GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2025

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

RE: License #: AS500403218
Investigation #: 2025A0604015
Van Dyke Home

Dear Ms. 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 (248) 972-9136.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

Enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS500403218 |
| | |
| **Investigation #:** | 2025A0604015 |
| | |
| **Complaint Receipt Date:** | 07/02/2025 |
| | |
| **Investigation Initiation Date:** | 07/02/2025 |
| | |
| **Report Due Date:** | 08/31/2025 |
| | |
| **Licensee Name:** | Central State Community Services, Inc. |
| | |
| **Licensee Address:** | Suite 201 - 2603 W Wackerly Rd<br>Midland, MI 48640 |
| | |
| **Licensee Telephone #:** | (989) 631-6691 |
| | |
| **Administrator:** | Alyssa Valenti |
| | |
| **Licensee Designee:** | Paula Barnes |
| | |
| **Name of Facility:** | Van Dyke Home |
| | |
| **Facility Address:** | 74501 Van Dyke Romeo, MI 48640 |
| | |
| **Facility Telephone #:** | (586) 752-6686 |
| | |
| **Original Issuance Date:** | 08/11/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/11/2025 |
| | |
| **Expiration Date:** | 02/10/2027 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A has unexplained injuries including recent abrasions and previously broken ribs. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/02/2025 | Special Investigation Intake<br>2025A0604015 |
| 07/02/2025 | APS Referral<br>Referral received from Adult Protective Services (APS). Assigned to APS Worker, Emily Poley |
| 07/02/2025 | Special Investigation Initiated - Letter<br>Email to APS Worker, Emily Poley |
| 07/03/2025 | Inspection Completed On-site<br>Completed unannounced onsite investigation. Interviewed Staff, Traci Hascall, Anitra Bryant and Resident A. Received copies of incident reports. |
| 08/18/2025 | Contact - Document Sent<br>Email to and from APS Worker, Emily Poley. APS did not substantiate. Guardian reported to APS that Resident A has moved |
| 08/18/2025 | Contact - Document Sent<br>Email to Alyssa Valenti and Paula Barnes |
| 08/19/2025 | Contact- Document Sent<br>Email to Alyssa Valenti and Paula Barnes. Requested additional information |
| 08/20/2025 | Contact- Document Received<br>Email from Alyssa Valenti |
| 08/22/2025 | Contact- Document Received<br>Email from Alyssa Valenti. Received copies of Resident A's Person Centered Plan (PCP), health care appraisal, resident information record, incident report, and Henry Ford Hospital discharge papers |

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| 08/25/2025 | Contact- Document Sent<br>Email to Alyssa Valenti. Received return email. |
| 08/28/2025 | Contact- Document Sent<br>Email to Melissa Sprague, Macomb County Community Mental Health Case Manager |
| 09/02/2025 | Contact- Document Received<br>Email from Melissa Sprague. Sent return email |
| 09/04/2025 | Exit Conference<br>Completed exit conference by phone with Alyssa Valenti |

**ALLEGATION:**

**Resident A has unexplained injuries including recent abrasions and previously broken ribs.**

**INVESTIGATION:**

I received a complaint regarding the Van Dyke Home on 07/02/2025. It is alleged that Resident A resides at the Van Dyke Home and is diagnosed with chronic developmental delay and is non-verbal. On 06/24/2025, Resident A was observed to have superficial abrasions on his back and neck that were not present on the morning of 06/24/2025. On 05/11/2025, Resident A was taken to the hospital due to having broken ribs, in which no explanation was provided by the group home. There are concerns that Resident A is being abused.

On 07/03/2025, I completed an unannounced onsite investigation. I interviewed Staff, Traci Hascall, Anitra Bryant and Resident A. I received copies of incident reports.

On 07/03/2025, I interviewed Acting Home Manager and Medication Coordinator, Traci Hascall. She stated that she had not seen staff do anything to hurt Resident A. Ms. Hascall stated that Resident A was bitten and scratched by Resident B causing scratches and marks on his back. Resident B has been in the hospital since he assaulted Resident A. She also indicated that Resident A recently slipped in water after another resident took a shower and left water on the floor in hallway. Ms. Hascall believed that Resident A had broken ribs before he moved into the home but does not have any information as to how they were broken. She stated that the third shift noticed he had some bruising around ribs. Ms. Hascall indicated that Resident A can communicate what he wants such as saying “pop” or can say he is “hurt” but is unable to describe what happened.

On 07/03/2025, I interviewed Staff, Anitra Bryant. She believes that injuries to Resident A are old. She stated that she saw old marks on Resident A's back when she started at home. She indicated that Resident A did have bruises from the incident with Resident B. Ms. Bryant indicated that the only violent person in home is Resident B and he is currently at a psychiatric hospital. She stated that Resident B makes verbal and physical threats, and it is progressing.

On 07/03/2025, I attempted to interview Resident A. Resident A has limited verbal ability and was unable to answer questions as to how injuries occurred. Resident A did lift his right pant leg during interview to expose an area with scrap and bruise. Ms. Hascall indicated that she believed Resident A got this injury when he slipped in water after another resident took a shower.

On 07/03/2025, I received a copy of incident reports for Resident A. The incident report dated 07/01/2025 indicates that a housemate took a shower and left water on the floor in hallway. Resident A came out of room and slipped on water in hallway and has a red scratch mark under the left eye. The incident report dated 06/24/2025 indicates that Resident B was coming out of Resident A's room and he was not supposed to be in there. Staff noticed a bite mark and scratches on Resident A. Staff separated residents. A second incident report dated 06/24/2025 indicates that staff were checking Resident A for injuries and Resident B became verbally aggressive and abusive to staff and Resident A, trying to attack him. Staff separated the residents and Resident A was taken to the emergency room. The incident report dated 06/12/2025 indicates that staff were assisting Resident A in the bathroom. When staff helped pull down his pull up staff noticed a bruise on his inner right thigh approximately the size of a soft ball. Resident A did not show signs or pain and still will continue to monitor. The incident report dated 05/10/2025 indicates that morning staff came in at 8:00 am and third shift showed them the bruising on Resident A's chest, left side. Staff called the assistant manager right away and instructed staff to take Resident A to urgent care. Urgent care sent Resident A to Henry Ford Hospital emergency.

On 08/18/2025, I received an email from APS Worker, Emily Poley. She indicated that APS did not substantiate the allegations. She also reported that Resident A has since been moved from home.

On 08/22/2025, I received email from Administrator, Alyssa Valenti. She confirmed that Resident A was moved from the home on 07/18/2025. On 08/25/2025, Ms. Valenti indicated that he was moved as it was reported he feared one of the other residents in home.

On 08/22/2025, I received copy of Resident A's Person Centered Plan (PCP) dated 07/03/2024, current health care appraisal dated 03/20/2025, resident information record, incident report dated 05/10/2025 and Henry Ford Hospital Discharge papers dated 05/13/2025. Resident A's resident information record indicates that he was placed in the home on 04/03/2025. Resident A's discharge papers from Henry Ford Hospital indicate that he was at the hospital from 05/12/2025-05/13/2025. Resident A was seen at hospital for multiple rib fractures involving four or more ribs. Resident A's PCP indicates that staff will provide 24- hour supervision within the home and during leisure/community outings. Resident A requires indirect supervision (within earshot) in the home and direct supervision (within eyesight) in the community. Staff will ensure that Resident A is maintained in a safe and structured environment. His PCP also indicates that due to his unstable gait he should not be left in the shower alone. He may struggle to get himself up from the bed/chair. Caregivers should assist Resident A with standing up. He also relies on caregivers to assist with walking further distances and due to this unsteady gait may need to hold the hands of his caregivers to remain safe.

On 09/02/2025, I received email from Resident A's Macomb County Community Mental Health Case Manager, Melissa Sprague. Ms. Sprague indicated that her concern regarding the home was regarding the manager quitting and an assistant manager taking on most the responsibilities.

I completed an exit conference by phone on 09/04/2025 with Administrator, Alyssa Valenti. I informed her of the violation found and that a copy of the special investigation report would be mailed once approved. I also informed her that a corrective action plan would be requested. Ms. Valenti stated that she has a whole new team and new manager at the Van Dyke home. All the old staff are gone. She indicated that they were having staffing issues and a very high staff turnover at home. She believed that staff may not have been documenting injuries thinking the previous shift had done so, however, the staff working during Resident A's placement are no longer there. Ms. Valenti also stated that when Resident A was seen at hospital his broken ribs were in various stages of healing, and she believed there may have been issues with bone density.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Resident A's personal needs for supervision, protection and safety were not met at the home. Resident A was placed at the Van Dyke home from 04/03/2025- 07/18/2025. During his placement he was found to have injuries to ribs, eye, chest, |

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| | back, inner thigh and right leg. Resident A was in a physical altercation with Resident B and sustained injuries to chest and back on 06/24/2025. It was also reported that Resident A slipped in water on 07/01/2025 and the incident report notes he had scratch under left eye. Home Manager, Traci Hascall believed Resident A also injured his leg during this incident, however, injury to leg is not noted on incident report. Resident A was found to have bruise on thigh on 06/12/2025, however, cause was unknown. Resident A was seen at Henry Ford Hospital on 05/12/2025 and found to have broken ribs. Staff interviewed believed that Resident A's ribs were broken prior to moving into the home, however, the date and cause of the injury is unknown. Resident A's PCP dated 07/03/2024 indicates that he requires direct supervision (within eyeshot) in the community and indirect supervision (within earshot) in the home. Despite the need for supervision, Resident A sustained multiple injuries. |
| **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:**<br>**(a) Use any form of punishment.**<br>**(b) Use any form of physical force other than physical restraint as defined in these rules.** |
| **ANALYSIS:** | There is not enough information to determine that Resident A was being physically abused by staff at home. Resident A has limited verbal ability, and the cause of all his injuries is unknown. Resident A was found to have injuries to ribs, eye, chest, back, inner thigh and right leg. Resident A was in a physical altercation with Resident B on 06/24/2025. It was also reported that Resident A slipped in water on 07/01/2025 and the incident report notes he had scratch under left eye. Home Manager, Traci Hascall believed Resident A also injured his leg during this incident. Resident A was moved from the home on 07/18/2025. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

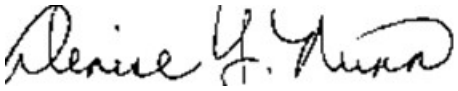
## IV. RECOMMENDATION

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

09/04/2025

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/01/2025

Denise Y. Nunn — Date
Area Manager