GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2024

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

RE: License #: AL390007092
Investigation #: 2025A0581005
Fountain View Ret Vil of Port #1

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
REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL390007092
Investigation #:	2025A0581005
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/16/2024
Report Due Date:	12/13/2024
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 of Port #1
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	05/02/1989
License Status:	1ST PROVISIONAL
Effective Date:	10/02/2024
Expiration Date:	04/01/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS

	Violation Established?
Direct care staff, Brianna Hooper, was verbally and physically abusive to Resident F.	No
Direct care staff, Brianna Hooper and Shabriea Wiggins, made threatening comments about Resident F.	No
Additional Findings.	Yes

****To maintain the coding consistency of residents across past investigations and renewal licensing study reports, the resident in this special investigation report is not identified in sequential order.*

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0581005
10/16/2024	APS Referral - made via email
10/16/2024	Special Investigation Initiated – Telephone - Interview with Complainant.
10/16/2024	Contact - Telephone call made - Interview with direct care staff, Ethan Miller
10/18/2024	Inspection Completed On-site - Interviewed staff and reviewed documentation
10/18/2024	Contact - Telephone call made - Left voicemail with direct care staff, Brianna Hooper
10/18/2024	Contact - Telephone call made - Interview with Shabriea Wiggins.
10/18/2024	Contact - Document Sent - Email to the Workforce Background Check section
10/18/2024	Contact - Telephone call made - Left voicemail with direct care staff, Tandra McKinney
10/18/2024	Contact - Telephone call received - Interview with direct care staff, Tandra McKinney
11/18/2024	Contact - Telephone call received - Received voicemail from Complainant

12/02/2024	Contact - Telephone call made - Contact with Complainant.
12/06/2024	Contact - Telephone call made - Interview with direct care staff, Brianna Hooper
12/06/2024	Contact - Document Sent - Sent email to Workforce Background Check
12/06/2024	Referral - Law Enforcement - Referred allegations to Portage Police Dept.
12/06/2024	Exit conference with the licensee designee, Connie Clauson, via telephone.

ALLEGATION:

- **Direct care staff, Brianna Hooper, was verbally and physically abusive to Resident F.**

- **Direct care staff, Brianna Hooper and Shabriea Wiggins, made threatening comments about Resident F.**

INVESTIGATION: On 10/14/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged approximately three weeks ago, direct care staff, Brianna Hooper, was verbally and physically abusive towards Resident F when caring for her. The complaint alleged Brianna Hooper threw Resident F's soiled clothing across her room and left the clothes there to be picked up by direct care staff, Ethan Miller.

On 10/15/2024, I received an additional complaint, which alleged on or around 10/07/2024, staff Brianna Hooper and Shabriea Wiggins, talked rudely about Resident F and joked they were “pulling the plug” to kill her. Additionally, the complaint alleged Brianna Hooper and Shabriea Wiggins called Resident F “a stupid bitch”.

On 10/16/2024, I interviewed Complainant via telephone. Complainant stated Resident F was admitted to the facility on 07/19/2024 and passed away on 10/10/2024 after getting admitted to hospice. Complainant could not recall the specific date or day of the week, but stated approximately 3-4 weeks ago, Resident F reported she pulled her call string alerting staff she needed assistance using the bathroom; however, when staff, Brianna Hooper, came into her room she yelled, “You already went! Get in the bathroom! Take your pants off!” Complainant stated staff, Brianna Hooper, cleaned up Resident F after having diarrhea, but was rough with her. Complainant also stated Brianna Hooper did not fully clean up Resident F,

which resulted in Resident F also having to clean herself up. Complainant stated Brianna Hooper took Resident F's soiled clothing, which were covered in feces, and threw them across her room. Complainant stated Resident F's toilet was also clogged from the incident and Brianna Hooper did not help Resident F with cleaning it or unclogging it. Subsequently, Complainant stated Resident F had to clean up the toilet herself.

Complainant stated direct care staff, Ethan Miller, came into Resident F's bedroom and assisted Resident F with unplugging her toilet, cleaning up her bedroom, and washing her soiled clothes. Complainant stated Resident F was humiliated from the whole incident.

Additionally, Complainant stated on or around 10/08/2024, Resident F's health declined. Complainant stated despite Ethan Miller not being on the schedule to work, it was requested he sit with Resident F in her bedroom for company since Resident F and Relative F1 liked Ethan Miller. Complainant stated Brianna Hooper and Shabriea Wiggins made fun of Ethan Miller for spending time with Resident F and were "harassing" him. Complainant stated Brianna Hooper and Shabriea Wiggins were overheard making comments like "I bet you're going to cry at [Resident F's] funeral". Additionally, Complainant stated Brianna Hooper and Shabriea Wiggins were also heard saying they were going to unplug Resident F's oxygen. Complainant stated albeit the comments made by Brianna Hooper and Shabriea Wiggins were threatening; Complainant did not believe there was evidence to suggest Brianna Hooper or Shabriea Wiggins unplugged Resident F's oxygen tank because Ethan Miller was in her bedroom the entire time.

On 10/16/2024, I interviewed direct care staff, Ethan Miller, via telephone. Ethan Miller recalled the incident whereas Resident F's soiled clothing had been thrown across Resident F's bedroom. He stated he did not recall the specific day or date of the incident, but stated it occurred on 1st shift, but he observed it when he came in around 2 pm for the start of his 2nd shift. He stated upon entering Resident F's bedroom he observed her soiled clothing on the floor and her toilet was covered in feces. He stated Resident F was also sitting on a bed pad that was covered in feces. He stated Brianna Hooper helped change Resident F's clothing but allowed her to sit on a soiled bed pad. Ethan Miller stated Brianna Hooper did not say anything to him about the incident and he cleaned up Resident F's bedroom.

Additionally, Ethan Miller stated he worked with Shabriea Wiggins on or around 10/07/2024 or 10/08/2024. He stated while in the facility, Brianna Hooper, came into the building despite being assigned to work in a neighboring building, and both she and Shabriea Wiggins reported, "We can't wait for that stupid old bitch to die" referencing Resident F. He stated they also said, "That bitch got my friend banned" in reference to Brianna Hooper not being able to work in the building. He stated both staff laughed about their comments. Ethan Miller stated he was so concerned for Resident F's welfare he stayed in her room all night to ensure nothing happened to her. Ethan Miller stated Brianna Hooper worked with direct care staff, Tandra

McKinney, in the neighboring building the night he heard Brianna Hooper and Shabriea Wiggins make threatening comments about Resident F.

On 10/18/2024, I conducted an unannounced inspection at the facility. I interviewed direct care staff, Melvina Higgins. She stated Resident F did not always need staff assistance with toileting; however, prior to Resident F passing away she was experienced bouts of diarrhea. She stated Resident F needed assistance from staff in cleaning herself up, which was provided by staff. She stated Resident F would pull the call string to alert staff when she needed assistance. Melvina Higgins stated she was not aware of any incidences where staff, including Brianna Hooper or Shabriea Wiggins, were rough with Resident F, refused to assist her, treated her inappropriately, called her names, or threatened her. Melvina Higgins stated right before Resident F passed away, Ethan Miller, reported to her Brianna Hooper and Shabriea Wiggins, were rude to Resident F by “saying bad things about her”. Melvina Higgins stated Ethan Miller did not report any additional information to her at that time; therefore, she did not believe Resident F was in any danger from either Brianna Hooper or Shabriea Wiggins. Melvina Higgins denied ever hearing Brianna Hooper or Shabriea Wiggins ever say anything inappropriate to or about Resident F.

On 10/18/2024, I interviewed staff, Shabriea Wiggins, via telephone. Shabriea Wiggins denied all the allegations. Shabriea Wiggins stated she did not often work directly with Resident F as she only administered medications to her a couple times. Shabriea Wiggins stated she was “cordial” with Resident F and described no issues. Shabriea Wiggins stated, however, she did not get along with Ethan Miller, because he did not do his job while he worked. She stated he often spoke to Relative F1 on the phone about providing particular care to Resident F like sitting with her; however, Shabriea Wiggins stated Ethan Miller would sit in the facility’s living room rather than sit with Resident F in her bedroom. Shabriea Wiggins stated Ethan Miller lied to Relative F1 and to the facility’s management about her and Brianna Hooper making inappropriate comments about Resident F.

On 10/18/2024, I interviewed staff, Tandra McKinney, via telephone. Tandra McKinney denied staff, Brianna Hooper, ever leaving the neighboring facility to interact with staff, Shabriea Wiggins, on or around 10/07/2024 or 10/08/2024. She stated she had never heard or overheard either Shabriea Wiggins or Brianna Hooper make any negative, inappropriate, or threatening comments about Resident F or any other residents, as alleged. Tandra McKinney texted me her written statement, which she provided to the facility’s Administrator and Licensee Designee, Connie Clauson, on 10/10/2024. The written statement from Tandra McKinney was consistent with her statement to me. She acknowledged working with Brianna Hooper on 10/07/2024 and 10/08/2024; however, she stated Brianna Hooper went to the neighboring building for a ”second” at the request of the neighboring facility’s manager and denied being aware of her leaving the building on 10/08/2024.

On 12/06/2024, I interviewed staff, Brianna Hooper, via telephone. Brianna Hooper’s statement to me was consistent with Melvina Higgins’ and Shabriea Wiggins’

statements to me. Brianna Hooper also denied the allegations. She also stated she told Ethan Miller she did not want to work with him because he was lazy. She stated she believed he retaliated after she expressed her concern and dislike for him.

On 12/06/2024, I interviewed licensee designee, Connie Clauson, via telephone. Connie Clauson stated she also conducted an investigation regarding the allegations and did not find enough evidence supporting them. She stated Ethan Miller was no longer working at the facility as he was inappropriate with her and other staff. She stated he walked off a shift; therefore, his employment was terminated. She stated since his employment was terminated there had been no additional issues in the facility with staff working together.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my investigation, which included interviews with Complainant, direct care staff, Ethan Miller, Brianna Hooper, Shabriea Wiggins, Melvina Higgins, and Tandra McKinney, there is no supporting evidence that staff, Brianna Hooper and Shabriea Wiggins, called Resident F inappropriate names, treated her disrespectfully or without dignity by throwing her feces soiled clothing across her room and/or not assisting her with cleaning up after she experienced diarrhea, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(f) Subject a resident to any of the following: **(iv) Threats.**
ANALYSIS:	Despite the severity of the allegations, based on my investigation, there is no supporting evidence or any corroborating statements that either direct care staff, Brianna Hooper or Shabriea Wiggins, stated they would unplug Resident F's oxygen tank. Both Brianna Hooper and Shabriea Wiggins denied the allegations and Ethan Miller was the only staff to overhear them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/16/2024, Complainant stated both Brianna Hooper and Shabriea Wiggins had been fired from the facility over the summer by the facility's former Administrator, Brandy Aucunas; however, both of these staff continued to work in the facility.

Ethan Miller stated Brandy Aucunas quit working in the facility and when the licensee's Regional Operations Director, Karen Hodge, took over; however, her employment was terminated. Ethan Miller stated the facility's Licensee Designee, Connie Clauson, allowed Brianna Hooper and Shabriea Wiggins to continue working in the facility.

On 10/16/2024, I emailed Workforce Background Check (WBC) section staff, Katelyn Haskin, and requested if either Brianna Hooper or Shabriea Wiggins fingerprints were attached to the facility. Katelyn Haskin responded to my email documenting Brianna Hooper was found to be eligible for employment on 02/03/2020; however, the licensee withdrew her status. Katelyn Haskin stated she determined Brianna Hooper was assigned as actively working at another assisted living facility. Katelyn Haskin documented Brianna Hooper had her fingerprints completed on 05/15/2024 through the other assisted living facility. She documented that due to Brianna Hooper having her fingerprints completed within the last year, the licensee could attach her to the facility without having to pay for new fingerprints.

On 10/21/2024, I received another email from Katelyn Haskin documenting Shabriea Wiggins had fingerprints completed through the WBC on 11/02/2023; however, these fingerprints were not completed by the licensee as they were attached to other assisted living facilities or adult foster care facilities.

On 12/06/2024, licensee designee, Connie Clauson, stated she was trying to work with the WBC on obtaining a new username and password for the WBC website.

She stated at this time, she was unable to enter new staff at the facility but could enter them under other facilities whereas she and/or other staff under the licensee access to the website. I informed Connie Clauson I would email Katelyn Haskin for her requesting assistance on her behalf.

Upon review of the facility's electronic file, I determined the facility has a repeat violation of the Adult Foster Care Facility Licensing Act Of 1979 MCL 400.734b(2). According to the 2024 Renewal Licensing Study Report, dated 09/05/2024, the licensee did not have fingerprints completed for direct care staff, Marchelle McKissic, despite her date of hire being identified as 07/23/2024. The licensee's Corrective Action Plan (CAP), dated 10/02/2024, documented all employees would be scheduled for fingerprinting during their orientation, the Administrator or designee would ensure fingerprinting was completed within 10 business days of hire, employees who are unable to complete fingerprinting within 10 days of hire would not be placed on the schedule until fingerprinting results were completed, and the Administrator was responsible ensuring ongoing compliance with the rule.

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.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster

	care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Neither staff, Breana Hooper nor Shabriea Wiggins, had Workforce Background Checks for the facility. Though Breana Hooper and Shabriea Wiggins had fingerprints completed on 05/15/2024 and 11/02/2023, respectively, these fingerprints were not connected to the licensee or facility, but rather they were connected to other assisted living and/or adult foster care facilities. Consequently, neither staff has been deemed eligible to work at Fountain View Ret Vil of Port #1, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

On 12/06/2024, I conducted the exit conference with the licensee designee, Connie Clauson, via telephone. She agreed with my findings and stated she had come to the same conclusion upon completion of her own investigation. Connie Clauson stated she was in the process of trying to obtain a new username and password from the WBC in order to send staff for fingerprinting; however, she has been unable to listed on the WBC account as an Administrator.

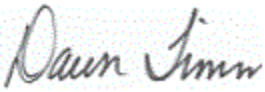
IV. RECOMMENDATION

I recommend continuation of the provisional license, which allows the licensee sufficient time to implement the corrective action plan, dated 10/02/2024.

12/09/2024

Cathy Cushman Date
Licensing Consultant

Approved By:



12/09/2024

Dawn N. Timm Date
Area Manager