



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2025

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

RE: License #: AS250291671
Investigation #: 2025A0572034
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 black ink that reads "Anthony Humphrey". The signature is fluid and cursive, with a large loop at the end of the last name.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250291671
Investigation #:	2025A0572034
Complaint Receipt Date:	05/02/2025
Investigation Initiation Date:	05/02/2025
Report Due Date:	07/01/2025
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Vuai Finney
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 MENTALLY ILL AGED

II. ALLEGATION(S)

Violation Established?	
Resident A was not allowed to return to the home from the hospital.	Yes

III. METHODOLOGY

05/02/2025	Special Investigation Intake 2025A0572034
05/02/2025	Special Investigation Initiated - Letter Complainant.
05/02/2025	Contact - Telephone call made CMH, Sara Reynolds.
05/05/2025	Inspection Completed On-site Home Manager, Ellen Porter.
05/05/2025	Contact - Telephone call received Manager, Jamilla Banister.
05/06/2025	Exit Conference Licensee Designee, Paula Barnes.
06/13/2025	Contact - Document Sent CMH, Sara Reynolds.
06/24/2025	Contact - Telephone call made Resident A's Guardian.
06/24/2025	Exit Conference Licensee Designee, Paula Barnes.
06/25/2025	APS referral An APS referral was made.

ALLEGATION:

Resident A was not allowed to return to the home from the hospital.

INVESTIGATION:

On 05/02/2025, the local licensing office received a complaint for investigation. Contact will be made with the licensed AFC within the coming days. An APS referral will be made.

On 05/02/2025, contact was made with the Complainant regarding the allegation. The Complainant informed that Resident A is currently in the hospital but is now medically stable to return to Vassar Road Home, however; the home is not accepting Resident A back. Vassar Road Home began a 24-hour discharge prior to Resident A arriving at the hospital, citing being medically complex, which needed emergent medical intervention and behavioral issues. Resident A has no new medical needs at this time. Vassar Road Home is not assisting with obtaining placement and states that it is up to the Lapeer County CMH worker to obtain placement. The Complainant informed Vassar Road AFC that they are unable to evict anyone to the hospital as that was inappropriate use of the healthcare continuum.

On 05/02/2025, I contacted CMH Case Manager, Sara Reynolds regarding the allegation. Sara Reynolds confirmed that Vassar Road AFC had issued a 24-hour discharge notice but she was not exactly sure why as Community Mental Health (CMH) were meeting with Genesee Health Systems (GHS) in regards to Resident A's behaviors. A plan was being initiated to provide 1-on-1 for Resident A but they had not heard back from the facility. Resident A current behaviors consisted of self-harm and nothing to do with aggression towards any staff or residents.

On 05/05/2025, I made an unannounced onsite to Vassar Road Home, located in Genesee County. Interviewed was Home Manager, Ellen Porter. Ellen Porter does not know the exact reason why Resident A was discharged but knows that Resident A was transported to the hospital due to a medical emergency. Resident A suffered from excessive bleeding due to exposed intestines that Resident A pushes through rectum. Hurley Medical Center said that they were unable to do surgery.

On 05/05/2025, Program Manager, Jamilla Banister called me regarding the allegation. Jamilla Banister informed that they had given Resident A an emergency discharge notice due to several incidents of inappropriate behaviors, aggression towards staff and destruction of property. Jamilla Banister also cited that the health concerns exceed their level of care. Jamilla Banister was informed that they will have to take Resident A back and/or assist with finding another placement for Resident A because the hospital is not an appropriate placement.

On 05/05/2025, I reviewed the 24-Hour discharge notice, dated for 04/25/2025. The discharge was to be in effect on 04/26/2025 at 4:00pm. Discharge is due to the following:

- Multiple incidents of indecent exposure.
- Physical aggression towards staff, including assault.

- Destruction of property, including damage to infrastructure and broken furniture.
- Invasion of personal space and inappropriate peer interactions.
- Repeated damage to bedroom doors and other home fixtures.
- Emerging health risks that exceed the level of care that they can provide.

On 05/05/2025, I reviewed Resident A's Treatment Plan. It indicates that targeted interventions for property destruction, stealing food, inappropriate self-stimulation, tantrum behaviors, relieving self in places not a bathroom and elopement.

On 05/06/2025, contact was made with Licensee Designee, Paula Barnes regarding the allegation. Paula Barnes was informed that Resident A would have to return home due to being transported to hospital for a medical need and is ready to be discharged from the hospital, or they will need to assist with obtaining placement for Resident A. Paula Barnes informed that they are in the process of obtaining placement for Resident A and if it doesn't go through, then they will accept Resident A back.

On 06/13/2025, I contacted CMH Case Manager, Sara Reynolds for an update. Sara Reynolds informed that Resident A moved to another facility on 05/07/2025. Resident A was ready for discharge from the hospital but was given a 24-hour discharge on 04/25/2025 and was there until a new placement was found.

On 06/24/2025, I contacted Resident A's Guardian regarding the allegation. Resident A's Guardian informed that Vassar Road Home called to say that Resident A was being given a 24-hour discharge notice, and they are unable to take Resident A back and that the Lapeer County Case Manager would be responsible for obtaining placement. The Guardian was told it was due to being destructive. Resident A is in a new placement and appears to be doing well.


APPLICABLE RULE	
R 400.14302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: (b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not

	<p>have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:</p> <p>(i)The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.</p>
ANALYSIS:	<p>Based on the interviews of Home Manager, Program Manager, Complainant and Guardian, there is enough evidence to establish a rules violation. Resident A was transported to the hospital via ambulance due to a medical emergency. On or around that time, Resident A was given a 24-hour discharge notice and was not allowed to return home, although the hospital is not an appropriate placement.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 05/06/2025, an exit conference with Licensee Designee, Paula Barnes was held regarding the results of the special investigation. On 06/24/2025, another exit conference with Licensee Designee, Paula Barnes was held due to the amount of time that had elapsed with the case still being opened.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an appropriate corrective action plan.

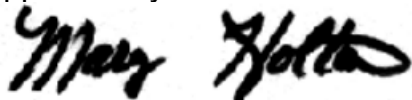


06/25/2025

Anthony Humphrey
Licensing Consultant

Date

Approved By:



06/25/2025

Mary E. Holton
Area Manager

Date