GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2022

Dominique Miller
Residential Options Inc.
2400 Science Parkway
Okemos, MI 48864

RE: License #: AS230010627
Investigation #: 2022A1033033
Kemler Road Home

Dear Ms. Miller:

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,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230010627
Investigation #:	2022A1033033
Complaint Receipt Date:	09/13/2022
Investigation Initiation Date:	09/13/2022
Report Due Date:	11/12/2022
Licensee Name:	Residential Options Inc.
Licensee Address:	2400 Science Parkway Okemos, MI 48864
Licensee Telephone #:	(517) 374-8066
Administrator:	Dominique Miller
Licensee Designee:	Dominique Miller
Name of Facility:	Kemler Road Home
Facility Address:	3138 Kemler Road Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2556
Original Issuance Date:	12/01/1986
License **Status:**	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A forced Resident B to perform oral sex on him in the kitchen of the facility. Concern residents are not being supervised adequately.	Yes

III. METHODOLOGY

09/13/2022	Special Investigation Intake 2022A1033033
09/13/2022	Special Investigation Initiated - Telephone Interview with Licensee Designee, Dominique Miller.
09/19/2022	Contact - Face to Face- Meeting with CMH, Aaron Bakken, Gina Wright, Ghadeer Nasser, Justin Caughey, MDHHS, Rebbeca Schalow, Guaridan A1, Guardian B1, AFC Licensing, Dawn Timm & Jana Lipps, Kemler Rd. Home staff, Shawn Hose, and Licensee Designee, Dominique Miller.
09/21/2022	Contact - Telephone call made Interview with MDHHS APS Specialist, Rebbeca Schalow via telephone.
09/22/2022	Inspection Completed On-site Interview with direct care staff, Shelly Weitzel-Sholl, Home Manager, Shawn Hose, Resident A. Review of Resident A & B guardianship papers.
10/24/2022	APS Referral- APS referral not required, already an open APS investigation.
10/24/2022	Contact – Telephone call made Interview with Guardian A1, via telephone.
10/24/2022	Inspection Completed-BCAL Sub. Compliance
11/03/2022	Contact – Document Received Received email statement from APS Worker, Rebecca Schalow, regarding interview with direct care staff, Michelle Durham.
11/03/2022	Contact – Telephone Call Received Interview with direct care staff, Joseph Mbaka.
11/09/2022	Exit Conference

	Exit Conference completed with Licensee Designee, Dominique Miller, via telephone.

ALLEGATION:
Resident A forced Resident B to perform oral sex on him in the kitchen of the facility. Concern residents are not being supervised adequately.

INVESTIGATION:

On 9/8/22 I received a voicemail message from Licensee Designee, Dominique Miller, at the Kemler Road Home adult foster care facility (the facility). Ms. Miller's voicemail noted she wanted to discuss an incident that occurred at the facility between Resident A and Resident B related to inappropriate sexual activities. I had completed a prior investigation regarding inappropriate sexual activities between Resident A and Resident B on 8/12/22.

On 9/13/22 I interviewed Ms. Miller, via telephone. Ms. Miller reported Resident A reported to staff that Resident B forced her to perform oral sex on him in the kitchen of the facility on 9/3/22. Ms. Miller reported Resident A and Resident B had been sitting at the kitchen table working on a craft project and while the two direct care staff members on duty were busy caring for other resident needs, Resident A and Resident B were left unattended. Ms. Miller reported the Home Manager, Shawn Hose, interviewed Resident A, who reported she was very upset by the incident and that Resident B had forced her to perform oral sex on him. Ms. Miller reported Resident B had been overheard, by an unnamed direct care staff, on the telephone, telling his aunt that he "forced [Resident A]" to perform oral sex in the kitchen. Ms. Miller reported direct care staff members reported the incident to Adult Protective Services (APS) and are planning for a *Relationship Meeting* with Community Mental Health (CMH) team members for Resident A and Resident B, Guardian A1, Guardian B1, and APS worker, Rebecca Schalow. Ms. Miller inquired whether I would like to attend this meeting to further discuss this incident. It was reported that the meeting would be held on 9/19/22 at 1pm.

On 9/19/22 a *Relationship Meeting* was held at the Clinton, Eaton, Ingham Community Mental Health office. In attendance were, Guardian A1, Guardian B1, Ms. Schalow, Ms. Hose, CMH Case Manager for Resident A, Ghadeer Nasser, CMH Case Manager for Resident B, Gina Wright, CMH Behavior Treatment Specialist, Justin Caughey, CMH Residential Coordinator, Aaron Bakken, Adult Foster Care Licensing Area Manager Dawn Timm, and myself. During the meeting Guardian B1 reported that he was not comfortable with the sexual relationship currently existing between Resident B and Resident A and that he did not consent to this relationship. He requested this relationship cease to continue at this time. Guardian A1 reported that she had previously consented to this relationship but now she is no longer supportive of this relationship continuing and would like this relationship to cease to continue as well. Ms. Miller reported that due to staffing challenges it will be difficult

to maintain supervision of the two residents as the facility has another resident who requires two direct care staff members to assist with transfers and direct care staff member cannot maintain or accommodate keeping visual contact with Resident A and Resident B to provide for their safety and supervision while caring for this resident and the remaining residents in the facility. It was reported in this meeting that there was not an eyewitness who observed the alleged assault.

On 9/21/22 I interviewed Eaton County DHHS Adult Protective Services Specialist Rebecca Schalow, via telephone. Ms. Schalow reported she made a visit to the facility on 9/15/22 and interviewed Resident A. Ms. Schalow reported Resident A stated, in this interview, that she was sitting at the kitchen table working on an art project with Resident B. Ms. Schalow reported Resident A stated she tried to walk out the backdoor of the facility, which is in the kitchen area. Resident A then reported Resident B stated, “please do this thing for me,” and then put his hand on her head and put his penis in her mouth. Ms. Schalow reported Resident A stated she did it for a minute and then she stopped and ran out the door. Ms. Schalow reported she asked Resident A, “what made the act stop?” and Resident A responded, “when he took his hand off my head.” Ms. Schalow reported that Resident A stated, she had told Resident B “no” multiple times, but he kept saying, “please.”

On 9/22/22 I completed an on-site investigation at the facility. I interviewed direct care staff, Shelly Weitzel-Sholl. Ms. Weitzel-Sholl reported that she had not worked the date of the alleged incident on 9/3/22. Ms. Weitzel-Sholl reported she worked the following day on 09/04/2022 and when she arrived to work Resident A grabbed her and was crying, “you weren’t here, and I needed you!” Ms. Weitzel-Sholl reported that Resident A stated to her Resident B had “put that thing in my mouth,” referring to his penis. Ms. Weitzel-Sholl reported Resident A said it was “awful” and that she “does not feel safe.” Ms. Weitzel-Sholl reported Resident B targets members of the household with sexual advances and he does not listen to staff members when they say “no” to him and reported that she does not feel he will listen to residents when they say “no” either. Ms. Weitzel-Sholl reported, “He’s not a good fit here.” She further reported she does not think Resident B is going to leave Resident A alone. She reported, “We have a two-person assist here.” She reported that if Resident B thinks staff is preoccupied with another task, he will focus on asking Resident A for sexual favors and he does not listen when Resident A says “no.”

During on-site investigation, on 9/22/22, I interviewed direct care staff member Ms. Hose. Ms. Hose reported that she was not present in the home on the date and time of the alleged assault. Ms. Hose reported that she stopped by the home the date of the incident and Resident A confided in her regarding Resident B forcing her to perform oral sex on him. Ms. Hose reported that attempts were made to discuss the event with Guardian A1, but she could not get through to Guardian A1 until just before the *Relationship Meeting* on 9/19/22. Ms. Hose reported that it is difficult to provide line of sight supervision for Resident A and Resident B as the facility does have a resident who requires a two-person assistance so there are times when the

two staff members working are both busy at the same time. Ms. Hose reported Resident B came to the facility on a 30-day discharge notice from a previous facility, due to inappropriate behaviors. Ms. Hose reported that the facility must admit who CMH refers to the facility and they are not allowed to refuse a referral.

During on-site investigation, on 9/22/22, I interviewed Resident A who had approached me for an interview as she was familiar with me from previous investigation that was closed on 8/12/22. Resident A reported she wanted to share about the incident with Resident B which occurred on 9/3/22. Resident A reported she was working on crafts in the kitchen with Resident B and he "asked me to do something gross." She reported Resident B had asked her to "suck on his penis." Resident A reported she attempted to say "no" to this request and tried to walk out the backdoor of the facility, but Resident B kept saying, "please, please, please." Resident A reported then Resident B put his hand on the back of her head and pushed her head toward his penis. Resident A reported she did put his penis in her mouth for a minute and then got up and ran out the door. Resident A reported this happened because there were no staff around to help her.

During the on-site investigation on 9/22/22, I reviewed both Resident A and Resident B's guardianship papers. Resident A has been assigned a partial guardianship, by the Eaton County Probate Court, with the following authorities granted:

1. "Consent to any necessary medical or surgical treatment, except extraordinary procedures including, but not limited to, sterilization, vasectomy, abortion, organ transplants from the ward to another person and experimental treatment.
2. Make programming and placement decisions on behalf of the ward.
3. Release information, consent to photographs and fingerprints.
4. Arrange and consent to the living arrangements of the ward.
5. Make all legal, contractual, and financial decisions on behalf of the ward, subject to paragraph 7 below.
6. Arrange any and all travel and transportation of ward, subject to paragraph 8 below.
   IT IS FURTHER ORDERED THAT the ward shall retain the right to:
7. Make financial decisions for up to $___ each week.
8. Make travel decisions regarding travel less than 1 miles.
9. Make decisions on daily dress and daily programs and activities except as set forth above."

I reviewed Resident B's guardianship papers which described that Resident B has been assigned a FULL guardianship by the Ingham County Probate Court, with the following authorities granted related to his physical well-being:

1. "The custody of the person of the ward & power to establish ward's place of residence.

2. If entitled to custody of the ward, the duty to make provision for the ward's care, comfort, and maintenance and, when appropriate, arrange for ward's training and education.
3. The duty to secure services to restore the ward to best possible state of mental and physical well-being so that the ward can return to self-management at earliest possible time.
4. The duty to take reasonable care of ward's clothing, furniture, vehicles, and other personal effects and commence protective proceedings if ward's property needs protection,
5. The power to give the consent or approval that is necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service."

On 9/20/22, I reviewed two *AFC Licensing Division – Incident/Accident Reports* (IR) from the facility. There was a separate report completed for Resident A and Resident B. The IR for Resident A was dated for 9/6/22 and completed by Ms. Hose. The IR was signed by Ms. Miller on 9/12/22. Under the section titled, *Explain What Happened/Describe Injury (if any)* it stated, "Home Manager stopped into Kemler Rd. home unexpectedly on 09.03.2022 and [Resident A] approached the home manager in a room upstairs in tears, home manager asked her what was wrong, and [Resident A] responded that she didn't want to do it. Home Manager asked her what happened and [Resident A] said he made me do it." Under the section titled, *Action Taken by Staff/Treatment Given*, it stated, "Home manager asked her who made her do what. [Resident A] responded he made me give him head. HM asked her if she called for staff and she stated, "how could I he was holding my head down" HM asked her where it happened and she stated at the table doing crafts." Under section titled, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it stated, "HM asked where staff were and [Resident A] said JM was doing meds and MD had went into the bedroom to check on [Resident C]. HM spoke to both staff to make them aware and requested staff monitor their actions closely. HM reported to ROI, GDNS, CMH, case mgrs. & A. Bakken, APS on the next business day (9.6)."

The IR reviewed for Resident B was dated for 9/6/22 and completed by Ms. Hose. The IR was signed by Ms. Miller on 9/12/22. Under the section titled, *Explain What Happened/Describe Injury (if any),* it stated, "Home manager stopped into Kemler Rd. home unexpectedly on 09.03.2022 and [Resident A] approached home manager in a room upstairs in tears, after HM talked to [Resident A] HM went and talked to [Resident B] who denied it had occurred." Under the section titled, *Action Taken by Staff/Treatment Given,* it stated, "HM talked to [Resident B] about what had happened that morning. [Resident B] indicated that they had been at the table doing crafts but he "didn't do anything." Under section titled, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it stated, "HM asked where staff were and [Resident B] said they left the room but nothing happened. HM spoke to both staff to make them aware and requested staff monitor their actions closely. HM reported to ROI, GDNS, CMH case mgrs & A. Bakken, APS on the next business day (9.6). Next day he told staff he had made her."

On 10/24/22 I reviewed the *Assessment Plan for AFC Residents* form for Resident A, dated 7/8/22 and signed by Guardian A1 and previous licensee designee, Jessica Stultz. Under section I. Social/Behavioral Assessment, subsection *J. Controls Sexual Behavior*, it states, “uses devices in her room, recent sexually active, needs help avoiding potential coercion, may engage in sexual activity in inappropriate places.”

On 10/24/22 I reviewed the *Assessment Plan for AFC Residents* form for Resident B, dated for 8/15/22 and signed by Guardian B1 and Ms. Miller. Under section *I. Social/Behavioral Assessment*, subsection *I. Controls Aggressive Behavior*, it states, “[Resident B] controls physical aggressive behavior but will be verbally aggressive with staff and housemates, calling names and racial comments, “flipping” off staff or cursing, etc. He has been known to “grab” staff inappropriately. [Resident B] has made verbal threats towards staff in prior locations including, “I’m going to rape you” and various types of name calling. It is reported that he has had no follow through with his verbal threats. [Resident B] has been in a physical altercation with a housemate at his prior location.” Under subsection, *J. Controls Sexual Behavior*, it states, “Verbal comments and nicknames (babe, honey, mom etc.) also inappropriate touching of staff. He has engaged in sexual activity with his female housemate in public area. Receiving sexual education by CMH case manager to improve his understanding of when another is desiring or agreeable to sexual contact, and what the law says about sexual contact, participating in a private location. Staff provide verbal reminders about appropriate language and interactions with housemates, staff and others.”

On 11/03/2022 I received an email correspondence from Ms. Schalow reporting an interview she held with direct care staff member, Michelle Durham, on 9/6/22. Ms. Schalow reported that Ms. Durham had been working on the date of the alleged incident, 9/3/22. Ms. Durham reported to Ms. Schalow that she and direct care staff, Joseph Mbaka, were both working on this date. Ms. Durham reported that Resident A and Resident B were sitting in the kitchen working on crafts and she had to go assist another resident. Ms. Durham reported to Ms. Schalow that Mr. Mbaka was in the upper level of the home, administering medications. Ms. Durham reported to Ms. Schalow that when she had completed assisting the other resident, she came in to check on the residents and found Resident A crying in her bedroom. She reported Resident A stated Resident B had forced her to “give him head.” Ms. Durham reported that at this time Resident B was now in the living room of the facility. Ms. Durham reported to Ms. Schalow that neither she nor Mr. Mbaka observed the event as they were both attending to other resident needs at the time of the alleged incident. Ms. Durham further reported to Ms. Schalow that she knows a lot of people feel uncomfortable around Resident B, including staff members. She stated that a lot of the staff try to ensure that Resident B is not left alone with anyone but this was not a written rule, just something that they practice. She stated that Resident B has touched her leg inappropriately before and that she has had to tell him that he cannot do that.

On 11/3/22 I interviewed Mr. Mbaka, via telephone. Mr. Mbaka reported he was working on 9/3/22 during the time of the alleged incident and was in the upper level of

the facility. Mr. Mbaka reported Resident B did admit to forcing Resident A to perform oral sex on him, initially, but later changed his statement. Mr. Mbaka reported he did not witness the alleged event.

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 upon interviews with Ms. Miller, Ms. Hose, Ms. Weitzel-Sholl, Ms. Schalow, Resident A, statements from the *Relationship Meeting* conducted on 9/19/22, review of guardianship papers, IRs, and *Assessment Plan for AFC Residents* forms for Resident A and Resident B, it can be determined that on 09/03/2022 direct care staff members did not provide for the protection and safety of Resident A. Although, there was not an eyewitness to the sexual assault, there was documented evidence Resident A "needs help avoiding potential coercion" and Resident B is currently "receiving sexual education by CMH case manager to improve his understanding of when another is desiring or agreeable to sexual contact." Despite knowing Resident A's *Assessment Plan for AFC Residents* documented Resident A was susceptible to coercion and Resident B's *Assessment Plan for AFC Residents* documented Resident B does not yet possess full knowledge of proper consent for sexual advances, facility direct care staff members did not provide proper supervision to these residents to ensure their protection and safety on 09/03/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

11/03/2022

_____

Jana Lipps Date
Licensing Consultant

Approved By:

11/03/2022

_____

Dawn N. Timm Date
Area Manager