



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

May 22, 2026

Jasmine Boss  
JARC  
Suite 100  
6735 Telegraph Rd  
Bloomfield Hills, MI 48301

RE: License #: AS630246169  
Investigation #: 2026A0465020  
Grosberg

Dear Ms. Boss:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Stephanie Gonzalez".

Stephanie Gonzalez, LCSW  
Adult Foster Care Licensing Consultant  
Bureau of Community and Health Systems  
Department of Licensing and Regulatory Affairs  
Cadillac Place, Ste 9-100  
Detroit, MI 48202  
Cell: 248-308-6012

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630246169
<b>Investigation #:</b>	2026A0465020
<b>Complaint Receipt Date:</b>	03/26/2026
<b>Investigation Initiation Date:</b>	03/27/2026
<b>Report Due Date:</b>	05/25/2026
<b>Licensee Name:</b>	JARC
<b>Licensee Address:</b>	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
<b>Licensee Telephone #:</b>	(248) 940-9617
<b>Administrator:</b>	Jasmine Boss
<b>Licensee Designee:</b>	Jasmine Boss
<b>Name of Facility:</b>	Grosberg
<b>Facility Address:</b>	32146 Staman Circle Farmington Hills, MI 48336
<b>Facility Telephone #:</b>	(248) 478-2566
<b>Original Issuance Date:</b>	03/14/2002
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/14/2024
<b>Expiration Date:</b>	12/13/2026
<b>Capacity:</b>	6

<b>Program Type:</b>	DEVELOPMENTALLY DISABLED

## ALLEGATION(S)

	Violation Established?
Resident A has been sexually assaulted by Resident B over the last several years. It is unknown if other residents are also being abused by Resident B. Direct care staff are aware of this and have not contacted the police nor taken any action to stop it.	Yes

## II. METHODOLOGY

03/26/2026	Special Investigation Intake 2026A0465020
03/27/2026	Special Investigation Initiated - Letter I spoke to Adult Protective Services Worker, Carmen Smith, via email
04/01/2026	Contact – Document Sent Email exchange with APS Worker, Carmen Smith
04/03/2026	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, observed residents, reviewed facility files and interviewed direct care staff, Dwayne Carter and Marissa Mason
04/06/2026	Contact - Document Received Facility documents received via email
04/13/2026	Contact - Document Received Facility documents received via email
04/15/2026	Contact - Telephone call made I spoke to Guardian A1 via telephone
04/16/2026	Contact - Document Received Facility documents received via email
04/20/2026	Contact - Document Received Facility documents received via email
04/20/2026	Contact - Telephone call made I spoke to licensee designee, Jasmine Boss, via telephone
04/29/2026	Contact – Document Sent

	Email exchange with Office of Recipient Rights Officer, Rachel Moore
05/13/2026	Contact - Telephone call made I spoke to Ms. Boss via telephone
05/13/2026	Contact - Face to Face A zoom call was conducted between Stephanie Gonzalez, Kristen Donnay, Carmen Smith and Lenora Goodman
05/13/2026	Contact - Telephone call made I spoke to Guardian B1 via telephone
05/13/2026	Contact - Telephone call made I spoke to direct care staff, Judith Lubana via telephone
05/13/2026	Contact - Telephone call made I spoke to direct care staff, Ada Hardy, via telephone
05/13/2026	Contact - Telephone call made I spoke to direct care staff, Marcella Robinson, via telephone
05/13/2026	Contact - Telephone call made I spoke to Easter Seals Supports Coordinator, Ashley Perdue, via telephone
05/13/2026	Contact – Document Sent Email exchange with Office of Recipient Rights Officer, Rachel Moore
05/14/2026	Contact - Telephone call received I spoke to corporate staff, Shaindle Braunstein, via telephone
05/18/2026	Contact – Telephone call made I spoke to Ms. Boss via telephone
05/21/2026	Contact – Telephone call made I spoke to Dr. Gary Yashinsky via telephone
05/21/2026	Contact – Telephone call made I spoke to Ms. Boss and Ms. Shaindle via telephone
05/22/2026	Contact – Telephone call made I spoke to Ms. Robinson via telephone
05/22/2026	Exit Conference

	I conducted an Exit Conference with licensee designee and administrator, Jasmine Boss, via telephone
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**ALLEGATION:**

**Resident A has been sexually assaulted by Resident B over the last several years. It is unknown if other residents are also being abused by Resident B. Direct care staff are aware of this and have not contacted the police nor taken any action to stop it.**

**INVESTIGATION:**

On 3/26/2026, a complaint was received, alleging that Resident A has been sexually assaulted by Resident B over the last several years. It is unknown if other residents are also being abused by Resident B. Direct care staff are aware of this and have not contacted the police nor taken any action to stop it. The complaint stated that direct care staff have physically abused Resident B as a form of retaliation for this behavior. On 4/16/2026, an email was received with additional information related to this complaint. The email stated that it is unknown if Resident C is also being sexually abused by Resident B. The complaint stated there is concern that Resident B is sexually abusing other residents in the home.

On 3/27/2026 and 4/1/2026, I spoke to Adult Protective Services Worker, Carmen Smith via email and zoom. Ms. Smith stated that she is still in the process of completing her investigation regarding this complaint. Ms. Smith stated that she will be substantiating for the sexual abuse of Resident A by Resident B. Ms. Smith stated that she will not be substantiating against direct care staff for the physical abuse of Resident B.

On 4/29/2026 and 5/13/2026, I spoke to Office of Recipient Rights Officer, Rachel Moore, via telephone. Ms. Moore stated that her investigation is currently ongoing and she has not made a determination as of yet.

On 5/13/2026, I attended a zoom call with Department of Licensing & Regulatory Affairs area manager, Kristen Donnay and Adult Protective Services Specialist Carmen Smith and her supervisor, Lenora Goodman. Ms. Smith and Ms. Goodman stated that the Farmington Hills Police Department investigated this complaint, and no criminal charges will be filed against Resident B.

On 4/3/2026, I conducted an onsite investigation. The home specializes in caring for the developmentally disabled population. At the time of my onsite investigation, there were six residents residing at the facility. Due to the developmental delays and non-verbal communication skills of the residents, I was unable to interview them for this investigation. I completed a walk-through of the facility, observed residents,

reviewed facility files and interviewed direct care staff, Dwayne Carter and Marissa Mason.

I reviewed Resident A's record. The *Face Sheet* stated that Resident A was admitted to the facility on 3/11/2002, and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Autism and Non-Verbal. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, in non-verbal, needs assistance with all personal care tasks and does not require use of assistive devices.

I reviewed Resident B's record. The *Face Sheet* stated that Resident B was admitted to the facility on 6/28/2016, and has a legal guardian, Guardian B1. The *Health Care Appraisal* listed Resident B's medical diagnosis as Developmental Disability and Seizure Disorder. The *Assessment Plan for AFC Residents* stated that Resident B requires supervision in the community, has a history of inappropriate sexual behavior and requires monitoring by staff, requires verbal prompts and assistance by staff to complete self-care tasks and does not require use of assistive devices for mobility. I reviewed Resident B's *Easter Seals/MORC Crisis Prevention & Safeguard Plan*, dated 7/8/2025. Resident B has been receiving 1:1 staffing at the facility on a daily basis from 11:00pm – 7:00am since 4/3/2023. The crisis plan stated the following:

**SAFETY PRECAUTIONS:** Remove Resident B or others from the environment- Take to calming area in another part of the house. BTPRC approved restriction: Resident B will have enhanced staffing in his home in order to allow staff to intervene when he tries to sexually aggress towards others. Resident B will go up to other housemates or staff and attempt to grab their private areas. This may be due to him having elevated testosterone levels. He typically engages in this most often during the night shift, but recently this has been also happening during the day. When Resident B walks toward another individual to grab them, staff should step between and escort the other individual to another room. Resident B should be given prompts/reminders that he can use his bedroom to have "private time" for masturbation if he desires. Staff should frequently engage Resident B in appropriate physical interactions (high 5s, fist bumps, hand hugs, etc.) to help him understand appropriate physical greetings. **FADE PLAN:** When Resident B has gone a full quarter without trying to sexually aggress others, enhanced staffing can be faded first during the less vulnerable parts of the night and later during the most vulnerable. Fade trials can also include having the extra staff present, but responsible for more than just Resident B. **CAREGIVER(S) ACTIVITIES TO DE-ESCALATE A CRISIS SITUATION:** Approach CALMLY and speak in a LOW, QUIET VOICE at the first signs of agitation, as well as during the interaction. State (or something similar to), "You are safe and I'm not going to hurt you". Relax your (caregiver's) whole body. Do not argue, command, demand, or disagree, or say no. Instead, use phrases such as "later", or "after we finish." Be consistent. Stay firm. Don't appear afraid. Be supportive. Communicate a sincere, genuine desire to help. Request may be better

understood if they are very specific and concrete with step-by-step directions. Go for a walk together. Position yourself slightly to the side, in a face-to-face position, with your safety. Keep out of kicking range. Caregivers are to know Resident B's whereabouts within the home and the yard at all times. Whenever Resident B is in the company of his housemates' close staff supervision is needed at all times. Caregivers are to maintain visual monitoring in close proximity to Resident B when he is in his yard. Close monitoring is needed to ensure that he does not leave the home, to maintain his safety and maintain safety of others. During waking hours, visual and auditory checks occur every 15 minutes. While in TV room staff should be able to see Resident B walk towards doors with exits and redirect him accordingly.

I reviewed Resident C's record. The *Face Sheet* stated that Resident C was admitted to the facility on 3/11/2002, and has a legal guardian, Guardian C1. The *Health Care Appraisal* listed Resident C's medical diagnosis as Autism, Developmental Disability and Non-Verbal. The *Assessment Plan for AFC Residents* stated that Resident C requires supervision in the community, is non-verbal, requires assistance with personal care tasks and does not require use of assistive devices.

I reviewed Resident D's record. The *Face Sheet* stated that Resident D was admitted to the facility on 5/31/2016, and has a legal guardian, Guardian D1. The *Health Care Appraisal* listed Resident D's medical diagnosis as Developmental Disability. The *Assessment Plan for AFC Residents* stated that Resident D can move independently in the community, independently completes self-care tasks and does not require use of assistive devices for mobility.

I reviewed Resident E's record. The *Face Sheet* stated that Resident E was admitted to the facility on 5/31/2016, and has a legal guardian, Guardian E1. The *Health Care Appraisal* listed Resident E's medical diagnosis as Developmental Disability and Vision Impaired. The *Assessment Plan for AFC Residents* stated that Resident E requires supervision in the community, needs assistance with personal care tasks and uses a cane for mobility assistance.

I reviewed Resident F's record. The *Face Sheet* stated that Resident F was admitted to the facility on 6/12/2015, and has a legal guardian, Guardian F1. The *Health Care Appraisal* listed Resident F's medical diagnosis as Developmental Disability. The *Assessment Plan for AFC Residents* stated that Resident F requires supervision in the community, needs assistance with personal care tasks and does not require use of assistive devices.

I reviewed the *Incident/Accident Reports* for the last three years and found the following information specific to this complaint:

3/10/2023 @ 12:30am (Location: Resident A's bedroom); Completed by Mattie Gates: Once my shift started, I did my nightly checks going to each room to check on everyone. As I went to sit at the kitchen table to read the staff logbook, resident B

ran out his room into another housemate's room. I went behind him and saw him pulling off housemates' shirt. I was redirecting him to leave but he refused and continued to try to remove housemate out the bed. As I was attempting to assist roommate away from Resident B, Resident B was forcefully trying to pull me away as I had the other person served. Then proceeded to pull down housemate's underwear. Staff #2 comes out the bathroom to help as Resident B tried to force his private part inside other roommate. Myself and staff #2 separated both guys then Resident B went back to his room and the person served wasn't harmed. They were monitored throughout shift and I informed my manager. Contacted the manager and redirected Resident B. Continue to monitor for safety and follow IPOS and Crisis Plan.

6/12/2023 @2:00am (location: living room); Completed by Ellen Hilliard: After signing for patio furniture delivery, Resident B was observed pulling another roommates pants down. Resident B was redirected to another room of the house and roommate was redressed and redirected to another part of the house. Both were monitored until afternoon staff arrived. Home Manager notified.

7/26/2023 @ 6:13pm (Location: Resident B's bedroom); Staff working: Sherri Smith and Dajai Miller: Staff informed that Resident B was trying to take his roommate to his bedroom. Staff had to help separate the two so that Resident B couldn't cause harm. Staff came into the bedroom to assist with separation of Resident B and his roommate.

4/15/2024 @ 11:00am (Location: backyard fenced area); Staff working: Brandie Whelan, Marisa Mason and Sherri Smith: Resident B went outside to the fenced area. Resident A was already outside. Resident B pulled down Resident A's pants and pulled Resident A onto his lap. Staff removed Resident A and covered him. Resident B pulled up his pants and went into the house. Staff will continue to monitor closely. Supports Coordinator and Behaviorist will be contacted.

5/24/2024 at 9:30am; Staff working: George Freeman and Suante Roberson: Resident B grabbed roommate and attempted to take him into his room. A staff and I stopped him from doing so. We took Resident B to his room. (3 IR's all completed by the three staff)

6/8/2024 at 6:10am (Resident A's bedroom); Staff working: Maimouna Diallo and Koffi Dzilan: At 6 o'clock, I was trying to shower Resident B while Resident B snuck out and went to Resident A's room to sexually aggress him. He was caught at the right time and brought back to his room. We monitored him until he calm down. We took Resident A to a safe place, very far away from Resident B.

10/1/2024 at 8:00am (Location: Hallway); Staff working: Mattie Gates: Resident B was up all night, but around 3am, he came to the front of the house and tried to come into his housemate's bedroom. Staff immediately walked towards him and told

him to go back into his room. Staff told him to go back to his room. Staff continued to monitor him and inform the manager on his behavior.

11/14/2024 at 1:10pm (Location: Resident A's bedroom); Staff working: Duane Carter: Resident B was observed leaving Resident A's room. Upon further investigation by staff, Resident A's pants were found to be partially pulled down. Continue to monitor for safety. Monitor Resident B's behavior and conduct.

1/19/2025 at 6:15pm (Location: Resident A's bedroom); Staff working: Latisha Calloway, Maimouna Diallo, and Koffi Dzilan: I just got finish feeding them french fries. Resident B was done. Resident A came behind him like 4 minutes later. Resident B came up to me talking in baby talk. He helped Resident A put his bowl in the sink then grab his arm, pulled him to Resident B's room and shut the door. I jumped up out the chair, opened the door. Resident B then tried to shut the door. He then took Resident A's shirt off. He then stood Resident A up and pulled his pants down then pulled his down. I pulled Resident A up off Resident B, trying to separate the two. By that time, Diallo and Koffi came in and sent Resident B to his room. I took Resident A into the restroom and put him on another brief.

1/19/2025; Staff working: Latisha Calloway (Note: This IR was on a piece of plain lined paper and did not contain any additional information): Then he {Resident B} sat Resident A on top of his naked body. I pulled Resident A up and kept pulling him away, telling Resident B to stop and pushing him away by me yelling, telling Resident B to stop. By that time, Diallo and Koffi came running in.

12/2/2025 at 12:25am (Location: Resident A's bedroom); Completed by Marcella Robinson: Resident B was caught leaving Resident A's room. Upon further investigation, Resident A was putting on his shirt and pants was half-way down. Monitored for safety and behavior. Monitored Resident B's behavior and conduct.

2/1/2026 at 2:34am (Location: Resident A's bedroom); Staff working: Marcella Robinson, Ada Hardy and Randi Kramer; Staff Ada Hardy and Randi Kramer were also listed on the IR as working at the time of the incident): As I was sitting in the living room, Resident B did not walk pass. He went through the bathroom into Resident A's room and violated him. I caught him coming out. Staff didn't watch Resident B go pass them into Resident A's room. Checked Resident A for bruises. Staff cleaned sheets and Resident A and Resident B were redirected back to their rooms.

2/1/2026 at 2:36am (Location: Resident A's bedroom); Staff working: Randi Kramer and Ada Hardy: I came back from the kitchen and Resident B was walking back into his room. Marcella {Robinson} said that Resident B had gone through the bathroom and went into Resident A's room.

2/1/2026 at 2:34am (Location: Resident A's bedroom); Completed by Ada Hardy: {At} 2am I checked on Resident A in his room sleeping. 2:34am, I witnessed

Resident B sneaking out of Resident A's room. I went in to check on Resident A. I witnessed semen on Resident A's bed, pants. His bed was off the frame partially. I examined Resident A. He had a scratch on his side. He was showered and bedding was changed. He appeared to still be sleepy. He laid down and went back to sleep.

2/6/2026 at 6:00am (Location: Resident A's bedroom); Completed by Ada Hardy: I sat everyone down at the dining table for breakfast. Came back into the kitchen, put pots into the sink. I heard Resident D say "Uh oh," and I seen Resident B and Resident A missing. I went into the room and Resident B had Resident A hugging on him with no clothes. I tried to tell Resident B to stop and he wouldn't. I pulled Resident A off of Resident B. Resident A hadn't finished his breakfast. The two were separated and Resident A was washed and straightened up and sat down to finish his breakfast.

3/6/2026 at 6:45am (Location: Kitchen); Completed by Mattie Gates: Resident B was talking to another resident, telling him to suck his private part. Nothing happened between them. Staff just made sure they kept them apart. They were monitored throughout the shift. Staff informed management.

5/10/2026 at 9:40am (Location: Patio); Staff working: Randi Kramer and Marcella Robinson: Resident B went outside in the backyard on the patio. Walked to the end and pulled his pants down with his hand near his genitals. He was immediately directed to pull his pants up and come inside. He complied. Told Resident B to come inside and sit down please. Monitored for safety and health.

I reviewed the *Office Visit Note*, dated 4/10/2026, which documented that Resident A was seen by Dr. Gary Yashinsky for a sexual assault exam. The report stated the following: Resident A is here for evaluation of reported sexual assaults. Apparently, there was a series of rapes perpetuated on this patient by another housemate. The initial complaint was made anonymously. It was not reported initially but eventually reported to the authorities and criminal charges are being made. Resident A is non-verbal and has no complaints at this time. Apparently, this has been happening from 7 – 14 days ago. Rectal exam shows an enlarged prostate. There is no evidence of bruising, abrasions, edema. There is no evidence of any blood. No evidence of trauma. Rectal tone appears to be normal.

I reviewed the *Physician's Note*, dated 5/13/2026, which was written and signed by Dr. Gary Yashinsky. The document stated the following: Resident A is a patient of mine. I had the opportunity to examine him on 4/10/2026. He was allegedly the victim of a sexual assault perpetrated by another housemate. On examination, there was no evidence of any sexual assault. There was no evidence of bruising, lesions, edema or excoriations of the rectum. There was no blood or evidence of trauma. Rectal tone was normal. He does have an enlarged prostate.

On 4/3/2026 I spoke to direct care staff, Duane Carter, while onsite at the facility. Mr. Carter stated that he has worked at the facility for one year. Mr. Carter stated, "I am

familiar with Resident B and his behaviors. And Resident A is non-verbal and cannot communicate. Resident B does have a history of seeking sexual interactions with Resident A and so we have to keep them separated at all times. We make sure that they are always on opposite sides of the house. Resident B only focuses on Resident A and always tries to take him into the room to engage in inappropriate sexual behavior. I don't believe any sexual abuse is happening, but I believe that Resident B has attempted to pull Resident A into the room and attempted to do things with him. Resident B will try to reach for Resident A because he wants to take him into his bedroom. I have never seen Resident B make it that far with Resident A. I have never observed Resident B actually sexually abuse Resident A. I have not seen Resident B take an interest in any other resident. We keep Resident A and Resident B separated at all times and we monitor them closely. I feel this is enough to keep all residents safe." Mr. Carter denied knowledge of this complaint being true. On 5/21/2026, I conducted a follow-up phone call with Mr. Carter, to interview him regarding the incident report he completed on 11/14/2024 at 1:10pm. Mr. Carter stated, "I do remember writing that incident report. I was working that day, and I saw Resident B coming out of Resident A's bedroom. I went into the room to check on Resident A, and his pants were down and he was pulling them up. I checked Resident A and Resident B, and I looked for semen and I didn't see any. I redirected Resident B and I monitored resident A. I did not call the police. I did not take Resident A to the hospital. I didn't see anything that made me think he needed to go. I did look at his rectum, and I didn't see anything concerning. Jasmine Boss and Marisa Mason were both at the facility and present when this incident occurred. They were aware that this happened. I heard them talking about it. Nothing was done."

I spoke to direct care staff, Marisa Mason, via telephone while onsite at the facility. Ms. Mason stated, "We are aware of the allegations regarding Resident B, and we are going to cooperate in any way needed. The police came to the facility earlier this week and interviewed staff. We have two staff on duty at all times during daytime hours and we have three staff on duty daily from 3:00pm – 11:00pm. Resident B also receives 1:1 staffing daily from 11:00pm – 7:00am for safety and supervision. We are aware of Resident B's behavioral issues, and we are doing everything to monitor and keep all residents safe. I am not aware of any incident in which Resident A, nor any other resident, has been sexually abused by Resident B. I have never mistreated or caused physical harm to Resident B."

On 4/15/2026, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I am not aware of any indication of physical or sexual assault of Resident A. I am not aware of any physical harm or sexual penetration of Resident A by Resident B. I am aware that Resident B has sexual behaviors and seeks out Resident A. However, I have always been told that they are ensuring Resident A's safety. If any physical harm occurred to Resident A, it was never communicated to me by staff. I did not receive any incident reports from the facility of any concerns. Resident A did undergo a sexual assault exam in April 2026, and nothing was found. I did approve Resident A's move to a new facility approximately three weeks ago, so he is no longer living at

the facility with Resident B.” Guardian A1 denied knowledge of this complaint being true, however, Guardian A1 stated he did not receive copies of the incident reports referenced in this report.

On 4/20/2026 and 5/13/2026, I spoke to licensee designee and administrator, Jasmine Boss, via telephone. Ms. Boss stated, “I am aware of the complaint, and we had Resident A and Resident C complete sexual assault exams. Both exams came back with no signs of sexual assault. The doctor said he saw no scar tissue. We did implement a 1:1 staff for Resident B daily from 11:00pm – 7:00am in 2023. We did ask for 1:1 staffing 24/7 but it was not approved by Easter Seals/MORC. I know that there are things that were missed by staff. Every time an incident occurred, staff completed an incident report. However, I was not aware that I needed to review them and sign them. I did not know that I was supposed to be doing this. I will start doing this immediately. We also moved Resident A and the other non-verbal residents to another facility to ensure their safety and protection while your investigation is being completed. I don’t believe anything happened, but I will await your findings.”

On 5/13/2026, I spoke to Guardian B1 via telephone. Guardian B1 stated, “For the last year, the staff told me that they had hired people to watch Resident B to make sure he wasn’t doing these things. And they didn’t do this. They were supposed to make sure this wasn’t happening and they did not do that. If the staff were following his IPOS, none of this would have happened. What Resident B is doing is wrong and I know that. But at the same time, the staff are supposed to be watching him and making sure these things aren’t happening. This is sickening and awful.”

On 5/13/2026, I spoke to direct care staff, Judith Lubana via telephone. Ms. Lubana stated that she has worked at the facility for two years. Ms. Lubana stated, “I am familiar with all of the residents. Resident B has a history of inappropriate sexual behavior and seeks out Resident A daily. We must keep Resident B away from Resident A to keep him safe. There was one time that I saw Resident B lead Resident A into the living room area and I immediately redirected and separated them. I have never personally observed Resident B sexually abuse Resident A. I have never seen any signs of blood, semen or injuries on any resident. Recently, Resident B was outside exposing his genitals to the neighbors, and we do have children that live in this area. Resident B is assigned medication to help with his behavior, but the medications are not helping. He does not listen and continues to engage in the same behaviors daily regardless of how often he is redirected. I keep my distance from Resident B, when needed, for my own safety. I feel he needs a higher level of supervision than we can provide here.”

On 5/13/2026, I spoke to direct care staff, Ada Hardy, via telephone. Ms. Hardy stated that she has worked at the facility since 2024. Ms. Hardy stated, “Resident A is non-verbal and Resident B has a history of engaging in inappropriate sexual behavior. Resident A has been sexually abused by Resident B. I witnessed it with my own eyes. I don’t remember the date, but there was a time that I was working,

and I noticed that Resident A and Resident B were missing. I went to Resident A's bedroom and found them both naked, with Resident B thrusting Resident A from behind. I immediately told Duane Carter, and he came in to help me get Resident B off of Resident A. I cleaned Resident A up and changed his clothing. I am not sure if there was penetration because I did not actually see if the penis entered the rectum. So, I did not call the police or take Resident A to the hospital. There was another time I was working when Resident B was able to sneak past me and two other staff, including his 1:1 staff, and was able to enter Resident A's room without us knowing. We found out that Resident B was in Resident A's bedroom when he walked out of the room. He was quiet when he went in, but he didn't care about being loud when he came out. I went into Resident A's bedroom, and he had semen on his clothing and on his bed sheets. I cleaned and changed Resident A's clothes and bed sheets and then I put him back to bed. I completed an IR. This type of incident has happened several times when I have worked at the facility. The first time it happened, I had only been working at the facility for two weeks, so it was around September 2024. I remember seeing Resident A and Resident B go into the bedroom. At that time, I was not aware of Resident B's behaviors, and I had not been told that I needed to keep them separated. So, I did not intervene or separate them at that time. Afterwards, I spoke to the home manager and she told me that I had to keep them separated at all times. Resident B moves quick and it's hard to know where he is at all times. And there was also a period of time when he did not have 1:1 staffing. I didn't know the history to know what was happening. I didn't know that sexual assault was occurring. Resident B should have been removed from the home a long time ago. I have written at least four IR's over the last two years of incidents where Resident B has engaged in inappropriate sexual behavior with Resident A. I was never told to call the police or take Resident A to the hospital. I was only told to file an IR. I did not inspect Resident A's rectum for injury. I have never seen Resident B go after any other resident, only Resident A. I have written at least four IR's over the last two years of incidents where Resident B has engaged in inappropriate sexual behavior with Resident A. Why do you guys care now? I have been confused why no one did anything to stop this from happening." Ms. Hardy denied knowledge of any physical mistreatment of Resident B. Ms. Hardy acknowledged the sexual abuse of Resident A by Resident B is accurate.

On 5/13/2026 and 5/22/2026, I spoke to direct care staff, Marcella Robinson, via telephone. Ms. Robinson stated that she has worked at the facility for one year. Ms. Robinson stated, "Resident B is always trying to get Resident A alone for sexual reasons. We are supposed to make sure they stay away from each other. During the daytime, things are usually good. But nighttime is difficult and Resident B becomes anxious. I usually work mornings at the facility, and rarely work nights, so I don't see Resident B's behavior as much as other staff. But there was a time when I witnessed Resident B attempt to sexually abuse Resident A. One night, it was in February 2026 when I was working, Resident B got past his 1:1 staff and he managed to get past me and the third staff working. That night, I was working along with Ms. Hardy and Ms. Kramer. He was able to sneak into Resident A's bedroom. I didn't even know he was in the bedroom until he came out. I only knew he was in there because

I heard him come out of Resident A's bedroom. I immediately went into Resident A's bedroom, and he was putting a shirt on and his pants were on. I saw semen on his clothes and bed sheets. I don't know how long Resident B was in Resident A's bedroom. The only thing we could do was redirect Resident B. He got past all of us. I checked Resident A and saw a scratch mark on his hip. And I completed an IR. We separated them and we cleaned Resident A and changed his sheets and put him back to bed. This is the only time I have witnessed it. I did not look at his anal area. Nothing was done. We did not call police or take Resident A to hospital. We called the home manager and an IR was done. Resident B always dry humps Resident A and they have clothes on. He doesn't go after the other residents. I've never seen him physically penetrate Resident A. I have never caught him fully naked with Resident A. It is always a rub out. Resident A was able to sneak past us that night by going through the bathroom, so we didn't see him pass us. The problem is night shift does not properly supervise Resident B. He keeps getting past his 1:1 staff. That's the problem." Ms. Robinson denied knowledge of physical mistreatment or harm of Resident B. Ms. Robinson acknowledged that this complaint is accurate as it relates to the sexual abuse of Resident A by Resident B. During the phone call on 5/22/2026, Ms. Robinson stated, "I told management when the two incidents occurred in February 2026. I completed IR's and I spoke to my manager, Duane Carter, via telephone as well. He was aware of the issues. I always followed up my IR's with a phone call to the manager and I always sent my IR's in as required. Management knew what was going on. Everyone knew. Even staff that worked at other facilities knew what was going on."

On 5/13/2026, I spoke to Easter Seals Supports Coordinator, Ashley Perdue, via telephone. Ms. Perdue stated, "I have been Resident B's supports coordinator since November 2023. Resident B has sexual behaviors, and we did make efforts to manage his behavior and keep the other residents safe. We placed chimes on the doors and had Resident B wear jingle bells on his wrist. We also approved a 1:1 staff for eight hours a day, from 11:00pm – 7:00am. I was told he was more stable during the day and that his seeking behavior was occurring mostly at night. I was not aware of any of these concerns and incidents until now. The facility did not communicate these concerns to me. We are seeking new placement for Resident B, but we are unsure where he will be accepted at this time."

On 5/14/2026, I spoke to corporate staff, Shandle Braunstein, via telephone. Ms. Braunstein stated, "We have issued an *Emergency Discharge Notice* to Resident B and we moved Resident A to a different facility. As of now, a new placement has not been found but we are working with the case manager and guardian on this."

On 5/21/2026, I spoke to Dr. Gary Yashinsky via telephone. Dr. Yashinsky stated, "The facility called me in April 2026 and told me there was an allegation of sexual abuse with Resident A as the victim. I advised the staff to take Resident A to the hospital, but they decided to bring him to see me instead. I did complete an exam of Resident A, but my exam would only be able to assess for sexual assault in the prior two days. The rectum area heals pretty quickly and so the exam was only relevant

going back a few days. I did not know what there was physical evidence to confirm that sexual assault had occurred, and I was never told by the staff that semen was found in Resident A's room or that there were incidents of him being found naked with another resident."

On 5/21/2026, I spoke to Ms. Boss and Ms. Shaindle via telephone. Ms. Boss and Ms. Shaindle stated, "We know Resident B has a history of inappropriate sexual behavior. However, I was never made aware of all of these incidents until February 2<sup>nd</sup>, 2026, when I went to the facility and began looking at the incident reports and saw the 2/2/2026 IR. Prior to this, I was not aware of these concerns. The staff never called us to notify us of these issues. Prior to now, honestly, I only saw incident reports that came through to us via the fax machine. I don't check for each IR at each home. Managers at each home review them. We are trying to figure out why all the staff did not escalate this issue to recipient rights or the supports coordinator or our whistleblower line. There were so many opportunities for staff to have escalated this and they did not. We have hired a private firm to conduct an independent investigation because we want to understand how this could have happened."

On 5/21/2026, I spoke to direct care staff, Randi Kramer, via telephone. Ms. Kramer stated that she has worked at the facility for two years. Ms. Kramer stated, "My job is to keep Resident A and Resident B separated at all times. I have been assigned as 1:1 staff for both Resident A and Resident B. When I am working, I am responsible to monitor and keep them separated. We are supposed to restrict Resident A to the kitchen and tv room. Resident B is restricted to the living room area. It proves to be quite challenging at times with Resident B because he tries to pull Resident A into private areas of the home for sexual reasons. I was working on 2/1/2026, and that night I was the assigned 1:1 for Resident B. I went into the kitchen and when I came back into the living room, Ms. Hardy stated that Resident B was coming out of Resident A's bedroom. I immediately went into Resident A's bedroom, and the mattress was partially off the bed and there was semen on Resident A's clothes and bed. He did ejaculate on Resident A's blanket. Resident B is very sneaky and very skilled. I don't think he was in Resident A's room very long. I had only left into the kitchen for a few moments. Resident B wasn't in there long enough to do anything. I looked Resident A over and checked him and he was fine. I failed at my job that night. I went into the kitchen a couple of times to get my coffee mug, and nothing happened those times. I knew that Resident B was awake, and I thought it was okay to go into the kitchen to grab a banana. It was that quick. On 2/6/2026, I was also working when a second incident happened. I was working that day with Ms. Hardy and Ms. Gates. That day, Ms. Hardy was the assigned 1:1 for Resident A and Ms. Gates was the assigned 1:1 for Resident B. We were setting breakfast out for the residents and Ms. Gates had gone to the bathroom for a duration of time. Another resident alerted us that Resident A and Resident B were missing. We went into Resident A's bedroom and found Resident A fully naked and Resident B naked from the waist down. Resident B was standing behind Resident A and was sandwiched against him, skin to skin. I separated them. I did not see Resident B's penis inside Resident A or out, I didn't see anything on Resident A's butt area so there was no

indication that intercourse happened. We wiped Resident A down and re-dressed him. I didn't call the police or take Resident A to the hospital for an exam. After both incidents in February 2026, I completed IR's both times. I also spoke to my manager, Mr. Carter, personally the next day after the 2/1/2026 incident. I have always been told to leave IR's on the desk and that Mr. Carter or the manager would review, make sure it was correct and then fax it over to management. There are no receipts that come out of the fax machine because it is broken so we don't know for sure if they go through. I never knew I had to also fax all IR's. He was aware of it, and he was aware it was an ongoing problem. I asked Mr. Carter why he hasn't gotten Resident B out of the house because it is unsafe and so sad that Resident A cannot move about the home freely. I was under the impression that, because Mr. Carter told me he had a large folder with multiple emails and documentation regarding the ongoing concerns regarding Resident B's behavior and attempts to get him removed from the home, that upper management had to know. I tend to think they know and they wanted Resident B to stay and not lose his home."

On 5/22/2026, I conducted an Exit Conference with licensee designee and administrator, Jasmine Boss, via telephone. Ms. Boss stated that she is in agreement with the findings of this report and intends to accept the issuance of the six-month provisional license.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.</b>
<b>ANALYSIS:</b>	<p>According to Resident B's <i>Assessment Plan for AFC Residents and Crisis Prevention and Safeguard Plan</i>, Resident B has a long history of inappropriate and aggressive sexual behavior. Due to these behaviors, a 1:1 enhanced staffing was implemented on 4/3/2023 for eight hours per day, between the hours of 11:00pm – 7:00am. Door chimes were also installed on all bedroom doors and Resident B was asked to wear a jingle bell on his wrist.</p> <p>According to the <i>Incident/Accident Reports</i>, dated between 3/10/2023 and 5/10/2026, despite the above safety measures, Resident B sexually assaulted Resident A eight times and</p>

	<p>attempted to sexually assault Resident A four additional times. Resident B sexually assaulted Resident A on 3/10/2023 at 12:30am, 6/12/2023 at 2:00am, 4/15/2024 at 11:00am, 11/14/2024 at 1:10pm, 1/19/2025 at 6:15pm, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am and 2/6/2026 at 6:00am. On 5/10/2026, Resident B was found outside in the yard, exposing his genitals to the neighboring homes, which include family homes with children. Resident B attempted to sexually assault Resident A on 7/26/2023 at 6:30pm, 5/24/2024 at 9:30am, 6/8/2024 at 6:10am and 10/1/2024 at 8:00am.</p> <p>Over the three-year period of 2023 - 2026, the intervention plan implemented by the facility has remained the same, despite Resident B's continued sexual aggression and sexual abuse of Resident A. The 1:1 staffing from 11:00pm – 7:00am was not sufficient as Resident B was attempting to and/or did sexually assault Resident A at various times of the day, not just during sleeping hours. Additionally, Resident B was assigned a 1:1 staff effective 4/3/2023 and was still able to sexually assault Resident A during sleeping hours on 6/12/2023 at 2:00am, 4/15/2024 at 11:00am, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am, and 2/6/2026 at 6:00am.</p> <p>According to Ms. Lubana, Ms. Hardy, Ms. Robinson and Ms. Kramer, Resident B's aggressive sexual behaviors have continued to remain consistent despite the interventions in place. According to Ms. Hardy and Ms. Robinson, they have witnessed Resident B sexually assault Resident A.</p> <p>Based on the information above, there is sufficient information to confirm that the facility did not implement a sufficient behavioral intervention plan to ensure the safety of Resident A.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident care.</b>
	<b>(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	According to the <i>Incident/Accident Reports</i> , dated between 3/10/2023 and 5/10/2026, Resident B sexually assaulted Resident B eight times and made attempts to sexually assault Resident B four times. Resident B sexually assaulted Resident

	<p>A on 3/10/2023 at 12:30am, 6/12/2023 at 2:00am, 4/15/2024 at 11:00am, 11/14/2024 at 1:10pm, 1/19/2025 at 6:15pm, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am and 2/6/2026 at 6:00am. Resident B attempted to sexually assault Resident A on 7/26/2023 at 6:30pm, 5/24/2024 at 9:30am, 6/8/2024 at 6:10am and 10/1/2024 at 8:00am.</p> <p>According to Ms. Hardy, Ms. Robinson, Mr. Carter and Ms. Kramer, they have witnessed Resident B engage in inappropriate and aggressive sexual behavior toward Resident A at various times throughout the last two years. According to Ms. Lubana, Ms. Hardy, Ms. Robinson and Ms. Kramer, Resident B's aggressive sexual behaviors have continued to remain consistent toward Resident A despite the interventions in place.</p> <p>Based on the information above, direct care staff did not adequately protect Resident A from being physically and emotionally harmed by Resident B during the three years that the abuse has been occurring.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident care.</b>
	<b>(4) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>According to the <i>Incident/Accident Reports</i>, dated between 3/10/2023 and 5/10/2026, Resident B sexually assaulted Resident A eight times and made attempts to sexually assault Resident A four times. Resident B sexually assaulted Resident A on 3/10/2023 at 12:30am, 6/12/2023 at 2:00am, 4/15/2024 at 11:00am, 11/14/2024 at 1:10pm, 1/19/2025 at 6:15pm, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am and 2/6/2026 at 6:00am. Resident B attempted to sexually assault Resident A on 7/26/2023 at 6:30pm, 5/24/2024 at 9:30am, 6/8/2024 at 6:10am and 10/1/2024 at 8:00am.</p> <p>Over the three-year period of 2023 - 2026, the intervention plan implemented by the facility has remained the same, despite Resident B's continued sexual aggression and sexual abuse of Resident A. The 1:1 staffing from 11:00pm – 7:00am was not sufficient as Resident B was attempting to and/or did sexually assault Resident A at various times of the day, not just during sleeping hours. Additionally, Resident B was assigned a 1:1 staff effective 4/3/2023 and was able to divert from staff</p>

	<p>supervision and sexually assault Resident A during sleeping hours on 6/12/2023 at 2:00am, 4/15/2024 at 11:00am, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am, and 2/6/2026 at 6:00am.</p> <p>According to Ms. Lubana, Ms. Hardy, Ms. Robinson and Ms. Kramer, Resident B's aggressive sexual behaviors have continued to remain consistent despite the interventions in place. According to Ms. Hardy, Ms. Robinson and Ms. Kramer, they have witnessed Resident B sexually assault Resident A.</p> <p>On 5/10/2026, Resident B was found outside in the yard, exposing his genitals to the neighboring homes, which include minor occupants.</p> <p>Based on the information above, there is sufficient information to confirm that direct care staff have not ensured Resident A's safety and protection during the time that he has resided at the facility. Additionally, the facility has failed to ensure Resident B's safety and protection from escalated sexualized behavior outside of the home, which could lead to police involvement and harm to public citizens.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.689</b>	<b>Resident health care.</b>
	<b>(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.</b>
<b>ANALYSIS:</b>	<p>According to the <i>Incident/Accident Reports</i>, Resident B was unsupervised and alone with Resident A on 4/15/2024 at 11:00am, 11/14/2024 at 1:10pm, 1/19/2025 at 6:15pm, 12/2/2025 at 12:25am, 2/1/2026 at 2:34am and 2/6/2026 at 6:00am. During these six incidents, direct care staff were unable to confirm if a physical sexual assault and/or penile penetration occurred between Resident A and Resident B. In all six incidents, Resident A was not transported to the hospital for a sexual assault exam by direct care staff, nor was a police report filed. In total, there were seven direct care staff, Mattie Gates, Brandie Whelan, Marisa Mason, Sherri Smith, Duane Carter, Latisha Calloway, Marcella Robinson, Ada Hardy and Randi Kramer, that all failed to obtain needed medical care for Resident A at various times between the dates of 4/15/2024 and 2/6/2026, approximately two years.</p>

	Based on the information above, there is sufficient information to confirm that the facility failed to properly obtain medical care for Resident A to assess him for sexual assault, physical injury and/or sexually transmitted diseases.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.693</b>	<b>Incident notification, incident records.</b>
	<b>(3) An incident must be recorded on a department-approved form, or a facility form that contains the same information, and retained in the facility for 2 years.</b>
<b>ANALYSIS:</b>	<p>I reviewed 17 incident reports between the dates of 3/10/2023 and 5/10/2026. All 17 incident reports referenced attempts and/or sexual abuse of Resident A by Resident B. All 17 incident reports did not contain Ms. Boss's signature. Additionally, several of the incident reports were missing required information.</p> <p>According to Guardian A1, Guardian B1 and Ms. Moore, they were never provided with copies of the incident reports and were unaware of the sexual abuse that was occurring.</p> <p>According to Ms. Boss, she was not aware that she was required to review and sign all incident/accident reports completed for the facility.</p> <p>Based on the information above, there is sufficient information to confirm that direct care staff and Ms. Boss failed to properly complete, review and sign the incident/accident reports related to the sexual abuse of Resident A by Resident B over a three-year period.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**III. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend issuance of a six-month provisional license.



5/22/2026

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Stephanie Gonzalez  
Licensing Consultant

Date

Approved By:



For

05/22/2026

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Denise Y. Nunn  
Area Manager

Date