GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 8, 2024

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

RE: License #: AS250291671
Investigation #: 2024A0569016
Vassar Road Home

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250291671
Investigation #:	2024A0569016
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/09/2024
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Regina Wheaton
Licensee Designee:	Paula Barnes
Name of Facility:	Vassar Road Home
Facility Address:	3220 Vassar Road Burton, MI 48519
Facility Telephone #:	(989) 513-7503
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/22/2022
Expiration Date:	04/21/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
• **Resident A was observed with black eyes and a bloody nose on 1/6/24.**	Yes
• **Resident B had access to the medication cabinet on 1/18/24.**	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0569016
01/10/2024	APS Referral Complaint from APS.
01/10/2024	Special Investigation Initiated - Letter Email from Brandi Morris, APS worker.
02/08/2024	Contact - Telephone call made Contact with Michelle Salem, RRO.
02/08/2024	Contact - Telephone call made Contact with Alvontae Huddleston, staff person.
02/08/2024	Contact - Telephone call made Contact with Penelope Tohm, GHS case manager.
02/08/2024	Contact - Telephone call made Contact with Tonisha Fisher, staff person.
02/08/2024	Inspection Completed On-site
02/08/2024	Inspection Completed-BCAL Sub. Compliance
02/08/2024	Exit Conference Contact with Paula Barnes, licensee designee.
02/08/2024	Corrective Action Plan Requested and Due on 03/01/2024

ALLEGATION:

Resident A was observed with black eyes and a bloody nose on 1/6/24.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A was observed to have a black eye and bloody nose on 1/6/24. The complainant reported that the cause of the injuries was unknown.

An unannounced inspection of this facility was conducted on 2/8/24. Resident A is non-verbal and could not give a statement regarding this allegation. Resident A was observed to be appropriately dressed and groomed with o current, visible injuries. Resident A was observed to be ambulatory and was walking around the facility without staff assistance.

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed. Resident B stated that he observed the cause of Resident A's injuries. Resident B stated that he was walking around outside of the facility "a few weeks ago" and came inside of the facility to "warm up". Resident B stated that when he walked in the facility, he observed Resident A on the couch in the living room. Resident B stated that he then observed Alvontae "tae" Huddleston, staff person, "yelling at" Resident A. Resident B stated that Resident A had stolen some sugar and a drink from the kitchen of the facility and Alvontae Huddleston was upset at Resident A. Resident B stated that he then observed Alvontae Huddleston "punch" Resident A in his face twice. Resident B stated that he then went back outside of the facility and did not observe what happened after this incident. Resident B stated that he later observed Resident A to have a black eye and bloody nose. Resident B stated that he had not observed Alvontae Huddleston physically mistreat any of the residents on any other occasion.

Resident C was alert and oriented to person, place, and time. Resident C was appropriately dressed and groomed with no visible injuries. Resident C stated that he was in his bedroom "a few weeks ago" and decided to go to the kitchen to get something to drink. Resident C stated that he entered the living room and observed Resident A on the couch, and Alvontae Huddleston was standing over Resident A and yelling at Resident A. Resident C stated that he then observed Alvontae Huddleston "punch" Resident A twice in Resident A's face with a closed fist. Resident C stated that he immediately turned around and went back to his bedroom. Resident C stated that he did not know what happened after the incident, but that he did observe Resident A to have a black eye.

Alvontae Huddleston, staff person, stated on 2/8/24 that he did work the second shift on 1/6/24. Alvontae Huddleston stated that nothing significant happened during his shift

and he left the facility between 7:00-7:30pm. Alvontae Huddleston stated that none of the residents had any physical altercations during his shift. Alvontae Huddleston stated that Resident A did not have any black eyes or any other injuries when he left his shift. Alvontae Huddleston stated that he did not hit or physically mistreat Resident A. Alvontae Huddleston stated that he did not know how Resident A received his injuries. Alvontae Huddleston stated that Resident A does not self-harm in any way. Alvontae Huddleston stated that he was then informed by his manager, Ellen Porter that he was suspended from working until an investigation was completed and he has not been back to the facility since 1/6/24. Alvontae Huddleston stated that he did not have any other information regarding this incident.

Ellen Porter, home manager, stated on 2/8/24 that she observed Resident A to have a black eye on 12/27/23. Ellen Porter stated that Resident A had taken Resident C's hot chocolate and Resident C became upset and hit Resident A. Ellen Porter stated that she then observed Resident A's other eye to be bruised on 1/6/24. Ellen Porter stated that she then called EMS to take Resident A for medical treatment, but they simply treated Resident A with first aid in the facility. Ellen Porter stated that Resident B and Resident C then made statements identifying Alvontae Huddleston, staff person, as the person that hit Resident A, causing the black eye. Ellen Porter stated that Alvontae was then immediately suspended pending an investigation.

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:	Resident A was observed with an unexplained black eye and bloody nose on 1/6/24. Resident B and Resident C both stated that they observed Resident A on the couch in the living room, and that Alvontae Huddleston, staff person, was standing over Resident A and yelling at him. Resident B and Resident C both stated that they observed Alvontae Huddleston "punch" Resident A in his face, twice, with a closed fist. Resident B and Resident C both stated that they then observed Resident A with a black eye following this incident. Alvontae Huddleston denied that he hit Resident A but stated that Resident A was observed with the black eye following Alvontae Huddleston's shift. Alvontae Huddleston also admitted that Resident A does not exhibit any self-injuring behaviors. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B had access to the medication cabinet on 1/18/24.

INVESTIGATION:

The complainant reported that on 1/18/24 Resident B was observed to go into the kitchen of the facility, pick up the keys to the medication cabinet, and open the medication cabinet. The complainant reported that Resident B had snacks that were locked in the same cabinet as the medications, and Resident B then retrieved some snacks.

Penelope Thom, GHS case manager, stated on 2/8/24 that she was present when this incident occurred. Penelope Thom stated that she was sitting at the dining room table while a staff person was in the kitchen preparing a meal. Penelope Thom stated that she was the case manager for Resident A, Resident B, and Resident C. Penelope Thom stated that she observed Resident B go into the kitchen and pick the keys up from the counter. Penelope Thom stated that Resident B then went to the locked cabinet where the resident medications are located, unlocked the cabinet, opened the door, and grabbed some popcorn that he had stored in the cabinet. Penelope Thom stated that she redirected Resident B and told Resident B that he could not have access to the cabinet. Penelope Thom stated that the staff person was unaware that Resident B had gotten the key and opened the cabinet. Penelope Thom stated that when she redirected Resident B, the staff person then turned around and also verbally redirected Resident B. Penelope Thom stated that Resident B did not take any of the resident

medications but could have easily done so. Penelope Thom stated that it appeared to her that Resident B was “very comfortable” in taking the keys and seemed to be “very familiar” with what key to use to unlock the cabinet as if he had dome this prior to this incident.

Tonisha Fisher, staff person, stated on 2/8/24 that she was the staff person working when this incident occurred. Tonisha Fisher stated that she was the only staff person working due to another staff person leaving to have a TB test completed. Tonisha Fisher stated that she had the keys and used them to open another cabinet in the kitchen to get food out to prepare for the meal. Tonisha Fisher stated that she set the keys on the counter and Resident B was standing near the counter. Tonisha Fisher stated that Resident B was “very quick” and grabbed the keys. Tonisha Fisher stated that Resident B then went to the cabinet to get his snacks and she heard Resident Penelope Thom tell Resident B that he should not be in the cabinet. Tonisha Fisher stated that she turned around and also verbally redirected Resident B. Tonisha Fisher stated that she told Resident B that he needed to ask staff to get his snacks for him. Tonisha Fisher stated that the facility policy is that staff are to have the keys “on their person” at all times.

Ellen Porter, home manager, stated on 2/8/24 that Resident B had taken the keys from a drawer or countertop on 1/18/24 and used them to open the medication cabinet because he wanted some popcorn that belonged to him. Ellen Porter stated that the facility policy states that staff must keep the keys “on their person at all times” so that the residents can not use them. Ellen Porter stated that she conducted an in-service with all of the staff regarding the policy following this incident.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	The complainant reported that Resident B was able to get the staff keys on 1/18/24 and use them to open the medication cabinet. Penelope Thom stated that she observed this incident occur. Tonisha Fisher admitted that this incident did occur. Tonisha Fisher and Ellen Ported also stated that the facility policy is that staff are to keep the keys “on their person” at all times so that the resident do not have access to them. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Paula Barnes, licensee designee, on 2/8/24. The findings in this report were reviewed and a corrective action plan was requested.

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

2/8/24

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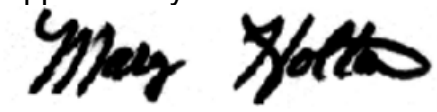
Kent W Gieselman Date
Licensing Consultant

Approved By:



2/8/24

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Mary E. Holton Date
Area Manager