GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2025

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

RE: License #: AS250385494
Investigation #: 2025A0779046
Wilson 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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250385494
Investigation #:	2025A0779046
Complaint Receipt Date:	07/31/2025
Investigation Initiation Date:	07/31/2025
Report Due Date:	09/29/2025
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Vuai Finney
Licensee Designee:	Paula Barnes
Name of Facility:	Wilson Road Home
Facility Address:	6359 W Wilson, Clio, MI 48420-8420
Facility Telephone #:	(989) 631-6691
Original Issuance Date:	05/02/2017
License **Status:**	REGULAR
Effective Date:	11/02/2023
Expiration Date:	11/01/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 7/28/2025, staff Sierra Hunter yelled at Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

07/31/2025	Special Investigation Intake 2025A0779046
07/31/2025	APS Referral Complaint was referred to APS.
07/31/2025	Special Investigation Initiated - Telephone Spoke to recipient rights investigator, Matt Potts.
08/05/2025	Inspection Completed On-site
08/05/2025	Contact - Telephone call made Spoke to Resident A.
08/11/2025	Contact - Telephone call made Phone interview conducted with staff person, Courtney Diawara.
09/10/2025	Exit Conference Held with licensee designee, Paula Barnes.

ALLEGATION:

On 7/28/2025, staff Sierra Hunter yelled at Resident A.

INVESTIGATION:

On 7/31/2025, a phone conversation took place with recipient rights investigator, Matt Potts, who confirmed that he was investigating the same allegations. Investigator Potts stated that Resident A told him that his prescription eye drops are stored in the refrigerator and that he went into the refrigerator to get them and then Staff Sierra Hunter yelled at him, asking him why he got into the medicine cabinet. Investigator Potts stated that Resident A did not provide any more details as to what Staff Hunter had said to him. Investigator Potts reported that Staff Hunter has denied yelling at Resident A and claims that Resident B was present to witness the interaction between her and Resident A.

On 8/5/2025, an on-site inspection was conducted and Resident B was interviewed. Resident B stated that he remembers Resident A cussing at Staff Hunter about something related to Resident A's medication. Resident B stated that he did not see or hear Staff Hunter yell or cuss at Resident A. Resident B stated that he likes Staff Hunter and that she does not yell or cuss at any residents.

On 8/5/2025, administrator Vuai Finney stated that he had spoken to Resident A about this alleged incident and that Resident A admitted that he cusses at Staff Hunter and claimed that Staff Hunter cussed at him back. Admin Finney reported that Resident A told him that Staff Hunter is nice and talks to all the other residents but she ignores him. Admin Finney stated that Staff Hunter denied ever yelling at Resident A.

On 8/5/2025, staff person, Phillip Parrish, stated that Resident A told him that he got into a verbal fight with Staff Hunter and that they cussed each other out. Staff Parrish stated that it is quite clear that Resident A does not like Staff Hunter, but he does not know why. Staff Parrish stated that he has never seen Staff Hunter yell or cuss at Resident A or any other resident.

On 8/5/2025, Staff Hunter stated that she is a new staff person, that she has only been working at this home a few weeks, and that Resident A has been picking at her ever since she started there. Staff Hunter stated that she was the med passer on 7/28/2025 and that Resident A had a bottle of eye drops in front of him on the table and she did not know where he got them from. Staff Hunter stated that she had never passed eye drops to Resident A before. Staff Hunter reported that Resident A started cussing at her because he did not like her questioning him about where he got the eye drops from. Staff Hunter claims that she did not yell or cuss back at Resident A. Staff Hunter stated that all she did was ask Resident A where he got the eye drops from and Resident A went off on her.

On 8/5/2025, a phone call was made to Resident A, who admitted that he cussed at Staff Hunter about where he got his eye drops from. Resident A stated that his eye drops are kept in a box in the refrigerator and that he gets them every night and takes them to the staff to give them to him. Resident A reported that Staff Hunter thought he had gone into the med cabinet to get the eye drops and started yelling at him about it. Resident A claims that Staff Hunter cussed at him but could not say exactly what Staff Hunter had said to him. Resident A claims that no other residents or staff were around to witness the incident.

On 8/11/2025. A phone interview was conducted with staff person, Courtney Diawara, who confirmed that she worked with Staff Hunter on 7/28/2025. Staff Diawara stated that Staff Hunter asked Resident A where he got his eye drops from and that it was Resident A who got upset and was cussing. Staff Diawara stated that Staff Hunter did not yell or cuss at Resident A and was not disrespectful toward Resident A in any way. Staff Diawara reported that Resident A does not like Staff Hunter for some reason and picks at Staff Hunter a lot. Staff Diawara stated that she has never witnessed Staff Hunter yell at cuss at any residents.

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:	Resident B stated that he remembers Resident A cussing at staff person, Sierra Hunter, about something to do with his medication, but that he did not see or hear Staff Hunter yell or cuss at Resident A. Staff Hunter denies yelling or cussing at Resident A. Staff person, Courtney Diawara, worked with Staff Hunter on 7/28/2025 and stated that Staff Hunter did not yell or cuss at Resident A. Staff Diawara reported that it was Resident A who cussed at Staff Hunter. There are no known witnesses to confirm that Staff Hunter yelled or cussed at Resident A. There was no evidence found to warrant a violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/31/2025, ORR investigator, Matt Potts, stated that Resident A told him that his eye drops are stored in the refrigerator. Investigator Potts stated that Resident A claims that he gets his eye drops out of the refrigerator and takes them to the staff.

On 8/5/2025, staff person, Phillip Parrish, confirmed that Resident A's eye drops are kept in a locked box inside the refrigerator. Staff Parrish stated that Resident A is able to get into the locked box and take his eye drops to staff every night, so staff can make sure he gets them.

On 8/5/2025, staff person Sierra Hunter, stated that she has only worked at this home for a few weeks, but that she has never given Resident A eye drops and did not even know he was prescribed eye drops. Staff Hunter stated that on 7/28/2025, Resident A showed up in the med room with his eye drops and said that he had gotten them out of the refrigerator.

On 8/5/2025, Resident A confirmed that he goes into the refrigerator every night to get his eye drops and takes them to staff. Resident A stated that he knows how to get into the locked box that is kept in the refrigerator and that no staff have told him not to do that.

During the on-site inspection on 8/5/2025, there was a lock box viewed to be located inside the refrigerator. Resident A's prescribed eye drops were seen sitting on a shelf inside the refrigerator, next to the lock box. The eye drops were easily accessible for anyone to take. The label located on the eye drops, Xalatan/Latanoprost .005%, stated that they were prescribed on 3/20/2023 and were to be given as 1 drop in both eyes at bedtime. Resident A's medication administration record (MAR) was reviewed and the eye drop medication was not listed on the MAR. The last time the eye drops were listed on Resident A's MAR, as being given to Resident A, was back in February 2025.

On 9/10/2025, an exit conference was held with licensee designee, Paula Barnes. LD Barnes stated that she was not aware of the situation regarding Resident A's medication and that they will make sure a new lock box is purchased that Resident A and cannot gain access to. LD Branes stated that they will make sure the eye drops are still needed and if so, add that prescription to the MAR, as well as provide med training to the staff.

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:	On 8/5/2025, Resident A's prescription eye drops were viewed to be sitting on a shelf inside the refrigerator. The medication was sitting next to a lock box and was easily accessible for anyone to take. Resident A has been going into the refrigerator and getting his medication from the lock box and taking it to staff every night. Resident A's prescribed medication was not properly stored and secured in a locked container.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	It was confirmed that Resident A was prescribed eye drops that are to be administered every night at bedtime and that Resident A has been administered those eye drops for quite some time now. On 8/5/2025, Resident A's eye drops were not listed anywhere on the MAR since February 2025 and there was no evidence that staff have been administering the eye drop medication since February.
CONCLUSION:	**VIOLATION ESTABLISHED**

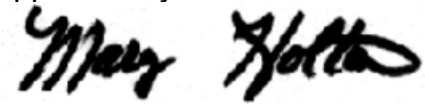
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

9/10/2025

Christopher Holvey — Date
Licensing Consultant

Approved By:



9/10/2025

Mary E Holton — Date
Area Manager