GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2022

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

RE: License #: AS250385494
Investigation #: 2022A0779019
Wilson Road 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 (906) 226-4171.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250385494
Investigation #:	2022A0779019
Complaint Receipt Date:	01/25/2022
Investigation Initiation Date:	01/26/2022
Report Due Date:	03/26/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Regina Wheaton
Licensee Designee:	Paula Ott
Name of Facility:	Wilson Road Home
Facility Address:	6359 W Wilson, Clio, MI 48420-8420
Facility Telephone #:	(810) 687-0202
Original Issuance Date:	05/02/2017
License **Status:**	REGULAR
Effective Date:	11/02/2021
Expiration Date:	11/01/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was hit in the head 4-5 times a month ago by Resident B and had to be hospitalized. Resident B continues to threaten Resident A and Resident A is not safe in the home.	No
Additional Findings	Yes

III. METHODOLOGY

01/25/2022	Special Investigation Intake 2022A0779019
01/25/2022	APS Referral Complaint was referred to AFC licensing by APS.
01/26/2022	Special Investigation Initiated - Telephone Interview conducted with administrator, Regina Wheaton.
01/27/2022	Inspection Completed On-site
02/02/2022	Contact - Telephone call made Interview conducted with staff person, Marcell Jones.
02/02/2022	Contact - Telephone call made Interview conducted with home manager, Jehan Shamid-Deen.
02/04/2022	Contact - Telephone call made Interview conducted with program manager, Jamilla Cheatom.
02/04/2022	Contact - Telephone call made Spoke to GHS nurse practitioner.
02/07/2022	Contact - Telephone call made Spoke to Resident A's GHS case manager.
03/08/2022	Exit Conference Conducted with administrator, Regina Wheaton.

ALLEGATION:

Resident A was hit in the head 4-5 times a month ago by Resident B and had to be hospitalized. Resident B continues to threaten Resident A and Resident A is not safe in the home.

INVESTIGATION:

On 1/26/22, a phone interview was conducted with administrator, Regina Wheaton, who confirmed that there was a physical altercation between Resident A and Resident B at the beginning of December 2021. Ms. Wheaton stated that Resident A was the resident that instigated the altercation. She reported that Resident A went to Resident B's bedroom and was very confrontational and that is when the fight took place. Ms. Wheaton stated that the police were called and that even though Resident A had no visible injuries, he was taken to the hospital. She stated that Resident B was also taken to the hospital and treated for a broken hand. Ms. Wheaton reported that Resident A suffers from extreme anxiety and paranoia and that his psychosis has gotten much worse recently. She stated that Resident A has been delusional and making on-going false allegations about Resident B and other residents stealing and/or messing with his stuff. She reported that Resident A seems focused on Resident B for some unknown reason.

On 1/27/22, an on-site inspection was conducted. Interviews were conducted with Resident A and Resident B.

Resident A admitted that in early December 2021, he confronted Resident B about messing with his coat. He admitted that he attempted to take a swing at Resident B and that is when the physical fight started. Resident A stated that Resident B grabbed him by his shirt, which pulled his head down, and then punched him 2-3 times in the head. Resident A reported that he went to his room to get away from Resident B, that there were no other residents around to see the fight and that staff came to the hallway and were telling them to stop. Resident A then went on a long tangent about how Resident B and other residents keeping messing with his stuff and stealing from him. He stated that he had to buy an expensive safe in order to keep them away from his things and that has not even stopped them. Resident A claims that Resident B has made keys to get into his room and knows how to get into his safe. When asked if he has told anyone in the house how to get into his safe, Resident A said that he had not and had no explanation has to how Resident B and other residents could get into the safe. Resident A stated that he had lumps on his head after the fight and that he went to the hospital. He stated that he has no lasting or visible injuries. Resident A stated that he has not had any further physical altercations with Resident B or any other resident since. Resident A stated that he and his parents want to get Resident B kicked out of this house.

Resident B admitted that he punched Resident A in the head but stated that he was only protecting himself. Resident B stated that Resident A came to his room, started banging on his door and would not stop until he answered it. Resident B claims that he told Resident A that he was on the phone and asked him to go away, but that Resident A would not leave. Resident B stated that Resident A threw a punch and that he was protecting himself. He stated that he hit Resident A in the head a few times, that Resident A asked him to stop and he did. Resident B stated that the incident happened

fast and that he is not sure if there was anyone else around to see what happened. Resident B reported that Resident A is paranoid that people are stealing from him, but that no one in the home is doing that. Resident B denied that he has made keys to get into Resident A's room and stated that he has no idea how to get into Resident A's safe. Resident B stated that Resident A is very hard to get along with and that none of the other residents like him. He stated that he tries to stay away from Resident A, but that Resident A won't leave him alone or stop accusing him of things he is not doing. Resident B stated that he could have really hurt Resident A if he wanted to, but that he did not want to fight with him and only felt like he had to protect himself. Resident B stated that he has no plans to further fight with Resident A, that the fight was the first and only time it has become physical between them, and that he wishes Resident A would just leave him alone. When asked where staff were at the time of the fight, Resident B said that staff were not present in the hallway when it happened and that they arrived there quickly, but it was over by the time they arrived there. He stated that all the staff try their best to work with Resident A, but that Resident A won't stop falsely accusing people of things they are not doing.

During the on-site inspection on 1/27/22, administrator, Ms. Wheaton, was interviewed. Ms. Wheaton stated that Resident B is not the problem, that Resident B is not an on-going threat to Resident A, and that Resident B does not have any significant issues with any other residents in the home. Ms. Wheaton reported that the physical altercation between Resident A and Resident B took place on 12/3/2021 and that there has not been any further physical incidents between them. She stated that Resident A went to the hospital on the night of the incident, but that the wait there was too long and Resident A refused to stay and be seen. She stated that they took Resident A back to the hospital the next day on 12/4/21 and Resident A was seen by a physician, but there were no injuries found and Resident A was not admitted into the hospital. Ms. Wheaton showed pictures that were on her phone and that were taken of Resident A on 12/4/21. There did not appear to be any visible signs of injuries on Resident A's face or head areas. Ms. Wheaton stated that Resident A continues to have verbal conflicts with multiple other residents and falsely accuse them of stealing and/or messing with his things. She stated that they have tried several things to help Resident A with his paranoia, such as, changing the locks on his bedroom door three times, allowing him to purchase a safe for his room, and allowing him to change roommates several times. Ms. Wheaton reported that the home does not have enough room/space for Resident A to have a private room and that Resident A's current roommate is the only resident that will agree to share a room with him. Ms. Wheaton stated that staff are keeping a closer eye on Resident A and are working with the other residents to have them avoid conflict with Resident A, knowing that he is not doing well. She stated that they continue to work with Resident A's guardians, GHS case manager and physicians regarding the best way to help Resident A. Ms. Wheaton feels that Resident A's guardians are in denial regarding the severity of Resident A's psychiatric issues and have allowed Resident A to change is psychiatric medications several times, which is only making the situation worse.

There was a brief and/or incomplete incident record (IR) completed regarding the physical altercation between Resident A and Resident B. The IR documents that the incident took place on 12/3/21. It states that staff overheard a conversation in which Resident A was accusing Resident B of putting dirty on his coat. The IR says that Resident B punched Resident A in the face but does not provide any further or detailed information. It does state that police were called and that both residents were taken to the hospital.

Resident A and Resident B's written assessment plans document that they are both quite independent and able to complete all the activities of daily living on their own. Resident A's plan confirmed his paranoia and delusional behaviors and that he has a difficult time getting along with others.

On 2/2/22, a phone interview conducted with staff person, Marcell Jones. He stated that he was the staff working on 12/3/21 and when the physical altercation between Resident A and Resident B took place. Mr. Jones stated that he heard the conflict happen but did not actually witness the physical altercation take place. He stated that the fight was over before he could arrive to the hallway to observe what was happening. Mr. Jones reported that Resident A did not appear to be hurt at all, but that the police recommended that both residents go to the hospital. He stated that Resident B was treated for a broken hand, but the wait time to see Resident A was too long and Resident A refused to wait to be seen. Mr. Jones stated that Resident A had no visible injuries and did not complain of having any pain. He stated that Resident A and Resident B were getting along fine the rest of that night. Mr. Jones reported that he feels that Resident A is the issue, not Resident B. He stated that Resident A is extremely paranoid and is always having problems getting along with the other residents. He stated that he is not aware of any other physical altercations between Resident A and Resident B and that he has not witnessed Resident B making any verbal threats toward Resident A.

On 2/2/22, a phone interview was conducted with home manager, Jehan Shamsid-Deen, who stated that Resident A did not appear to have any visible injuries after the altercation with Resident B on 12/3/21. He stated that Resident A was seen at the hospital on 12/4/21, but that no injuries were found and Resident A was sent back home. Mr. Shamsid-Deen stated that Resident A suffers from schizophrenia and extreme paranoia and that Resident A is the problem, not Resident B. He reported that Resident A continues to falsely accuse other residents of things and instigate verbal conflicts. Mr. Shamsid-Deen stated that other than this incident with Resident A, Resident B has been doing much better recently and that he has not witnessed Resident B making any verbal or physical threats towards Resident A. Mr. Shamsid-Deen stated that he does not feel that Resident B is an on-going threat to Resident A. He stated that Resident A keeps convincing his guardians that his medications need to be changed, which is not helping Resident A. He feels that Resident A's guardians are in denial about how severe Resident A's paranoia and delusions are.

On 2/4/22, a phone interview was conducted with program manager, Jamilla Cheatom. She stated that Resident B has not been physical with any other residents other than this one occurrence with Resident A on 12/3/21. Ms. Cheatom does not believe that Resident B is an on-going threat to Resident A and stated that if she felt that was the case, she would provide Resident B with a discharge notice. Ms. Cheatom stated that Resident A is the one who initiates the conflicts with other residents. She reported that they have repeatedly looked into Resident A's allegations against the other residents and have never found any proof that any other residents are messing with or have stolen any of Resident A's things. Ms. Cheatom stated that they have made many accommodations to Resident A in attempts to ease his paranoia, but nothing has seemed to work long-term. She stated that they are continuing to work with Resident A's guardians, GHS case manager and physicians, but has also provided them with a 30-day discharge notice for Resident A.

On 2/4/22, a phone conversation took place with GHS nurse practitioner, Mary Kosman, who stated that she has been treating Resident A for his schizophrenia, paranoia, and delusional behavior. She confirmed that there have been multiple medication changes recently for Resident A. Ms. Kosman reported that Resident A has wanted changes made to his psychiatric medications and that his guardians go along with his requests. Ms. Kosman stated that extreme paranoia is baseline for Resident A and that she believes that changes in his medications will not have any significant impact. She stated that she has spoken to multiple staff at this home and that they all report to her that Resident A is the one who is confrontational and initiates the conflicts with other residents.

On 2/7/22, a phone conversation took place with Resident A's GHS case manager, David Stashko. He stated that all the staff he has spoken with at this home report that Resident A is the instigator of all conflicts with other residents. Mr. Stashko stated that Resident A is very paranoid and delusional and that it is difficult to determine what, if any, of what Resident A alleges is true. He reported that he agrees that Resident A's guardians seem to be in denial about the severity of Resident A's mental illness and that the guardians just accept what Resident A tells them as truth and/or fact. Mr. Stashko stated that he is continuing to work with this home to best meet Resident A's needs as he continues to work with Resident A's guardians and GHS to find a new and more appropriate placement for Resident A. Mr. Stashko stated that he feels that Resident A is safe to remain in this home until a new placement can be found.

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:	It appears that the physical altercation that took place on 12/3/21 between Resident A and Resident B was initiated by Resident A and that no further physical incidents have taken place since. Resident A admitted that he took the first swing at Resident B. Resident B claims that he was just protecting himself. Staff were not present to witness and/or able to prevent the incident from taking place. All staff interviewed claim to have never witnessed Resident B to continue to verbally threaten Resident A. All staff at this home, Resident A's GHS case manager and nurse practitioner, all state that Resident A is extremely paranoid and delusional and seems to be the one that initiates any conflicts he may be involved in. This home continues to work with Resident A, his guardians and GHS case manager and physicians in order to best meet his needs. The home has provided Resident A, his guardians and GHS a 30-day discharge notice and efforts are being made to find Resident A a new and more appropriate placement. There was insufficient evidence found to prove that Resident A is not being provided adequate protection and safety at this home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site inspection on 1/27/22, this home was only able to provide a written IR (incident report), regarding the physical altercation between Resident A and Resident B, that was incomplete, did not provide any detailed information and was not signed by any staff or administrator/licensee designee.

On 1/27/22, administrator, Ms. Wheaton, stated that Resident A was taken to the hospital and seen by physicians on 12/4/21. Ms. Wheaton also stated that Resident A's guardians had Resident A admitted into the hospital for a psychiatric evaluation, in which Resident A stayed for several days, just before the Christmas holiday in 2021. She was not sure of the exact dates Resident A was hospitalized and could not find an IR documenting either of these incidents.

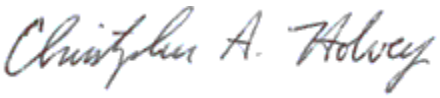
On 2/1/22, home manager, Mr. Shamid-Deen, confirmed the two hospital visits for Resident A in December 2021, with one including a stay of several days. Mr. Shamid-

Deen could not confirm if an IR had been completed for either incident and stated that he would look for and provide them if they exist. As of the date of this report, no IR has been provided.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.**
ANALYSIS:	On December 3, 2021, Resident A and Resident B were involved in a physical altercation, which resulted in both residents going to the hospital. An incident report (IR) was completed but it did not provide any detailed information and was not signed by any staff or administrator/licensee designee. Resident A was taken back to the hospital on 12/4/21 and seen by physicians. He was also taken to the hospital some time in late December 2021, at which time he was admitted and stayed several days. Within 48 hours of each incident, the licensee has failed to complete and/or provide the adult foster care licensing division a written report documenting the events regarding either of these two hospital visits for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

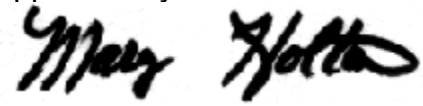
Upon receipt of an approved written plan of correction, it is recommended that the status of this home's license remain unchanged.



3/8/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



3/8/2022

Mary E Holton Date
Area Manager