GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

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

RE: License #:	AS250010737
Investigation #:	2025A0872043
	Richfield House

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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010737
Investigation #:	2025A0872043
Complaint Receipt Date:	06/20/2025
Investigation Initiation Date:	06/23/2025
Report Due Date:	08/19/2025
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Sharon Butler
Licensee Designee:	Paula Barnes
Name of Facility:	Richfield House
Facility Address:	4478 Vassar Rd Flint, MI 48506
Facility Telephone #:	(810) 736-1203
Original Issuance Date:	12/11/1985
License Status:	REGULAR
Effective Date:	05/21/2024
Expiration Date:	05/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 6/17/2025, Resident A was found with a large gash on the back of his head. Resident A was taken to the hospital where it was discovered he also has a swollen jaw. Resident A has received numerous marks, bruises, and injuries over the past several months that are unexplained.	Yes

III. METHODOLOGY

06/20/2025	Special Investigation Intake 2025A0872043
06/23/2025	APS Referral I made an APS complaint online
06/23/2025	Special Investigation Initiated - Letter I made an APS complaint
06/25/2025	Inspection Completed On-site Unannounced
07/01/2025	Contact - Document Sent I emailed the AD and LD requesting information related to this complaint
07/02/2025	Contact - Document Received Documentation received
07/16/2025	Contact - Telephone call received Spoke to acting program coordinator, Vuai Finney
07/16/2025	Contact - Document Received Documentation received from APC Finney
07/16/2025	Contact - Telephone call received I spoke to RRO Pat Shepard
07/16/2025	Contact - Telephone call made I spoke to Richfield Township Police Lieutenant/Detective Michael Bernard

07/16/2025	Contact - Document Received I received a copy of the hospital report regarding Resident A
07/16/2025	Contact - Document Received I received a copy of the Richfield Township Police report regarding Resident A
07/21/2025	Contact - Telephone call made I interviewed Guardian A1
07/22/2025	APS Referral I made another APS complaint regarding my findings
07/25/2025	Exit Conference I conducted an exit conference with the licensee designee, Paula Barnes
07/25/2025	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: On 6/17/2025, Resident A was found with a large gash on the back of his head. Resident A was taken to the hospital where it was discovered he also has a swollen jaw. Resident A has received numerous marks, bruises, and injuries over the past several months that are unexplained.

INVESTIGATION: On 06/25/2025, I conducted an unannounced onsite inspection of Richfield House Adult Foster Care facility. I interviewed the home manager (HM), Robin Prince. I was unable to interview Resident A because he is no longer living at this AFC home.

HM Prince confirmed that on 06/17/2025, Resident A was found bleeding from a gash on his head. According to HM Prince, on the morning of 6/17/2025, staff Derrick Webster called her and told her that staff had called him to report that Resident A had blood all over his head. Staff were instructed to send Resident A to the hospital. HM Prince said that the cause of Resident A's injury is unknown. HM Prince told me that she worked on 06/16/2025 from 2pm-10pm and when she left, Resident A was fine. Staff Keisha Jackson and Prince Clausell worked third shift on 06/16/25 from 10pm-6am and Staff Clausell was in charge of Resident A's care. When first shift staff arrived on 06/17/2025, they noticed the injury to Resident A's head.

HM Prince said that because of Resident A's injury, staff Prince Clausell has been suspended. HM Prince told me that none of the residents in this facility are verbal. Resident A does not have any behavioral problems, he does not have a history of falls, and he is wheelchair bound. Resident A relies on staff for all personal care, protection, and supervision. I asked if any of the residents has a history of violence and HM Prince said no. I asked if Resident A has a history of self-harm and she said that prior to April

2025, Resident A used to hit himself on occasion. Resident A had an infected tooth removed in April 2025 and since that time, he has been eating more, and he has not been engaging in self-harming behavior. Therefore, staff suspected that Resident A was engaging in self-harming behavior because he was in pain. I asked HM Prince if a police complaint has been made regarding this incident and she said yes.

HM Prince and I talked about the fact that over the past 6 months, Resident A has had other unexplained injuries. HM Prince confirmed this and said that the previous injuries were thought to be self-harming behavior. I asked her if any of the staff were working on all the days of the previous incidents and she said that she does not know. HM Prince said that Staff Clausell has worked at this facility for under a year.

On 07/02/25, I received AFC documentation related to this complaint. Resident A was admitted to this facility on 07/21/2004. When Resident A was discharged from the hospital in June 2025, he was relocated to Majestic Care of Flushing. According to Resident A's Assessment Plan, he requires full staff assistance with toileting, bathing, grooming, dressing, and personal hygiene. Resident A uses a wheelchair for ambulation. According to Resident A's Health Care Appraisal, he is diagnosed with cerebral palsy, constipation, hypothyroid, hypertension, dental issues, and myalgia.

I reviewed Resident A's Genesee Health System Individualized Plan of Service (IPOS) dated 06/25/2024. According to this document, Resident A has resided at Richfield House AFC for 20 years. He has support from family and his guardian. Resident A has a history of physical aggression toward others including grabbing, squeezing, and/or scratching. Resident A also has a history of disruptive behavior such as forcefully striking a surface, and/or forcefully hitting himself. Resident A has a need for frequent attention and staff is required to check him every 2 hours during waking hours and once every 4 hours during nighttime/sleeping hour "to make sure that his brief is clean and not soiled."

I reviewed an Incident/Accident Report (IR) dated 01/24/2025 completed by HM Robin Prince. According to this IR, Resident A was observed with a swollen left hand, a swollen right knee, and a temperature. Staff contacted Resident A's guardian and sent him to McLaren hospital for an evaluation.

I reviewed an IR dated 02/05/2025 completed by HM Prince. According to this IR, Resident A was observed with a swollen mouth and eye. Staff contacted his guardian, and he was sent to McLaren hospital for an evaluation.

I reviewed an IR dated 03/22/2025 completed by staff Prince Clausell. According to this report, "I was cleaning (Resident A's) hands, face, and lips when I accidentally stab (him) in the center soft spot of his eye. I called the home manager twice before another employee advise I fill out a IR."

I reviewed an IR dated 04/19/2025 completed by HM Prince. According to this IR, HM Prince entered Resident A's room and noticed Resident A had a black bruise under his right eye. HM Prince contacted Resident A's primary care physician.

I reviewed an IR dated 05/14/2025 completed by staff Derrick Webster. According to this IR, "When doing bed check at 4pm I (observed Resident A) had a small bruise over left eye."

I reviewed an IR dated 06/17/2025 completed by staff Patrice Askew. According to this IR, "Staff (Patrice Askew) went into (Resident A's) room to check his blood pressure when staff noticed a bloody gash on the top of his skull. Called 911 and notified management." Resident A was sent to McLaren hospital for treatment.

I reviewed another IR dated 06/17/2025 completed by home manager, Robin Prince. According to this IR, "(Robin Prince) got at the home the cops and ambulance was here. Took (Resident A) to hospital. (Staff Askew) showed pics to (me). (Keisha Jackson) came to write a report she went out in garage to find blood pillowcase and gauze put in trash bag with gloves."

I reviewed a staff statement completed by staff Keisha Jackson dated 06/17/2025. According to Staff Jackson, "I Keisha Jackson was working 3rd shift with Prince (Clausell.) This morning I was in the room with (Resident B) I heard noises coming from in room with (Resident A). Prince was in there with him so I went in room to check on them. (Resident A's) face was red. I asked Prince why his face was red he said his face was dirty and he had just washed it. So I went back to changing (Resident B) when I was done I went back in there he was brushing (Resident A's) hair and it was wet. Shift was over so I went home. Got a call from work about 9:15 asking if I knew what happened to (Resident A's) head. So I told Patrice (Askew) to check washer machine for the towel Prince used to clean his face as he said it was no where to be found so I came back to job around 10:35 I went to trash and found pillowcase and bloody gauze in trash from last night."

I reviewed a staff statement completed by staff Patrice Askew dated 06/17/2025. According to Staff Askew, "I goes into (Resident A's) room around 9:10 to check his blood pressure after giving (Resident B) her shower. While checking his blood pressure I noticed that his hair was hard so I went to look at his head and noticed it was a bloody gash on the top of his head. I then went to grab my other staff (Shayla) to show her. We then called the manager and they told us to call 911 which we did. After doing all those things I called Keisha to ask her if she knew what happen, she then told me that Prince was brushing his hair this morning and it was wet and she was hearing noises in the room as well. After hearing the noises she said she peeped in there and his face was red. She said she asked him why was it red and he said he was just cleaning his face."

I reviewed the staff schedules for the dates and times of all these incidents. I did not note that there was common staff working on all dates and times of Resident A's injuries.

I reviewed the Richfield AFC floor book. According to the note from staff Prince Clausell who worked from 10pm-6am on 06/15/2025, “Upon arrival (Resident A) was sleep, received brief checks, personal care, 0 behavioral problems, took meds, ate 100% of breakfast 75% of lunch, body check done, good shift.”

The home manager, Robin Prince worked on 06/16/2025 from 2pm-10pm and she noted, “was sleeping when staff arrived 0 meds changes were made to briefs ate dinner.”

Prince Clausell worked on 06/16/2025 from 10pm-6am and he noted, “upon arrival (Resident A) was sleeping, received 2 awd at hour brief checks, 15 min checkups, 0 behavioral problems, body checks, good shift.”

On 07/16/2025, I received a telephone call from the acting program coordinator (APC), Vuai Finney. According to APC Finney, on 06/17/0225, he made a police complaint to Richfield Township Police Department via Genesee County Recipient Rights Officer, Pat Shepard. APC Finney agreed to email me a copy of the police complaint.

On 07/16/2025, I received a telephone call from Genesee County Recipient Rights Officer (RRO), Pat Shepard. RRO Shepard confirmed that she is investigating the complaint regarding Resident A. RRO Shepard told me that she has interviewed staff Prince Clausell and he confirmed that Resident A received a cut on his head but said that the cut was accidental. Staff Clausell said that he was reaching for Resident A’s cologne bottle and dropped it on Resident A’s head, causing the injury. RRO Shepard asked Staff Clausell if he reported the injury to anyone and he said no. Staff Clausell told RRO Shepard that he used gauze and Resident A’s pillowcase to clean the wound to his head and admitted that he threw the gauze and pillowcase in the garage trash after tending to Resident A.

On 07/16/2025, I spoke to Richfield Township Lieutenant Michael Bernard via telephone. Lt. Bernard confirmed that he is investigating the complaint regarding Resident A, and he agreed to send me a copy of the police report. Lt. Bernard said that he has attempted to contact staff Prince Clausell, but his messages have not been returned. Lt. Bernard said that he is going to offer Staff Clausell a polygraph regarding these allegations.

I reviewed the Richfield Township Police report dated 06/17/2025, completed by Officer Nolff. Officer Nolff responded to Richfield AFC regarding a possible aggravated assault on a vulnerable adult. Officer Nolff investigated and observed a 4cm long laceration on the top of Resident A’s head along with a right swollen jaw. Resident A also had redness along his neck below his beard line. Officer Nolff seized a garbage bag that was in the garage. It contained pieces of bloody gauze, a black hairbrush, and a bloody pillowcase that was still damp. He interviewed several staff including Prince Clausell. Staff Clausell told Officer Nolff that he was attempting to put cologne on Resident A and dropped the bottle onto his head, causing the injury. He admitted to using gauze and a pillowcase to help with the bleeding of Resident A’s head. Officer Nolff asked him why

he did not complete an Incident/Accident report, and he said he was scared and in shock. Officer Nolff asked him if he deliberately caused the injury to Resident A head by hitting him or throwing it at him and he said no.

On 07/16/2025, I received a copy of the McLaren hospital notes dated 06/17/2025 regarding Resident A. According to EMS, Resident A was potentially assaulted by a group home worker at his AFC home and was seen at the ER due to a laceration on his scalp and a swollen right jaw. Hospital staff noted that Resident A sustained a “2cm partial thickness laceration to the crown of the head” and he required one staple to close the wound. Resident A had a CT scan of his head and face with no fractures noted. Hospital staff noted “soft tissue swelling right maxillary mandibular area within a skin and subcutaneous fat.” The emergency room doctor noted, “Given that we have opened an Adult Protective Services case against the patient I do not believe his is safe to go back to his facility as this is where the alleged assault happened. Patient is therefore being admitted pending further investigation.”

On 07/21/2025, I interviewed Guardian A1 via telephone. I reviewed the allegations with him, and he acknowledged that Resident A was injured while living at Richfield House AFC. Guardian A1 said that currently, Resident A is at Majestic Care of Flushing for rehabilitation due to previous injuries. Guardian A1 told me that when Resident A is finished with rehabilitation, he will not be returning to Richfield House and will be going to a new AFC facility.

I attempted to contact staff Prince Clausell on several occasions but as of 07/28/2025, he has not returned my messages.

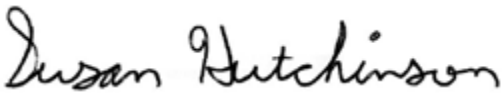
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
Rule 308.	**(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.**
ANALYSIS	On 06/17/25, Resident A was sent to the hospital due to a wound on the top of his head and a swollen jaw. The home manager, Robin Prince left the facility on 06/16/25 at 10pm and said that Resident A was “fine.” Staff Prince Clausell worked from 10pm-6am on 06/16/25 and he was in charge of Resident A’s care. Staff Clausell did not report any unusual incidents related to Resident A. However, staff found bloody gauze and a bloody pillowcase in the garage garbage which Staff Clausell later admitted he used to clean Resident A’s head. Staff Clausell

	told police that he accidentally dropped Resident A's cologne bottle on his head and said that he was shocked and scared, which is why he did not report it. Resident A has had other unexplained injuries over the past several months. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/25/2025, I conducted an exit conference with the licensee designee, Paula Barnes. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Barnes agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

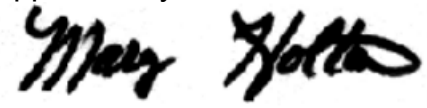
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



July 28, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



07/28/2025

Mary E. Holton Area Manager	Date