GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2025

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS090068464
Investigation #:	2025A0123048
	Fisher Road CLF

Dear Karon Lee:

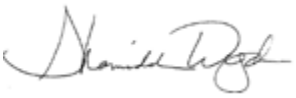
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090068464
Investigation #:	2025A0123048
Complaint Receipt Date:	08/04/2025
Investigation Initiation Date:	08/06/2025
Report Due Date:	10/03/2025
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Karon Lee
Licensee Designee:	Karon Lee
Name of Facility:	Fisher Road CLF
Facility Address:	2918 Fisher Road Bay City, MI 48706
Facility Telephone #:	(989) 684-1272
Original Issuance Date:	12/01/1995
License Status:	REGULAR
Effective Date:	09/20/2023
Expiration Date:	09/19/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 07/31/2025, Staff Kim Curtis was yelling at Resident A.	Yes
Staff Kim Curtis pushed Resident A's head.	No

III. METHODOLOGY

08/04/2025	Special Investigation Intake 2025A0123048
08/06/2025	Special Investigation Initiated - On Site Interviewed staff and Resident A.
08/06/2025	Contact- Document Received Requested documentation received.
08/07/2025	APS Referral APS referral completed.
08/11/2025	Contact - Telephone call made I interviewed staff Vanessa Torres.
08/14/2025	Contact - Telephone call made I left a voicemail requesting a return call from staff Kim Curtis.
08/15/2025	Contact - Telephone call made I interviewed staff Kim Curtis.
08/19/2025	Contact- Document Sent Email sent requesting incident report.
08/20/2025	Contact- Document Received Received copy of incident report.
08/20/2025	Exit Conference I conducted an exit conference with licensee designee Karon Lee.

ALLEGATION:

- **On 07/31/2025, Staff Kim Curtis was yelling at Resident A.**
- **Staff Kim Curtis pushed Resident A's head.**

INVESTIGATION: On 08/06/2025, I conducted an on-site at the facility. I interviewed area supervisor Jen Garcia. Home manager Leslie Shufelt was present. Jen Garcia stated that staff Kim Curtis resigned, and staff Vanessa Torres is currently not present. Resident A denied the allegations to recipient rights and adult protective services. There were issues between Staff Curtis and Staff Torres, as they were arguing last Thursday while on shift (on 07/31/2025). Later that morning both Staff Curtis and Staff Torres made complaints about each other. Assistant home manager Deontay Ray walked into the conflict between Staff Curtis and Staff Torres and observed them bickering back and forth. Staff Ray overheard Staff Curtis yelling at Resident A.

During this on-site, I interviewed Resident A in their bedroom. Resident A was observed sitting in their wheelchair. No visible marks or bruises were observed. Resident A was asked if they knew how long they have lived in the facility and if they liked living here. Resident A did not know how long they've lived in the facility, and I could not understand Resident A's response to if they liked living here, but it sounded like "*eh*." Resident A was asked if they feel safe, Resident A said "*no*." When asked why, Resident A said, "*I don't know*." Resident A was asked if she knows staff Kim Curtis. Resident A stated, "*I think so*." Resident A denied having any issues with Staff Curtis. Resident A stated they have witnessed staff arguing but do not know their names. Resident A denied that anyone has raised their voice or yelled at them, been rude, or has pushed Resident A in the head.

During this on-site, I also interviewed assistant home manager Deontay Ray. Staff Ray stated that on 07/31/2025 he arrived at the facility around 8:15 am. Staff Ray stated that staff Kim Curtis and staff Vanessa Torres were working. Staff Ray stated that you could feel the tension between the two staff. Staff Ray stated the staff had begun bickering back and forth with one another. Staff Ray stated that he tried to intervene and requested they take turns taking breaks. Staff Ray stated that the staff were blaming one another for doing things while on shift. Staff Ray stated that at one point he had to raise his voice at both staff to get them to stop. Staff Ray tried to redirect them and asked them to focus on the residents. Staff Ray stated that he had to call home manager Leslie Shufelt. Staff Ray stated he witnessed Staff Curtis get in Resident A's face and also yell at Resident A while Resident A was in the bathroom. Staff Ray stated that Staff Curtis said, "*You've got five minutes to put pants on and ring because I'm not coming back in here!*" Staff Ray denied witnessing Staff Curtis push Resident A's head. Staff Ray stated that Staff Curtis was more aggressive verbally, that she speaks loudly, so when she yelled, it sounded like screaming. Staff Ray stated that staff's behavior was uncalled for and could have been prevented. Staff Ray stated that he spent about 20 minutes outside with Staff Curtis, trying to get Staff Curtis to calm down. Staff Ray stated that Staff Curtis left during her shift to go

to the main office and complain about Staff Torres. Staff Ray stated this behavior happened in front of residents, but the other residents present at that time, besides Resident A, were non-verbal.

During this on-site, I observed all six residents in the facility. They appeared clean and appropriately dressed.

On 08/06/2025, I received a copy of Resident A's *Assessment Plan for AFC Residents* dated 04/10/2025. It notes that Resident A utilizes a wheelchair, shower chair, gait belt, briefs, seatbelt, and ARJO lift (as needed). For toileting, it states that Resident A wears briefs, needs staff assistance with transfers to and from the toilet and with clean up. For dressing, Resident A requires staff assistance for most dressing. For walking/mobility it notes that Resident A uses a wheelchair, gait belt for mobility, and an ARJO lift as needed for transfers.

On 08/11/2025, I interviewed staff Vanessa Torres via phone. Staff Torres stated that on 07/31/2025, she was working with staff Kim Curtis. Staff Curtis requested assistance with Resident A in the bathroom. Staff Torres went to the bathroom, and Staff Curtis was yelling, because Resident A was sitting sideways on the toilet. Staff Curtis was yelling at Resident A to reposition themselves. Staff Curtis put her hands on Resident A's head and pushed Resident A a couple of times to get Resident A to move. Staff Torres stated she asked Staff Curtis why she would do that. Staff Torres stated she stepped in to assist Resident A, then went to assist another resident. Staff Torres stated that when she left out of the bathroom at that point, she felt it was okay to do so, because Staff Curtis was no longer yelling. Staff Torres stated Resident A was not speaking at all but was startled. Staff Torres stated that she spoke up for Resident A. Staff Torres stated that sometime later, assistant home manager Deontay Ray arrived at the home a little after the incident occurred. Staff Torres stated that she reported it to Staff Ray and home manager Leslie Shufelt. Staff Torres stated that she has never witnessed Staff Curtis put her hands on residents prior to this. Staff Torres stated that Staff Curtis does get frustrated at times, but not to this extreme.

Staff Torres further stated that at another time during this shift on 07/31/2025, Staff Curtis took over her duties feeding a resident after telling Staff Torres to go into the bathroom to assist Resident A with toileting. Staff Torres stated Staff Curtis told her to use the ARJO lift when Staff Torres needed assistance pulling Resident A's pants up. Staff Torres said no, and requested a two-person-assist because Resident A does not require an ARJO. Staff Torres stated that Staff Ray and Staff Curtis then went into the bathroom to assist Resident A. Staff Curtis started yelling at Resident A immediately after, and Staff Torres heard the screaming from the kitchen. Staff Torres stated that Staff Ray verbally prompted Resident A, and Resident A cooperated with Staff Ray. Staff Torres asked Staff Ray why he allowed Staff Curtis to yell. Staff Ray stated he didn't, that he was going to document it, and that he told Staff Curtis to step back and calm down. Staff Torres stated that Staff Ray made a call to home manager Staff Shufelt while he and Staff Curtis were in the garage. Staff

Torres stated that she could not make out what was said, but she heard Staff Curtis yelling at Staff Ray, while Staff Shufelt was on the phone.

Staff Torres stated that at one point, Staff Curtis was in the kitchen yelling at Staff Ray who was standing in the living room. Staff Curtis was complaining about having to do the dishes, saying it's not her job because she was the medication passer. Staff Curtis felt she should not have to cook, assist with showers, etc., and complained that Staff Torres didn't assist her with doing the dishes. Staff Torres stated that it was 9:00 am, and residents had just finished breakfast. Staff Torres stated that this is when she and Staff Curtis got into disagreement. Staff Torres stated that Staff Curtis walked off her shift around 9:30 am. Staff Torres stated that Staff Curtis resigned after learning this incident was reported to recipient rights.

On 08/15/2025, I interviewed former staff Kim Curtis via phone. Staff Curtis stated that she got Resident A up from bed and assisted Resident A to the bathroom. Resident A was facing the ledge. Staff Curtis stated she handed Resident A their clothing and left out of the bathroom. Resident A rang their call light, Staff Curtis went back in and noticed she grabbed the wrong clothing, so went and got another pair of pants. Staff Curtis stated she tried to reposition Resident A, and Resident A would not cooperate. Staff Curtis stated she got Staff Ray to help. Staff Curtis stated that Staff Ray yelled at Resident A to stand up, and that Staff Ray refused to assist Resident A. Staff Curtis denied yelling. Staff Curtis stated that she has a "*loud voice*" but said Staff Ray was yelling. Staff Curtis denied pushing Resident A's head. Staff Curtis stated that she quit because other staff refuse to help with tasks, and that management never does anything.

On 08/20/2025, I received a copy of the A*FC Licensing Division- Incident/Accident Report* dated 07/31/2025 and signed by staff Leslie Shufelt on 08/01/2025. The incident report states in summary that it was reported to management that staff Kim Curtis yelled at and pushed Resident A's head. A recipient rights complaint was filled out, and Staff Curtis was pulled from the schedule pending investigation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's representative, a copy of all of the following resident's rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	On 08/06/2025, I conducted an on-site at the facility. I spoke with area supervisor Jen Garcia and home manager Leslie

	Shufelt. They report that assistant home manager Deontay Ray overheard Staff Curtis yelling at Resident A. Resident A was interviewed. Resident A stated they don't feel safe, but did not explain why. Resident A denied having any issues with staff Kim Curtis but admitted hearing staff arguing. Resident A denied anyone yelled at them or pushed their head. Staff Deontay Ray was interviewed and confirmed that he witnessed staff Kim Curtis yelling at Resident A and bickering with Staff Vanessa Torres. Staff Ray stated the behavior happened in front of residents, but the other residents present at that time were non-verbal. On 08/11/2025, I interviewed staff Vanessa Torres. Staff Torres reported witnessing Staff Curtis yelling at Resident A during two separate instances, and at Staff Ray. On 08/15/2025, I interviewed staff Kim Curtis who denied the allegations. Staff Curtis stated Staff Ray was the staff that yelled at Resident A. There is a preponderance of evidence to substantiate a rule violation in regard to Resident A not being treated with consideration and respect. Both staff Deontay Ray and Staff Vanessa Torres reported witnessing staff Kim Curtis yelling at Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

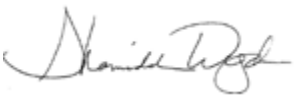
APPLICABLE RULE	
R 400.14308	**Resident Behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 08/06/2025, I conducted an on-site at the facility. Resident A was interviewed. Resident A denied anyone yelled at them or pushed their head. Staff Deontay Ray was interviewed. He stated he did not witness Staff Curtis push Resident A's head.

	On 08/11/2025, I interviewed staff Vanessa Torres. Staff Torres stated that she witnessed Staff Curtis push Resident A's head. On 08/15/2025, I interviewed staff Kim Curtis who denied the allegations. Staff Curtis denied pushing Resident A's head. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 08/20/2025, I conducted an exit conference with licensee designee Karon Lee via phone. I informed Karon Lee of the findings and conclusions.

IV. RECOMMENDATION

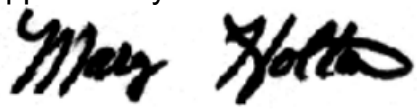
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home (capacity 3-6).



08/20/2025

Shamidah Wyden Date
Licensing Consultant

Approved By:



08/20/2025

Mary E. Holton Date
Area Manager