GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

Raul Presas
Maplewood Group AFC, LLC
PO Box 508
Eaton Rapids, MI 48827

RE: License #: AM230388711
Investigation #: 2022A0783038
Maplewood Group AFC LLC

Dear Mr. Presas:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230388711
Investigation #:	2022A0783038
Complaint Receipt Date:	04/07/2022
Investigation Initiation Date:	04/08/2022
Report Due Date:	06/06/2022
Licensee Name:	Maplewood Group AFC, LLC
Licensee Address:	11300 Columbia Hwy Eaton Rapids, MI 48827
Licensee Telephone #:	(517) 927-7996
Administrator:	Raul Presas
Licensee Designee:	Raul Presas
Name of Facility:	Maplewood Group AFC LLC
Facility Address:	11300 Columbia Hwy Eaton Rapids, MI 48827
Facility Telephone #:	(517) 927-7996
Original Issuance Date:	07/11/2018
License Status:	REGULAR
Effective Date:	01/11/2021
Expiration Date:	01/10/2023
Capacity:	10
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A regularly sexually assaulted females at the facility by grabbing their breasts.	Yes
Despite direct care staff members being aware of Resident A's sexually acting out behaviors, Resident A sexually assaulted Resident B.	Yes
Resident B had an unexplained bruise on her back.	No

III. METHODOLOGY

04/07/2022	Special Investigation Intake – 2022A0783038
04/08/2022	Special Investigation Initiated - On Site
04/08/2022	Contact - Face to Face interviews with home manager and direct care staff member Connie Parker and direct care staff members Allison Teves, Savannah Tackett, and John Castanon.
04/08/2022	Contact - Face to Face interviews with Resident A, Resident B, Resident C, and Resident D
04/08/2022	Contact - Telephone call made to licensee designee Raul Presas
04/11/2022	Contact - Telephone call made to Guardian A1
04/11/2022	Contact - Document Received – Second complaint with similar allegations (included in this report)
04/14/2022	Contact - Document Received – Written incident reports from Resident A's previous home
05/19/2022	Contact - Document Received – Written *Incident/Investigation Report* from Eaton County Sheriff's Office
05/24/2022	Contact - Telephone call made to Jacqueline Lloyd at Tri-County Office on Aging (TCOA)
05/24/2022	Contact - Telephone call made to Raul Presas

05/24/2022	Exit Conference with Raul Presas
05/31/2022	Contact -Telephone call made to Guardian B1 and direct care staff members Savanna Tackett, Allison Teves, Connie Parker, John Castanon and Tiffany Leonard
06/03/2022	Inspection Completed Onsite
06/03/2022	Contact – Face to face interview with Resident B
06/03/2022	Exit Conference with Raul Presas

ALLEGATION:

Resident A regularly sexually assaulted females at the facility by grabbing their breasts.

INVESTIGATION:

On April 7, 2022, I received a denied adult protective services (APS) complaint via centralized intake that stated Resident A, age 76, is diagnosed with a history of stroke, major brain damage from the stroke, and speech and language issues due to the stroke. The written complaint stated Resident A has drug induced Parkinson's disease, chronic gout, kidney issues, high blood pressure, and digestive issues. The written complaint stated prior to having a stroke Resident A exhibited hoarding behaviors and was uncomfortable with having people in his personal space. The written complaint stated Resident A had undiagnosed mental health issues such as possible OCD, bipolar disorder, or autism. The written complaint stated Resident A is currently grabbing the breasts of every woman he sees at the facility including the staff, other residents, and the physicians. The written complaint stated one female resident was staying in her room because Resident A was grabbing her. The written complaint stated Resident A got out of his room and got into bed with the female resident one night. The written complaint stated Resident A's physicians adjusted Resident A's medications to assist him with calming down and adjusting to his new home. The written complaint stated Resident A was recently placed at the facility after being removed from his previous adult foster care home for the same sexually acting out behaviors.

On April 11, 2022, I received a second denied APS complaint via centralized intake that stated Resident A has touched staff and other residents inappropriately. The written complaint stated there was a previous incident with another resident where Resident A tried to get into her bed. The written complaint cited concern that the previous incidents were not properly documented. The written complaint stated Resident A was transported from the facility on April 7, 2022 and would not be allowed to return.

On April 8, 2022, I completed an unannounced onsite investigation at the facility and attempted to interview Resident A who was in his bedroom when I arrived. Resident A would not or could not answer basic questions unrelated to the allegations in the complaint, nor would Resident A respond to any questions directly related to the allegations. Resident A began to quickly walk toward me with his arms and hands extended so I left the room. I noted that Resident A followed me into the common area of the facility, then turned and attempted to walk down the hallway where the female residents' bedrooms are located. I noted that the female staff members were unable to redirect Resident A and called upon the male staff member who was working, and he redirected Resident A back to his bedroom.

On April 8, 2022, I interviewed direct care staff member and home manager Connie Parker who stated Resident A was admitted to the facility on March 31, 2022, and that she and licensee designee Raul Presas visited Resident A at his previous home (another adult foster care home) and Resident A did not display any sexually acting out behavior. Ms. Parker said the manager at the other facility told her that Resident A "exposed himself" while he was living in that facility on one occasion but did not disclose that Resident A had a pattern of sexually acting out behavior. Ms. Parker said the facility home manager did disclose that Resident A was discharged due to the incident of sexually acting out via exposing himself. Ms. Parker said as soon as Resident A was admitted to this AFC and Guardian A1 left the facility, Resident A "immediately" began sexually acting out toward "one resident after another." Ms. Parker stated direct care staff members "couldn't keep up with" Resident A's sexually acting out behavior. Ms. Parker stated Resident A touched the breasts of three of five female residents admitted to the facility both above and below clothing as well as the breasts of visitors and direct care staff members. Ms. Parker stated to supervise Resident A and redirect his unwanted sexual touching staff members "tried to make [Resident A] stay in his bedroom" and "tried to keep eyes on him" at all times which was not possible because staff members needed to tend to other residents; some of whom required assistance from both staff members for transferring, mobility, etc., as well as administering medication, cleaning, and preparing and serving meals. Ms. Parker said staff members visually monitored Resident A every five minutes. Ms. Parker said after the sexually acting out behavior started, she contacted Guardian A1 who told her Resident A had sexually acting out behavior two years prior and refused to confine Resident A to his bedroom, including for meals which is what Ms. Parker said she proposed to Guardian A1. Ms. Parker said Guardian A1 told her in the past a medication adjustment corrected the problem, so she contacted Resident A's physician who prescribed different medications to Resident A, but Resident A continued to sexually assault every female with whom he came in contact including the female residents at the facility by grabbing females' breasts above and below their clothing.

On April 8, 2022, I interviewed direct care staff member Allison Teves who said Resident A was admitted to the facility approximately one week prior and that since his arrival, he had sexually assaulted Residents B, C, and D by touching their

breasts above and below their clothing. Ms. Teves said she was told nothing upon Resident A's admission of any history of sexually acting out behavior. Ms. Teves said on one occasion she was in the kitchen doing dishes and her co-worker John Castanon was administering residents' medication which is when Resident A came out of his bedroom and entered Resident C's bedroom unbeknownst to the two staff members working at the time. Ms. Teves said she heard Resident C scream, "get out of here, leave me alone pervert" and when she went to investigate, she observed Resident C in bed and Resident A was standing over her with his hands down Resident C's shirt. Ms. Teves said she and her co-worker John Castanon were able to redirect Resident A away from Resident C. Ms. Teves described Resident C as "shook up, teary, and out of breath" after Resident A assaulted her by touching her on the breasts under her shirt. Ms. Teves said Resident C told her Resident A "got [her] but [she] was OK." Ms. Teves said there was another incident when she was working with Mr. Castanon when Resident A attempted to get in Resident B's bed and was redirected. Ms. Teves said she observed Resident A "grab [Resident B's] breasts" on more than one occasion. Ms. Teves said Resident A also touched Resident D's breasts on at least one occasion and Resident D had not been leaving her room since. Ms. Teves described Resident A as "strong" and stated staff members "had to grab [Resident A] and pull him off" female residents at the facility when he had his hands on the females' breasts. Ms. Teves said Resident A sexually assaulted nearly every female that entered the facility by touching their breasts both under and above clothing. Ms. Teves said staff members attempted to "make" Resident A stay in his bedroom and attempted to make visual contact with Resident A every five minutes, which was not always possible considering there are two staff members to care for eight residents; some of whom require assistance from both staff members, and that meals must be prepared and served, laundry must be washed and dried, medication administered, etc.

On April 8, 2022, I interviewed direct care staff member Savanna Tackett who stated upon Resident A's admission to the facility, approximately 10 days prior, staff members were told nothing about Resident A having any history of sexually acting out. Ms. Tackett stated the first thing Resident A did as soon as he arrived at the facility was "lifted [Resident B's] shirt and groped her." Ms. Tackett stated staff members learned immediately upon his arrival through experience that Resident A had this behavior, however, he continued to touch Resident B's breasts on more than one occasion and touched the breasts of Residents C and D. Ms. Tackett stated Resident A "took the opportunity" to touch female residents' breasts while staff members were busy doing other things. Ms. Tackett stated staff members were instructed to attempt to stay in the kitchen area so that Resident A could be seen exiting his bedroom to prevent the female residents from being sexually assaulted by Resident A, however two staff members cannot make visual contact with Resident A often enough to prevent Resident A from touching female residents' breasts because there are many other responsibilities including several residents who require assistance from two staff members for personal care. Ms. Tackett said the female residents at the facility are "scared and will not come out of their bedrooms" which is not normal behavior for the residents.

On April 8, 2022, I interviewed direct care staff member John Castanon who said Resident A was admitted to the facility approximately ten days prior and that he was told Resident A was nonverbal and required frequent redirection but was cooperative. Mr. Castanon denied he was told Resident A had any history of sexually acting out behaviors. Mr. Castanon said after Resident A was there “a few” days he noted Resident A touched Resident B on the breasts and after that it was “very frequently” that Resident A touched the breasts of the female residents at the facility. Mr. Castanon said he observed Resident A touched Resident C and Resident D on the breasts and that Resident D would no longer leave her bedroom because Resident A “bothers her.” Mr. Castanon said Resident A regularly groped female staff members’ and visitors’ breasts who came to the faciality in addition to residents. Mr. Castanon said Resident A consistently attempts to leave his bedroom to access the female residents’ bedrooms located in a separate hallway. Mr. Castanon said staff members attempt to “stay posted” in the kitchen so they can see if Resident A leaves his bedroom but that is not reasonable all the time. Mr. Castanon said two staff members are responsible for caring for all resident needs, including those who require assistance from both staff members at once in addition to administering medication, cooking, and cleaning so they cannot stay in the kitchen. Mr. Castanon said “something needs to be done” about Resident A because staff members could not protect the women at the facility with their current workload. Mr. Castanon said Resident A should have someone “keeping eyes on him” at all times as he saw female residents get sexually assaulted by Resident A touching their breasts above and below clothing on at least four occasions.

On April 11, 2022, I spoke to Guardian A1 who said Resident A was given a 30-day discharge notice from his previous facility for touching female staff and visitors on the breasts and for exposing himself to a female resident which was communicated to facility manager Connie Parker. Guardian A1 said she gave written incident reports from the previous facility outlining Resident A’s sexually acting out behavior to Ms. Parker. Guardian A1 said Ms. Parker told her she did not want to tell direct care staff members that Resident A had a history of sexually acting out and after strong urging by Guardian A1 Ms. Parker did not agree that she would share that part of Resident A’s history with staff members. Guardian A1 said she was notified on or about April 5, 2022, that Resident A had been grabbing female residents, visitors, and staff members on their breasts regularly since he admitted to the facility. Guardian A1 said she instructed Ms. Parker to call for an ambulance for Resident A so he could be assessed at a geriatric psychiatric facility if she felt Resident A was a danger to the female residents at the facility. Guardian A1 said she was “proactive” in discussing Resident A’s prior sexually acting out behavior with Ms. Parker and that she advised her what to do when Ms. Parker called and explained the problem.

On May 31, 2022, I spoke to Guardian B1 who said he was notified by a direct care staff member that Resident A had been touching Resident B, other residents, and staff members on the breasts both above and under their clothing. Guardian B1 stated this was “an ongoing issue.”

On May 24, 2022, I spoke to TCOA case manager Jacqueline Lloyd who said prior to Resident A moving into the facility he had a recent history of disrobing in front of female residents but that he had not been sexually aggressive nor actively touching/assaulting people, which is what was communicated to the licensee designee Raul Presas. Ms. Lloyd said when Resident A was admitted to the facility, he had grabbed women on the breasts previously but that it had only been female staff members and not residents. Ms. Lloyd said Resident A needed a lot of prompting, persuading, and coaching to get him to agree to shower, eat, shave etc. and that additional money was allocated for Resident A's care. Ms. Lloyd said on April 5, 2022, she was notified by Ms. Parker that since admitting to the facility on March 31, 2022, Resident A sexually assaulted several female residents, visitors, and staff members by grabbing their breasts above and below clothing. Ms. Lloyd said Ms. Parker also told her Resident A attempted to get into the bed of another resident. Ms. Lloyd said Ms. Parker told her that Resident A saw his physician and his medications were adjusted but "as soon as they redirected [Resident A], he was [touching] someone else." Ms. Lloyd said Ms. Parker told her that staff members "were trying to keep [Resident A] in his bedroom" to protect the female residents at the facility. Ms. Lloyd said she advised Ms. Parker to contact an ambulance for Resident A so he could be evaluated at a geropsychiatric clinic.

On April 8, 2022, I interviewed Resident B who said Resident A sexually assaulted her the previous evening and that she did not feel safe at the facility with Resident A there.

On April 8, 2022, I interviewed Resident C who said Resident A "grabbed [her] breasts."

On April 8, 2022, I interviewed Resident D who said Resident A "touched [her] all over" including on her breasts. Resident D said Resident A reached down her shirt and touched her breasts until a staff member intervened. Resident D said she would no longer leave her bedroom, not even to go to the bathroom or to eat meals. I noted that Resident D had a portable commode in her bedroom.

On May 19, 2022, I received an *Incident/Investigation Report* from the Eaton County Sheriff's Department dated April 8, 2022. The written report stated the deputy on scene spoke to Residents B, C, and D. The written report stated Resident B reported that Resident A raped her (see below) as well as kissed her neck and touched her breasts. The written report stated Resident C reported her breasts were touched. The written report stated Resident D told the deputy that Resident A touched her on her neck and moved his hands toward her breasts but never actually touched her on the breasts. The written report stated Resident A touched the breasts of four female staff members at the facility. The written report stated Resident A was transferred from the facility to the hospital where he was combative and attempted to touch a female nurse's breasts.

On April 14, 2022, I received two written *AFC Licensing Division Incident/Accident Reports* concerning Resident A from his previous facilities. According to Guardian A1 a copy of each written report was provided to facility manager Connie Parker. The most recent written report dated February 8, 2022, stated Resident A "grabbed a guest inappropriately as she walked by in the hallway." The written incident report stated a 30–day discharge notice would be issued, that Resident A's PRN medication was administered, Guardian A1 and Resident A's physician were contacted, and staff were trained on handling inappropriate sexual behavior from a resident. The prior incident report was dated March 27, 2018, and indicated Resident A grabbed a female resident on the breast and that staff began visually monitoring Resident A in the common areas of the home.

On April 8, 2022 and May 24, 2022, I spoke to licensee designee Raul Presas who said prior to Resident A moving into the facility he requested information from (TCOA) and from the home manager at Resident A's previous adult foster care home and he was not told that Resident A had a history of sexually acting out behavior. Mr. Presas said he was told Resident A was discharged from his previous home for "dropping his pants" in front of another resident who requested that Resident A be discharged. Mr. Presas said he visited Resident A at his previous adult foster care home before he admitted him to the facility and based upon all his contacts, he had no reason to believe that Resident A was "a potential threat" to any female residents or staff members at the facility. Mr. Presas said approximately five days after Resident A's admission to the home he was notified that Resident A had touched female residents, staff members and visitors on the breasts. Mr. Presas said he notified Resident A's case manager at TCOA and Guardian A1 and explained that he would have to issue a 30–day written discharge notice if this behavior could not be changed. Mr. Presas stated Resident A was evaluated by a physician who adjusted his medication. Mr. Presas said he directed staff members to "keep eyes on" Resident A "24/7." Mr. Presas acknowledged that two direct care staff members were scheduled to care for eight residents, some of whom required assistance from both staff members for things such as transferring or bathing. Mr. Presas stated direct care staff members were also responsible for other duties within the home such as cooking and cleaning. Mr. Presas said even though two staff members could not always keep Resident A in line of sight, staff members planned so that one staff member could be available to monitor Resident A whenever possible. Mr. Presas said Resident A was encouraged to stay in his bedroom on the "lower level" of the home away from the female residents and staff members "did their best" to keep Resident A in their line of sight unless he was believed to be asleep. Mr. Presas stated on April 8, 2022, he called for an ambulance for Resident A so that he could be evaluated for the sexually acting out behavior and Resident A was admitted for psychiatric treatment.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on statements from Ms. Parker, Ms. Teves, Ms. Tackett, Mr. Castanon, Mr. Presas, Guardian A1, Ms. Lloyd, observations at onsite investigation, and written documentation reviewed as part of this investigation, it can be determined that Resident A did not have a recent history of touching female residents' breasts that was communicated to Mr. Presas prior to Resident A's admission to the facility. However, according to statements and written documentation reviewed, Resident A began sexually assaulting female residents at the facility almost immediately upon his admission and continued to have access to female residents, one of whom was touched on the breasts multiple times. The efforts made to protect the female residents at the facility were limited, such as attempting to visually monitor Resident A when there were only two staff members working and residents who required assistance from both staff members, encouraging Resident A to stay in his bedroom, seeking a medication adjustment for Resident A, and notifying Guardian A1 and Ms. Lloyd at TCOA. Guardian A1 and Ms. Lloyd both advised home manager Connie Parker to call for an ambulance for Resident A so he could be evaluated medically and psychologically to help stop the sexually acting out behavior, and that was not done until several days later immediately following my onsite investigation. Resident B, Resident C, and Resident D were not protected when Resident A, whose sexually acting out behavior presented almost immediately upon admission, sexually assaulted Resident B multiple times by touching her breasts above and below her clothing and sexually assaulted Resident C and Resident D by touching their breasts as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A raped Resident B.

INVESTIGATION:

On April 8, 2022, I was onsite at the facility investigating the previous allegation in this report and was notified by Resident B that Resident A raped her in the early morning hours of April 8, 2022. On April 11, 2022, I received a second denied APS complaint via centralized intake that stated Resident B is a 73-year-old female who is diagnosed with Huntington's disease. The written complaint stated on April 7, 2022, Resident A raped Resident B.

On April 8, 2022, I interviewed Resident B who said Resident A pulled down her clothing and raped her in her bed earlier that morning. Resident B said Resident A's penis penetrated her vagina during the rape. Resident B said direct care staff member John Castanon "pulled" Resident B off her which is why Resident A stopped. Resident B stated she told direct care staff members Allison Teves and Connie Parker that Resident A raped her. Resident B stated she did not feel safe at the facility as she was "worried" that Resident A may sexually assault her again. Resident B stated that was the first time Resident A touched her in a sexual way.

On April 8, 2022, and April 11, 2022, I spoke to direct care staff member and home manager Connie Parker said who said on April 8, 2022, Resident B alleged that Resident A raped her in her bedroom during the early morning hours that day. Ms. Parker stated she was not at the facility at the time of the alleged rape nor when Resident B initially reported it. Ms. Parker said staff members John Castanon and Shyla Edwards were working at the time of the alleged incident and staff members John Castanon and Allison Teves were working at the time Resident A reported Resident B raped her. Ms. Parker said Resident B told her Resident A raped her in her bed and direct care staff member John Castanon "pulled [Resident A] off [Resident B]" which Mr. Castanon denied. Ms. Parker said Mr. Castanon told her he saw Resident A leaving Resident B's bedroom but the longest he could have been in there was three minutes. Ms. Parker said Mr. Castanon noted that Resident B was in bed and her shirt was pulled up and her breasts exposed, but her bottom half was clothed. Ms. Parker said Mr. Castanon said Resident B did not disclose to him that Resident A raped her. Ms. Parker said she was told by Ms. Teves that when Resident B reported to her that Resident A raped her, her pants were pulled down around her ankles, which is unusual for Resident B. Ms. Parker stated she did not report the alleged rape to the police nor anyone else because she "didn't think [Resident B] was being factual" in her account of being raped by Resident A. Ms. Parker described Resident B as "man crazy," and stated Resident B and Resident A appear to be familiar with one another as they lived in the same facility before. Ms. Parker said Resident B "is constantly talking about how she wants sex," and stated Resident B "is very handsy."

On April 8, 2022, I interviewed direct care staff member John Castanon who said he worked on April 8, 2022, when Resident B stated that Resident A raped her. Mr. Castanon came into the hallway from administering medication in the room across the hall from Resident B's bedroom and he noted that Resident A was "trying to climb into" Resident B's bed and Resident B's shirt was pulled up and her breasts were exposed. Mr. Castanon said Resident B was clothed from the waist down. Mr. Castanon said the encounter "looked mutual," and he "chased" Resident A out of Resident B's bedroom and did not report the incident to anyone because he believed the contact was consensual. Mr. Castanon mentioned that he previously saw Resident A "put his hands up" Resident B's shirt and "kiss" Resident B but Resident B did not seem upset and told him that she and Resident A previously knew one another.

On April 8, 2022, I interviewed direct care staff member Shyla Edwards who said she was working on April 7, 2022, when she observed that Resident A went into Resident B's bedroom while she was in another resident's bedroom and her co-worker John Castanon was administering medication in a third resident's bedroom. Ms. Edwards said Resident A could not have been in Resident B's bedroom for longer than five minutes because she previously looked in on Resident B and Resident A was not there. Ms. Edwards said she saw Resident A walking out of Resident B's bedroom and he was fully clothed. Ms. Edwards said she immediately went into Resident B's bedroom to assess her, and Resident B told her Resident A "didn't do anything to her" when he came into her bedroom. Ms. Edwards said Resident B's shirt was pulled up and her breasts were exposed, and she was under a blanket from the waist down. Ms. Edwards described Resident B as having "a smirk" on her face and stated she did not appear upset.

On April 8, 2022, I spoke to direct care staff member Allison Teves who stated she was working on April 8, 2022, when Resident B reported that Resident A raped her. Ms. Teves said she arrived for work between 6:00 am and 8:00 am and as she assisted Resident B from bed for the day, she noted that Resident B's pants and adult brief were both pulled down between her ankles and her knees. Ms. Teves denied that she ever saw Resident B with her pants down before. Ms. Teves said Resident B was covered with bedding and she was clothed on top. Ms. Teves said she got Resident B out of bed and assisted her to the bathroom which was when Resident B told her that Resident A raped her "last night." Ms. Teves described Resident B's demeanor as matter of fact or nonchalant and denied that Resident B appeared upset. Ms. Teves said even though Resident B identified the encounter as "rape," Ms. Teves determined Resident B was "a willing participant" because Resident B knows Resident A from living together at another facility.

On April 8, 2022 and May 31, 2022, I spoke to direct care staff member Savanna Tackett who stated she and Ms. Teves assisted Resident B with getting out of bed on April 8, 2022 and Ms. Tackett noted that Resident B's pants and adult incontinence brief were "down around [Resident B's] ankles" which is uncommon for

Resident B. Ms. Tackett denied that Resident B offered nor did she ask for an explanation about why Resident B's pants and brief were pulled down.

On May 19, 2022, I received a copy of *Incident/Investigation Report* from the Eaton County Sheriff's Department dated April 8, 2022. The written report stated, "[Resident B] reported to me last night she was asleep in her room when [Resident A] came into her room and climbed in bed with her. [Resident B] stated this startled her because she was asleep. [Resident B] told [Resident A] no because he started kissing her neck and touching her breasts. [Resident B] then told me [Resident A] had sex with her. [Resident B] said [Resident A] penetrated her vagina with his penis. [Resident B] wanted to press charges and consented to a SANE kit." The written report stated further investigation would be conducted by the detective bureau.

On May 24, 2022, I spoke to licensee designee Raul Presas who stated he learned that Resident A allegedly raped Resident B during the overnight shift on April 8, 2022. Mr. Presas said staff members did not immediately notify the authorities or Resident B's guardian immediately due to Resident B's past behavior. Mr. Presas said Resident B asked Resident A to come to her bedroom for sex on April 6, 2022, and that Resident B asked Resident A to show her "his private parts." Mr. Presas said in addition to specifically pursing Resident A, Resident B also made inappropriate sexual comments to male staff members and visitors. Mr. Presas said both staff members who were working at the time of the alleged assault reported both Resident A and Resident B were fully clothed following the incident and that staff member John Castanon "heard the [bedroom] door open" and responded right away so it was not thought that Resident A raped Resident B. Mr. Presas said not contacting the authorities immediately to report the alleged rape was "a poor decision based on [Resident B's] history." Mr. Presas said Resident B reported to the emergency medical technicians who were responding to a report that Resident A was attacking female residents and needed psychiatric treatment and they dispatched police who took Resident B's report on April 8, 2022.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Though the investigation did not necessarily prove that Resident A raped Resident B, based on statements from Resident B, Ms. Parker, Ms. Teves, Ms. Tackett, Mr. Castanon, Mr. Presas, and the written police report received from the Eaton County Sheriff's Department, I determined that Resident B consistently reported that Resident A raped her. According to prior information in this report I determined that Resident A sexually assaulted Resident B by touching her breasts prior to the alleged rape and staff members were aware. Staff members Allison Teves and Savanna Tackett observed Resident B with her pants and adult brief pulled down, which was unusual, yet no action was taken. Resident B reported the alleged rape to staff members Allison Teves, John Castanon, and Connie Parker who all failed to take any action to protect Resident B, nor did they report the alleged rape to the proper authorities for investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B had an unexplained bruise on her back.

INVESTIGATION:

On April 14, 2022, I received a complaint via centralized intake that stated Guardian B1 noted a bruise on Resident A's back. The written complaint stated the bruise was not there on April 8, 2022, per the staff member who assisted Resident B with getting dressed. The written complaint stated police made contact with Resident B at Guardian A1's home and took pictures.

On May 19, 2022, I received a written *Incident/Investigation Report* from the Eaton County Sheriff's Department dated April 8, 2022. The written report stated, "I was later contacted by [Guardian B1] about a bruise that appeared on [Resident B's] back on 4/9/22. The bruise was not there on 4/8/22 per Savanna Tackett who helped dress [Resident B]. When I made contact with Maplewood on 4/9/22 Savanna said she located the bruise today when she dressed [Resident B]. Savanna told [Resident B's] family about the bruise when they picked her up for a visit. I made contact with [Resident B] at [Guardian B1's] house and took photographs of the bruise." The *Incident/Investigation Report* stated no charges were pending at this time "pending further investigation by [detective bureau]."

On May 31, 2022, I spoke to Guardian B1 who said he took Resident B to his home on April 9, 2022, at approximately 10:00 am and discovered a red mark on Resident

B's back in the rib area. Guardian B1 said he contacted the facility via telephone and told a staff member he discovered a red mark on Resident B's back and he wanted to know if staff members noticed. Guardian B1 said the staff member he talked to told him that the red mark was not there the night before and stated she did not see a red mark nor have any idea how it was caused. Guardian B1 said Resident B was not aware that she had a red mark on her back and had "no idea" how it happened. Guardian B1 said Resident B stated she was not in pain. Guardian B1 denied that Resident B ever reported that any staff member at the facility hurt her or did anything that could have caused the red mark on Resident B's back. Guardian B1 said Resident B was at the hospital on April 8, 2022, and hospital staff never reported seeing a red mark nor bruise on Resident B's back. Guardian B1 said Resident B has Huntington's Disease and regularly falls and experiences involuntary movements.

On May 31, 2022, I spoke to direct care staff member Savanna Tackett who said she noted a red mark on Resident B's back on her rib area either "late at night" on April 8, 2022 after Resident B returned from the hospital or "early in the morning" on April 9, 2022 but she could not recall with complete certainty when she observed the red mark. Ms. Tackett described the red mark as "long and thin" and remarked that it looked as if it could have been caused by the railing on Resident B's bed. Ms. Tackett said she asked Resident B about the red mark and Resident B was not aware she had a red mark on her back and did not know what caused the mark. Ms. Tackett stated Resident B did not fall, stumble, nor do anything else to her knowledge that could have caused the red mark on Resident B's back. Ms. Tackett stated she asked co-workers who all denied having any knowledge of how Resident B sustained a red mark on her back. Ms. Tackett denied having any concerns about any staff members at the facility hurting Resident B and denied that Resident B ever told her that someone hurt her or caused the red mark on her back.

On May 31, 2022, I spoke to direct care staff member Allison Teves who said she is responsible for dressing Resident B daily and that she assisted her with getting dressed on April 8, 2022 and did not see a red mark or bruise on Resident B's back. Ms. Teves denied that Resident B mentioned having any pain in her back nor that anyone at the facility caused a red mark or bruise on her back. Ms. Teves denied having any concerns regarding any of her coworkers and the way they interact with Resident B.

On May 31, 2022, I spoke to direct care staff member and home manager Connie Parker who stated Resident B has a "scar" on her back that is "faint red" in color which is located on her mid to upper back in the rib cage area. Ms. Parker stated the scar was present when Resident B was admitted to the facility and that Resident B did not have a bruise on her back on April 8, 2022. Ms. Parker said after staff member told her Resident B had a bruise on her back, she examined Resident B's back and only noted the pre-existing scar. Ms. Parker said Resident B never reported that she fell, bumped into anything nor was otherwise injured to cause a bruise on her back, however Resident B has Huntington's Disease which causes

involuntary movements and occasional falls. Ms. Parker denied that Resident B ever alleged anyone harmed her, nor that she had any concerns regarding any staff members' interactions with Resident B. Ms. Parker stated the "scar" on Resident B's back was present at the time of the interview.

On May 31, 2022, I spoke to direct care staff member John Castanon who said part of administering Resident B's medication is placing a "patch" on Resident B's back and in doing that he never observed a bruise or red mark on Resident B's back. Mr. Castanon said, "it wouldn't surprise [him] if [Resident B] had a bruise on her back because she has Huntington's Disease and she frequently plops down," and has involuntary movements. Mr. Castanon said Resident B never reported that she fell or otherwise injured her back and denied that Resident B ever reported pain in her back. Mr. Castanon said he regularly observes his co-workers interacting with Resident B and never had any concerns. Mr. Castanon said Resident B never alleged that any staff member did something to her to cause a bruise on her back.

On May 31, 2022, I spoke to direct care staff member Tiffany Leonard who said at one time she observed a "light red" mark on Resident B's back but stated she believed the red mark was always there and was not "a new bruise." Ms. Leonard said Resident B has a faint red mark on the right side of her mid to upper back on the rib area that has been there since Resident B was admitted to the home and was still there at the time of the interview. Ms. Leonard stated though she did not think the red mark was "new," but Resident B has Huntington's Disease which causes her to fall and have involuntary movements often which do result in bruises at times. Ms. Leonard said she had no concerns that any staff member at the facility caused the mark on Resident B's back and denied that Resident B ever told her that anyone hurt her or caused the mark on her back.

On June 3, 2022, I made contact with Resident B at the facility and she told me that she was not aware of a red mark or bruise on her back until direct care staff member and home manager Connie Parker showed Resident B a photograph of the mark on her back. Resident B said she did not know when or how the mark appeared and that she was not aware of it until someone else pointed it out to her. Resident B denied that anyone harmed her in any way nor did anything to cause a bruise on her back. Resident B said she has Huntington's Disease which causes her to fall often and experience involuntary movements, so it is possible the mark was caused that way. Resident B denied that anyone harmed her in any way or caused the mark on her back. Resident B stated she believed the mark was still there, so she did not believe it was a bruise. Resident B showed me her back and I observed a faint red mark on Resident B's mid to upper back in the rib area, as described by Guardian B1 who reported seeing the same mark on April 9, 2022.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Though the investigation revealed that Resident B had a red mark on her back that could not be explained, it cannot be confirmed with certainty when the red mark appeared or if Resident B was at the facility at the time as Resident B went to the hospital and to the home of Guardian B1 before the red mark was discovered. Statements from some staff members and my observation of Resident B revealed that the mark on Resident B's back may not have been a bruise at all as it has always been there and was there on June 3, 2022. There is lack of evidence to prove that the red mark on Resident B's back was caused by anyone at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Pending the results of the SANE kit performed on Resident B and the outcome of the investigation conducted by the Eaton County Sheriff's Department, based on the severity of the quality of care related violations established in this special investigation report I recommend issuance of a 1st provisional license.

Leslie Herrguth 06/06/2022

_____

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 06/13/2022

_____

Dawn N. Timm Date
Area Manager