



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 11, 2024

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

RE: License #: AS250291671
Investigation #: 2024A0569011
Vassar Road Home

Dear Paula Barnes:

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Kent W. Gieselman". The signature is written in a dark ink and is positioned above the typed name and address.

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250291671
Investigation #:	2024A0569011
Complaint Receipt Date:	11/17/2023
Investigation Initiation Date:	11/17/2023
Report Due Date:	01/16/2024
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Barnes
Licensee Designee:	Paula Barnes
Name of Facility:	Vassar Road Home
Facility Address:	3220 Vassar Road Burton, MI 48519
Facility Telephone #:	(810) 742-2745
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/22/2022
Expiration Date:	04/21/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED
--	----------------------

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with a bruise under his eye on 11/9/23.	Yes

III. METHODOLOGY

11/17/2023	Special Investigation Intake 2024A0569011
11/17/2023	APS Referral Complaint received from APS.
11/17/2023	Special Investigation Initiated - Letter Email from Brandi Morris, APS worker.
12/12/2023	Contact - Document Received Email received from Brandi Morris, APS.
01/08/2024	Contact - Telephone call made. Contact with Matt Potts, RRO.
01/08/2024	Contact - Telephone call made. Attempted contact with Otis Williams, GHS case manager. Left voicemail requesting return phone call. Otis Williams is currently on sick leave.
01/08/2024	Contact - Telephone call made. Contact with Rataveon Miller, staff person.
01/08/2024	Contact - Telephone call made. Contact with Jason Miller, staff person.
01/10/2024	Contact - Telephone call made. Attempted contact with Crisann Haven, GHS case manager.
01/10/2024	Contact - Document Received Email from Matt Potts.
01/10/2024	Contact - Telephone call made. Attempted contact with Crisann Havens, GHS case manager. Left voice mail requesting a return phone call. Crisann Haven is currently on sick leave.

01/11/2024	Contact - Telephone call made. Attempted contact with Marcus McKee, psychologist. Left voicemail requesting a return phone call.
01/11/2024	Contact - Telephone call received. Contact with Marcus McKee, psychologist.
01/11/2024	Contact- Telephone call made. Contact with Guardian
01/11/2024	Exit conference. Exit conference with Paula Barnes, licensee designee.

ALLEGATION:

Resident A was observed with a bruise under his eye on 11/9/23.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A was observed to have a bruise and swelling under his right eye. The complainant reported that the cause of the injury was unknown. The complainant reported that Resident A's left eye was also swollen and red.

Brandi Morris, APS worker, stated on 11/17/23 that she investigated this complaint. Brandi Morris stated that Resident A was taken to urgent care on 11/10/23 for treatment of his eyes. Brandi Morris stated that Resident A was diagnosed with conjunctivitis and prescribed an anti-biotic eye drop. Brandi Morris stated that she did not substantiate abuse or neglect in her investigation and closed her investigation.

Matt Potts, recipient rights officer, stated on 1/8/24 that he is investigating this allegation. Matt Potts stated that there are two issues regarding Resident A's eyes. Matt Potts stated that Resident A has been treated for conjunctivitis in his left eye, but the bruise under his right eye was not due to conjunctivitis. Matt Potts stated that Resident A's right eye injury was sustained during the third shift on 11/9/23- 11/10/23. Matt Potts stated that the two staff who worked the third shift were Jason Miller and Rataveon Miller. Matt Potts stated that the staff reported that Resident A was observed in his bedroom, banging his head against his dresser which caused the bruise. Matt Potts stated that Resident B has stated that he remembered observing Jason Miller "shoving" Resident A's head against the dresser. Matt Potts stated that he has not determined if Resident B's statement is reliable and has not concluded his investigation. Matt Potts

submitted photos he took of Resident A on 11/10/23. The photos document that Resident A had a bruise and swelling under his right eye on 11/10/23.

An unannounced inspection of this facility was conducted on 1/8/24. Resident A has been diagnosed with Autism and intellectual disability and is non-verbal. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A's file was reviewed. Resident A's file contains documentation that he was treated on 11/10/23 for conjunctivitis of his left eye and was prescribed eye drops. Resident A's right eye was also examined, but no further treatment was prescribed. Resident A's plan of service documents that Resident A does not require 1:1 or "line of sight" supervision. Resident A's file contains an incident report (IR) dated 11/9/23. The IR documents that Resident A was observed with a black right eye on 11/10/23 by first shift staff. The IR documents that the Jason Miller and Rataveon Miller, third shift staff, reported that Resident A had hit his head against his dresser while "having a behavior" during their shift. The IR documents that Resident A was taken to urgent care for evaluation. The corrective measures for the IR document that staff "will continue IPOS plan".

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he got up during the night to go to the bathroom on one occasion "a while ago". Resident B stated that he walked by Resident A's bedroom, and the door was open to Resident A's bedroom. Resident B stated that he observed Jason Miller "shove" Resident A's head into the dresser in Resident A's bedroom "two or three times". Resident B stated that he just went back to his bedroom and went back to bed. Resident B stated that he did not know the exact date that this happened. Resident B stated that he was unaware if Resident A was injured from this incident. Resident B stated that he felt safe around Jason Miller, and never observed Jason Miller mistreat Resident A any other time. Resident B could not recall any further information.

Andre Bland, staff person, stated on 1/8/24 that he has worked the third shift with Jason Miller. Andre Bland stated that he has never observed Jason Miller mistreat any of the residents. Andre Bland stated that Resident A was observed with a bruise under his right eye on 11/10/23 by first shift staff. Andre Bland stated that he did not observe how Resident A sustained his injury. Andre Bland stated that Resident A does hit himself in his head or with his hand when Resident A becomes upset. Andre Bland stated that he has observed Resident A exhibit these behaviors on "a couple" of occasions, but Resident A is easily redirected to stop hitting himself.

Jason Miller, staff person, stated on 1/8/23 that he did work the third shift on 11/9/23-11/10/23. Jason Miller stated that Resident A had come to living room where he and Rataveon Miller, staff person, were cleaning. Jason Miller stated that Resident A was looking for a snack and it was about 3:00am. Jason Miller stated that Resident A "is obsessed with food" and frequently approaches staff wanting a snack. Jason Miller stated that Resident A became upset when he didn't get a snack "immediately" because he was trying to finish what he was doing. Jason Miller stated that Resident A then

urinated on himself, and it “made a mess” on the floor of the living room. Jason Miller stated that he then redirected Resident A to return to his room, and that he would assist Resident A with changing his brief and get him a snack as soon as the mess in the living room was cleaned up. Jason Miller stated that Resident A did go to his bedroom and Jason Miller and Rataveon Miller started cleaning up the mess left by Resident A. Jason Miller stated that he then “heard banging” coming from Resident A’s bedroom, so he immediately went to Resident A’s bedroom to see what happened. Jason Miller stated that he observed Resident A between his dresser and the wall, and Resident A had hit his head on his dresser. Jason Miller stated that he helped Resident A “get cleaned up” and got Resident A a snack. Jason Miller stated that Resident A then went back to bed and remained in bed for the shift. Jason Miller stated that he then left around 6:30am on 11/10/23. Jason Miller stated that he did not observe any injury to Resident A’s eye, but did complete and incident report and reported the incident to the first shift staff coming in. Jason Miller stated that he did not push Resident A’s head into his dresser or mistreat Resident A in any way.

Rataveon Miller, staff person, stated on 1/8/23 that he did work the third shift on 11/9/23-11/10/23 with Jason Miller. Rataveon Miller stated that around 3:00am Resident A came into the living room wanting a snack. Rataveon Miller stated that Resident A became upset, and “wet himself”, making a mess on the living room floor. Rataveon Miller stated that Jason redirected Resident A and Resident A went back to his bedroom. Rataveon Miller stated that he and Jason started cleaning up the mess when they heard a “bang” from Resident A’s bedroom. Rataveon Miller stated that Jason Miller went to Resident A’s room while Rataveon Miller finished cleaning up in the living room. Rataveon Miller stated that he did not observe Resident A, but Jason Miller told Rataveon Miller that he found Resident A between his dresser and the wall, and Resident A had hit his head on his dresser. Rataveon Miller stated that he did not observe an injury to Resident A, but Jason Miller did complete an incident report. Rataveon Miller stated that Jason Miller’s account seemed reasonable because Resident A does hit himself in the head or bang his head when he gets upset. Rataveon Miller stated that he has never observed Jason Miller physically mistreat any of the resident in this facility.

Marcus McKee, GHS psychologist, stated on 1/11/24 that he works with Resident A and Resident B. Marcus McKee stated that Resident B generally tells the truth, especially about major events that he has witnessed or been a part of. Marcus McKee stated that Resident B is trustworthy and usually “straight forward” when he accounts details of things he has observed. Marcus McKee stated that he would “tend to believe” Resident B’s statement that he observed Jason Miller “slam” Resident A’s head into his dresser.

Resident A’s guardian (Guardian) stated on 1/11/24 that he has worked with Resident A for several years. Guardian stated that he has never known Resident A to slam his head against floors, walls, or his dresser. Guardian stated that this account “doesn’t sound like [Resident A]. Guardian stated that Resident A will hit himself in his head with his hand when he becomes upset but does not bang his head. Guardian stated that

Resident A can be very difficult and frustrating to work with and Guardian would not be surprised if a staff person “lost their temper” with Resident A.

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Resident A was observed with a bruise and swelling under his right eye on 11/10/23. Jason and Rataveon Miller, brothers, reported that this injury occurred during their third shift from 11/9/23-11/10/23. Jason Miller and Rataveon Miller stated that Resident A sustained the injury after slamming his own head against his dresser when he became upset during the night about getting a snack. Resident B stated that he witnessed Jason Miller “slam” Resident A’s head into his dresser “two or three” times when Resident B got up to use the bathroom. Marcus McKee stated that Resident B’s statement is most likely credible based on working with Resident B in therapy. Guardian stated that Resident A will hit himself in his head with his hand at times, but that Resident A does not slam his own head into walls, floors, dressers, etc. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

An exit conference was conducted with Paula Barnes, licensee designee, via email on 1/11/24. Paula Barnes was contacted by phone but was out of her office. I was instructed to send Paula Barnes an email. The findings in this report were reviewed and a corrective action plan was requested.

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

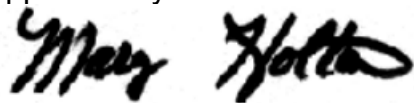


1/11/24

Kent W Gieselman
Licensing Consultant

Date

Approved By:



1/11/24

Mary E. Holton
Area Manager

Date