GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2025

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

RE: License #: AS630407345
Investigation #: 2025A0626010
Waterview 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (313) 456-0380.

Sincerely,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407345
Investigation #:	2025A0626010
Complaint Receipt Date:	01/24/2025
Investigation Initiation Date:	01/24/2025
Report Due Date:	02/23/2025
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:	Waterview Home
Facility Address:	121 Waterview Lake Orion, MI 48362
Facility Telephone #:	(248) 690-9280
Original Issuance Date:	05/18/2021
License **Status:**	REGULAR
Effective Date:	11/18/2023
Expiration Date:	11/17/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
Untrained direct care staff are administering medications.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2025	Special Investigation Intake 2025A0626010
01/24/2025	Special Investigation Initiated - Telephone Special investigation initiated via telephone interview with complaint source, who wishes to remain anonymous.
01/27/2025	Referral - Recipient Rights Emailed referral to Office of Recipient Rights.
01/27/2025	APS Referral Adult Protective Services (APS) referral was not required due to the allegations not rising to the level of abuse or neglect.
01/28/2025	Contact - Face to Face Completed unannounced onsite investigation at Waterview Home. Interviews were completed with Resident D, home manager, Annette Perry, and direct care staff member, James Thompson.
01/31/2025	Contact - Document Sent An email was sent to licensee, requesting employee trainings.
02/03/2025	Contact - Document Received An email was received from Jamie Webb, human resources clerk for Central State Community Services, containing employee medication administration training certificates.
02/26/2025	Contact - Document Sent An email was sent to the recipient rights specialist, Rishon Kimble, requesting an update and to inquire about any concerns regarding the home.

02/26/2025	Contact - Telephone call made Conducted phone interviews with Waterview employees, Roger Criss, Cristiane Spencer, and Angellic Guyton.
02/26/2025	Contact – Telephone call received Conferenced with recipient rights specialist, Rishon Kimble. Ms. Kimble is going to open an investigation regarding the medications.
02/27/2025	Exit Conference I conducted the exit conference with Paula Barnes, via telephone. She agreed with the findings and stated they would be implementing additional training in medication administration.
03/06/2025	Contact – Telephone call made I conducted phone interviews with Relative A1, B1, B2, and C2.
03/14/2025	Exit Conference I conducted a second exit conference, via telephone, with Paula Barnes to discuss the change of recommendation to a provisional license.

ALLEGATION:

Untrained direct care staff members are administering medications to residents.

INVESTIGATION:

On 01/24/2025, I received a referral, via email, alleging that direct care staff members who are not trained in medication administration are administering medications to residents.

On 01/24/2025, I initiated my investigation via conducting a phone interview with the complainant, who requested anonymity. Complainant stated that Roger Criss and Annette Perry are the only ones working at Waterview who are trained in administrating medications, but they are not the only ones administering them. Complainant stated the home is for developmentally disabled residents and only one is verbal. There are four residents in the home, two females and two males

On 01/28/2025, I completed an unannounced onsite investigation at Waterview Home and completed an interview with home manager, Annette Perry. Ms. Perry has been employed at Waterview for a little over a year and has been with the company for approximately three years. Ms. Perry denied that anyone who is not trained for medications is giving them. I requested and reviewed the four residents' medication administration records (MAR). While reviewing them, I observed medications were

being administered by Ms. Perry, Roger Criss, and the program coordinator, Alyssa Valenti, as indicated by their initials and signatures on the MARs. I requested employee files for all current employees. Ms. Perry brought me only her file containing all required trainings in it including her medication administration training. Ms. Perry explained the trainings for the other employees are at the main office, including their training certificates and would need to be requested.

On 01/28/2025, I interviewed direct care staff member, James Thompson. Mr. Thompson stated he has worked at Waterview for approximately seven months. He stated he took the medication training but hasn't gotten his certificate of completion due to not having done a simulated medication pass to receive completion. He denied ever working alone, he is always on shift with Ms. Perry, and he denied ever administering medications, stating, he tries to stay away from that. Mr. Thompson denied ever seeing anyone except Ms. Perry and Mr. Criss pass medications.

I asked to speak with the residents and Ms. Perry informed me that the only one who is verbal is Resident D. I observed Resident A, Resident B, and Resident C to be neat and clean and appearing to be in good health. I said hello to all of them and did not get any responses.

On 01/28/2025, I completed a private interview with Resident D in his room. He stated he has been at Waterview for approximately 20 years and knows everything that happens there. He likes it at Waterview and feels safe. He stated he works at Kroger and is happy that he makes money. Resident D stated only Ms. Perry and Mr. Criss have given him medications. He denies anything he doesn't like happening in the home.

On 02/26/2025, I conducted a phone interview with Roger Criss. Mr. Criss stated he has worked at Waterview Home, as a direct care staff member for approximately three years. Mr. Criss stated that he and Annette Perry are the only two who administer medication, and he denied seeing anyone else administer them. He stated he has been trained in medication administration. Mr. Criss denied having any concerns regarding anything going on in the home.

On 02/26/2025, I attempted to conduct a full interview with Cristiane Spencer, via telephone. Ms. Spencer has been employed at Waterview Home as a direct care staff member for approximately 3.5 years. Ms. Spencer denied ever administering medications to residents. Ms. Spencer then asked if she had to talk to me because she did not want to, and the call was ended.

On 02/26/2025, I conducted a phone interview with Angellic Guyton. Ms. Guyton works at Waterview Home as a direct care staff member. Ms. Guyton informed me that Roger Criss and Annette Perry are the only staff members who administer medications. She denied any concerns regarding anything in the home.

On 03/06/2025, I conducted a telephone interview with Relative B1. He stated he was concerned about Resident B being left in her bedroom all day and not being brought out

into common areas of the home. He stated he and his ex-wife had talked to the home manager about it and believes it has gotten better. He explained he was worried about Resident B getting the care she deserves. Relative B1 stated he was concerned when he found out about a previous investigation, but he found out that the staff members involved were terminated from their employment.

On 03/06/2025, I conducted a telephone interview with Relative B2. Relative B2 informed me that she has talked to Ms. Perry about the investigation, and she has full confidence in her and her ability to care for Resident B. She stated Ms. Perry explained to her there was a former employee harassing her and the former employee has been making allegations. She saw Resident B yesterday and everything was good. She stated they have family going there to see Resident B and to keep an eye on her and her care. She stated Resident B is receiving some of the best care she has ever gotten, and she does not have any concerns.

On 03/06/2025, I conducted a telephone interview with Relative A1. Relative A1 stated she had received a letter regarding an investigation in November. She stated that she has no concerns regarding the care of Resident A, but there were concerns regarding Ms. Perry requesting that they take Resident A to appointments and to a scheduled surgery. She stated this is difficult for her and her husband to do, due to Resident A being in a wheelchair and they are in their 70's. She stated the care agreement states that the facility would be responsible for transporting to appointments. I advised her to remind them of that if they request for her to transport to an appointment and she cannot.

On 03/07/2025, I conducted a telephone interview with Relative C1. She informed me that Resident C has a diagnosis of autism and cannot speak, but he appears to be ok. She stated her only concern regarding Resident C's care is that he has put on weight and is now overweight. She visits regularly and has not had other concerns.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on the information gathered through my investigation, there is not sufficient evidence to conclude that there are any staff untrained in medication administration administering medications to residents. The MARs for all residents were reviewed and the only initials on them were that of the home manager, Annette Perry, direct care staff member, Roger Criss, and program manager, Alyssa Valenti, all of whom have

	certificates for completing medication administration training. The only resident able to be interviewed, and the four direct care staff members interviewed, denied ever seeing anyone besides Ms. Perry and Mr. Criss administering medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/28/2025, during my unannounced onsite investigation, I reviewed MARs for the four residents who currently reside in the Waterview Home.

Resident A's MAR has a prescription listed for melatonin 15mg and 10 mg, take two tablets at bedtime, simvastatin 20mg, take one tablet by mouth at bedtime, B-complex, take one capsule by mouth daily, and vitamin D3, take one capsule by mouth daily, Prempro, take one tablet by mouth in the morning, and Sentry tab, take one tablet by mouth in the morning, none of these medications were administered during the month of January 2025.

Resident B’s MAR has prescriptions for folic acid, one mg, one tablet by mouth daily, it was not administered during the month of January.

Resident C's MAR has a prescription for aripiprazole 10mg, with no further instructions, this medication had not been administered in the month of January.

I questioned Ms. Perry about these medications, and she stated the pharmacy never delivered them and she admitted to not having contacted the pharmacy or the prescriber, for assistance. I advised her that it is the responsibility of the home to contact the pharmacy and the physician to inquire about the missing medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	On 01/28/2025, I reviewed the medication administration records for all four residents in the home, and I was able to

	verify the medications that were not being administered. This was confirmed with the home manager, Annette Perry, who stated the prescribed medication was not delivered and she admitted to not having contacted the pharmacy or the prescriber, for assistance.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report 11/30/2023, CAP dated 12/07/2023.** **Special Investigation Report #2023A0991032 dated 10/13/2023, CAP dated 10/30/2023.** **Renewal Licensing Study Report dated 10/28/2021, CAP dated 11/08/2021.** **Special Investigation Report #2021A0611027 dated 10/08/2021, CAP dated 10/21/21.**

INVESTIGATION:

On 01/28/2025, during the unannounced onsite investigation, I requested resident information records. I was provided records for Resident C and Resident D. When I asked about Resident A and Resident B, Ms. Perry informed me that they did not have them.

On 02/27/2025, I conducted an exit conference, via telephone, with Paula Barnes. The findings were discussed, and Ms. Barnes agreed with the findings and stated she is going to plan on implementing refresher trainings regarding medication administration and possibly disciplinary action.

On 03/14/2025, I conducted an exit conference, via telephone, with Paula Barnes to discuss the change of recommendation to a provisional license being issued, due to the repeat violations involving medication administration. Ms. Barnes stated they will likely accept the provisional license and will make the decision upon reviewing the special investigation report.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.**

	(ii) Social security number, date of birth, case number, and marital status. **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.**
ANALYSIS:	On 01/28/2025, I requested resident information records for all four residents and discovered Resident A and Resident B did not have them.
CONCLUSION:	**VIOLATION ESTABLISHED**

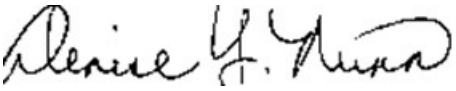
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, issuance of a provisional license is recommended.

03/14/2025

Sara Shaughnessy Date
Licensing Consultant

Approved By:



03/21/2025

Denise Y. Nunn Date
Area Manager