



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

January 13, 2022

Paula Ott  
Central State Community Services, Inc.  
Suite 201  
2603 W Wackerly Rd  
Midland, MI 48640

RE: License #: AS630405663  
Investigation #: 2022A0605012  
Seymour Home

Dear Ms. Ott:

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,

A handwritten signature in cursive script that reads "Frodet Dawisha".

Frodet Dawisha, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place, Ste 9-100  
Detroit, MI 48202  
(248) 303-6348

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630405663
<b>Investigation #:</b>	2022A0605012
<b>Complaint Receipt Date:</b>	11/22/2021
<b>Investigation Initiation Date:</b>	11/22/2021
<b>Report Due Date:</b>	01/21/2022
<b>Licensee Name:</b>	Central State Community Services, Inc.
<b>Licensee Address:</b>	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
<b>Licensee Telephone #:</b>	(989) 631-6691
<b>Administrator/Licensee Designee:</b>	Paula Ott
<b>Name of Facility:</b>	Seymour Home
<b>Facility Address:</b>	241 Cheltenham Oxford, MI 48371
<b>Facility Telephone #:</b>	(248) 572-6040
<b>Original Issuance Date:</b>	03/04/2021
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/04/2021
<b>Expiration Date:</b>	09/03/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED/ DEVELOPMENTALLY DISABLED MENTALLY ILL/AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
On 11/15/2021, all the residents were left home alone. It is unknown how long the residents were left home alone. There is always supposed to be two staff on site as the residents are not allowed to be left unsupervised.	Yes
Resident A is having sex with a man that comes to Seymour Home and the staff help Resident A into bed to have sex with this man.	No

## III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A0605012
11/22/2021	APS Referral Adult Protective Services (APS) denied referral.
11/22/2021	Special Investigation Initiated - Telephone I left a voice mail message to Oakland County Office of Recipient Rights (ORR) Rishon Kimble advising her that I was investigating these allegations.
11/24/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed the home manager Dionne Thompson, direct care staff (DCS) Nahbria Thompson and Resident A. I observed Residents B, C, D, E, and F.
11/24/2021	Contact - Telephone call made I interviewed the home manager regarding allegations that were called in on intake #183531 regarding Resident B.
12/06/2021	Contact - Telephone call made I contacted Office of Recipient Rights (ORR) Rishon Kimble who stated she is not investigating allegations regarding intake #183531.
12/28/2021	Contact - Telephone call made I attempted to call Resident B who is deaf and non-verbal using Purple Video Relay Service, but Resident B was unavailable, so a message was left.

12/28/2021	Contact - Telephone call made I interviewed DCS Daniqua Draper, Jeffrey Brand, Christine Gatton, Open Arms supports coordinator Nicholas Tait, Resident B's guardian Jim Stark with Macomb-Oakland Guardian Inc., (MOGI) regarding the allegations.  I left a message for Dr. Theresa Moore with MOGI.
12/28/2021	Contact - Telephone call received I received a return call from Dr. Theresa Moore with MOGI regarding the allegations.
01/06/2022	Contact - Telephone call made I interviewed Resident A via telephone using a sign language interpreter through Purple Video Relay Service regarding the allegations.
01/12/2022	Exit Conference I left a message for licensee designee Paula Ott with my findings.

**ALLEGATION:**

**On 11/15/2021, all the residents were left home alone. It is unknown how long the residents were left home alone. There is always supposed to be two staff on site as the residents are not allowed to be left unsupervised.**

**INVESTIGATION:**

On 11/22/2021, intake #183461 was referred by Adult Protective Services (APS) who denied their referral regarding Residents A, B, C, D, E, and F were left home alone unsupervised without any staff on 11/15/2021.

On 11/22/2021, I initiated my special investigation by contacting Office of Recipient Rights (ORR) Rishon Kimble advising her I was investigating these allegations.

On 11/22/2021, ORR Rishon Kimble emailed me the following contact:

“I did speak to the support coordinator (Nicholas Tait) with Open Arms Coordination Services, Inc., contracted with Macomb-Oakland Regional Center (MORC), and he said when he arrived on 11/15/2021 there was no staff there, but Nahbria Thompson (staff) showed up about 15 minutes later and the house supervisor (Dionne Thompson) showed up about 30 minutes after that. He said that all six residents were home, and no one was there prior to that. Nicholas said Nahbria could not give him a good reason as to why she wasn't there, and she stated that another staff (Christine Gatton) was supposed to be there with the residents. From my understanding, this home is supposed to always have two staff. The manager (Dionne) stated that when she left, Christine and Nahbria

were both on shift and Nicholas said the manager did look puzzled and asked Nahbria where she went when Nick told Dionne that no one was at the home. I also spoke to Christine Gatton who told me that she did not work at that home on 11/15/21 and she resigned from working at this company in October (she believes). Christine says that may have kept her on the schedule, but she did not work there on that date and stated she would never leave the Individuals home alone. Last thing, Nick said that both Dionne and Nahbria were not able to provide him with a schedule, but Dionne sent me the schedule and Christine and Nahbria are on the shift for that day. I have a call into the provider to see if Christine is still an employee or when/if she resigned.”

On 11/24/2021, I conducted an unannounced on-site investigation. The following individuals were present; the house supervisor Dionne Thompson, direct care staff (DCS) Nahbria Thompson, Residents A, B, C, D, E, and F. I reviewed November 2021 staff schedule.

I attempted to interview Residents A, B, C, D, and E but they were non-verbal. I tried to interview Resident F, but he was unable to respond to my questions given his cognitive disability.

On 11/24/2021, I interviewed the house supervisor Dionne Thompson regarding the allegations. Ms. Thompson has been with Central State for 15 years, but only one year as the house supervisor. She usually works the morning shifts 7:30AM-7:30PM. Ms. Thompson stated Central State prefers a supervisor on shift plus two DCS, but because they are short staffed, there is only two staff on shift, including the house supervisor. On 11/15/2021, Ms. Thompson arrived at Seymour Home around 7:30AM and her daughter Nahbria Thompson and Christine Gatton were on shift. Nahbria was working the midnight shift at 7:30PM-7:30AM on 11/14/2021 and then the morning shift on 11/15/2021. She stated Ms. Gatton was working the morning shift on 11/15/2021 too. Ms. Thompson stated after 15 minutes, she left Seymour Home to run errands since both Nahbria, and Ms. Gatton were on shift. Ms. Thompson stated she had to pick up a debit card from Central State’s other group home, Hickory Ridge, then went to Dr. Pinelli’s office to pick up Resident A’s hospital bed script. Ms. Thompson picked up lunch for all the residents and returned to Seymour Home around 12:45PM. When she arrived, Open Arms support coordinator Nicholas Tait was present as was Nahbria, but Ms. Gatton was not. Shortly after, Mr. Tait’s supervisor Elizabeth Culberson arrived at the home and Mr. Tait advised Ms. Culberson that when he arrived at Seymour Home around 10AM, there was no staff. Mr. Tait also told Ms. Culberson that Resident A opened the garage door and let me into the home. Ms. Thompson stated, “I questioned Nahbria and Nahbria said, I went to the store and Christine was here.” Ms. Thompson stated Nahbria went to the store to purchase cigarettes. Ms. Thompson stated she called and texted Ms. Gatton but received no response. Ms. Thompson stated this was an isolated incident; however, Ms. Thompson has left only one staff at Seymour Home when there are only two residents so Ms. Thompson can “run errands.”

I reviewed the staff schedule provided by Ms. Thompson for November 2021 and on 11/15/2021, Dionne Thompson (7:30AM-7:30PM), Nahbria Thompson (7:30AM-7:30PM) and Christine Gatton (7:30AM-3:30PM) were scheduled to work that day. Ms. Thompson stated she did not have the schedule available for the support coordinator Mr. Tait because she was unable to locate the schedule, but then located it and forwarded it to Mr. Tait.

On 11/24/2021, I interviewed DCS Nahbria Thompson regarding the allegations. Nahbria is the house supervisor's daughter and has worked for Central State for one year. Nahbria works first shift with Ms. Thompson from 7:30AM-7:30PM. Nahbria stated on 11/15/2021, she was scheduled to work the first shift with both Ms. Thompson and Christine Gatton. Nahbria stated Ms. Thompson left shortly after arriving on shift at 7:30AM to "run errands," and Nahbria and Ms. Gatton were left with all the residents. Nahbria stated around 11:30AM-11:40AM she told Ms. Gatton she was running to the store for cigarettes and will be right back. Nahbria stated she returned to Seymour Home at 12PM and saw Nicholas Tait, the supports coordinator in the driveway. Mr. Tait told Nahbria, "the residents are alone, by themselves." Nahbria told Mr. Tait, "Christine was here." Mr. Tait told Nahbria that Resident A opened the garage door for him, and Resident A told Mr. Tait there is no staff here. Resident A communicated with Mr. Tait via her tablet as Resident A is deaf and non-verbal. Nahbria contacted Ms. Gatton, but Ms. Gatton did not answer her phone or respond to Nahbria's text message. I asked to view the text message, but Nahbria stated it was no longer on her phone. Nahbria stated a week ago, Ms. Gatton was a no call no show for her shift, so Nahbria said, "this did not surprise me." Mr. Tait asked Nahbria where Ms. Thompson was and Nahbria told Mr. Tait, "I don't know." Mr. Tait then completed his meeting with Resident A and then requested to view the staff schedule, which was not available as Ms. Thompson was unable to locate it. Nahbria stated this was an isolated incident.

On 12/28/2021, I interviewed DCS Daniqua Draper regarding the allegations via telephone. Ms. Draper works the midnight shifts Sundays and Wednesdays. Ms. Draper stated whenever she worked the midnight shift, Dionne Thompson and Nahbria Thompson work the morning shift. She stated her shift ends Monday mornings at 7:30AM; however, sometimes when Ms. Thompson is running late, Ms. Thompson will text Ms. Draper advising Ms. Draper that Ms. Thompson will be arriving late. Ms. Draper did not work midnight on 11/14/2021; therefore, she was not present on 11/15/2021. Ms. Draper stated either Ms. Thompson or Nahbria told her that someone from licensing will be contacting her asking about residents being left alone. Ms. Draper stated she has never left any residents alone without any staff. She stated DCS Christine Gatton only worked briefly about three weeks at Seymour Home, and she is unsure if Ms. Gatton worked any days in November 2021.

On 12/28/2021, I interviewed assistant house supervisor Jeffrey Brand via telephone regarding the allegations. Mr. Brand has worked at Seymour Home for 20 years. He works the second shift, 3:30PM-11:30PM. On 11/15/2021, Mr. Brand was on vacation but heard that supports coordinator Nicholas Tait arrived at Seymour Home and all the residents were left alone, unsupervised as there was no staff on shift. Mr. Brand heard

that Nahbria arrived at Seymour Home shortly after Mr. Tait, then the house supervisor Dionne Thompson arrived hours later. Mr. Brand stated the two staff who were scheduled to work were Dionne Thompson and Nahbria Thompson. Mr. Brand stated DCS Christine Gatton terminated her employment with Central State the end of October 2021 or on 11/01/2021; however, Ms. Gatton was not on the staff schedule for November 2021. Mr. Brand stated he knows this because he worked with Ms. Gatton on her last day at Seymour Home and both Mr. Brand and Ms. Gatton ended up working a double shift because staff never showed up for their shifts. Mr. Brand cannot recall what staff did not show up. Mr. Brand stated he has heard complaints from past staff who have quit Central State stating that both Ms. Thompson and Nahbria have left residents unattended during their shifts; therefore, he is not surprised about the incident on 11/15/2021.

On 12/28/2021, I interviewed Open Arms supports coordinator Nicholas Tait via telephone regarding the allegations. On 11/15/2021, Mr. Tait had a scheduled monthly appointment to verify the wellbeing of all the residents at Seymour Home as Mr. Tait is Residents A, B, C, D, E, and F's supports coordinator. When he arrived, he knocked on the door and there was no answer. He stated then Resident A opened the garage door and advised Mr. Tait there was no staff here and that all residents were home alone unsupervised. Mr. Tait stated Nahbria arrived shortly after he did and stated DCS Daniqua Draper was home, but he is not sure if that is the correct name. He then said Ms. Thompson arrived with lunch for the residents. Mr. Tait requested to view the staff schedule, but Ms. Thompson did not have it available; therefore, he was unable to view it to see who was scheduled that morning. Mr. Tait stated there is no 1:1 staff for any of the residents; however, there should always be one staff on shift for all the residents. Mr. Tait stated this was an isolated incident where the residents were left home alone.

On 12/28/2021, I interviewed DCS Christine Gatton via telephone regarding the allegations. Ms. Gatton stated she did not work 11/15/2021 because she had quit employment with Central State either at the end of October 2021 or on 11/01/2021. Ms. Gatton quit because there were too many no call/no show staff at Seymour Home and she had another job, so this impacted her other job. Ms. Gatton stated on 11/15/2021, she was working at her other place of employment and has a punch card to prove it. She stated she has never and would never leave any resident unattended and does not know why Ms. Thompson and her daughter Nahbria are saying she was there.

On 12/28/2021, I contacted via telephone Resident A's legal guardian Jim Stark with MOGI regarding the allegations. Mr. Stark stated he was never informed that Resident A was left alone unsupervised at Seymour Home on 11/15/2021 without any staff. Mr. Stark stated there must be a staff always at home with Resident A as she requires 24-hour supervision and personal care. Mr. Stark will follow-up with Seymour Home regarding the incident.

On 01/06/2022, I interviewed Resident A via telephone using the sign language interpreter Purple Video Relay Service. The allegations were discussed. Resident A stated on 11/15/2021, Dionne Thompson and Nahbria Thompson were working that



morning. She stated Ms. Thompson left to go grocery shopping and Nahbria was left with the residents. Resident A stated then Nahbria was gone. She stated, "We were looking for her. We called her name and looked in the bedrooms, but she wasn't there." Resident A stated, "I looked out the window and saw Nick motioning to open the door with his hand." Resident A stated, "I opened the garage door for Nick, and he was concerned that there was no staff." Resident A stated after 30 minutes, Nahbria showed up. She stated, "we were nervous, paranoid because we didn't know where staff was." Resident A stated Nick asked her, "Where did staff go?" Resident A stated, "I don't know." Resident A stated it has happened many times where there was no staff. She was unable to provide any further details.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
<b>ANALYSIS:</b>	Based on my investigation and information gathered, there were insufficient DCS on duty at all times for the supervision, personal care, and protection of Residents A, B, C, D, E, and F on 11/15/2021. Open Arms support coordinator arrived at Seymour Home and found all the resident's home alone, unsupervised as there was no DCS on shift. The house supervisor Dionne Thompson and DCS Nahbria Thompson were on shift when both left all the residents unattended on 11/15/2021. Resident A stated that Dionne Thompson and Nahbria Thompson were on shift and left her and the other residents, home alone. According to Resident A, staff have left residents home alone unsupervised more than once.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

<b>ANALYSIS:</b>	Based on my investigation and information gathered, Residents A, B, C, D, E, and F were not provided with supervision, protection, and personal care as defined in their assessment plan. According to the support coordinator Nicholas Tait with Open Arms, he provides services to all the residents at Seymour Home and all the residents' IPOS indicate that they must be supervised always with at least one DCS on shift always.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A is having sex with a man that comes to Seymour Home and the staff help Resident A into bed to have sex with this man.**

**INVESTIGATION:**

On 11/24/2021, I received additional allegations regarding Resident A having sex with an unknown man at Seymour Home and staff are getting Resident A ready by putting Resident A in bed for this man.

On 11/24/2021, I contacted the house supervisor Dionne Thompson via telephone regarding the additional allegations. Ms. Thompson stated she reported these allegations to the licensing consultant assigned to Seymour Home when she learned this was happening, which was about three weeks ago. Ms. Thompson stated that Resident A wrote a note and gave the note to DCS Jeffrey Brand. The note said, "Can you help me get into bed. My friend is coming and going to buy me breakfast and then going to have sex with him." Ms. Thompson stated Mr. Brand did what Resident A asked and put her in bed and this man arrived at Seymour Home and had sex with Resident A in her bedroom. Ms. Thompson stated she called Mr. Tait regarding Resident A having sex and Mr. Tait told Ms. Thompson, "It's her (Resident A) right to have sex and you cannot violate her right." Mr. Tait told Ms. Thompson to have the visitor sign the visitor log, check the visitor's identification card, and then complete the Covid-19 protocol. Ms. Thompson stated she followed this process when the man arrived at Seymour Home. I asked Ms. Thompson if she contacted Resident A's guardian, Jim Stark with Macomb-Oakland Guardianship, Inc., and she stated yes today. I asked Ms. Thompson what the name of the man was according to the visitor's log and Ms. Thompson stated, "I can't read his signature. He scribbled his name." Ms. Thompson stated this man has come to the home only twice and both times has had sex with Resident A. Ms. Thompson stated Resident A met this man at the deaf community and if staff do not allow Resident A to see this man, Resident A becomes angry and tells staff, "You can't violate my rights." Ms. Thompson stated Resident A has been refusing to take her psychotropic medications because "they make her (Resident A) gain weight." Ms. Thompson stated whenever Resident A is not on her medications, she makes poor decisions. Ms. Thompson and Mr. Tait have discussed safe sex protocols with Resident A, but Resident A chooses not to follow them. Resident A told

Ms. Thompson, "I don't like using a condom because it doesn't feel good." Ms. Thompson stated there is nothing in Resident A's individual plan of service (IPOS) and crisis plan completed by MORC regarding protocols for Resident A having sex.

On 12/06/2021, I contacted ORR Rishon Kimble regarding Resident A having sex at Seymour Home. Ms. Kimble stated she will not be investigating these allegations as it would be a violation of Resident A's rights if Resident A is told she cannot have sex. However, there should be mention of protocol/procedures in Resident A's IPOS/Crisis Plan regarding what staff should follow if/when Resident A does have sex at Seymour Home.

On 12/28/2021, Ms. Draper was interviewed regarding allegations that Resident A was having sex at Seymour Home. Ms. Draper stated one day in November 2021, she was at Seymour Home signing her timecard when a man showed up at the home. Ms. Draper saw Resident A approach Ms. Thompson with her tablet asking Ms. Thompson "to put her (Resident A) in bed." Ms. Draper stated Ms. Thompson did not want to put Resident A in bed, so Resident A became angry and said, "It's my right." Ms. Draper stated she then left and did not know what happened. Ms. Draper stated Resident A can read lips and then uses her tablet to communicate with staff. Ms. Draper stated Central State's policy regarding visitors is to take their temperature, have them sign on the visitor log and wear their mask. Ms. Draper stated earlier this month, she was on shift with DCS Jeffrey Brand. There was a knock on the door, and it was a man, the same man that Ms. Draper saw in November 2021. Resident A told Ms. Draper she (Resident A) was not expecting anyone, but Mr. Brand allowed this man into the home. Ms. Draper stated she's not sure if Mr. Brand checked this man's ID or had this man sign the visitor's log, but stated the man was wearing a mask. Ms. Draper stated she saw this man point to Resident A's bedroom, but Resident A refused, and both remained in the living room for about 30 minutes communicating in sign language and then the man left. Ms. Draper is unsure if there are any protocols/procedures in Resident A's IPOS/Crisis Plan regarding Resident A having sex at Seymour Home.

On 12/28/2021, I interviewed Mr. Brand regarding the allegations pertaining to Resident A having sex at Seymour Home. Mr. Brand stated he and other staff were informed by the supports coordinator Nicholas Tait that Resident A is allowed to have visitors and that Resident A "can do whatever she wants." Mr. Brand stated one day in November 2021, Resident A asked Mr. Brand, "put me in bed," which he did. Then this man arrived at Seymour Home and both this man and Resident A had sex in Resident A's bedroom. Mr. Brand reported this to Ms. Thompson who reached out to Mr. Tait. Mr. Tait told Ms. Thompson, "Resident A has the right to have whoever she wants in her room and if she wants to have sex, she has the right to have sex because she pays rent." Mr. Brand stated they followed what Mr. Tait told them even though this was not in Resident A's IPOS/Crisis Plan. Mr. Brand stated about three weeks ago, Resident A tried to hurt herself after the same man she had sex with went to the deaf community and told everyone, "I had sex with her and her thing sticks." Mr. Brand stated this information got back to Resident A and that's when Resident A tried to cut herself. He stated Resident A has superficial marks on her left arm. Since this incident, Resident A's visitors are

only allowed in the living room of Seymour Home. Mr. Brand stated, “we tried to shut this down when Resident A first asked to be put in bed to have sex, but Nicholas said we can’t do that.”

On 12/28/2021, I interviewed Mr. Tait regarding the allegations pertaining to Resident A having sex at Seymour Home. Mr. Tait stated all residents have the right to express themselves sexually, including Resident A. He stated he has discussed safe sex with Resident A but that he nor anyone else can limit Resident A from having sex. Mr. Tait stated there is no policy or procedure in place with regards to Resident A’s IPOS/Crisis Plan; however, staff must check visitor’s ID, sign the visitor’s log, and follow Covid-19 protocols. Mr. Tait reported a meeting was held with Resident A’s guardian, supports coordinator and Ms. Thompson on how best to keep Resident A safe when she has sex. Currently they are exploring that without violating her rights. Mr. Tait stated the staff at Seymour Home were following the protocols he informed them to follow and advised staff they cannot violate Resident A’s rights and stop her from having sex.

On 12/28/2021, I interviewed Resident A’s legal guardian Jim Stark with MOGI regarding Resident A having sex at Seymour Home. Mr. Stark stated he was not aware that Resident A was having sex until after the fact as he received a call from the support coordinator Nicholas Tait. Resident A talked to Mr. Stark about a man coming to visit her at Seymour Home which Mr. Stark told Resident A that he needed to “check the guy out,” before he visited with Resident A. Mr. Stark was told by Mr. Tait that this man was an old friend of Resident A’s, but then heard that the man was having sexual relations with Resident A. Mr. Stark stated he has not approved any man and/or visitor for Resident A and he wanted to do his due diligence first before authorizing any visitors for the safety of Resident A and the other residents who live at Seymour Home that he is guardian for. Mr. Stark stated there was a meeting he was unable to attend, but MOGI’s psychologist Dr. Theresa Moore was present with Nicholas Tait and Mr. Tait’s supervisor Elizabeth Colbourn. Mr. Stark stated it was determined at the meeting that the house supervisor Dionne Thompson must get approval from Mr. Stark on any of Resident A’s visitors first to ensure Resident A’s safety as well as the safety of the other residents. Mr. Stark stated, “Why they allowed that to take place, I don’t know.” Mr. Stark stated he understand Resident A has rights, but he needs to ensure her safety and not knowing who this man is, is not safe for Resident A.

On 12/28/2021, I interviewed via telephone MOGI’s psychologist Dr. Theresa Moore regarding the allegations pertaining to Resident A having sex at Seymour Home. Dr. Moore stated she has known Resident A for years. Resident A is alert and oriented and knows what she wants. Dr. Moore stated she too was not aware that Resident A was having sex at Seymour Home as no one from Seymour Home contacted her nor Mr. Stark. Dr. Moore called Ms. Thompson who advised Dr. Moore that according to Nicholas Tait and his supervisor, Elizabeth Colbourn, Seymour Home would be violating Resident A’s rights if staff did not allow Resident A to have sex. Dr. Moore told Ms. Thompson, “You should have called us because this man could have done something to Resident A.” Dr. Moore stated according to Ms. Thompson, Resident A and this man were “hours in the room having sex.” Dr. Moore stated she immediately contacted Mr.

Stark who stated he was aware she wanted to have visitors but was never aware that Resident A was having sex with a man at Seymour Home. Dr. Moore stated she along with Nicholas Tait and his supervisor Elizabeth Colbourn had a meeting and Dr. Moore told Mr. Tait and Ms. Colbourn that this man cannot come to Seymour Home and have sex with Resident A. Mr. Tait told Dr. Moore this would be a rights violation and that they cannot tell Resident A she cannot have sex. Dr. Moore is concerned that Resident A is not being safe because she does not wear a condom during sex. Resident A can become pregnant as she has already lost custody of her first child. Dr. Moore is concerned about Resident A's mental state because in the past, Resident A has attempted to harm herself and has sent naked pictures of herself to random men; therefore, a female staff must be in the bathroom with Resident A. Dr. Moore stated there is nothing in Resident A's IPOS/Crisis Plan that address safety concerns regarding Resident A's sexual relations.

On 01/06/2022, Resident A was interviewed regarding allegations she was having sexual relations with a man visiting Seymour Home. Resident A stated, "I told Dionne my boyfriend was coming over and Dionne said, Ok. I then told her I was going to have sex and it was my right." Resident A stated even though her boyfriend has visited her five times at Seymour Home, they only had sex a couple of times. She stated, "Now we only sit in the living room and not in my bedroom." Resident A stated her guardian Jim Stark is now aware of her having sex and Mr. Stark told Resident A, "be careful." She provided no other information.

On 01/06/2022, I reviewed Resident A's IPOS/Crisis Plan completed by MORC on 06/29/2021. According to the IPOS and Crisis Plan, "while Resident A is visiting with friends in the community, staff will accompany Resident A to assist with all her personal care needs and safety." There is no mention in the IPOS or the Crisis Plan regarding visitors at Seymour Home or regarding Resident A having sexual relations and what policy/procedures to follow to ensure her safety.

On 01/12/2022, I left a voice mail message for licensee designee Paula Ott with my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	(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.
<b>ANALYSIS:</b>	Based on my investigation and information gathered, Resident A's personal needs, including protection and safety, was attended to at all times by staff at Seymour Home. Resident A was authorized to have visitors come to Seymour Home. However, Resident A began having sexual relations with a man

	<p>who she referred to as her boyfriend in November 2021. After Resident A began having sex with this man, the house supervisor contacted Resident A's supports coordinator Nicholas Tait with Open Arms. Mr. Tait advised Ms. Thompson that staff cannot stop Resident A from having sex as this is her right and not allowing Resident A to have sex is a violation of Resident A's rights. Mr. Tait advised Ms. Thompson to verify the man's identification, have the man sign the visitor log and to follow Covid-19 protocol, which the staff did. In addition, Mr. Tait and Ms. Thompson discussed safe sex protocols with Resident A. However, Resident A's guardian Jim Stark with MOGI was not aware that Resident A was having sex at Seymour Home due to concerns about the "man," coming into the home. Resident A's guardian is working with Mr. Tait and Ms. Thompson to have safety protocols put in place for Resident A. Therefore, the staff at this home were following the direction of Resident A's support coordinator due to Resident A's IPOS/Crisis Plan not having any protocols in place regarding Resident A's sexual relations.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**IV. RECOMMENDATION**

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

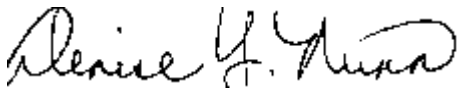


01/12/2022

Frodet Dawisha  
Licensing Consultant

Date

Approved By:



01/13/2022

Denise Y. Nunn  
Area Manager

Date