GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2025

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

RE: License #: AM250083741
Investigation #: 2025A0779048
Lara 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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250083741
Investigation #:	2025A0779048
Complaint Receipt Date:	08/11/2025
Investigation Initiation Date:	08/11/2025
Report Due Date:	10/10/2025
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dale McAlpine
Licensee Designee:	Paula Barnes
Name of Facility:	Lara House
Facility Address:	6151 W.Lake Road Clio, MI 48420
Facility Telephone #:	(810) 687-2350
Original Issuance Date:	06/22/2001
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 8/4/2025, residents were left alone in a van while staff entered the GHS building.	Yes

III. METHODOLOGY

08/11/2025	Special Investigation Intake 2025A0779048
08/11/2025	APS Referral Complaint was referred to APS centralized intake.
08/11/2025	Special Investigation Initiated - Telephone Spoke to ORR investigator.
08/19/2025	Inspection Completed On-site
08/21/2025	Contact - Telephone call made Spoke to administrator.
09/10/2025	Exit Conference Held with licensee designee, Paula Barnes.

ALLEGATION:

On 8/4/2025, residents were left alone in a van while staff entered the GHS building.

INVESTIGATION:

On 8/11/2025, a phone call was made to ORR (Office of Recipient Rights) investigator, Pat Shepard, who confirmed that she was investigating the same allegations. ORR Shepard stated that she had spoken to the two staff involved and they admitted that three residents were briefly left in the van alone. ORR Shepard stated that the staff claimed that one of the residents inside the GHS building was feeling dizzy and staff needed assistance from another staff to walk him out to the van. ORR Shepard stated that the staff did not provide a specific length of time the residents were left in the van alone.

On 8/19/2025, an on-site inspection was conducted and staff persons, Contica Hightower and Kanquesha Stevenson, were interviewed. They confirmed that they

were the two staff who transported four residents to the GHS building for blood draws/labs on 8/4/2025. Staff Hightower and Stevenson stated that they were having trouble with Resident A's blood draw, so Staff Hightower took Resident B, Resident C, and Resident D out to the van, where she sat with them. They reported that after his blood draw, Resident A was feeling light-headed and Staff Stevenson called Staff Hightower to ask her to come inside the building and assist her with walking Resident A out to the van. Staff Hightower admitted that she went into the building and left the other three residents in the van unsupervised. Staff Hightower reported that she shut the van off, rolled the windows down and took the keys with her. Staff Hightower and Staff Stevenson stated that the residents were left alone for only two minutes or less and that all the residents were in the van when they returned. Staff Hightower and Stevenson stated that none of the residents require any enhanced supervision but acknowledged that the residents are not able to be in the community unsupervised.

On 8/19/2025, Resident A, Resident B, Resident C, and Resident D were viewed to be clean, well-groomed, and appeared to be doing well. Due to their cognitive deficiencies, none of the residents were able to be interviewed and/or remembered the incident in question.

On 8/21/2025, a phone call was made to the administrator, Dale McAlpine, who stated that this incident should have never happened and that staff knew that the residents cannot be left unsupervised. Admin McAlpine stated that none of the residents have any required enhanced supervision but are not able to be in the community unsupervised. Admin McAlpine reported that the residents were left alone for only a few minutes and nothing negative took place.

The *Assessment Plan for AFC Residents* for Resident B, Resident C, and Resident D were reviewed. The plan for Resident B states that she is able to utilize public transportation unsupervised. The plans for Resident C and Resident D states that they require 24-hour supervision and cannot be out in the community unsupervised.

On 9/10/2025, an exit conference was held with licensee designee, Paula Barnes, who confirmed that this incident should have never happened. LD Barnes stated that the staff inside the GHS building should have asked GHS staff for assistance with walking Resident A out to the van and that the staff involved will be provided training to address this issue.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Staff person, Contica Hightower, admitted that on 8/4/2025, she left Resident B, Resident C, and Resident D alone in the van in the parking lot of the GHS building. It was confirmed that Resident C and Resident D require 24-hour supervision and are not allowed to be out in the community unsupervised. There was sufficient evidence found to warrant citation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

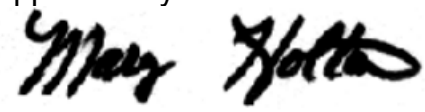
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, I recommend the status of this adult foster care license remain unchanged.

9/15/2025

Christopher Holvey Date
Licensing Consultant

Approved By:



9/17/2025

Mary E. Holton Date
Area Manager