GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 3, 2021

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AL410289728
Investigation #: 2021A0357018
InterActions Residential Treatment

Dear Ms. Kross:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains sexually explicit language.

I. IDENTIFYING INFORMATION

License #:	AL410289728
Investigation #:	2021A0357018
Complaint Receipt Date:	05/04/2021
Investigation Initiation Date:	05/04/2021
Report Due Date:	06/03/2021
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Candy McKenney
Licensee Designee:	Jessica Kross
Name of Facility:	InterActions Residential Treatment
Facility Address:	300 68th St. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 493-6013
Original Issuance Date:	09/15/2008
License Status:	REGULAR
Effective Date:	03/15/2021
Expiration Date:	03/14/2023
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B claimed he was sexually assaulted by Resident A in the bathroom.	Yes

III. METHODOLOGY

05/04/2021	Special Investigation Intake 2021A0357018
05/04/2021	Special Investigation Initiated - Telephone
05/04/2021	Adult Protective Services Denied the complaint.
05/04/2021	Contact - Telephone call made Telephone interview with Therapist, James Domagala, at Pine Rest, InterActions Residential Treatment.
05/04/2021	Contact - Telephone call received Received telephone call from Candy McKenney, Home Manager.
05/04/2021	Contact - Document Received Received and reviewed Resident A and Resident B's Assessment Plans, Behavioral Treatment Plans, Person Centered Plans, Health Appraisal, CRS Care Progress Notes, Incident Accident Reports, Psychiatry Notes and InterActions 12-15 minute checks on 1st, 2nd, and 3rd. shifts for both Resident A and Resident B for May 1, 2021.
05/25/2021	Inspection Completed On-site
05/25/2021	Contact - Face to Face I conducted a video interview with Resident A and Resident B with the Clinician, James Domagda present. I also interviewed James Domagda, Cody Wright, Supervisor, Direct Care Staff, Deshawn Hughes, Julia Rafferaud and Australyah Coleman.
05/25/2021	Contact – Face to Face with Candy McKenney.
05/26/2021	Contact – Kent County Sheriff Left a message for a Detective to return my call.

06/02/2021	Conducted an exit conference by telephone with the Licensee Designee, Jessica Kross.

ALLEGATION: Resident B claimed he was sexually assaulted by Resident A in the bathroom.

INVESTIGATION: On 05/04/2021, our Lansing office received an Adult Protective Services (APS) Investigation Report. APS had denied the complaint for investigation. The complaint stated that Resident A is currently a resident in Pine Rest. "*On 05/01/2021, (Resident B) went in the bathroom with a male peer, (Resident A). When staff found (Resident B), he claimed he was sexually assaulted. (Resident A) pushed (Resident B) down and licked him on his groin in area and anus. Kent County Sheriff Department was contacted. (Resident B) received a rape kit yesterday."*

On 05/04/2021, I telephoned and spoke with Therapist, James Domagala, at Pine Rest, InterActions Residential Treatment. He explained that two residents (Resident A and Resident B) were found in the bathroom together and one accused the other of a sexual assault. Resident B was taken to YWCA for evaluation on Monday 05/03/2021. He reported that the police were involved. He reported both residents involved are on 15-minute checks. He said I should speak with the Manager Candy McKenney.

On 05/04/2021, I received a telephone call from Candy McKenney, Home Manager/ Administrator and she provided the history of the Resident A and Resident B. She stated she will work with us on setting interviews with the two residents. She also agreed to provide copies of Resident A and Resident B's information. She also reported that the YWCA called the home and told the staff that they will not report to InterActions what they found related to their assessment of Resident B related to HIPPA.

On 05/04/2021, Ms. McKenney sent me emails with attachments of Resident A and Resident B's, Assessment Plans, Health Care Appraisals, Person Centered Plans, Behavioral Treatment Plans, CRS Care Progress Notes, Incident Accident Reports, Psychiatry Notes and InterActions Treatment Program 12-15 minute checks on 1st, 2nd, and 3rd. shifts for both Resident A and Resident B for May 1, 2021. I reviewed all of these documents.

On 05/04/2021, I reviewed "*Interactions Treatment Program 12-15 minute checks on 1st. & 2nd. shifts. 25-30 minute checks on 3rd. shift. Make sure you see body and breath every single check."* Initials of staff were recorded on every 15 minute check. According to the IR the time of the incident was at 2015 for both Resident A and Resident B. Resident A was noted as "anxious," and Resident B was recorded as "calm." This report recorded a missed check at 2140, but this was after the incident.

On 05/04/2021, I reviewed the Incident / Accident Report (IR) dated 05/01/2021, at 2015PM, signed by Psych Tech, (Direct Care Staff) Deshawn Hughes and Candy McKenney, Administrator on 05/04/2021. In the section of the report where it asked to explain what happened read as follows: *During the 15 minute check, (Resident A) was suspected to be in the bathroom with another peer (Resident B). (Resident B) stayed silent in the bathroom while peer 1 (Resident A) tried to tell staff it was just him in the bathroom, and blocked (Resident B) from being seen. Peer 1 (Resident A) eventually stepped out of the bathroom, but had the door blocked so that it'd be difficult to see another body in said room. (Resident A) eventually stepped out as well with two staff to witness. Both residents had a different story to tell about the situation. (Resident B) says he was taken advantage of and was afraid to speak up. Staff told both residents to keep distance away from each other in the meantime.* Action taken by staff: "*Staff prompted. Contacted clinical on-call staff who put residents on peer boundaries."* Corrective measures taken to remedy and/or Prevent Recurrence "*Staff will increase checks on bathroom hallway. Both residents reminded to respect appropriate boundaries. Police contacted to take reports from residents and staff.'*

On 05/04/2021, I reviewed an IR dated 05/03/2021, signed by Direct Care Staff, Lilly Smith on 05/03/2021, and signed by Candy McKenney, Administrator, on 05/04/2021. Resident A's name was on this report. In summary staff were passing medications and Resident A was noted to be screaming at the medication passer and threatened to throw his water onto the medication passer. Resident A continued to make racial and homophobic slurs towards staff. "*He was talking to staff about how he asked God for forgiveness for giving a male peer oral sex the other night. He stated he was trying to help the peer out because the peer said his penis wouldn't function due to his medications. (Resident A) stated that he gave the peer oral sex to help him out with his issue."* On the report the Corrective Measures Taken to Remedy and/or Prevent Recurrence read: "*Staff will continue to prompt and encourage (Resident A) to use prosocial skills and positive coping skills. Information relayed to clinical team members."*

On 05/04/2021, I reviewed an IR dated 05/03/2021, signed by Direct Care Staff, Deshawn Hughes on 05/03/2021, and signed by Candy McKenney, Administrator, on 05/04/2021. The name on this report was Resident B's. This report stated that during the 15-minute checks (Resident B) was suspected to be in the bathroom with another peer. Mr. Hughes explained that Resident A blocked the bathroom door and eventually stepped aside. The report stated: "*Both residents had a different story to tell about the situation. (Resident B) says he was taken advantage of and was afraid to speak up. Staff told both residents to distance away from each other in the meantime."* Staff contacted clinical. Residents were placed on peer boundaries. The section of Corrective Measures read: "*On-call CMH Supervisor contacted James Domagala. Staff will increase checks on bathroom hallway. Residents both reminded of appropriate boundaries. Police contacted to take reports from residents and staff. YWCA contacted to complete rap kit. (Resident B) attempted to call Legal Guardian*."

On 05/04/2021, I reviewed, and IR completed by Direct Care Staff, Lilly Smith on 05/03/2021, and signed by Candy McKenney, Administrator, on 05/04/2021. Resident B's name was on this report and the same information concerning the admission of what Resident A had done to Resident B was recorded. *"The corrective measures read that the Clinical staff was informed of peer's statement. Peer was reminded to display appropriate boundaries."*

On 05/04/2021, I reviewed Resident A's Adult Foster Care Assessment, signed by Sarah Michlatcher, LLMSW, on 02/22/2021. Resident A is a 62-year old male and was admitted to the facility on 02/19/2021. Under the section of moving independently in the community it stated "*No. (Resident A) has a history of inappropriate sexual acting out in the community and will be monitored by staff while at InterActions program."* Resident A's Behavioral Support Plan was referenced. I reviewed his Behavior Treatment Plan dated 01/29/2021. It noted that Resident A must stay within 5ft. from staff in the community. If he needs to use the restroom in the community a male staff shall accompany him into the bathroom. Resident A's assessment plan read that he has difficulty communicating at times as he tends to perseverate on specific topics and avoid directly answering questions asked of him. The assessment plan under section of "Controls Sexual Behavior," *"No, (Resident A) has a history of inappropriate sexual acting out and has a CSC (Criminal Sexual Conduct) conviction for which he served time in prison. (Resident A) will need to be monitored in the unit to ensure the safety of himself and other residents and staff. See Resident A's BSP for more information."* In Resident A's Behavior Treatment Plan it read that Resident A has a history of "…*impulsive behavior, sexually inappropriate behavior, boundary issues,…(Resident A) has also had a history of multiple psychiatric admissions and experience in residential settings for much of his adult life…(Resident A) has also been incarcerated regarding aggressive and sexually inappropriate behavior in the community…"* The plan read that they were to reduce, "Target Behaviors." The plan defined "Sexually Inappropriate Behavior/Comments:" "*Defined as making comments of a sexually explicit nature or otherwise behaving in a sexually explicit manner i.e. using verbal language, commenting on others bodies, or gestures, asking peers to enter bathrooms and/or bedrooms or participate in sexual behavior, touching others in a sexual manner;…"* Under the section of "Proactive Strategies," *"(Resident A) is more symptomatic with his mental illness; i.e. perceiving placements as dangerous or not meeting his needs…" "****Staff will be sure to know where (Resident A) is at all times****."* (This was in bold print in the plan.) *(Resident A) has a history of….engaging in sexual behavior in residential programs. This is more likely to occur if/when (Resident A) is more symptomatic with his mental illness: i.e. perceiving placements as dangerous or not meeting his needs…"*

On 05/04/2021, I reviewed Resident A's Health Care Appraisal dated 02/19/2021. Resident A's recorded Diagnoses as: "*Bipolar, Schizoaffective, HTN, diabetes*." The document read that he has a "*history of sexual assault*."

On 05/04/2021, I reviewed Resident A's CRS Person Centered Plan of Care, Effective 03/09/2021, author Trechaun Gonzalez, Case Manager. One of his problems was identified as: "*Interpersonal Skills. Long-Range Goal:…(Resident A) will learn and practice interpersonal relationship skills and terminate self-damaging behaviors (such as sexually acting out) as evidenced by an increased in healthy boundaries with others." "(Resident A) will attend therapy to discuss sexual urges and appropriate way to respond to these urges as evidenced by decreased inappropriate sexual behaviors…"*

On 05/04/2021, I reviewed Resident A's Psychiatric Progress Note dated 04/02/2021. I reviewed a note by Darci Evans DO which read: *"I do agree with the addition of narcissistic personality to the diagnostic impression."* Under the "*Identifying Information:…Patient is on court order for treatment and medication compliance expires 12/17/2021. The patient does not have a guardian. He does have a payee (InterAct of Michigan)."* "*Plan from last appointment: Patient presents as sexually provocative and manipulative with narcissistic traits. Seems to take no responsibility for recent aggression and property damage places blame on others. Notes his annoyance with staff he identifies as homosexual while sharing examples of his own homosexual behaviors."* This document read that Resident A had a recent sexual encounter with another peer. (Peer not identified) Dr. Evans had written: "*Evaluating patient's personality he has found to have a grandiose sense of self importance being above the rules at the unit, he is highly attention seeking, he has a clear sense of entitlement believing he deserves special treatment special items and is above the rules, he is noted to exploit multiple peers for money and sexual favors, he has shown no empathy towards his hurtful actions towards staff and peers, he presents as arrogant and haughty."*

On 05/04/2021, I reviewed CRS Care Provider Progress Notes (1st/2nd) by Deshawn Hughes dated for 05/01/2021. Under section in the report of *"Behavioral Concerns this Shift:? Yes (Was with another resident in the bathroom) Behaviors Displayed: Sexualized behavior."* In this same document it recorded: "*Problem: Histrionic Personality Disorder."*

On 05/04/2021, I reviewed Resident B's Adult Residential Treatment Admission Application dated 02/26/2019. Resident B has a guardian, Sanilac Public Guardian, Sandusky, Michigan. He was in his family home and then in three different AFC home is Sanilac County. This document indicated that Resident B has boundary issues by invading personal space of others and touches others without asking. He has a history of sexual behavior in other residential programs with both males and females. He has a history of trying to grope males and females and a charge of CSC 4th. Degree was reduced to misdemeanor, no registration. He also has a Conduct Disorder. Resident B has had several Psychiatric Hospitalizations. "Justification for placement: Court Ordered."

On 05/04/2021, I reviewed Resident B's AFC Assessment and Plan which was completed on 04/23/2020 by Ciesa Alison LMSW. He is 28-year old male admitted

to the facility on 04/23/2019. The assessment plan asked if Resident B controls Sexual Behavior and it said *"No. (Resident B) endorses that he is a homosexual, and has a past engaged in much inappropriate electronic use to obtain pornography. He was charged with a CSC. See BSP for support."* In his Behavior Support Plan under *"Other Information, Comments/Special Instructions: (Resident B) has had multiple placements in the past year. He is referred to Interactions to provide education and consistent coaching to reduce verbal aggression, medications difficulties, and sexually inappropriate behaviors…"* One of the goals was to have Resident B to reduce…."sexual inappropriate behavior/comments…" *Target behaviors to Reduce Sexually Inappropriate Behavior/Comments: Defined as making comments of a sexually explicit nature or otherwise behaving in a sexually explicit manner i.e. using verbal language or gestures, asking peers to enter bathrooms and/or bedrooms to participate in sexual behavior, touching others in a sexual manner;…"* "***Be sure to know where (Resident B) is at all times."*** *(This was in bold in the report) "(Resident B) has history of walking away from placements as well as inappropriate sexual behavior while in programs. He has been reported to have engaged in holding hands with peers in the program, this should be redirected."*

On 05/04/2021, I reviewed Resident B's Behavioral Treatment Plan dated 03/23/2021. This document that Resident B's presenting problem was in part "*impulsive behavior, sexually inappropriate behavior, boundary issues…He experiences to having perseverative thought process, asking of strategic and repetitive questions, compulsive behaviors…impulse control issues, low frustration tolerance, impaired judgment, difficultly with respecting and setting boundaries and limited intellectual functioning. He has been incarcerated regarding theft, aggressive and sexually aggressive behavior in the community."*

On 05/04/2021, I reviewed Resident B's Health Care Appraisal dated 05/22/2020. The diagnoses were recorded as *Anti-Social Personality Disorder, ADHD, Depressive Disorder, Impulse Control, Intellectual Disabled, and Diabetes.* It also read that he had limited insight and was guarded.

On 05/04/2021, I reviewed Resident B's CRS Person Centered Plan of Care 05/22/2020. The long range goal for his Antisocial Personality Disorder was for Resident B "…*will engage in healthy boundaries/social skills, and increase is ability to have empathy by learnings skills to decrease risk taking behaviors, impulsivity and manipulative behaviors by the end of tx (treatment) plan.* Resident B will attend therapy once a week "*to develop coping skills and learn ways to get his needs met appropriately as evidenced by a decrease in risk taking /manipulative behavior per BSP data*…" He will also attend at least 2 groups daily.

On 05/04/2021, I reviewed Resident B's Psychiatric Progress Note dated 09/18/2020, by Darci Evans, DO. The reason for the visit was a follow-up on irritability and impulsivity. The document read: "*The patent's primary concern today is getting Viagra. He states he is unable to achieve an erection (for purposes of*

masturbation) without the use of pornography. He does not have access to the internet or any pornography…due to his misuse of them…." He repeatedly asks about getting the approval for this medication." Under the section of "Mental Status *Exam: Insight: Limited. The patient is able to tell me what he needs to do in order to move to the next level of care. Judgement: Poor. He continues to exhibit some poor boundaries."* Dr. Evans wrote that (Resident B's) *"primary focus today is getting Viagra for the purposes of masturbating. I expressed to the patient that I agree with Dr. Michelakis that this medication is not necessary nor it is appropriate at this time. He was disappointed but accepted the decision. It is possible Risperdal could be contributing to erectile dysfunction, but he seems to have no problems if he has access to porn, to this points way from that…".*

On 05/04/202, I reviewed the Psychiatry Progress note from 02/19/2021, by Darci Evans DO. This document indicated that Resident B is very focused on getting Viagra, "…*stating that he is unable to get an erection without having access to pornography. He states this has been going on for approximately 6 to 7 months. He gets frustrated when we declined to approve Viagra, indicating that it is not a necessary medication for his health and well-being while in residential treatment."*

On 05/25/2021, I conducted a video interview with Resident A. Cody Wright, Supervisor, was in the bedroom of Resident A and he setup the video. Therapist, James Domagala, was with me during the interview. He said he wanted to talk to a male, not to me as a female. He said, "*he had to help (Resident B) with his tool. Help him to get his mojoe like Austin Powers."* He explained that (Resident B) had given him "*the sign*," for having oral sex. I asked what the sign was, and he said it was, "*a tip of his head to one side/head nod*." He stated further that they were both consenting adults. He stated that they met in the bathroom and that (Resident B) was in the bathroom first. He reported that they tried to do it before, but they did not finish it. He said "*I had to do this. I got down on my knees to service him and it didn't take long. I had oral sex with him."* He stated further that he turned (Resident B) over and he put his tongue on his butt cheeks and on his annus but there was no penetration. He said he came clean and told the truth and told the staff what had happened. He said that he heard (Resident B) say that he threw him to the floor. He denied throwing Resident B to the floor.

On 05/25/2021, I conducted an interview with Resident B by video. Cody Wright, Supervisor, was in the bedroom of Resident A and he setup the video. Therapist, James Domagala, was with me during the interview. We were in a conference room. I asked him about the incident with Resident A. Resident B stated he was in the bathroom with Resident A told him to pull his pants down and Resident A physically touched him, and Resident A was on the ground. "*He was giving me oral sex. I resisted and I said no. He touched my ass too. I kept saying no. I was assaulted. It wasn't my fault. It is not a good idea that (Resident A) be there in the facility. It happened before, between us. He did it to another person who lives here. I avoid him. He keeps coming around in my room. I don't feel comfortable around him. I reported it to staff and I called my family."* Mr. Domagala reminded Resident B that

he has requested to use the telephone and he called the Kent County Sheriff. Resident B reported that the officers came to interview him on Sunday. He reported that he went to the YWCA to be checked out. He said that the YWCA talked to him and took pictures but told him nothing.

On 05/25/2021, I conducted a face-to-face interview with staff, Julia Rafferaud. She reported that they conduct 15-minute checks on each resident and that they have to see each resident. She stated that they were unable to find Resident A. She said she checked the courtyard which is outside of the facility and he was not there. She stated they did not know where he was. She said the Mr. Hughes heard Resident A in the bathroom and they did not find Resident B and they figured out they were in the bathroom together. She said the bathroom door was locked. She said MrHughes was standing there and Resident A cracked the door opened and stated he was in the bathroom taking a poop and then he shut the door. She said Mr. Hughes kept talking and finally Resident A left the bathroom and walked away. Then Resident B came out of the bathroom. She reported that both residents were put on Peer Boundaries by the clinical staff. She said that Resident A and Resident B cannot be together anywhere inside or outside of the facility and they as staff have to keep an eye on each one and separate them if they are together. She also reported that they cannot see the two bathroom doors on the hall-side of the facility so this makes it very difficult to see who is going in or coming out of the two bathrooms. She reported that the two residents were sexually involved with oral sex. She said that Resident A has done this to another resident before and that resident has left the facility.

On 05/25/2021, I conducted a face-to-face interview with Cody Wright, Supervisor. Mr. Domagala was also present. He explained that he was doing outings with other residents in their van when the incident occurred, but staff informed him as soon as he returned to the facility. He reported that Resident B has poor insight, and he can be pretty “sneaky.” He has made up stories in the past. He reported that staff had told him what had happened, and he had interviewed both Residents A and B. He stated that Resident B said that Resident A had coached him (Resident B) into the bathroom and Resident A pulled his pants down and Resident A was kneeling on the floor and he had oral sex with him. Resident B repeatedly asked if he was in trouble. Mr. Wright stated that he interviewed Resident A. He stated that Resident A does not tell the truth and has mental health issues. He said that Resident A told him that he serviced Resident B and he got him to ejaculate which helped Resident B. Mr. Wright also stated that Resident B said that he wanted to press charges against Resident A, and he wanted a full police report because he was raped. He said that Resident B called the Kent County Sheriff, and they came to the facility and conducted interviews with both Resident A and B. The sheriff suggested they call the YWCA. He reported they did call the YWCA and they came to the facility but they were unable to interview Resident B because he is guarded, and the guardian did not call back to give permission for the interview and due to the guardianship Resident B could not consent. I asked Mr. Wright to explain the procedure on how staff check on residents. He explained that the staff go in two’s, with their clip board to look at each resident and they initial their form when they see each resident. He

said due to the incident both residents were placed on “Peer Boundaries,” which means the two residents are not to be with each other or in the same area (6 feet apart) and not in the bathroom together.

On 05/25/2021, when I finished the interviews with Resident A and B, Mr. Domagala reported that he had interviewed Resident A about the incident, and he had told him that he had put his tongue on Resident B and when was at or near the annus when he found Resident B to be unclean, so he did not penetrate him. He also confirmed that both residents are manipulative and do not always tell the truth. He did confirm that both Resident A and Resident B did acknowledge that there was oral sex involved but Resident B reported he was raped.

On 05/25/2021, I conducted an interview with staff Deshawn Hughes. He verified that he had completed the two IR’s, one on Resident A and one on Resident B. He reported that they did not find Resident A and he is on 15 minute checks. They did not know where Resident A was. He heard noises from the bathroom and he figured out Resident A was in the bathroom. He demonstrated by using the door in the conference room how Resident A did not let him look into the bathroom and how he blocked the entrance to the bathroom by his body and Resident A did not tell him the truth that Resident B was in the bathroom. Finally Resident A moved away from the bathroom door and they found Resident B inside the bathroom. He stated that Resident B told them that Resident A threw him to the floor.

On 05/25/2021, I conducted a face-to-face with staff, Australyah Coleman. She reported that she was in charge of passing medications on the day of the incident. She also reported that another resident was sick, and she was sending that resident to the emergency room, so she was very busy. She said that Ms. Rafferaud had reported that they could not find Resident A and Mr. Hughes was knocking on the bathroom door and found that Resident A was in the bathroom and he kept saying no one else was in the bathroom with him. She explained how Resident A stood in front of the door and blocked the door. She said that Resident B pulled her aside when they were in the courtyard together and told her he did not know what had happened when he was in the bathroom. He said he told Resident A to get out. He told her that Resident A told him to pull his pants down. She reported that Resident B told her that he told Resident A, no. She went on to say that Resident B told her that Resident A got down on his knees and he had to push Resident A off of him with his arms. She said that Resident B wanted to call the police because he said he was raped.

On 05/25/2021 and on 06/01/2021, I interviewed Candy McKenny, Administrator. She acknowledged that both residents are court ordered to be at InterActions and that Resident B is fully guarded. She explained that Resident A was with another resident in a sexual way and that resident was moved out of the facility. She stated that with the staff they have, they are not able to know where Resident A and Resident B are at, at all times. She acknowledged that the staff cannot see the two bathrooms from the milieu due to the structure of the facility. She said they are

checking with the two Recipient Rights offices on being able to lock the two bathroom doors so residents have to ask staff to unlock the doors because the other two bathrooms, staff can visually see them. She also reported that Resident B is manipulative and he does not tell the truth. She stated that Jen Victor had written the PCP and put in the document that staff are to know where Resident A and Resident B are at, at all times. She said they schedule three staff on first and second shift with one passing medication and the other two provide cares and supervision. She acknowledged that they cannot do that much supervision and they are also having difficulty in finding and keeping staff due to Covid.

On 06/02/2021, I conducted a telephone exit conference with Jessica Kross, the Licensee Designee and she said she understood the citations and she could not disagree with my findings.

APPLICABLE RULE	
R 400.15305	**Resident protection**
	(1) A resident shall be assured privacy, and protection from moral, social and financial exploitation.
ANALYSIS:	Both residents, Resident A and Resident B have a documented history of sexually acting out and were to be monitored closely by staff. Despite this history and supervision requirement the two residents were able to meet and engage in sexual activity without staff's knowledge.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400. 15303	**Resident care: licensee responsibilities.**
	(1) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A and Resident B's plans stated that the staff were to know where both residents were at all times. On May 1, 2021, the staff were unable to find Resident A and upon their discovery both Residents A and B were found in the bathroom together where Resident A preformed a sexual act on Resident B. During this investigation it was found that the staff did not know where Resident A was located, until they found Resident A in

	the bathroom with Resident B and therefore, they did not know where Resident B was located until they found him in the bathroom. The licensee failed to provide supervision and protection as specified in the resident's written assessment plan that the staff were to know where Resident A and Resident B were at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION:

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remind unchanged.

Arlene B. Smith 06/03/2021

Arlene B. Smith MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/03/2021

Jerry Hendrick Date
Area Manager