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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 5, 2025

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

RE: License #: AS250291671
Investigation #: 2025A0569015
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,

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 #:	2025A0569015
Complaint Receipt Date:	12/19/2024
Investigation Initiation Date:	12/19/2024
Report Due Date:	02/17/2025
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 #:	(989) 513-7503
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/22/2024
Expiration Date:	04/21/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
Resident A was observed with a black eye on 12/18/24. Resident A sustained the black eye from being physically mistreated by Rataveon Miller, staff person.	Yes

III. METHODOLOGY

12/19/2024	Special Investigation Intake 2025A0569015
12/19/2024	APS Referral Complaint from APS.
12/19/2024	Special Investigation Initiated - Telephone Contact with Matt Potts, RRO.
01/27/2025	Contact - Telephone call made Attempted contact with Rataveon Miller, staff person. Left voicemail requesting return call.
02/04/2025	Contact - Telephone call made Attempted contact with Rataveon Miller, staff person. Left voicemail.
02/05/2025	Contact - Telephone call made Contact with Matt Potts, RRO.
02/05/2025	Contact - Telephone call made Contact with Guardian.
02/05/2025	Contact - Document Sent Email to Michael Grant, APS worker.
02/05/2025	Inspection Completed On-site
02/05/2025	Inspection Completed-BCAL Sub. Compliance
02/05/2025	Exit Conference Exit conference with Paula Barnes, licensee designee.

ALLEGATION:

Resident A was observed with a black eye on 12/18/24. Resident A sustained the black eye from being physically mistreated by Rataveon Miller, staff person.

INVESTIGATION:

This complaint was received via LARA-BCHS-complaints@michigan.gov. The complainant reported that staff observed Resident A with a black eye on 12/18/2024. The complainant reported that staff did not know how Resident A sustained the black eye. The complainant reported that Resident A was sent to the emergency room on 12/18/2024 for medical attention.

An unannounced inspection of this facility was conducted on 2/5/2025. Resident A is non-verbal and could not be interviewed regarding this incident. Resident A was appropriately dressed and groomed with no visible injuries.

Resident A's file contains an incident report (IR) dated 12/18/2024. The IR documents that staff arriving for the first shift on 12/18/2024 at 6:30am observed Resident A to have a black left eye. The corrective measures were applying first aid to Resident A then taking him for medical attention.

Resident B was interviewed during the inspection on 2/5/2025. 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 during the night of 12/17/2024 to 12/18/0224, Resident B got up during the night to use the bathroom. Resident B stated that he observed Resident A in his bedroom "acting up". Resident B stated that he observed Rataveon Miller, staff person, go into Resident A's bedroom and punch Resident A in his face. Resident B stated that he then heard Resident A "scream out" when Resident A was hit. Resident B stated that he then went back to bed and reported what he observed to the facility manager the next morning.

Resident C was interviewed during the inspection on 2/5/2025. Resident C was alert and oriented to person, place, and time. Resident C was appropriately dressed and groomed with no visible injuries. Resident C stated that he woke up during the night on 12/17/2024-12/18/2024 because he was thirsty. Resident C stated that he left his bedroom to go to the kitchen to get a drink. Resident C stated that he observed Rataveon Miller in Resident A's bedroom and was upset with Resident A. Resident C stated that he then observed Rataveon Miller punch Resident A in his face with a closed fist. Resident C stated that he did not recall if Rataveon Miller was saying anything to Resident A or not. Resident C stated that Rataveon Miller was then fired.

Ellen Porter, facility manager, stated on 2/5/2024 that Resident A was observed with a black eye on the morning of 12/18/2024 and had not had a black eye when Resident A went to bed on 12/17/2024. Ellen Porter stated that Rataveon Miller was the third shift

staff person working 12/17/2024 to 12/18/2024. Ellen Porter stated that two residents reported what they had witnessed during the night of 12/17/2024 to 12/18/2024 and Rataveon Miller was terminated from employment.

Attempted contacts with Rataveon Miller have been made. Rataveon Miller has not responded to the voicemails left for him.

Matt Potts, recipient rights officer stated on 2/5/2025 that he also investigated this complaint. Matt Potts stated that he was able to interview Rataveon Miller, and that Rataveon Miller denied that he hit Resident A. Matt Potts stated that Rataveon Miller's account was inconsistent and that he was untruthful in his answers. Matt Potts stated that he substantiated physical abuse of Resident A by Rataveon Miller. Matt Potts stated that Rataveon Miller was terminated from employment.

Resident A's guardian (Guardian) stated on 2/5/2025 that she is aware of this incident, and that staff did report Resident A's black eye to her. Guardian did not have any specific concerns regarding Resident A's care at this facility. Guardian stated that Resident A can be a "handful" when Resident A is agitated and sometimes will wake up at night and "walk around". Guardian stated that the staff person accused of hitting Resident A has been terminated and that there have been no other incidents of staff mistreating 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:	The complainant reported that Resident A was observed with a black eye on the morning of 12/18/24. Resident B and Resident C both stated that they observed Rataveon Miller, staff person, in Resident A's bedroom and observed Rataveon Miller punch Resident A in his eye. Matt Potts stated that he found Resident B and Resident C's statements credible and substantiate physical abuse of Resident A by Rataveon Miller. 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, on 02/05/2025. The findings in this report were reviewed and a corrective action plan was requested.

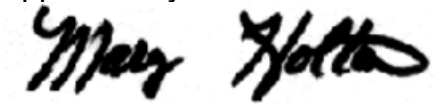
IV. RECOMMENDATION

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

02/05/2025

Kent W Gieselman — Date
Licensing Consultant

Approved By:



02/05/2025

Mary E. Holton — Date
Area Manager