



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2021

Donzell Dawkins
1109 16th Street
Bay City, MI 48708

RE: License #: AS090307605
Investigation #: 2022A0572007
Premier Care Assisted Living 3

Dear Mr. Dawkins:

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 (906) 226-4171.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090307605
Investigation #:	2022A0572007
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	01/02/2022
Licensee Name:	Donzell Dawkins
Licensee Address:	1109 16th Street Bay City, MI 48708
Licensee Telephone #:	(989) 295-7641
Administrator:	Donzell Dawkins
Licensee Designee:	n/a
Name of Facility:	Premier Care Assisted Living 3
Facility Address:	2204 S. Farragut Bay City, MI 48708
Facility Telephone #:	(989) 295-7641
Original Issuance Date:	08/05/2010
License Status:	REGULAR
Effective Date:	02/20/2021
Expiration Date:	02/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident A failed to wait for staff to take her for a walk, so when she returned to the home, she said she was raped by Resident B in a field.	Yes

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A0572007
11/04/2021	APS Referral APS referral made
11/04/2021	Special Investigation Initiated - On Site
12/17/2021	Contact - Telephone call made Resident A's Guardian.
12/17/2021	Contact - Telephone call made Licensee, Donzell Dawkins.
12/17/2021	Exit Conference Licensee, Donzell Dawkins.
12/17/2021	Contact - Telephone call made Resident A's Case Manager.
12/17/2021	Contact - Telephone call made Resident A's.

ALLEGATION:

Per incident report, Resident A failed to wait for staff to take her for a walk, so when she returned to the home, she said she was raped by Resident B in a field.

INVESTIGATION:

On 11/03/2021, the local licensing office received a complaint for investigation. APS, Law Enforcement and Recipient Rights were involved with the investigation.

On 11/04/2021, an unannounced onsite was conducted at Premier Care Assisted Living, located in Bay County, Michigan. Interviewed were, Licensee, Donzell Dawkins and Resident C.

On 11/04/2021, I interviewed Licensee, Mr. Dawkins regarding an allegation that Resident A failed to wait for staff to take her for a walk, so when she returned to the home, she said she was raped by Resident B in a field. Mr. Dawkins informed that Resident A ran off and she knows that she is not to go out into the community alone. He was the on-call manager, so he went out looking for her, but she had returned by then. She was gone approximately 45 minutes and she was fine. Her behavior did not appear to be anything out of the ordinary. A former staff indicated that Resident A had ran off and when she came back, she stated that she had been raped, but she said it loud and jokingly. She claimed that she had been raped by Resident B. Resident B has been in his home for several years and has never been an issue. Resident B informed that they had consensual sex but did not give any further details other than it was out in the field. He had never been sexually inappropriate before. Resident A has a history of making things up. Resident A returned home first and then Resident B returned a short time later. Resident A was taken to Shelterhouse for an examination and was there until 2am. Resident A's Guardian just asked can she return to the home, which is strange if she was raped by a resident in their home. She had been in one of his other homes before and she wasn't too big of an issue at that time, which is why he is considering taking her back.

On 11/04/2021, I interviewed Resident C regarding an allegation that Resident A was raped. He informed that he is her boyfriend, and he is the one who called the police. He saw both Resident A and Resident B walking outside, very close to each other. There was a fair nearby that he went to, to go look for her and he found her in a trailer at the fair. He told her to stay there while he goes to the bathroom, and she was normal. When he came back, she started yelling and screaming that she had been raped. He indicated that Resident B admitted to the police that he had sex with Resident A but tried to say that it was consensual.

On 11/04/2021, I received a copy of the examination that was conducted by Shelterhouse. There was no evidence that any forced entry was made.

On 11/04/2021, Resident A's Plan of Service was reviewed, and it indicates that she cannot go out into the community alone due to her cognitive delays and she can be easily manipulated.

On 11/04/2021, I reviewed the Incident Report, which indicated that Resident A eloped from the facility and upon her return, she jokingly stated that she was raped. Law Enforcement was contacted, and they were instructed to transport (Resident A) to Shelterhouse for an examination.

On 12/17/2021, I interviewed Resident A's previous Case Manager, Julie Hasse regarding an allegation that Resident A failed to wait for staff to take her for a walk, so when she returned to the home, she said she was raped by in a field. Ms. Hasse informed that Resident A was not supposed to go out into the community alone. Premier Care Assisted Living informed that she ran off several times and she is currently having elopement issues at her current home. According to Resident A, she was going to take bottles to the store when she was raped. She has a history of both being truthful and making false allegations. After the alleged rape incident, she did not appear to be devastated, but cognitively; she is of a 12- or 13-year-old. She could have been raped or it could have been consensual, but since she supposedly has a boyfriend in the home, she could have felt like she had to say that she was raped. Resident A was moved out of the home immediately, but within a couple days of moving, she wanted to move back to Premier Care Assisted Living. Resident A has resided in a Premier Care AFC Home before and never had any issues. Staff are always nice and easy to get along with. Resident A was taking to Shelterhouse for an examination and according to the guardian, there was nothing to suggest that she was sexually assaulted. Ms. Hasse was contacted again and asked if there was anything in her Plan of Service that would suggest that she was sexually active and they were not aware of her being sexually active. She had lived independently for 3 years prior to moving into Premier Care, but she always had staff and she had an electronic monitoring system so they would know where she was at, as all times. She informed that she did not receive a Police Report, but Resident A's Guardian may have one because she had been trying to get one.

On 12/17/2021, I contacted Licensee, Donzell Dawkins regarding Resident A to see if she had returned to Premier Care Assisted Living and he indicated that he was not taking her back as she foresee her being too much of an issue for them to handle. He informed that she was not sexually active prior to coming to his home but would say certain things. He never received a copy of the police report but mentioned that there has to be one because they were called and they were instructed to send her out for an examination.

On 12/17/2021, I interviewed Resident A's Guardian, regarding an allegation that Resident A failed to wait for staff to take her for a walk, so when she returned to the home, she said she was raped by in a field. She informed that she was contacted about the incident and that she heard that Resident A was sexually active with

Resident B, but she also heard that Resident A was sexually assaulted, but it was by someone in the community. She has not spoken to Resident A regarding this because she did not want her to relive the incident. She informed that she attempted to obtain a Police Report but was told that she could not get one because there are still investigating. She informed that she has not heard back from them regarding a report. She denied that Resident A was sexually active prior to moving into the facility and indicated that they kept track of her with an electronic monitoring system and she always had staff.

On 12/17/2021, I interviewed Resident A regarding how she liked Premier Care Assisted Living and if anything occurred while she was there. She said it was fine. When asked if anything happened to her while she was there, she stated, "Yeah." When asked what happened, "She stated, "It happened with (Resident B)." When asked what happened, she stated, "Sex happened." She went on to say that Resident B forced her to have sex and she didn't want to and that it only happened one time.

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:	According to the Licensee, Donzell Dawkins, Resident A ran off from the home without staff and when she returned, she claimed that she was raped, but said it jokingly. Resident C said that he found her at the fair and she seemed normal at first and then later said that she was raped. Resident A's Case Manager also indicated that she did not appear to be devastated about the allegation, so she does not know if it happened or not. She informed that a couple days after they moved her out of the home, she wanted to return, and she still wants to return to the home. Resident A's Guardian and Case Manager indicated that she was not sexually active prior to moving into Premier Care. Resident A informed that she was forced to have sex by Resident B.
CONCLUSION:	VIOLATION ESTABLISHED

On 12/17/2021, an Exit Conference was held with Licensee, Donzell Dawkins. He informed that he did not agree with the findings because Resident A left the home without permission and they cannot physically detain her without violating her rights, plus they are not a lockdown facility, and she was not receiving one-on-one care.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan, capacity (1 – 6).



12/17/2021

Anthony Humphrey
Licensing Consultant

Date

Approved By:



12/17/2021

Mary E Holton
Area Manager

Date