



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

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

RE: License #: AS630405663
Investigation #: 2026A0465007
Seymour 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,

A handwritten signature in cursive script that reads "Stephanie Gonzalez".

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS
 SPECIAL INVESTIGATION REPORT
 THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS630405663
Investigation #:	2026A0465007
Complaint Receipt Date:	12/09/2025
Investigation Initiation Date:	12/15/2025
Report Due Date:	02/07/2026
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Barnes
Licensee Designee:	Paula Barnes
Name of Facility:	Seymour Home
Facility Address:	241 Cheltenham Oxford, MI 48371
Facility Telephone #:	(248) 572-6040
Original Issuance Date:	03/04/2021
License Status:	REGULAR
Effective Date:	03/01/2024
Expiration Date:	02/28/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
On 12/5/2025, direct care staff, Tashera Muskey-Valley, verbally abused and threatened Resident A.	Yes

III. METHODOLOGY

12/09/2025	Special Investigation Intake 2026A0465007
12/09/2025	APS Referral Adult Protective Services Referral assigned to Precious Whitman for investigation
12/15/2025	Special Investigation Initiated - Letter Email exchange with Adult Protective Services Worker, Ms. Whitman
01/09/2026	Inspection Completed On-site I conducted an onsite investigation at the facility; I completed a walk-through of the home, observed residents, reviewed resident files, and interviewed direct care staff, Regina Wheaton.
01/12/2026	Contact - Document Received Email exchange with Ms. Whitman
01/12/2026	Contact - Document Received Received a copy of a voice recording via email from Ms. Whitman
01/12/2026	Contact – Telephone call made I left a voice mail for Guardian A1; Requested a return call
01/20/2026	Contact - Document Received Facility documents received via email
01/20/2026	Contact - Telephone call made I spoke to ex-direct care staff, Tashera Muskey-Valley, via telephone
01/21/2026	Contact – Telephone call made I left a second voice mail for Guardian A1; No return call as of yet
01/21/2026	Exit Conference I conducted an exit conference with licensee designee, Paula Barnes, via telephone

ALLEGATION:

On 12/5/2025, direct care staff, Tashera Muskey-Valley, verbally abused and threatened Resident A.

INVESTIGATION:

On 12/9/2025, a complaint was received, alleging that, during the month of August 2025, direct care staff, Tashera Muskey-Valley, verbally abused and threatened Resident A. The complaint stated that Resident A has cognitive impairment, has limited verbal communication, and is medically fragile. The complaint stated that on 12/5/2025, Resident A was having a behavior and Ms. Muskey-Valley screamed and cursed at him. The complaint stated that Ms. Muskey-Valley told Resident A to “shut the fuck up,” and “sit the fuck down.” The complaint stated that Ms. Muskey-Valley also told Resident A that he was going to jail.

On 12/15/2025 and 1/12/2026, I spoke to Adult Protective Services Worker, Precious Whitman, via email exchange. Ms. Whitman stated that she has completed an investigation of this complaint. Ms. Whitman stated that she did substantiate against direct care staff, Tashera Muskey-Valley, for verbal abuse. Ms. Whitman stated her investigation is now closed.

On 1/9/2026, I conducted an onsite investigation at the facility. I completed a walk-through of the home, observed residents, reviewed resident files, and interviewed direct care staff, Regina Wheaton. The facility specializes in caring for the developmentally disabled and mentally impaired populations. At the time of my onsite investigation, there were four residents residing at the facility, including Resident A. All four residents have limited communication skills and/or are non-verbal, therefore I was unable to interview residents for this investigation. I observed the home to be clean and in good condition. I observed all residents to be properly dressed and with adequate hygiene. I did not observe any concerns.

The *Face Sheet* stated that Resident A was admitted to the facility on 12/14/2021 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia, ADHD, and Anxiety. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of aggressive behavior, has limited safety skill knowledge, limited communication and understanding, can independently complete self-care tasks and does not require use of assistive devices. The *Incident/Accident Report*, dated 12/5/2025, stated the following:

12/5/2025 at 2:30pm; Completed by Regina Wheaton: Home supervisor (Regina Wheaton) was transporting another resident from his day program when I received a phone call from staff (Ms. Muskey-Valley), stating that Resident A was having an outburst and was destroying the home. He was throwing things at the residents that were in the home. He put his hand in the window and broke the glass. His arm was bleeding and Ms. Muskey-Valley called 911. Resident A was transported by ambulance for medical attention.

I reviewed the *Employee Files* for Ms. Muskey-Valley, which stated that she was suspended from work on 12/5/2025, pending an investigation into this complaint. The *Employment Termination Letter*, dated 1/14/2026, stated that Ms. Muskey-Valley's employment was terminated effective 1/14/2025 due to the outcome of the APS investigation, which was substantiated her for Abuse-Class III.

I spoke to direct care staff, Regina Wheaton, who stated that she has worked at the facility for six years. Ms. Wheaton stated, "I was working the day of this incident. Ms. Muskey-Valley normally worked the night shift, but on 12/5/2025, she came in for the day shift. In the afternoon, I left the facility around 2:45 pm to pick up another resident from day program. While enroute, I received a call from Ms. Muskey-Valley at 3:05 pm. She called me and was very upset. She said that Resident A was threatening her and the other residents and that he had broken a window. I tried to calm her down and told her to call 911, which she already had done. I did not hear her cuss or scream at Resident A when I was on the phone with her, but I could hear Resident A screaming in the background. He has a history of aggressive behavior, and this is something he does do when he is upset."

On 1/12/2026, I reviewed a copy of the voice recording from the 12/5/2025 incident. The recording was muffled at times, but I was able to hear Resident A and Ms. Muskey-Valley's voices throughout the recording. Throughout the call, I could hear both Resident A and Ms. Muskey-Valley screaming and yelling. Throughout the recording, Ms. Muskey-Valley can be heard saying to Resident A, "Hit me! Hit me! I will bust your little ass!", "I'll beat the fuck out of you!", and "Sit your ass down!"

On 1/20/2026, I spoke to ex-direct care staff, Tashera Muskey-Valley, via telephone. Ms. Muskey-Valley stated that she worked at the facility for five years prior to her termination from the facility. Ms. Muskey-Valley stated, "I was working the day of the incident, and I did say things I shouldn't have to Resident A. But I want to explain why. I normally worked third shift, and I had never seen Resident A act out. That day, I came in for the day shift and he began having a behavior out of nowhere. It was sudden and for no reason. I had never seen that side of him. I felt like I was in flight or fight mode.

He hit me with a trash can and was screaming and trying to attack me and the other residents. I felt like I had to protect them from him. I did try to redirect him and talk to him and that didn't work. He kept becoming more violent. I was scared and I tried to stay strong, but I was there alone with three vulnerable residents, and I felt like I had to protect us. I told him if he hit me, I would hit his ass back. I did cuss at him, and I know I shouldn't have, but I was scared. I was never going to physically hurt him. I was just trying to get him to leave us alone." Ms. Muskey-Valley acknowledged that this complaint is true.

On 1/21/2026, I conducted an exit conference with licensee designee and administrator, Paula Barnes, via telephone. Ms. Barnes is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	<p>(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following:</p> <p>(f) Subject a resident to any of the following:</p> <p>(i) Mental or emotional cruelty.</p> <p>(ii) Verbal abuse.</p> <p>(iii) Derogatory remarks.</p> <p>(iv) Threats.</p>
ANALYSIS:	<p>According to the voice recording and Ms. Muskey-Valley, she did scream, yell, curse at, and threaten Resident A on 12/5/2025, while on duty at the facility.</p> <p>Based on the information above, there is sufficient information to confirm that, on 12/5/2025, Ms. Muskey-Valley verbally abused and threatened Resident A.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez

1/22/2026

Stephanie Gonzalez
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

02/17/2026

Denise Y. Nunn
Area Manager

Date