GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 10, 2019

Jan Howell
Rhema-Armada Village Operating, LLC
22600 W. Main Street
Armada, MI 48005

RE: License #: AL500382676
Investigation #: 2019A0604018
The Villages Community

Dear Ms. Howell:

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382676
Investigation #:	2019A0604018
Complaint Receipt Date:	04/01/2019
Investigation Initiation Date:	04/01/2019
Report Due Date:	05/31/2019
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
Licensee Telephone #:	(586) 473-3227
Administrator:	Jan Howell
Licensee Designee:	Jan Howell
Name of Facility:	The Villages Community
Facility Address:	22570 Main Street Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuance Date:	08/02/2016
License **Status:**	REGULAR
Effective Date:	01/01/2019
Expiration Date:	12/31/2020
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

ALLEGATION(S)

	Violation Established?
Resident A disclosed she was raped by a former resident. The incident was not reported to the police.	Yes

II. METHODOLOGY

04/01/2019	Special Investigation Intake 2019A0604018
04/01/2019	Special Investigation Initiated - Telephone TC to Jan Howell
04/01/2019	Contact - Document Sent Email to Jan Howell
04/01/2019	Contact - Telephone call made TC to and from Jan Howell
04/02/2019	Inspection Completed On-site Completed onsite investigation. Interviewed Jan Howell, Resident A and Relative 1. Received copies of Resident A assessment plans.
04/02/2019	Comment Interview with Complainant
04/02/2019	Contact - Document Received Email from Jan Howell. Police report has been made.
04/03/2019	Contact - Document Sent Email to and from Jan Howell
04/26/2019	Contact - Document Received Email from Jan Howell. Sent return email.
06/28/2019	Exit Conference Completed exit conference with Licensee Designee, Jan Howell by email.

ALLEGATION:

Resident A disclosed she was raped by a former resident. The incident was not reported to the police.

INVESTIGATION:

I received a complaint regarding The Villages Community on 04/01/2019. The complaint indicated that an Adult Protective Services (APS) referral was made on 03/31/2019 and denied. The complaint alleged that Resident A has been diagnosed with a mild cognitive impairment and with major depressive disorder. Resident A is also of advanced age and frailty. A couple of weeks ago, Resident A disclosed to staff that she was raped. Initially Resident A did not show emotion when she made the disclosure and did not remember who the perpetrator was. Resident A disclosed the rape again to staff, but this time she identified the perpetrator as a former resident at the facility, Resident B. Resident B has since moved out of the facility and no longer has access to Resident A. The alleged assault occurred in Resident A's room, on her couch. There are no other details known at this time. The incident was not reported to the police because the family did not want that to happen.

I completed an onsite investigation on 04/02/2019. I interviewed Licensee Designee, Jan Howell, Resident A and Relative 1. I received copies of Resident A's assessment plans.

I interviewed Licensee Designee, Jan Howell. She stated that Resident A moved into the facility in October 2015. She stated that the alleged rape was first reported on 03/15/2019. A resident and family member came to her office to report a table mate claimed she was raped. Ms. Howell stated that Resident A continues to talk about the incident and last night stated that someone offered her a pill so she would not get pregnant. Ms. Howell stated that Resident A's story has changed over time. At one time she said there were "men" involved and then stated that Resident B who lived across the hall assaulted her. Ms. Howell sated that Resident B moved out of the facility on 03/25/2019. Ms. Howell stated that Resident B stayed in his room a lot. They never had reports of him being inappropriate with other residents. She stated that Resident B never stopped talking so none of the other residents wanted to sit with him. She stated that he was very smart and was sometimes considered a "know it all". Ms. Howell stated that when the maintenance man was taking down a sign for Resident B's room, Resident A stated, "that was a bad man".

I interviewed Resident A. She stated that she has lived at the facility for two to three years and likes it there. Resident A stated that she feels safe and things are well run. She gets along with staff and the other residents. Resident A stated that the man who lived across the hall used to come over every morning to warm his coffee and they would sit on the couch. Resident A stated that one morning, he grabbed her and she could not move. Resident A stated he decided he was going to have it with her.

Resident A stated that she was crying. Resident A stated that the man has since moved out and went up-north. She believed the incident occurred two years ago.

I interviewed Relative 1. She stated that Resident A's story has been changing since she began talking about alleged rape. Relative 1 stated that about three weeks ago Resident A told her brother that the man who used her microwave made a pass at her. Relative 1 stated that she never saw Resident B using Resident A's microwave. Relative 1 asked Resident A about incident and she again said that the man that uses her microwave made a pass at her. Relative 1 stated that Resident A then began talking about three brothers who all looked alike. Resident A stated that one of the brothers made a pass at her. Resident A says that all three brothers are now in jail. Relative 1 stated that Resident A now reports that the alleged incident involved Resident B who lived across the hall. Resident A has had recent health issues. She had stomach influenza and was sick and dehydrated. Relative 1 stated that last Wednesday Resident A was seen by a physician assistant (PA) and told PA that someone gave her a pill so she would not get pregnant. Relative 1 stated that she does not believe that anything occurred between Resident A and Resident B. She stated that Resident A has mild dementia. She has said other things in the past that were inaccurate such as stating that orphans are living with her daughter. Relative 1 stated that there are always staff present and she feels the facility provides adequate care and supervision. Relative 1 visits frequently and was visiting the day of alleged rape. She stated that she did not see anything out of place. She stated that she has only seen a bruise on Resident A from IV. She stated that Resident A has an alert button she wears and also has an alarm by her bed if she needs assistance.

I interviewed the Complainant on 04/02/2019. The Complainant stated they had concerns regarding how the allegation was handled. When Resident A alleged she was raped, the licensee did not contact law enforcement or request for Resident A to have a body check completed. The Complainant also stated that Resident B would use Resident A's microwave because his was broken. Resident B lived across the hall from Resident A.

I received an email from Jan Howell on 04/02/2019. Her email stated, "Detective Sharp from the Armada Police Department came to the building to do the police report. He took the information to discuss with his supervisor and called me to say we did our due diligence. The report number is 19-001134." Ms. Howell stated that the Detective spoke with her and Relative 1 and would not be doing any further investigating.

Licensee Designee, Jan Howell emailed former Adult Foster Care Licensing Consultant, Linda Pavlovski notes from her investigation of incident on 03/27/2019. Ms. Pavlovski stated that Ms. Howell also called and believes Ms. Howell promptly reported the incident to licensing.

I reviewed investigation notes completed by Jan Howell. Ms. Howell indicates that incident was first reported to her on 03/15/2019. She immediately went to resident's room and spoke with Resident A and Relative 1 who was visiting. Resident A stated that

the rape occurred the morning before on 03/14/2019. Relative 1 stated that she was visiting all morning on 03/14/2019.Resident then stated that it may have happened one month ago. Ms. Howell indicates that she offered to have a doctor examine Resident A or to call police. The family and resident declined offer. Ms. Howell continued her investigation and obtained written statements from staff. On 03/27/2019 she requested that Relative 1 have a urine test completed for Resident A. Ms. Howell concludes in notes that based on information received during the investigation, she was unable to substantiate any of the resident's claims and will close the investigation.

I reviewed Resident A's assessment plan dated 04/02/2019. The plan indicates that Resident A has mild cognitive impairment and is alert and orientated with some forgetfulness.

I completed an exit conference with Licensee Designee, Jan Howell by email on 06/28/2019. I informed her of the violation found. I also informed her that a copy of the special investigation report would be mailed once approved and that a corrective action plan would be requested.

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:	There is not enough information to determine that Resident A was not provided with protection and safety while residing at The Villages Community. There were no prior reports of Resident B displaying inappropriate behavior towards Resident A. Resident A has mild dementia. Ms. Howell and Relative 1 both stated that Resident A's report has changed since initially discussing the incident. Licensee Designee, Jan Howell, initiated an investigation once the allegations were reported to her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physician condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Licensee Designee, Jan Howell, was notified that Resident A stated she was raped on 03/15/2019. Resident A was not immediately seen by a medical professional to determine if she had any physical injuries or change in adjustment. Ms. Howell indicates that she offered to have a doctor examine Resident A or to call police. The family and resident declined offer.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences and death.**
	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	Licensee Designee, Jan Howell, was first notified that Resident A reported she was raped on 03/15/2019. Ms. Howell provided notes and staff statements that confirmed she immediately began an investigation of the alleged incident and interviewed Resident A and Relative 1 on 03/15/2019. Ms. Howell concludes in notes, that based on information received during the investigation, she was unable to substantiate any of the resident's claims and will close the investigation. I informed Ms. Howell that she needed to make a police report on 04/02/2019 and she contacted the Armada Police Department that day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

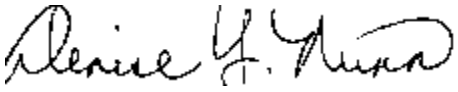
III. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change in the license status.

06/28/2019

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



07/10/2019

Denise Y. Nunn — Date
Area Manager