GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2025

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

RE: License #: AL390007092
Investigation #: 2025A0581019
Fountain View Ret Vil of Port #1

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

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 #:	AL390007092
Investigation #:	2025A0581019
Complaint Receipt Date:	02/28/2025
Investigation Initiation Date:	02/28/2025
Report Due Date:	04/29/2025
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:	Sara Johnson
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. ALLEGATION

	Violation Established?
A direct care staff was inappropriate with Resident J when she yelled at and taunted her on 02/26/2025.	No
A direct care staff hit Resident J with a grabber tool, stepped on her oxygen tube, and pushed her aggressively in her wheelchair.	No
Direct care staff did not administer medication to Resident J when she requested it on the evening of 02/26/2025.	No

**** To maintain the coding consistency of residents across special investigations and renewal reports, the residents in this renewal report are not identified in sequential order.*

III. METHODOLOGY

02/28/2025	Special Investigation Intake - 2025A0581019
02/28/2025	Special Investigation Initiated – Letter - Email with Complainant.
03/03/2025	Inspection Completed On-site - Interview with staff and residents
03/13/2025	APS Referral - APS investigating similar allegations - Not substantiating for abuse/neglect of resident.
04/01/2025	Contact – Telephone call made – Left message with direct care staff, Linetta Dixon.
04/01/2025	Contact – Telephone call made – Interview with direct care staff, Tori Martin.
04/02/2025	Contact – Document Received – email from Administrator, Sara Johnson.
04/02/2025	Exit conference with Administrator, Sara Johnson, and Licensee Designee, Connie Clauson, via email.

ALLEGATION:

- **A direct care staff was inappropriate with Resident J when she yelled at and taunted her on 02/26/2025.**

- **A direct care staff hit Resident J with a grabber tool, stepped on her oxygen tube, and pushed her aggressively in her wheelchair.**

- **Direct care staff did not administer medication to Resident J when she requested it on the evening of 02/26/2025.**

INVESTIGATION: On 02/28/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 02/26/2025 at approximately 8:30 pm, Resident J "went to look for her medications". The complaint alleged an unknown female direct care staff went into Resident J's bedroom, but Resident J asked her to leave. The complaint alleged the direct care staff had been told in the past not to come into her bedroom. The complaint alleged the direct care staff started "to taunt" Resident J by talking in a "sing song voice" and saying, "you can't walk this far" and "you can't put me out". The complaint alleged Resident J picked up her "grabber" and swung it at the direct care staff, but the direct care staff grabbed it out of Resident J's hands, broke it, and threw it in the garbage.

The complaint also alleged Resident J got in her wheelchair and went to the facility's common area, but couldn't find anyone because she was told by a direct care staff everyone was upstairs because "someone died". The complaint alleged Resident J was in pain and wanted her medication; however, the direct care staff told Resident J she had to go upstairs to get her medication.

The complaint further alleged the direct care staff took a hold of Resident J's wheelchair and "swung it back and forth across the hallway hitting doorways", which scared Resident J. The complaint also alleged the direct care staff stepped on Resident J's oxygen tubing which caused a disruption of oxygen to Resident J who is fully dependent on oxygen 24/7. The complaint alleged Resident J contacted a friend to come stay with her because she was fearful for her life and felt the staff was trying to kill her.

On 02/28/2025, I contacted Complainant via email; however, Complainant did not provide any additional pertinent information. Complainant documented in her email it was unknown if other residents were present when the incident with Resident J allegedly occurred. Complainant documented Resident J believes no one in the facility likes her. Additionally, Complainant documented Resident J has retold the incident several times and the main details have not changed.

On 03/03/2025, I conducted an unannounced inspection at the facility. I interviewed direct care staff, Jessica Kellogg. Jessica Kellogg stated the only resident who

passed away on or around 02/26/2025 was a resident in the neighboring facility. She denied any residents in Fountain View Ret Vil of Port #1 passing away on 02/26/2025; therefore, none of the staff working at the time of the alleged incident would have been busy dealing with a resident death in that building.

Jessica Kellogg stated she was not working in the facility at the time of the alleged incident, but stated direct care staff, Linetta Dixon, called her at approximately 9 pm reporting Resident J was displaying behaviors like screaming, hollering, and telling direct care staff, Tori Martin, she did not want her in her room. Jessica Kellogg stated Linetta Dixon reported to her Resident J hit Tori Martin with a grabber tool, was disturbing the residents in the common areas by calling them vulgar names, and throwing ice at them. Jessica Kellogg stated Linetta Dixon reported Tori Martin took the grabber tool away from Resident J after she was hit with it; however, Jessica Kellogg denied having information regarding Tori Martin hitting Resident J with the grabber tool.

Jessica Kellogg stated Resident J will “cause a scene” if she does not receive her medications right away; despite staff being in the middle of other activities like administering medications or providing personal care to other residents.

I interviewed Resident J whose statement was consistent with the allegations; however, she could not recall the names of any staff involved in the alleged incident. Despite Resident J stating staff broke her grabber tool, she stated she did not know what happened to the broken pieces. She stated the staff mocked her and told her she could not walk. Resident J denied hitting staff with the grabber tool although she stated she waved it around in her room at the staff. She stated when the staff was taking her back to her room, the staff pushed her in her wheelchair “as fast as she could” and “smashed” Resident J against the hallway walls. She stated residents and other staff witnessed the incident take place, but no one would help her despite her screaming for help. Resident J stated she received a bruise on her knee at the time of the incident, but it was no longer present.

Resident J also stated staff jumped up and down on her oxygen tube in the facility’s hallway. She stated residents were also around when the incident occurred; however, she stated since they do not like her they would not accurately report what occured. She stated the other staff working would not help her either. She could not recall losing oxygen when staff stomped on her oxygen tube.

Resident J stated she required an 8 pm pain medication on 02/26/2025; however, staff refused to administer it to her. Resident J could not recall if staff ended up administering the medication to her or not. She stated her spouse came to the facility that evening after she contacted her; however, her spouse also did nothing to help her.

I interviewed direct care staff, Melvina Higgins, who’s statement was consistent with Jessica Kellogg’s statement. Melvina Higgins stated Resident J has a history of

physically assaulting and being verbally aggressive to staff. She stated just a couple days ago Resident J hit her. Melvina stated Resident J will often ask for medications early, including as needed medications, and staff have to redirect her or remind her of her medication times. She denied staff not administering Resident J's medications as prescribed.

I interviewed Resident K who stated she has resided in the facility for approximately 1 year. She stated she recalled the incident involving Resident J on 02/26/2025. She stated Resident J screamed at staff and hit staff with her grabber tool. Resident K denied hearing either Linette Dixon or Tori Martin say anything inappropriate or rude to Resident J. Resident K stated Resident J frequently uses derogatory and vulgar language to both residents and staff.

Resident K stated Tori Martin assisted Resident J in her wheelchair down the facility's hallway; however, Resident K did not observe Tori Martin act in an aggressive manner. Resident K stated Resident J utilizes oxygen, but stated she did not observe any staff intentionally step on her oxygen tube or cut off her oxygen while Resident J was using it.

I also interviewed Resident L whose statement was consistent with Resident K's statement; however, she stated there are times when Resident J has to wait for her medications because she is requesting them when it is not the correct time for staff to administer the medication.

Resident K denied any issues regarding medications and stated she receives all her medications as prescribed.

During the inspection, I reviewed Resident J's February 2025 Medication Administration Record (MAR), which documented Linetta Dixon administered all of Resident J's controlled medications at 8 pm, as required. The MAR also documented Resident J is prescribed the as needed or PRN medication, Oxycodone Ir 5 mg Tablet with the instruction of "Take 1 Tablet by Mouth Every 6 Hours as Needed". According to the MAR, Linetta Dixon administered Resident J's Oxycodone tablet at 7:29 pm. The MAR documented it was "requested for pain" and provided Resident J "some relief".

Additionally, during the inspection, Melvina Higgins stated Resident J's grabber tool was in the staff's office/medication room, which I observed.

On 04/01/2025, I interviewed direct care staff, Tori Martin, via telephone. Though Tori Martin stated she would answer my questions regarding the incident, she stated she no longer worked for the licensee.

Tori Martin stated the incident with Resident J occurred approximately between 7 pm and 8 pm on 02/26/2025. She stated Resident J was requesting her Oxycodone medication for pain management; however, she and direct care staff, Linetta Dixon,

who was the assigned “med tech” were both busy and unable to administer the medication immediately to Resident J. Tori Martin stated Resident J continued pulling her call light to alert staff that she wanted the medication. Tori Martin stated she went down to assist Resident J each time she used the call light; however, Resident J told her she did not want her in her room. Tori Martin stated Resident J called her derogatory and offensive names, threatened her, and hit her with a grabber device. She denied hitting her with the grabber tool.

Tori Martin denied aggressively pushing Resident J in her wheelchair. She also denied stepping on Resident J’s oxygen tube. She stated Resident J’s oxygen tube became wrapped around the wheelchair wheels while Resident J was wheeling herself away from her. Tori Martin stated despite Resident J’s behavior towards her she assisted Resident J with getting the oxygen tube untangled from the wheel.

Tori Martin terminated the interview early as she stated she had prior engagements. Subsequently, I was unable to ask any additional questions relating to how she spoke to Resident J during the interaction or the incident on or around 02/26/2025.

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 multiple direct care staff, Resident J, Resident K, and Resident L, there is no supporting evidence any direct care staff, including Tori Martin and Linetta Dixon, mistreated Resident J the evening of 02/26/2025 by yelling at her, taunting her, hitting her with a grabber tool, pushing her aggressively in a wheelchair or stepping on her oxygen tube, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	There is no supporting evidence Resident J did not receive all her medications on the evening of 02/26/2025, including her as needed or PRN medication, Oxycodone 5 mg, for pain management.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/02/2025, I conducted my exit conference with Administrator, Sara Johnson, and Licensee Designee, Connie Clauson, via email whereas I explained my findings.

IV. RECOMMENDATION

I recommend the continuation of refusal to renew the license.

04/02/2025

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Cathy Cushman Date
Licensing Consultant

Approved By:

_____

Dawn N. Timm Date
Area Manager