GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

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

RE: License #: AM250083741
Investigation #: 2022A0779033
Lara House

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 (517) 284-9700.

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 #:	2022A0779033
Complaint Receipt Date:	04/22/2022
Investigation Initiation Date:	04/25/2022
Report Due Date:	06/21/2022
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 McAlphine
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:	08/01/2020
Expiration Date:	07/31/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A requires one-on-one supervision at all times, during waking hours. Staff did not provide proper supervision on 4/21/22, as Resident A was found in a bathroom with a female resident before dinner time and later the same day was found in another male resident's bedroom with that resident.	Yes

III. METHODOLOGY

04/22/2022	Special Investigation Intake 2022A0779033
04/25/2022	APS Referral Complaint was referred to APS centralized intake.
04/25/2022	Special Investigation Initiated - Telephone Spoke to recipient rights investigator, Kim Nguyen-Forbes.
04/26/2022	Inspection Completed On-site
05/03/2022	Contact - Telephone call made Interview conducted with staff person, Lisa Pennyman.
05/03/2022	Contact - Telephone call made Spoke to Resident A's GHS case manager.
05/23/2022	Exit Conference Conducted with administrator, Dale McAlphine.

ALLEGATION:

Resident A requires one-on-one supervision at all times, during waking hours. Staff did not provide proper supervision on 4/21/22, as Resident A Awas found in a bathroom with a female resident before dinner time and later the same day was found in another male resident's bedroom with that resident.

INVESTIGATION:

On 4/25/22, a phone conversation took place with recipient rights investigator, Kim Nguyen-Forbes, who confirmed that she was investigating the same allegations. Ms.

Nguyen-Forbes stated that Resident A just arrived at this home on 4/21/22 and is assigned a 1-on-1 staff due to this placement being a step down from the locked down facility where he came from. She stated that Resident A's GHS treatment plan states that he is to be provided 1-on-1 staffing during waking hours and that staff are to stay in the same room as him, except for when toileting or private time in his bedroom. Ms. Nguyen-Forbes reported that staff person, Jenny Beatty, was assigned as Resident A's 1-on-1 staff on 4/21/22 and when he was found unsupervised on two separate occasions that day.

On 4/26/22, an on-site inspection was conducted. Resident A was viewed to be clean, well groomed and appeared to be doing well. Due to his cognitive deficiencies and the fact that Resident A is non-verbal, Resident A was not able to be interviewed.

Resident A's assessment plan states that he is non-verbal and only requires minimal assistance and prompting from staff in order to complete all his activities of daily living. Resident A's GHS treatment plan was reviewed and it was confirmed that he requires 1-on-1 staffing during waking hours. The plan further describes 1-on-1 staffing as staff remaining in the same room as Resident A at all times, except when Resident A is toileting or requests "private time".

During the on-site inspection, assistant manager, Jenny Beatty, was interviewed. She confirmed that she was Resident A's assigned 1-on-1 staff on 4/21/22 and that she was aware of the allegations. When asked about two separate occasions when Resident A may have been left unsupervised on 4/21/22, Ms. Beatty stated that she was putting his file together at the dining room table and she saw him go into the bathroom. She stated that she did not know that Resident B was already in the bathroom. She reported that another staff found Resident A and Resident B sitting on the bathroom floor together. Ms. Beatty admitted that she did not follow him to the bathroom or check on him after he entered the bathroom. When asked to describe the second incident, Ms. Beatty stated that she was again sitting at the dining room table when she saw Resident A enter the bathroom. She reported that this is when she went to the staff office to grab something and came right back out to the dining room. Ms. Beatty stated that staff person, Lisa Pennyman, came to her and reported that she found Resident A in Resident C's bedroom alone with Resident C. Ms. Beatty confirmed that she was in-serviced on Resident A's treatment plan and understood what 1-on-1 staffing meant, but that it was her understanding that Resident A was only on 1-on-1 staffing for communication skill building and not for safety issues.

Resident B and Resident C both suffer from significant developmental delays and are non-verbal. Due to their cognitive deficiencies, neither Resident B nor Resident C were able to be interviewed.

On 4/26/22, staff person, Journey Whitehead, was interviewed, who confirmed that she was working with Ms. Beatty on 4/21/22. Ms. Whitehead stated that she was in the kitchen cooking, Ms. Beatty was working at the dining room table and Resident A was in eyesight in the living room. She stated that when she looked up, Resident A was gone

from the living room, so she went to go look for him and she found him sitting on the bathroom floor with Resident B. She stated that all the staff work as a team, but admitted that Ms. Beatty did not ask her to watch Resident A and/or be his 1-on-1 staff.

On 4/26/22, an interview was conducted with staff person, Kristy Benton-Mayes, who confirmed that she worked with Ms. Beatty on 4/21/22. She stated that when she was coming out of the laundry room, she passed Ms. Beatty in the hallway as Ms. Beatty was going into the staff office. Ms. Benton-Mayes reported that at this time, she heard Ms. Whitehead calling out Resident A's name, so she went to go help Ms. Whitehead find Resident A. She stated that they went to Resident A's bedroom first, before finding him in the bathroom with Resident B.

On 5/3/22, a phone interview was conducted with staff person, Lisa Pennyman, who confirmed that she worked on 4/21/22. Ms. Pennyman stated that she was cleaning in the back hallway when she saw Resident A alone with Resident C in Resident C's bedroom. She stated that she knew Resident A was not supposed to be in there so she took Resident A out to the dining room area where other staff were. Ms. Pennyman thinks that Ms. Beatty was in the front of the home, but she was not exactly sure where Ms. Beatty was at that time. She stated that she is sure though that Ms. Beatty was not in the back hallway or in Resident C's bedroom with Resident A. Ms. Pennyman reported that she did not see Resident A enter Resident C's bedroom, did not know that he was in there, and that she was not asked to keep an eye on Resident A and/or be his 1-on-1 staff.

On 5/3/22, a phone conversation took place with Resident A's GHS case manager, Penny Tohms. She stated that Resident A has 1-on-1 staffing for the main purpose of building communication skills with the staff, but to also prevent aggressive behaviors that Resident A is prone to displaying in the past. Ms. Tohms confirmed that Ms. Beatty was in-serviced on Resident A's treatment plan and what 1-on-1 staffing consists of.

/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:	Resident A's GHS treatment plan clearing states that Resident A is to be provided 1-on-1 staffing during waking hours. The plan further describes 1-on-1 staffing as staff remaining in the same room as Resident A at all times, except when Resident A is toileting or requests "private time". On two separate occasions on 4/21/22, Resident A was found by staff, who were not his assigned 1-on-1 staff person at the time, to be unsupervised and alone in other rooms with other residents. On these two occasions, Resident A was not provided the supervision and protection as specified in his written assessment or GHS treatment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/23/22, an exit conference was conducted with administrator, Dale McAlphine. He was informed that a written corrective action plan was required to address the licensing rule violation mentioned above.

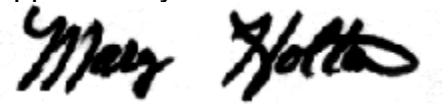
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

6/9/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



6/9/2022

Mary E Holton Date
Area Manager