GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

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

RE: License #: AS560012112
Investigation #: 2025A0360023
Mitchell House

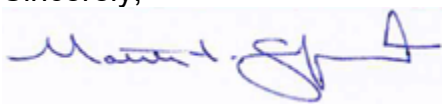
Dear Ms. Barnes:

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 (616) 356-0100.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS560012112 |
| | |
| **Investigation #:** | 2025A0360023 |
| | |
| **Complaint Receipt Date:** | 04/10/2025 |
| | |
| **Investigation Initiation Date:** | 04/10/2025 |
| | |
| **Report Due Date:** | 06/09/2025 |
| | |
| **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:** | Alyssa Valenti |
| | |
| **Licensee Designee:** | Paula Barnes |
| | |
| **Name of Facility:** | Mitchell House |
| | |
| **Facility Address:** | 305 E St Andrews St<br>Midland, MI 48640 |
| | |
| **Facility Telephone #:** | (989) 631-4982 |
| | |
| **Original Issuance Date:** | 06/08/1983 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 10/25/2023 |
| | |
| **Expiration Date:** | 10/24/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, AGED,<br>DEVELOPMENTALLY DISABLED, MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A missed two days of anti-seizure medication and was hospitalized. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/10/2025 | Special Investigation Intake<br>2025A0360023 |
| 04/10/2025 | Special Investigation Initiated - Telephone<br>ORR Keegan Sarker |
| 04/23/2025 | Inspection Completed On-site<br>ORR Keegan Sarker, Administrator Alyssa Valenti, Home manager Crystal Thorne, Resident A, DCSM Anessa Allen |
| 06/05/2025 | Contact - Telephone call made<br>Guardian A |
| 06/06/2025 | Exit Conference<br>With Paula Barnes |

**ALLEGATION:**

**Resident A missed two days of anti-seizure medication and was hospitalized.**

**INVESTIGATION:**

On 4/10/25, I contacted Central Michigan Community Mental Health Recipient Rights Officer Keegan Sarker. Ms. Sarker stated she was investigating a complaint regarding missed anti-seizure medication for Resident A that resulted in a hospitalization. Ms. Sarker and I scheduled an onsite inspection at the home for 4/23/25.

On 4/23/25, I conducted an onsite inspection at the home with Ms. Sarker. The administrator Alyssa Valenti stated she has investigated Resident A's missed medications and discovered that Resident A went without her prescribed Keppra for two days on 4/1/25 and 4/2/25. Ms. Valenti stated the home manager was off on vacation and the staff did not make anyone aware that they were out of the medication until the home manager, Crystal Thorn, returned on 4/2/25.

While at the home on 4/23/25, I interviewed the home manager, Crystal Thorne. Ms. Thorne stated she returned from vacation on 4/2/25 and the staff notified her that Resident A was low on Keppra but not that she had ran out. Ms. Thorne stated that Resident A had a seizure on 4/3/25 and was hospitalized. Ms. Thorne provided me with Resident A's April 2025 medication administration record which documented that Resident A was not administered Keppra on 4/1/25 or 4/2/25. Ms. Thorne also provided me with the after-visit summary from MyMichigan Health documenting that Resident A was hospitalized from 4/3/25 to 4/11/25 due to seizures. I then interviewed direct care staff member Anissa Allen. Ms. Allen stated she realized on 4/1/25 that Resident A was out of Keppra. She stated she contacted her primary doctor, but they would not refill her medication because it was prescribed through a different neurologist who had dropped Resident A as a patient due to a missed appointment months prior. Ms. Allen stated the hospital has provided Resident A with her prescription Keppra until she can be seen by a new neurologist.

While at the home on 4/23/25, I attempted an interview with Resident A however, due to limited verbal communication she was unable to be interviewed.

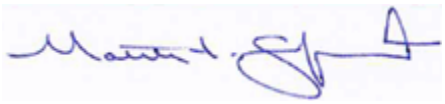
On 6/5/25, I contacted Guardian A by telephone. Guardian A stated he was notified of the missed medication and subsequent hospitalization. He stated he was very concerned that the home would allow the medication to run out before they attempted to refill the prescription. He stated aside from the missed medication he is very happy with the care in the home.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Interviews with Ms. Sarker, Ms. Valenti, Ms. Thorne, Ms. Allen and Guardian A revealed that Resident A was not administered her prescription Keppra on 4/1/25, 4/2/25 and was subsequently hospitalized on 4/3/25 due to seizures. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 6/6/2025 I conducted an exit conference with licensee designee Paula Barnes.

## IV. RECOMMENDATION

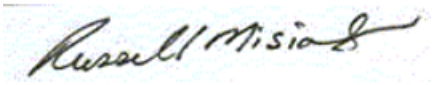
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



6/5/25

Matthew Soderquist — Date
Licensing Consultant

Approved By:



6/5/25

Russell B. Misiak — Date
Area Manager