GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 14, 2022

Melissa Doss
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM230249421
Investigation #: 2022A1029013
MLK Road Home

Dear Ms. Doss:

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230249421
Investigation #:	2022A1029013
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/22/2022
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Melissa Doss
Licensee Designee:	Melissa Doss
Name of Facility:	MLK Road Home
Facility Address:	300 North Michigan Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2374
Original Issuance Date:	04/09/2003
License Status:	REGULAR
Effective Date:	12/22/2020
Expiration Date:	12/21/2022
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The home manager, Ms. Johnson failed to determine a safety plan for Resident A after she had been sexually assaulted by Resident B at MLK Road Home.	No

III. METHODOLOGY

11/23/2021	Special Investigation Intake 2022A1029013
11/24/2021	Special Investigation Initiated – Telephone to Rachel Bato direct care staff member to get home managers contact information.
12/14/2021	Contact - Document Sent - Emailed Adult Protective Services (Eaton County) worker, Shelly Stratz and spoke with her on the phone.
12/14/2021	Contact - Face to Face with Venicia Hernandez, India Johnson, Resident A
12/16/2021	Contact - Telephone call made to Nicole Busch, Community Mental Health case manager
01/03/2022	Contact - Telephone call made to Resident B by adult foster care licensing consultant, Rodney Gill.
01/11/2022	Contact - Telephone call made to direct care staff member, Carlie Cobb. Left a message.
01/11/2022	Contact - Telephone call made to direct care staff member, Barbara Schultz
01/11/2022	Contact - Telephone call made to India Johnson whose role is a home manager at MLK Road Home.
01/11/2022	Exit Conference with licensee designee, Melissa Doss.

ALLEGATION:

The home manager, Ms. Johnson failed to determine a safety plan for Resident A after she had been sexually assaulted by Resident B at MLK Road Home.

INVESTIGATION:

On November 23, 2021, a complaint was received via adult protective services that Resident A was sexually assaulted at MLK Road Home by Resident B. Complainant voiced concerns home manager India Hudson was not going to develop a safety plan because there was no proof of the incident.

On December 13, 2021, new information was received from the BCHS online complaint system that Resident A had a sexual assault nurse exam completed and the results showed injury with an unknown cause. There were again concerns that home manager, India Johnson declined to take action against the concerns. Additional information included that Eaton County Sheriff's Department is investigating the assault with report number 2021-6391. Shelly Stratz from Eaton County Adult Protective Services will also now be investigating the incident. It was alleged Resident B came into the Resident A's bedroom during the night to sexually assault her but specific details were not described.

An *AFC Licensing Division – Incident / Accident Report* was received and signed by Melissa Doss on November 23, 2021, with the following explanation of what occurred:

> *"{Resident A} reported to staff that she was sexually assaulted. When questioned, she would not give details and declined to call 911 at the time. AM staff spoke with {Resident A} and she stated she would be willing to have a doctor see her. Staff took {Resident A} to Eaton County Hospital for a rape kit. Hospital contacted law enforcement and adult protective services."*

On December 14, 2021, 2021, I interviewed direct care staff member, Venicia Hernandez at MLK Road Home. She stated Resident A has not mentioned anything about the alleged assault since it occurred. After the incident, Resident A went to a crisis center for mental health treatment and returned Friday, December 10, 2021. Resident A has resided at MLK Road Home since April 21, 2021. According to direct care staff member Venicia Hernandez the resident bedroom doors at MLK Road Home automatically lock so there is no way that Resident B would be able to enter Resident A's bedroom unless she let him in or propped the door open. Normally, according to Ms. Hernandez, Resident A keeps her bedroom door closed when she is in the room. Ms. Hernandez stated over the past week (December 7-14) Resident A has been going to the neighbor's home and trying to walk in as she has been experiencing delusions and feels like they are her family. Ms. Hernandez stated the facility installed chimes on the side doors so direct care staff members know when she is leaving MLK Road Home. During the night, the direct care staff members' complete night checks but they do not open the doors and disturb residents at night. Home manager, India Johnson was also present at the time of the on-site investigation and she agreed with the above statements from Ms. Hernandez. She also gave direct care staff member phone numbers that were present for the incident.

I was able to observe Resident A's bedroom and the door was locked. The direct care staff members and the residents have the keys to open their individual bedroom doors.

The door was non-locking against egress and there was no way for another resident to open another resident bedroom door during the night if the door was closed.

I interviewed Resident A at MLK Road Home. Resident A stated she just returned home from receiving mental health treatment while being hospitalized. Resident A stated she believed it was possible for residents to enter her closed bedroom door during nighttime hours because other residents come in and steal her new clothes. Resident A could not explain how this occurred. Resident A stated Resident B went into her room and did some "kind of sex thing to her" and told her that no one would do anything. Resident A did not want to talk further about the incident. She said that afterward she told the direct care staff members and the police about the incident. Resident A stated she feels safe living at MLK Road Home.

During the on-site investigation, I was able to review the resident record for Resident A. According to her *Assessment* completed by Community Mental Health on April 22, 2021, "*she continued to report visual and auditory hallucinations. {Resident A} was symptomatic of delusional thoughts, evidenced by her reports that she wakes up to people punching her in the abdominal area. Historically, she has had similar reporting regarding individuals inflicting harm upon her. She will often attempt to show treatment team members the areas in which harm had been afflicted. Under the section titled Clinical Interpretive Summary, {Resident A} has extensive psychiatric history and has been served in various treatment programs within Community Mental Health. {Resident A} is symptomatic of persecutory delusions, which is evidence of her ongoing reports of feeling physically attacked*."

Resident A's *Assessment Plan for AFC Residents* (signed May 14, 2021) was also reviewed and there was nothing documented that Resident A required extra supervision during the evening or sleeping hours.

On December 16, 2021, I interviewed Nicole Busch, Community Mental Health case manager for Resident A. Ms. Busch spoke to Resident A about the incident and Resident A talked to her about being hit by someone but could not identify who it was. Ms. Busch stated this was a typical statement based on Resident A's past delusions. Ms. Busch stated she was not aware of statements at MLK Road Home regarding sexual abuse however, she has made claims in previous placements. Ms. Busch stated when she first started working with Resident A, there were substantiated reports of trauma related to her previous family environment. Since then, Resident A has not made any reports of sexual abuse or trauma according to Ms. Busch. Ms. Busch stated she was told originally the direct care staff members encouraged Resident A to go to the hospital but Resident A declined initially until direct care staff continued to discuss this with her, and she agreed.

On January 3, 2022, a phone interview was completed with Resident B by adult foster care licensing consultant, Rodney Gill. Resident B stated he was familiar with Resident A and stated that, "She was my girlfriend for a while, yes." He also indicated that they did "kiss, hug, and stuff" when they were in a relationship. Resident B continued by

stating that Resident A did not feel too good because she had backaches and recently had eye surgery for cataracts so he did not bother her too much. Resident B denied going into Resident A's bedroom November 21 and November 23, 2021, saying, "No, I do not remember doing that." Resident B also denied doing anything sexual with Resident A. He said that he never had sex with Resident A and explained that her room was nasty, that she kept her room dirty all the time. Resident B stated that she was a "nasty girl." He indicated that she kept food all over her floor. He said that she was sick, "sick in the head." Resident B stated that she was "mental" and he would never have sex or anything like that with her.

On January 11, 2022, I called direct care staff member, Barbara Schultz who she stated she was working the overnight shift on November 23, 2021, when Resident A asked for a PRN Tylenol. Ms. Schultz stated she asked Resident A what was wrong to which Resident A replied, "sexual assault." Ms. Schultz stated Resident A did not say anything else about the alleged assault after this. Ms. Schultz stated Resident A has a history of delusions related to inappropriate sexual contact and it appeared as though this too could be related to a delusion but it was her responsibility to report the allegation of sexual assault to police. Ms. Schultz stated an investigation was started the following morning after an officer from Eaton County Sheriff's Department came out to interview Resident A. Ms. Schultz stated she was unaware of the outcome of the investigation but during the interim Resident B was moved to another licensed AFC owned by the licensee. Ms. Schultz stated there have never been any reports of inappropriate sexual contact by Resident B toward any resident prior to this allegation. Ms. Schultz stated that she was not aware of Resident A and Resident B being in any type of consensual relationship. At the end of the night when Resident A reported this, Resident A voluntarily gave Resident B a hug. Ms. Schultz stated residents are not able to open other resident bedroom doors as each resident has their own key so it did not seem possible to Ms. Schultz that Resident B let himself in to Resident A's bedroom. Ms. Schultz stated sometimes residents will prop their door open, but she always had hers shut. Lastly, Ms. Schultz did not observe anything unusual during her shift on November 23, 2021, like any sexual contact between any resident. Ms. Schultz stated Resident A was taken for emergency mental health treatment on November 24, 2021.

On January 11, 2022, I spoke with direct care staff member, India Johnson whose current role is as home manager at MLK Road Home. According to what Ms. Johnson was told, after Resident A requested Tylenol, she told the direct care staff member what happened but she refused medical treatment and the police. Ms. Johnson stated Resident A wanted to wait until she (Ms. Johnson) arrived to work. Upon Ms. Johnson's arrival, the morning staff convinced her to agree to be transported to Eaton Rapids Medical Center. Ms. Johnson stated law enforcement interviewed her and spoke with Resident A but the last she heard; law enforcement had not interviewed direct care staff members that were present. Ms. Johnson stated she did not decline to do a safety plan rather she called her supervisor, Melissa Doss, for guidance about the safety plan for Resident A. Ms. Johnson stated she called the hospital back and informed them the safety plan was to increase monitoring and make sure Resident A's bedroom door was shut and locked when she was in her room. Ms. Johnson stated she also informed the

nurse Resident A had initially refused to call the police. Also, because of her delusions, Ms. Johnson stated they were waiting to hear what the hospital exam results were before determining the next steps. At the hospital, Resident A stated that she did not feel safe and she then went to Bridges crisis center. Ms. Johnson has not heard anything further from Eaton County Sherriff's Department about the results of the investigation.

On January 11, 2022, I completed the exit interview with licensee designee, Melissa Doss. She stated that the hospital staff was upset with Ms. Johnson because she did not have a plan to move Resident B out of the home or to keep them separate, however at that time, availability at other licensed properties owned by the licensee was unknown. Since the allegation, the two residents have not resided together.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	According to the *AFC Licensing Division – Incident / Accident* Report and interviews with Resident A she reported she was sexually assaulted around 2:00 a.m. on November 23, 2021, however the direct care staff member and licensee designee Melissa Doss handled the situation appropriately once Resident A disclosed. The direct care staff members conduct checks throughout the night to ensure the safety of the residents. They did not fail to protect her safety after the alleged incident occurred because direct care staff member, Ms. Schultz encouraged her to call law enforcement and go to the hospital. There is no indication Resident B entered her room that night as he denied sexually assaulting Resident A. Further Resident A's bedroom door was shut and locked that night and direct care staff members did not report any unusual activity. There were no previous incidents between the two residents before this allegation. Both resident remain separated from one another. Licensee designee, Melissa Doss ensured that Resident A was safe, contacted the medical center, and made sure that both residents were provided supervision, protection, and personal care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

___ 1/11/2022_____

Jennifer Browning Date
Licensing Consultant

Approved By:

01/14/2022

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Dawn N. Timm Date
Area Manager