside of her wrists, which he took pictures of while visiting Resident A. Relative A1 stated Resident A has a diagnosis

of dementia; therefore, she is unable to recall what happened to her or how she obtained the bruises. Relative A1 stated Portage Police Department was also involved. Relative A1 stated despite the incident, he believed Resident A was safe in the facility at this time.

Relative A1 forwarded me seven pictures of Resident A's injuries, which I reviewed. According to my review of these pictures, Resident A had multiple purple spots on the top of her left hand, wrist and lower arm that appeared to be bruises. These bruises were several inches in diameter. An approximate 1 inch in diameter bruise, yellow in color, was also observed on Resident A's left bicep. Additional pictures showed Resident A had an approximate 1.5 inch-2 inch in diameter purple bruise on the top of her right hand.

On 07/12/2024, I conducted an unannounced inspection at facility. I interviewed direct care staff, Jessica Kellogg. Ms. Kellogg stated on the morning of 07/09/2024, she walked into Resident A's bedroom to determine if she was awake. Ms. Kellogg stated when she walked into Resident A's bedroom she observed diarrhea on Resident A, as well as, on her floor. Ms. Kellogg stated due to her being in the process of administering resident medications, she left Resident A's bedroom and relayed the state of Resident A and her bedroom to direct care staff, Idaisha Carter. Ms. Kellog stated she was unable to assist Resident A immediately with getting cleaned up because she needed to finish administering resident medications. She stated Ms. Carter was unable to immediately assist Resident A because she was assisting another resident at that time. Ms. Kellogg stated direct care staff, Elaisha Burrell, offered to assist Resident A and help clean her room even though Ms. Burrell not being "on the clock". Ms. Kellogg stated Ms. Burrell worked the overnight shift until 6 am that morning but was still in the building because she needed a ride home from Ms. Kellogg at approximately 9 am.

Ms. Kellogg stated Ms. Burrell was in Resident A's bedroom for approximately 3-5 minutes when Ms. Kellogg heard "hollering" from Resident A's bedroom. Ms. Kellogg stated she was taking another resident's vital signs in their bedroom but left the resident to see what was occurring in Resident A's bedroom. Ms. Kellogg stated when she walked into Resident A's bedroom, she observed Resident A on her couch with no shirt on, and her pants were slightly pulled down. She stated Ms. Burrell had one of her hands over Resident A's wrists, which were crossed, and she was holding down Resident A's hands. Ms. Kellogg stated she observed Ms. Burrell roll Resident A onto her side and to try get Resident A's pants off in order to change them. She stated she heard Ms. Burrell tell Resident A her pants were wet and dirty, and they needed to come off.

Ms. Kellogg stated Resident A tried kicking Ms. Burrell. Ms. Kellogg stated Ms. Burrell told Resident A to stop hitting her; however, Resident A was non-compliant and continued displaying aggressive behaviors. Ms. Kellogg stated Resident A screamed "shut up" and "I didn't hit you" to Ms. Burrell. Ms. Kellogg stated once Resident A's pants were off, direct care staff, Idaisha Carter, went into Resident A's

bedroom to help clean Resident A up while Ms. Burrell retrieved cleaning supplies and cleaned up Resident A's bed and floor. Ms. Kellogg stated Resident A was naked on her couch for approximately 2-3 minutes while Ms. Carter gathered fresh clothing for Resident A. Ms. Kellogg stated Resident A was being cooperative with Ms. Carter and there were no further issues.

Ms. Kellogg stated when residents, including Resident A, are displaying aggressive behavior, then they try to give the resident space, try again after several minutes, or request another staff assist with providing care. Ms. Kellogg denied Ms. Burrell implementing any of these strategies in handling Resident A's aggressive behaviors.

Ms. Kellogg stated she left the facility with Ms. Burrell at approximately 9 am and when she returned at approximately 11 am, Resident A had observable bruises on her hands. Ms. Kellogg stated Resident A did not have any bruises on her wrists or hands at the time she left the facility with Ms. Burrell at 9 am. Ms. Kellogg stated Ms. Aucunas terminated Ms. Burrell that day upon discovering the bruises.

I also interviewed direct care staff, Idaisha Carter, during my inspection. Her statement to me was consistent with Ms. Kellogg's statement to me. She stated while the incident took place, she heard Ms. Burrell yell at Resident A to "stop" and "be still." She stated she also observed Ms. Burrell raise her hand towards Resident A as though she was going to hit her.

On 07/15/2024, I interviewed Portage Police Department detective, Brett Stapert. Detective Stapert stated Portage Police Department was not pressing charges against Ms. Burrell because Relative A1 did not want charges pressed. He stated his investigation was closed.

On 07/15/2024, I reviewed Portage Police report # 2024-00021823. According to the report, Officer Deleeuw interviewed Ms. Aucunas, Ms. Kellogg, Ms. Carter, and additional direct care staff, Lisa Hoskins. Their statements, including Ms. Hoskin's statement, to Officer Deleeuw were consistent with the statements these staff provided to me.

On 07/15/2024, Ms. Aucunas sent via email a copy of the facility's Incident/Accident Report (IR) relating to the 07/09/2024 incident. According to the IR, dated 07/10/2024, which was completed by Ms. Aucunas, documented Ms. Burrell "…was arguing with resident and resident became combative. Employee grabbed residents wrists to keep her from hitting her. She was also yelling at the resident making resident more agitated". The IR documented "Jessica Kellogg contact me, the administrator, and residents legal guardian, Relative A1". The corrective measure documented Ms. Burrell was terminated on 07/09/2024 after Ms. Aucunas was notified of the incident.

On 07/16/2024, I interviewed direct care staff, Elaisha Burrell, via telephone. Ms. Burrell's statement was consistent with Ms. Kellogg's and Ms. Carter's statements to

me. Ms. Burrell stated Ms. Kellogg and Ms. Carter left Resident A in her room with feces on her person and on the floor. She stated she was “helping out” by assisting Resident A despite her shift ending at 6 am. Ms. Burrell stated she went into Resident A’s bedroom and tried taking her clothes off since there was feces on them. She stated “normally [Resident A] has a small attitude”, but that morning Resident A was aggressively swinging and kicking at her. Ms. Burrell stated she grabbed Resident A’s arms with one of her hands and held her wrists in place to prevent her from hitting her. She denied holding her down aggressively or forcefully. She also denied raising her hand to hit Resident A. Ms. Burrell stated she cleaned Resident A up, changed her and cleaned the feces off the floor. She stated the entire incident lasted approximately 10 minutes.

Ms. Burrell stated Resident A already had “burgundy” colored marks on her wrists prior to the incident. She denied Resident A having bruises on her at the time she left the facility that morning. Ms. Burrell confirmed her employment was terminated from the facility.

On 07/16/2024, I contacted Resident A’s Transitions hospice nurse, Karen Golden, via telephone. Ms. Golden stated she observed Resident A in the facility on 07/10/2024, which was the day after the incident occurred. She stated Resident A has fragile skin; however, the bruising on her arms was “excessive”.

On 07/26/2024, I conducted another unannounced inspection at the facility. I interviewed the facility’s executive director, Brandy Aucunas. Ms. Aucunas’ statement was consistent with Ms. Kellogg’s and Ms. Carter’s statements to me. Ms. Aucunas stated she was in the facility at approximately 8 am or 8:30 am visiting with residents and staff when she heard Resident A “being loud”. She stated when she went into Resident A’s bedroom, she saw Resident A sitting naked on her couch while Ms. Burrell was cleaning the floors. She stated Ms. Kellogg was also in the room but believed she had just arrived as well. Ms. Aucunas stated she asked Resident A if she was hurt, and she reported she was not. She stated she looked Resident A over and did not observe any redness, bruising or signs of injuries. Ms. Aucunas stated either Ms. Kellogg or Ms. Carter got Resident A dressed while Ms. Aucunas escorted Ms. Burrell out of the building.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation, which included interviews with Relative A1, the facility's Executive Director and direct care staff, Brandy Aucunas, direct care staff members Jessica Kellogg, Idaisha Carter, and Elaisha Burrell, and Transitions hospice nurse, Karen Golden, as well my review of the facility's IR, dated 07/10/2024, Portage Police Department police report # 2024-00021823 and pictures taken by Relative A from the date of the incident, there is evidence supporting direct care staff, Elaisha Burrell, mistreated Resident A on 07/09/2024 when she held her arms down while trying to prevent Resident A from hitting her. Subsequently, Resident A suffered multiple bruises on the top of her hands, wrists, and arms from Ms. Burrell holding her down.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: Relative A1 stated he was not aware of facility staff obtaining medical attention for Resident A after bruises were discovered on her from the incident with Ms. Burrell.

Ms. Kellogg, Ms. Carter, and Ms. Burrell were unable to identify any staff who contacted any medical professionals after Resident A suffered bruises on her hands, wrists and arms from the incident with Ms. Burrell.

Ms. Aucunas confirmed medical treatment was not obtained for Resident A after the bruises were discovered; however, she stated Resident A was seen by hospice staff in the facility the following day on 07/10/2024. Ms. Aucunas stated this visit with hospice was a scheduled and preplanned visit whereas the hospice nurse would look her over, complete a skin check, review her medications, and complete vital checks.

Transitions hospice nurse, Ms. Golden, stated the agency was not contacted by any facility staff to report the incident between Resident A and Ms. Burrell on the day the incident occurred. She stated had a facility staff member contacted the agency on the date the incident occurred, a hospice nurse would have been to evaluate Resident A within approximately 45 minutes. Ms. Golden's statement to me regarding her visit with Resident A on 07/10/2024 was consistent with Ms. Aucunas' statement to me.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation, which included interviews with Relative A1, the facility's Executive Director and direct care staff, Brandy Aucunas, direct care staff, Jessica Kellogg, Idaisha Carter, and Elaisha Burrell, and Transitions hospice nurse, Karen Golden, facility direct care staff did not obtain medical attention for Resident A or contact her hospice agency after staff observed Resident A being held down by Ms. Burrell and observed significant bruises on hands, wrists and arms after the incident occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/31/2024, I attempted to conduct the exit conference with the licensee designee, Connie Clauson, via telephone; however, I was unable to reach her. I sent her an email explaining my findings.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

07/29/2024

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

08/02/2024

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Dawn N. Timm Date
Area Manager