GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 28, 2023

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

| | |
|---|---|
| RE: License #: | AS250010982 |
| Investigation #: | 2023A1039003 |
| | Warner 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,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS250010982 |
| | |
| **Investigation #:** | 2023A1039003 |
| | |
| **Complaint Receipt Date:** | 09/11/2023 |
| | |
| **Investigation Initiation Date:** | 09/12/2023 |
| | |
| **Report Due Date:** | 11/10/2023 |
| | |
| **Licensee Name:** | Central State Community Services, Inc. |
| | |
| **Licensee Address:** | Suite 201<br>2603 W Wackerly Rd<br>Midland, MI 48640 |
| | |
| **Licensee Telephone #:** | (989) 631-6691 |
| | |
| **Administrator:** | Sharon Butler |
| | |
| **Licensee Designee:** | Paula Barnes |
| | |
| **Name of Facility:** | Warner House |
| | |
| **Facility Address:** | 2473 Warner Rd<br>Flushing, MI 48433 |
| | |
| **Facility Telephone #:** | (810) 733-2780 |
| | |
| **Original Issuance Date:** | 09/02/1992 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/30/2021 |
| | |
| **Expiration Date:** | 09/29/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 09/07/23, Staff member Tikisha Mitchell, hit/slapped Resident A in the side of the head approximately 4 times with opened hand after Resident A urinated in the dining area. | Yes |

## III. METHODOLOGY

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|---|---|
| 09/11/2023 | Special Investigation Intake<br>2023A1039003 |
| 09/12/2023 | Special Investigation Initiated - Letter<br>emailed APS referral on 09/12/23 |
| 09/12/2023 | APS Referral<br>emailed referral on 09/12/23 |
| 09/12/2023 | Contact - Telephone call made<br>Interviewed Michelle Salem, GCHS-ORR. |
| 09/13/2023 | Inspection Completed On-site<br>Interviewed Asst. Manager, Taniyah James and Staff, Brianna Starling, and Resident A and B. |
| 09/19/2023 | Contact - Telephone call made<br>Interviewed licensee designee, Paula Barnes. |
| 09/19/2023 | Contact - Telephone call made<br>Interviewed staff, Tikisha Mitchell. |
| 09/19/2023 | Contact - Telephone call made<br>Interviewed home manager, Karand Houston. |
| 09/19/2023 | Exit Conference<br>Exit conference conducted with Licensee Designee, Paula Barnes. |

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| 09/20/2023 | Contact – Telephone call made<br>Interviewed administrator Sharon Butler |
| 09/20/2023 | Contact - Document Received<br>received medical information from administrator Sharon Butler regarding resident's diagnosis. |
| 09/20/2023 | Contact - Face to Face<br>interviewed Guardian A1 |

**ALLEGATION:**
**On 09/07/23, Staff member Tikisha Mitchell, hit/slapped Resident A in the side of the head approximately 4 times with opened hand after Resident A urinated in the dining area.**

**INVESTIGATION:**
On 09/12/23, I interviewed Michelle Salem, Genesee County Office of Recipient Rights (ORR) via telephone. I spoke to her regarding the investigation concerning a resident at Warner House being hit/slapped in the head. ORR Salem stated that she had spoken to staff member, Brianna Starling, who was working with staff member, Tikisha Mitchell, at the time of the allegations. ORR Salem also confirmed that Resident A was the resident involved in the allegations. ORR Salem stated that Staff Starling told her that Resident A had urinated on herself in the dining room and that Resident B was in the dining area as well. Staff Starling stated that Resident B is limited verbally but indicated to her that he did not witness Staff Mitchell hit Resident A.

On 09/13/23, I complete an unannounced on-site inspection at Warner House and interviewed the following people: Assistant Manager/Staff Taniyah James, Staff Brianna Starling, Resident A, and Resident B. The allegations were discussed first with Staff James. She stated that the home currently had 4 total residents. Staff James stated that Resident A is non-verbal and has limited forms of communication. She stated that she spoke with Resident A and that Resident A pointed to her head and indicated where Staff Mitchell hit her.

Staff James stated that she also spoke with Resident B about the allegations. Staff James stated that he was able to communicate that he was there when Resident A urinated on the floor in the dining area but that he did not know what happened after that. Staff James stated that his story has changed several times since the incident occurred. Staff James did note that Staff Mitchell was Resident B's favorite staff and that he may not have wanted to see her get in trouble.

Staff James stated that on 09/07/23, there were 2 staff members working 2nd shift, Tikisha Mitchell, and Brianna Starling. Staff James stated that Staff Mitchell was suspended immediately and has not worked since the incident was reported. Staff James stated that she has had to speak with Staff Mitchell in the past about spending equal time with all residents as she had been spending a lot of time with Resident B watching movies or WWE wrestling in his room.

On 09/13/23, I interviewed Staff Brianna Starling regarding the allegations. Staff Starling stated that she was aware of the allegations as she was the staff on duty with Staff Mitchell that day. She stated that at approximately 8:30 p.m. she was giving medication to Resident A and Resident A told her that she had to use the bathroom, but before she could take Resident A to the bathroom, she urinated on herself in the dining area. She then heard Staff Mitchell make a loud reaction to Resident A urinating on herself and on the dining room floor. Staff Mitchell asked her why she would do that and then Staff Mitchell slapped/hit Resident A in the side of her head approximately 3 to 4 times. Resident A then went to the bathroom to clean herself up.

Staff Starling further stated that Resident B was sitting at the dining room table finishing up a cup of water when this occurred. Staff Starling stated that she finished her shift and went home. She did not immediately report what had happened to supervision as she was unsure how to feel about the situation. She stated that she felt uneasy about what happened and called her Program Manager Sharon Butler the next morning to tell her what happened, but Ms. Butler was not available and did not answer. She then called the Home Manager Karand Houston and informed her of what she witnessed between Staff Mitchell and Resident A.

Staff Starling stated that she has attempted to speak to Resident B regarding the situation to see how he felt about what happened, but that Resident B shakes his head no or shrugs his shoulders when asked about the incident as if he does not know or remember. Staff Starling stated that she believes that Resident B does not acknowledge what happened because he does not want Staff Mitchell to get in trouble because she is his favorite staff member.

On 09/13/23, I interviewed Resident A regarding the allegations. Resident A is developmentally disabled, and her communication is severely limited. When she was asked about what happened she pointed to the floor multiple times. When asked if she urinated on the floor, she nodded her head yes. She was then asked what happened after she urinated, she then pointed to a spot on the side of her head several times. She was then asked if that is where Staff Mitchell hit/slapped her, and she nodded her head yes. Resident A was unable to communicate any other details of the incident.

Resident A has an appointed guardian. Her health care appraisal was reviewed and her diagnosis include: Bipolar – manic/severe, Obsessive Compulsive Disorder, Autism, Schizophrenia, Depression, Mental Retardation, and other health issues.

On 09/13/23, I interviewed Resident B regarding the allegations. Resident B is developmentally disabled, and his communication is severely limited but is able to use some sign language. When he was asked if he remembered what happened with Resident A in the dining area he pointed to the floor. When Resident B was asked if Resident B was pointing to the floor because Resident A urinated there he nodded yes. When Resident B was asked if anything happened after Resident A urinated on the floor, Resident B shrugged his shoulders and looked away. When asked if Resident B observed Staff Mitchell do anything to Resident A after Resident A urinated on the floor, Resident B shrugged his shoulders again and looked away. Resident B was unable to communicate any other details of the incident.

Resident B has an appointed guardian. His health care appraisal was reviewed and his diagnosis include: Intellectual Disability, and other health issues.

On 09/19/23, I interviewed Licensee Designee Paula Barnes via telephone regarding the allegations. She stated that she was aware of them and that the staff Mitchell was suspended and has not been back to work since the incident occurred.

On 09/19/23, I interviewed Home Manager (HM) Karand Houston via telephone regarding the allegations. HM Karand Houston stated that she was aware of them but that she honestly did not know exactly what happened as she was not there but that she believes that Staff Starling has always been honest regarding any issues in the past.

On 09/19/23, I interviewed Staff Tikisha Mitchell regarding the allegations. Staff Mitchell stated that the allegations were false and that she did not hit or slap Resident A. Staff Mitchell stated that Resident A was taking her medication and during that time she urinated on herself and on the dining room floor. Staff Mitchell said she then took Resident A to the bathroom and gave her a shower. Staff Mitchell stated that she did not yell or hit Resident A at all. Staff Mitchell stated that she has never had any past issues caring for residents.

On 09/20/23, I interviewed Administrator Sharon Butler regarding the allegations. She stated that she was aware of the allegations and that Staff Mitchell had been suspended since that time. She had no further information regarding the situation.

On 09/20/23, I spoke with Guardian A1 via telephone regarding the allegations involving Resident A. Guardian A1 stated that she was unaware of the allegations, and this was the first she was hearing of them. Guardian A1 stated that she has had no issues in the past with staff as they seem to care for Resident A and treat her very good. Guardian A1 stated that she was thankful for the update and that she would follow up with staff if she had further questions.

| APPLICABLE RULE | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |
| **ANALYSIS:** | Based on interviews with Resident A and Staff Brianna Starling and Taniyah James, there is a preponderance of evidence to suggest that Staff Tikisha Mitchell did mistreat Resident A and a rule violation did occur. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 09/19/23, I conducted an Exit Conference with Licensee Designee, Paula Barnes. I discussed the allegations and advised LD Barnes that I would be citing the rule violation listed above and that a corrective action plan would be needed.

## IV. RECOMMENDATION

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| I recommend that no changes be made to the licensing status pending the receipt of an appropriate corrective action plan. |

09/26/23

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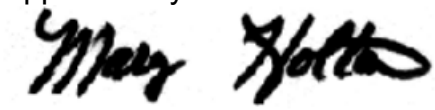
| Martin Gonzales<br>Licensing Consultant | Date |

Approved By:



09/28/23

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| Mary E. Holton<br>Area Manager | Date |