GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 25, 2024

Abdul Aleem
Hampton Manor of Montrose LLC
3115 Silverwood Dr.
Saginaw, MI 48603

RE: License #:	AL250414324
Investigation #:	2025A0872002
	Hampton Manor of Montrose

Dear Abdul Aleem:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL250414324
Investigation #:	2025A0872002
Complaint Receipt Date:	10/01/2024
Investigation Initiation Date:	10/02/2024
Report Due Date:	11/30/2024
Licensee Name:	Hampton Manor of Montrose LLC
Licensee Address:	9415 Vienna Rd. Montrose, MI 48457
Licensee Telephone #:	(810) 350-2600
Administrator:	Rachel Morgan
Licensee Designee:	Abdul Aleem
Name of Facility:	Hampton Manor of Montrose
Facility Address:	9415 Vienna Rd. Montrose, MI 48457
Facility Telephone #:	(810) 350-2600
Original Issuance Date:	12/13/2022
License Status:	REGULAR
Effective Date:	06/13/2023
Expiration Date:	06/12/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 10/01/2024, Resident A told staff that one of the other staff, Brett Hadaway, sexually assaulted Resident A on two separate occasions.	Yes

III. METHODOLOGY

10/01/2024	Special Investigation Intake 2025A0872002
10/02/2024	APS Referral I made an APS complaint via email
10/02/2024	Special Investigation Initiated - Letter I made an APS complaint via email
10/09/2024	Inspection Completed On-site Unannounced
10/16/2024	Contact - Document Received I received documentation from AD Morgan
10/17/2024	Contact - Telephone call made I spoke to Montrose Township police detective Scott McGuire about this complaint
10/17/2024	Contact - Document Received I received documentation from Det. McGuire
10/17/2024	Contact - Telephone call made I spoke to Relative A1
10/23/2024	Contact - Telephone call made I interviewed staff Jessica Sweet
10/23/2024	Contact - Telephone call made I interviewed staff Brett Hadaway
10/23/2024	Contact - Document Sent I exchanged emails with AD Morgan

10/24/2024	Contact - Telephone call made I interviewed Resident A's hospice nurse, Kenna Hyles
10/24/2024	Exit conference I conducted an exit conference with the licensee designee, Abdul Aleem

ALLEGATION: On 10/01/2024, Resident A told staff that one of the other staff, Brett Hadaway, sexually assaulted Resident A on two separate occasions.

INVESTIGATION: On 10/09/24, I conducted an unannounced onsite inspection of Hampton Manor of Montrose. I interviewed the administrator (AD), Rachel Morgan and Resident A. According to AD Morgan, on 10/01/24 Resident A approached staff and said, “He’s queer” referring to staff Brett Hadaway. Later, Resident A told staff, “He queered me” referring to Staff Hadaway. Staff asked what Resident A meant and he said, “He sucked my dick.”

AD Morgan immediately called the police (Montrose Township), Resident A’s family, and Resident A’s hospice social worker. AD Morgan also sent staff Brett Hadaway home for the day. AD Morgan spoke to Resident A who stated that this occurred on two separate occasions in Resident A’s room. AD Morgan said that she asked Resident A if he required medical attention, and he said no. According to AD Morgan, she and the home manager also spoke to the other residents in this facility and asked them if they had any concerns about any of the staff, specifically Staff Hadaway. AD Morgan also took Staff Hadaway off the staff schedule pending this investigation. AD Morgan stated that Resident A was questioned on four separate occasions regarding these allegations and his account of events was consistent all four times. According to AD Morgan, Staff Hadaway has only worked at her facility since September 2024. AD Morgan said that during her investigation, she determined that the incidents possibly happened on two separate occasions when two separate staff were working with Staff Hadaway.

AD Morgan said that Detective Scott McGuire from the Montrose Township Police Department was here earlier this morning to interview Resident A. AD Morgan said that during her internal investigation, she spoke to the other staff who were working with Staff Hadaway. Both staff she spoke to said that Staff Hadaway went into Resident A’s bedroom on one occasion during his shift. On one occasion, he was in Resident A’s room for approximately ½ hour and the second occasion he was in Resident A’s room for approximately 1 hour.

I interviewed Resident A in his bedroom where he was sitting in his wheelchair, watching television. Resident A is diagnosed with Parkinson’s Disease and although Resident A is of sound mind, it takes Resident A a long time to answer questions, and Resident A’s answers are typically very short. I spoke to Resident A about the allegations, and Resident A stated that on two separate occasions, “The guy” (referring to staff Brett Hadaway) put his lips on Resident A’s penis/dick. Resident A told me that

the first time this happened Resident A was on his bed and the second time it happened Resident A was in the corner of his bedroom. I asked Resident A if his clothes were on or off and Resident A said that his pants and underwear were off. I asked Resident A if Staff Hadaway said anything to Resident A during the incidents and Resident A said Staff Hadaway said something to the effect of “You like this.” I asked Resident A if Staff Hadaway touched Resident A anywhere else or if Staff Hadaway made Resident A touch him and Resident A said no. I asked Resident A if his body was harmed in any way, and Resident A said no. Although Resident A was cooperative during this interview, Resident A was obviously uncomfortable. Resident A told me that he feels embarrassed that this happened and said that he did not like it.

On 10/16/2024, I received AFC documentation related to this complaint. Resident A was admitted to this facility on 05/11/2023. The staff working with Staff Hadaway who witnessed him entering Resident A’s room were Kayla Moore and Jessica Sweet. AD Morgan said that Det. McGuire took statements from both Staff Moore and Staff Sweet.

On 10/17/2024, I spoke to Det. Scott McGuire about this complaint. Det. McGuire confirmed that he is investigating the allegations and is attempting to determine if Staff Hadaway sexually assaulted Resident A. According to Det. McGuire, he interviewed Staff Hadaway who denied the allegations. Det. McGuire said that he will be offering Staff Hadaway a polygraph and will let me know the results of his investigation.

On 10/17/2024, I received an email with attached documentation from Det. McGuire. Det. McGuire stated that he offered Staff Hadaway a polygraph which he refused saying that his lawyer advised him not to take it.

On 10/17/2024, I spoke to Relative A1 via telephone. I updated Relative A1 on the status of my investigation and answered questions, offering consultation. Relative A1 confirmed that Resident A’s hospice nurse examined Resident A and took urine and blood samples to check for sexually transmitted infections. Relative A1 said that she and her sisters have talked with Resident A who said that he still feels safe at this facility despite the incidents that took place.

On 10/23/2024, I interviewed staff Jessica Sweet via telephone. Staff Sweet said that she has worked at this facility for over a year, and she typically works 2nd shift, from 2pm-10pm. According to Staff Sweet, on 09/26/24 Staff Sweet was working with staff Brett Hadaway. While cleaning up in the dining room after dinner, Staff Sweet realized that she had not seen Staff Hadaway in “awhile” and Staff Sweet did not know where Staff Hadaway was. Shortly thereafter, the facility cook, Cat Wenkle told Staff Sweet that Resident A’s door was locked. Staff Sweet said that she went to Resident A’s door, tried to open it and when Staff Sweet realized it was locked, Staff Sweet unlocked it and entered the room. Staff Sweet stated that when entering the room, she found Staff Hadaway transferring Resident A from his wheelchair to Resident A’s recliner. Staff Sweet immediately said, “Why is this door locked?” and Staff Hadaway replied, “It’s just habit from working at other facilities.” Staff Sweet said she told Staff Hadaway, “We don’t lock doors at this facility so don’t let it happen again.” According to Staff Sweet,

Resident A did not say anything to her and neither did Staff Hadaway. Staff Sweet stated that she estimates that Staff Hadaway's whereabouts were unknown for over an hour, but Staff Sweet does not know how long Staff Hadaway was in Resident A's bedroom.

On 10/23/2024, I reviewed a written statement made by staff, Kayla Moore. According to this written statement, "On September 29, 2024 [Staff Hadaway] and I worked together. At around 5:30pm, [Staff Hadaway] accompanied [Resident A] from the dining table to his room. I assisted with clearing tables and attending to other residents. While aiding [Resident B], [Resident C's] call light was actively going off for about 15-20 minutes. Upon completing my task with [Resident B,] I inquired about (Staff Hadaway's) whereabouts with [another resident], who hadn't seen him since he took (Resident A) to his room. I then visited [Resident C's] room as her call light was still activated. Resident C had fallen asleep and was confused, asking why her dinner hadn't been brought to her. After explaining and ensuring she was content, I sought out [Staff Hadaway]. [Resident A's] door was closed so I knocked and attempted to open it, but it was locked. Using the master key, I unlocked the door and found both [Staff Hadaway] and [Resident A] in the bathroom. [Staff Hadaway] was in the process of pulling up [Resident A's] brief and bottoms, stating [Resident A] had experienced another bowel movement. When asked about the locked door, [Staff Hadaway] said it was out of 'habit.' I told him we do not lock doors within the facility. Later that evening, [Staff Hadaway] made several remarks about [Resident A] being homophobic, claiming that [Resident A] called him a 'homo'. This went on from 8:30pm until shift change at 10pm."

On 10/23/2024, I interviewed staff Brett Hadaway via telephone. Staff Hadaway said that he worked at Hampton Manor of Montrose for approximately 3 weeks and his last day was 10/01/2024. Staff Hadaway said that he only worked approximately 10-12 shifts and many of those were during his training. According to Staff Hadaway, he is aware of the allegations made against him and he said they are "bullshit." Staff Hadaway stated that he has worked in the AFC field for 8 years and Staff Hadaway has never had a complaint lodged against him.

Staff Hadaway further stated that he provided care to Resident A on several occasions with no problems. On one occasion, Staff Hadaway made a comment to Resident A about an ex-boyfriend. After that time, Resident A began making comments to Staff Hadaway about being a "homo" or a "queer." Staff Hadaway said that he did not take the comments personally because he understands that "his generation" tends to be homophobic. Staff Hadaway said that shortly after Resident A began making derogatory comments, the allegations of sexual assault came up. I asked Staff Hadaway if he ever sexually assaulted Resident A and he said no. I asked Staff Hadaway if he ever performed oral sex on Resident A and he said, "Hell no. I did nothing to this gentleman." Staff Hadaway said, "As soon as he found out I was homosexual, he started making rude comments to me."

Staff Hadaway acknowledged that when providing care for Resident A in his room, he would always close the bedroom door and would sometimes lock it as well. According to

Staff Hadaway, he was trained to ensure a resident's privacy when providing personal care. Whenever he changed Resident A's brief, he would do so in the living area in front of the door so he could transfer him right to his recliner. Therefore, Staff Hadaway said that he made sure the door was closed so nobody would walk in and see Resident A with his pants down. I asked Staff Hadaway if he locked the door every time, he provided care to Resident A and he said, "I don't know about every time but most of the time." I asked him if he ever closed and locked other resident's doors when providing personal care and he said, "No, because I changed the other residents in their bathroom instead of the living area."

I then asked Staff Hadaway how many times he was told not to lock Resident A's door when providing care and he said, "Just the one time." Staff Hadaway said that on one occasion, staff Jessica Sweet came in the room and told him, "We don't lock the doors here. Don't ever do that again." Staff Hadaway said that he said, "understood" and said that he never locked the door after that time. I asked him if any of the other staff ever told him not to lock Resident A's bedroom door and he said no. I specifically asked Staff Hadaway if staff Kayla Moore ever entered Resident A's room while the door was locked and told him that locked doors are not allowed and he said no. Staff Hadaway said that it is possible that other staff found the door locked when he was providing personal care to Resident A but Staff Sweet is the only one who told him not to do it.

I asked Staff Hadaway how long he would typically spend in Resident A's room, and he said 10-20 minutes. I asked Staff Hadaway if he ever spent ½ hour to 1 hour in Resident A's room and he said, "I don't know for sure, but I would say no. I was only in his room long enough to perform care and then I would leave." Staff Hadaway said that on one occasion, Resident A had a bowel movement that went up his back and all over the bathroom and he had to spend time cleaning Resident A and the bathroom, but he said that he does not believe it took him longer than 20 minutes to do so.

Staff Hadaway told me that he has been cooperating with the police, but he does not know the status of the investigation. Staff Hadaway asked me what he could do to protect himself from situations like this and I asked him if he would take a polygraph. Staff Hadaway said that the police asked him to take a polygraph, but he was "advised by counsel to say no." I asked him why and he said, "Because I'm already anxious enough about this whole fucking situation" and counsel told him that if the polygraph produced an inconclusive result, he would "look guilty."

I asked Staff Hadaway if he ever found Resident A to act confused or say nonsensical things and he said, "All the time." Staff Hadaway said that on one occasion, Resident A asked him to "remove his liver" and on another occasion, Resident A was pointing at the wall, talking about imaginary things. I asked Staff Hadaway why he thinks Resident A would lie about incidents like this and he said, "I have no idea."

On 10/23/2024, I emailed AD Morgan and asked her if staff ever reported to her, or if she has firsthand knowledge of Resident A being confused or making statements that do not make sense. AD Morgan said, "No, he's usually pretty straightforward."

On 10/24/2024, I reviewed AFC documentation related to Resident A. According to his Health Care Appraisal dated 07/23/24, Resident A is diagnosed with arthritis, dysphagia, coronary artery disease, progressive supranuclear palsy, and carpal tunnel. It is also noted that Resident A has difficulty communicating and suffers from general weakness. According to Resident A's Assessment Plan, Resident A requires staff assistance with transfers, eating, toileting, and bathing. Resident A uses a wheelchair for mobility.

On 10/24/24, I interviewed Resident A's hospice nurse (HN), Kenna Hyles, via telephone. HN Hyles said that she is aware of the allegations regarding Resident A and said that she has not talked to Resident A about the allegations. I asked HN Hyles if Resident A suffers from confusion or dementia, and she said no. HN Hyles told me that Resident A has aphasia which means that sometimes, although he knows the words he wants to say, the wrong words may come out of his mouth. HN Hyles said that she has never observed "any significant confusion" regarding Resident A and that he typically understands questions and can answer with 1-3 words. HN Hyles confirmed that Resident A has a difficult time communicating but said that she does not believe Resident A makes things up.

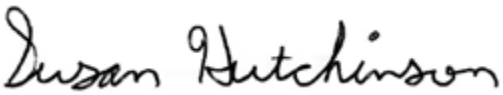
On 10/24/24, I conducted an exit conference with the licensee designee (LD), Abdul Aleem. I told him that I have concluded my investigation and explained which rule violation I am substantiating. LD Aleem said that once these allegations were made, staff Brett Hadaway's employment was terminated. LD Aleem said that the next day, he and AD Morgan held a staff meeting reminding staff of appropriate behavior with residents and that resident bedroom doors should never be locked. LD Aleem agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15305	**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:	Resident A reported being sexually assaulted by Staff Hadaway on two occasions. Resident A reaffirmed this assault when interviewed. Staff Sweet reported on 9/26/2024, Staff Hadaway locked the door while in Resident A's room with Resident A. Staff Sweet instructed Staff Hadaway to not to lock Resident A's door and to not let it happen again. Staff Sweet reported Staff Hadaway was in Resident A's locked room for an hour or longer. Staff Kayla Moore wrote a statement that on 09/29/2024, she found Staff Hadaway in Resident A's bedroom with the door locked. Staff Moore told AD Morgan that she estimates Staff

	Hadaway was alone with Resident A in his room for approximately ½ hour. Staff Moore wrote that she told Staff Hadaway that staff do not lock the resident's bedroom doors. Staff Hadaway denied sexually assaulting Resident A. Staff Hadaway admitted to locking Resident A's bedroom door when providing care but said that he was taught to do this for the resident's privacy. Staff Hadaway said that Staff Sweet told him that staff does not lock bedroom doors but said that none of the other staff told him that doors are not to be locked. AD Morgan and Resident A's hospice nurse said that Resident A is not diagnosed with dementia, he does not experience confusion, and Resident A does not have a history of making false or confusing statements. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

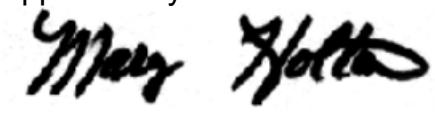
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



October 24, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



October 24, 2024

Mary E. Holton Area Manager	Date