GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

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

RE: License #: AS630405663
Investigation #: 2022A0612015
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) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405663
Investigation #:	2022A0612015
Complaint Receipt Date:	08/08/2022
Investigation Initiation Date:	09/13/2022
Report Due Date:	09/07/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	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:	09/04/2021
Expiration Date:	09/03/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff are leaving residents in wet briefs/adult diapers.	Yes

III. METHODOLOGY

08/08/2022	Special Investigation Intake 2022A0612015
09/13/2022	Special Investigation Initiated - Telephone Telephone call to complainant
09/13/2022	Contact - Document Sent I made a referral to Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR)
09/14/2022	Inspection Completed On-site On 09/14/22, I completed an unscheduled onsite investigation. I interviewed supervisor, Jeffrey Brand, direct care staff, Trashena Clemons, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F
09/15/2022	Contact - Telephone call made I completed a telephone interview with direct care staff Brandon Grass (legal name: Brittany Grass)
09/19/2022	APS Referral I made a referral to Adult Protective Services (APS) Centralized Intake
09/19/2022	Contact - Telephone call made I completed telephone interviews with direct care staff, Carl Gilbert, Micaiah Bullock, and program manager Jamilla Cheatom
09/19/2022	Contact - Document Received Recipient Rights Specialist Rishon Kimble emailed me copies of Resident A, Resident B, and Resident C's MORC Individual Plans of Service (IPOS)
09/19/2022	Contact - Telephone call made I made telephone calls to direct care staff, Ivan Hopson, Shamari Sheppard and Roger Criss. I called the phone number provided for

	program coordinator, Lakenya Jones. The phone number was no longer in service.
09/20/2022	Contact - Telephone call made I completed a telephone interview with direct care staff, Tiffany Jones
09/22/2022	Exit Conference Telephone call to licensee, Paula Barnes

ALLEGATION:

Direct care staff are leaving resident in wet briefs/adult diapers.

INVESTIGATION:

On 09/13/22, I received a complaint that indicates, the complainant was scheduled to work on 08/04/22 from 7:00 am-7:00 pm. She arrived 30 minutes late, two staff (names not provided) were sitting in the living room watching TV. A resident (name not provided) called for assistance with changing her brief at 7:15 am, staff had not attended to her. This issue has been happening all week, midnight staff does not change the resident's brief. When the morning shift arrives, the resident is wet. Direct care staff, Shamari left a resident in a wet brief and clocked out. Shamari did not change the resident or tell any other staff that the resident was wet. This is an ongoing issue. Staff are not changing the resident. Every morning her bed is wet all the way down to the mattress. I initiated my investigation with a call to the complainant. The phone number provided is no longer in service. The complaint indicates this employee ended her employment with the company on 08/05/22.

On 09/14/22, I completed an unscheduled onsite investigation. I interviewed supervisor, Jeffrey Brand, direct care staff, Trashena Clemons, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F.

On 09/14/22, I interviewed supervisor Jeffrey Brand. Mr. Brand stated he has worked at this home for 20 years. He was employed by the previous provider then, in 2020 Central State took over the home. He was previously the assistant home manager and was recently promoted to supervisor. Mr. Brand stated there have been several staff who recently left and are no longer employed with the company. Shamari Sheppard, Shardaisha (Shar) Carter, and Ivan Hopson are no longer employed with the company. Shardaisha (Shar) Carter quit in the middle of her shift after being notified that she was involved in a Recipient Rights investigation. Shamari Shepard is out on maternity leave, and Ivan Hopson stopped showing up for his scheduled shifts.

Mr. Brand stated Resident A, Resident B, and Resident C wear briefs and need staff assistance with changing their briefs. Mr. Brand stated staff are not required to

document on data sheets when residents are changed. However, when a staff changes a resident, they are expected to write the time and their initials on the brief. Residents should be changed every two hours. At the end of each shift, staff are expected to check each resident to make sure that they are dry before ending their shift. Mr. Brand stated on an unknown date, direct care staff, Tiffany Jones, told him that direct care staff, Brandon Grass was leaving residents in wet briefs and not changing the blue pad on their beds regularly. Mr. Grass was transferred to another home within the providers' network. Since then, there have been no issues regarding the residents not being changed properly or left in wet briefs. Mr. Brand stated a few weeks ago, on an unknown date, he worked on shift with Mr. Grass. During their shift, the Wi-Fi in the home went out. Resident A got very upset as she thought someone in the company turned the Wi-Fi off. Resident A destroyed property and scratched Mr. Brand's personal vehicle. Mr. Brand called the police and made a police report regarding the damage to his vehicle. Mr. Brand provided a copy of the August 2022, Seymour Home staff schedule and phone numbers for the Seymour home direct care staff.

On 09/14/22, I reviewed the Seymour Home staff schedule dated 07/23/22 – 08/05/22. On 08/04/22, the following staff worked:

Ivan Hopson and Shamari Sheppard 3:00 pm – 7:00 am (08/03/22 – 08/04/22)
Shardaisha (Shar) Carter and Jeffrey Brand 7:00 am – 7:00 pm
Shamari Sheppard and Ivan Hopson 7:00 pm – 7:00 am

On 09/14/22, I interviewed Resident A. Resident A is Deaf. This interview was conducted via relay phone (interpreter #26909.) Resident A stated one to two weeks ago on an unknown date, she was left in a wet brief for three to four hours. This occurred in the morning, the staff on shift was Brandon Grass. Resident A explained when she needs her brief to be changed, she calls staff using her tablet. Her tablet requires Wi-Fi. On this day, the Wi-Fi was "all messed up," and eventually stopped working. Resident A stated she called five times and told staff that she was wet and asked that they please come and change her. Resident A stated the staff told her that he was too busy. Resident A stated her bedding was also wet and needed to be changed. She changed her bedding independently. Resident A stated this was a one-time occurrence not an ongoing issue. Resident A stated on the day this occurred, she informed program coordinator Lakenya Jones about this issue.

On 09/14/22, I interviewed Trashena Clemans. Ms. Clemans stated she started two days ago; she is the assistant manager. Ms. Clemans stated she has only worked on shift with supervisor, Jeffery Brand and direct care staff, Tiffany Jones. Ms. Clemans stated Resident A, Resident B, and Resident C wear briefs. She has not observed any resident being left in a wet brief. Ms. Clemans did not have any additional information to provide.

On 09/14/22, I interviewed Resident B. Resident B is blind and non-verbal. Resident B wears briefs. I observed Resident B sitting in the living room. She was unable to answer questions related to this investigation.

On 09/14/22, I interviewed Resident C. Resident C has a colostomy bag and wears briefs. I observed that Resident C's colostomy bag was empty. Resident C is not a reliable source of information. Resident C answered yes and/or grunted to all questions asked. Resident C was unable/unwilling to answer open ended questions. When asked if her brief is changed regularly Resident C stated "yes".

On 09/14/22, I interviewed Resident D. Resident D was observed sitting in a chair in the living room, he was appropriately groomed. Resident D was holding a toy truck. He showed me the truck. Resident D is nonverbal, he was unable to answer questions related to this investigation.

On 09/14/22, I interviewed Resident E. Resident E was observed sitting on the couch in the living room. She was appropriately groomed. Resident E acknowledged me with a smile and a wave. Resident E was unable to answer questions related to this investigation.

On 09/14/22, I interviewed Resident F. Resident F was observed sitting in the living room, he was appropriately groomed. Resident F had a stuffed Iron Man toy. When asked interview questions Resident F repeated the words, "Iron Man" and "Dad." Resident F was unable to answers questions related to this investigation.

On 09/15/22, I completed a telephone interviewed direct care staff Brandon Grass. Brandon's legal name is Brittany Grass. This report will referrer to direct care staff, Grass using his preferred name, Brandon, his preferred pronouns he/him, and the title, Mr.

Mr. Grass has been working for the company for two and a half months. Mr. Grass stated Resident A, Resident B, and Resident C wear briefs. Mr. Grass explained because he is biologically female, he provides personal care to female residents. Mr. Grass stated Resident B and Resident C's brief is changed every hour and a half. Staff are not required to complete a data sheet to record when a resident is changed this is just a routine that staff follow. Resident A does not like anyone to enter her bedroom so when she needs to be changed Resident A uses her tablet to call the staff and tell them that her brief is wet, and she needs to be changed. Mr. Grass stated there are times when Resident A calls and asks to be changed, that he is assisting another resident. Resident A has to wait for him to finish caring for that resident before he can come and change her brief. Mr. Grass stated when he completes a visual check on Resident A without her calling on her tablet, Resident A will give him a thumbs up if she is dry or a thumbs down if she is wet and needs her brief to be changed. Mr. Grass stated when a resident is changed the time is written on their brief. The residents should be changed at least every two hours. Mr. Grass stated he has not observed any residents being left in a wet brief or not being changed every two hours. Mr. Grass denied that he has ever left any resident in a wet brief for longer than two hours.

Mr. Grass stated on an unknown date, he estimates it may have been 08/29/22 or 08/30/22, he worked from 7:00 am – 3:00 pm with supervisor, Jeffery Brand. During the

shift, the Wi-Fi at the home went out. Resident A got very upset as she thought someone in the company turned the Wi-Fi off. Resident A destroyed property and scratched Mr. Brand's personal vehicle. Mr. Grass stated on this day he changed Resident A at noon. He stated Resident A was not wet again during his shift and she did not require her brief to be changed again. Mr. Grass stated Resident A did not ask to be changed via a phone call, because she was unable to call without Wi-Fi, she also did not ask to be changed face to face.

On 09/19/22, I completed a telephone interview with direct care staff, Carl Gilbert. Mr. Gilbert stated, he has worked at the home for approximately two months. He works on the midnight shift. He usually works with direct care staff, Brandon Grass, or Tiffany Jones. Mr. Gilbert stated Resident A, Resident B, and Resident C wear briefs. They are changed every two hours. Staff are not required to complete a data sheet to record when a resident is changed. Mr. Gilbert stated because he is a male, he does not change female residents. As such, he has not personally changed Resident A, Resident B, or Resident C's brief. However, he stated when he works with Mr. Grass or Ms. Jones, he witnesses them changing the resident's briefs every two hours. Mr. Gilbert denied that any resident is left in a wet brief for longer than two hours. Mr. Gilbert stated Resident A communicates all her needs by calling staff using her tablet. He stated, staff respond to her immediately. Mr. Gilbert stated he has no concerns regarding the care the residents are receiving.

On 09/19/22, I completed a telephone interview with direct care staff, Micaiah Bullock. Ms. Bullock stated she has been employed with the company for one and a half months. Ms. Bullock picks up shifts at the Seymour home, she does not work there regularly. Ms. Bullock estimates that she has worked approximately five shifts at the home. Ms. Bullock stated Resident A, Resident B, and Resident C wear briefs. Staff change Resident A and Resident B's brief every two hours or as needed. When the residents are changed it is the expectation that staff write their initials and the time on the brief. Ms. Bullock stated she has not observed any resident being left in a wet brief for longer than two hours. Ms. Bullock stated Resident A uses her tablet to call staff and let them know when she needs her brief to be changed. Ms. Bullock also completes visual checks on Resident A. Ms. Bullock stated on 09/15/22, she worked the morning shift when she checked on Resident E there was menstrual blood on her bedsheets, she had bled through her brief. Ms. Bullock stated she gave Resident E a shower and changed her bedding. She is unsure if Resident E bled through her brief or if Resident E was not changed in a timely manner.

On 09/19/22, I completed a telephone interview with program manager Jamilla Cheatom. Ms. Cheatom oversees all thirty of Central States homes. Ms. Cheatom stated program coordinator, Lakenya Jones was terminated on 09/16/22. Her termination was not related to this investigation. Ms. Cheatom stated she has not received any complaints regarding the residents at Seymour home not being changed regularly or being left in wet briefs. Ms. Cheatom stated she believes this report was made as retaliation by a staff who is no longer employed with the company.

On 09/19/22, Recipient Rights Specialist, Rishon Kimble emailed me a copy or Resident A, Resident B, and Resident C's MORC Individual Plans of Service. Resident B's MORC Individual Plan of Service (IPOS) dated 06/01/22, indicates Resident B requires physical assistance with hygiene tasks. Resident C's MORC IPOS dated 06/01/22, indicates Resident C requires staff assistance with Activities of Daily Living (ADL's). Resident A's MORC IPOS dated 04/05/22, indicates Resident A can coordinate with her staff when she needs assistance. Resident A wears briefs and requires assistance with ADL care.

On 09/19/22, I called the phone number provided for direct care staff, Ivan Hopson. The phone rang a busy signal. I was unable to leave a voicemail. Then, I called the phone number provided for direct care staff Shamari Sheppard. I received a message that the subscriber is no longer in service. Lastly, I called the phone number provided for direct care staff Roger Criss. I received a message that stated the person you are trying to reach is not accepting calls at this time.

On 09/20/22, I completed a telephone interview with direct care staff, Tiffany Jones. Mrs. Jones stated she has worked at this home since February 2022, she works on all shifts. Ms. Jones stated Resident A, Resident B, and Resident C wear briefs. Resident A tells staff when she needs her brief to be changed. Resident B and Resident C are changed every two hours. Ms. Jones stated when a resident's brief is changed staff write the time and their initials on the brief. She also documents that the resident was changed in the resident's community living support (CLS) log. Residents should be changed before staff leave their shift. The staff who arrives on shift should check to assure the residents are clean and dry.

Ms. Jones stated when she would work on shift after direct care staff, Ivan Hopson and/or Shamari Sheppard she would find residents in soiled briefs, or briefs that had been on a resident for longer than two hours. She stated Mr. Hopson and Ms. Sheppard ended their employment with the company approximately one month ago. Ms. Jones has not observed any issue with other staff not changing the residents regularly. However, she stated Resident A has complained that direct care staff, Mr. Grass does not wipe her well enough when he changes her. Ms. Jones stated she has not found any resident's laying in soiled bedding as a result of not being changed. However, she has found residents laying on a soiled blue pad which is placed under the resident to protect their bedding. Ms. Jones further reports Resident E removes her menstrual pad at night so there are times that Resident E's bedding will be soiled, and she requires a shower.

On 09/22/22, I made a telephone call to licensee, Paula Barnes to conduct the exit conference. There was no answer. I left a detailed voicemail regarding my findings.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that personal care was not provided to Resident A as specified in her assessment plan. Resident A's Individual Plans of Service (IPOS) indicates she requires physical assistance with hygiene tasks and ADL care. Resident A stated on an unknown date she called direct care staff, Brandon Grass five times and asked to be changed. Resident A stated Mr. Grass told her that he was too busy. Resident A's bedding was also wet and needed to be changed. Resident A changed her bedding independently. Direct care staff, Tiffany Jones stated Resident A has complained that Mr. Grass does not wipe her well enough when he changes her brief. Mr. Grass confirmed that there are times when Resident A calls and asks to be changed however, Resident A has to wait for him to finish caring for other residents before she can be assisted. Mr. Grass further stated on an unknown date, he worked from 7:00 am – 3:00 pm Resident A's brief was only changed once, at noon.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the residents were not treated with dignity and respect and their personal needs were not attended to at all times. Direct care staff, Ms. Jones stated when she worked on shift after direct care staff, Ivan Hopson and/or Shamari Sheppard she would find residents in soiled briefs, or briefs that had been on a resident for longer than two hours. The blue pad that is placed under residents to act as a barrier between them and their bedding would be

	soiled. Ms. Jones and direct care staff, Ms. Bullock consistently reported Resident E has been observed with menstrual blood on her bedsheets, requiring a shower and her bedding to be changed. Resident A stated on an unknown date she called direct care staff, Mr. Grass five times and asked to be changed. Mr. Grass told her that he was too busy to assist her. Residents B, C, D, E, and F were interviewed however they were unable to answer questions related to this investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

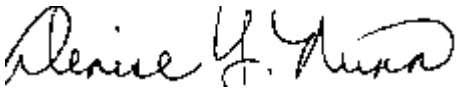
IV. RECOMMENDATION

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

09/22/2022

Johnna Cade — Date
Licensing Consultant

Approved By:



09/29/2022

Denise Y. Nunn — Date
Area Manager