GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 16, 2026

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

RE: License #:	AS250385494
Investigation #:	2026A1039010
	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,

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

License #:	AS250385494
Investigation #:	2026A1039010
Complaint Receipt Date:	11/20/2025
Investigation Initiation Date:	11/21/2025
Report Due Date:	01/19/2026
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:	11/02/2025
Expiration Date:	11/01/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
It is alleged that Staff Jonathon Grove showed residents pornography on his phone.	Yes
It is alleged that Staff does not give residents medication as prescribed.	No

III. METHODOLOGY

11/20/2025	Special Investigation Intake 2026A1039010
11/21/2025	APS Referral Completed via online referral.
11/21/2025	Special Investigation Initiated - Letter Completed online APS referral.
11/21/2025	Contact - Document Received APS denied complaint. No investigation.
12/29/2025	Contact - Document Received GHS ORR Shepard informed me that she is not complete with her investigation.
01/06/2026	Inspection Completed On-site I interviewed DCW Parrish, Resident A and Resident B.
01/06/2026	Contact - Telephone call made Phone interview with Home Manager Tameka Miller.
01/06/2026	Contact - Telephone call made Phone interview with Program Coordinator Vuai Finney.
01/06/2026	Contact - Document Received Received requested documentation from Program Coordinator Vuai Finney.
01/06/2026	Contact - Telephone call made Attempted to call Staff Johnathan Grove. No answer.

01/08/2026	Contact - Telephone call made Attempted to call Staff Johnathan Grove. No answer.
01/13/2026	Contact - Telephone call made Attempted to call Staff Jonathan Grove. No answer.
01/13/2026	Contact - Document Received GHS ORR Shepard emailed and said she substantiated the complaint.
01/13/2026	Exit Conference Completed with LD Barnes.
01/13/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff showed residents pornography on his phone.

INVESTIGATION:

On 11/20/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Staff showed residents pornography on his phone.

On 11/21/2025, a referral was made to Adult Protective Services (APS). The Department of Health and Human Services Centralized Intake denied the complaint and did not assign for investigation.

On 01/06/2026, I completed an unannounced onsite investigation at Wilson Road Home and interviewed the following people: Direct Care Worker Phillip Parrish, Resident A and Resident B.

On 01/06/2026, I interviewed Direct Care Worker (DCW) Phillip Parrish concerning the allegations. DCW Parrish stated that he was familiar with the allegations and that he did believe that they were true. DCW Parrish stated that the staff member that was involved is no longer working in the home. DCW Parrish stated that the staff member was Direct Care Worker (DCW) Jonathon Grove. DCW Parrish stated he was working with DCW Grove at the time of the incident. DCW Parrish stated that DCW Grove, Resident A and Resident B were in the dining room and Resident A was showing Resident B pictures of a naked woman on his phone. DCW Parrish stated that he went into the dining room and redirected them they should not be doing that. DCW Parrish stated that DCW Grove was in the dining room but did not see him show the residents any pictures on his phone. DCW Parrish stated that he does not know if DCW Grove

showed the residents any pictures but as far as he knows the residents stopped showing each other pictures. DCW Parrish stated that DCW Grove had only been working at the home for a week when the incident happened and he has not been back since. DCW Parrish stated that Resident A and Resident B told him that DCW Grove was showing them naked pics and videos on his phone but he did not see that happening while he was working. DCW Parrish stated that the residents have had to be redirected in the past about looking at inappropriate things on their phones in the common areas of the home. DCW Parrish stated that he doesn't know exactly what happened but he believes that he was suspended or quit.

On 01/06/2026, I completed an interview with Resident A in the staff office. Resident A appeared neat and clean and was able to communicate with no issues. Resident A is diagnosed with the following: Bipolar disorder, Unspecified paraphilic disorder and Antisocial personality disorder. Resident A stated that he was familiar with the allegations and that they were true. Resident A stated that he had his phone and was looking at naked pictures of someone he identified as his girlfriend. Resident A stated that he showed DCW Grove the pictures and then DCW Grove pulled his phone out and showed him a pornography video that he had on his phone. Resident A stated that Resident B was also there and they were in the dining room when it happened. Resident A stated that it was the first time a staff ever did anything like that and it has not happened since. Resident A stated that DCW Parrish came into the dining room and told them to put their phones away and stop showing each other inappropriate pictures. Resident A stated that DCW Grove did not come back after that shift and has not worked in the home since.

On 01/06/2026, I completed an interview with Resident B in the staff office. Resident B appeared neat and clean and was able to communicate with no issues. Resident B is diagnosed with the following: Unspecified bipolar disorder, Cannabis disorder, Intellectual disability and Localization-related idiopathic epilepsy. Resident B stated that he was familiar with the allegations and that they were true. Resident B stated that Resident A was showing DCW Grove a picture of a naked girl on his phone and then DCW Grove pulled his phone out and started showing Resident and himself naked pictures. Resident B stated that he told DCW Grove that he shouldn't be showing those pictures to them at work. Resident B stated that DCW Grove was a brand new staff and probably didn't know any better. Resident B stated that DCW Parrish came into the room and told them to put their phones away and stop showing each other inappropriate pictures. Resident B stated that no other staff had ever done that before and he told the case manager what happened. Resident B stated that he thinks DCW Grove got fired since he hasn't been back.

On 01/06/2026, I completed a phone interview with Home Manager (HM) Tameka Miller concerning the allegations. HM Miller stated that she was familiar with the allegations and she believed they were true. HM Miller stated that the DCW Grove is no longer working in the home after she spoke with the residents and it was revealed that he was showing pornography to residents on his phone. HM Miller stated that she reviewed

policy with the other staff members to ensure that they knew that this type of behavior was inappropriate.

On 01/06/2026, I completed a phone interview with Program Coordinator (PC) Vuai Finney concerning the allegations. PC Finney stated that he was aware of the allegations and believed that they were true. PC Finney stated that DCW Grove was suspended pending an investigation and he then quit the job. PC Finney stated that they have had no past issues with this type of incident and that supervision has gone over policy with the current staff to ensure they know what the rules are.

On 01/13/2026, Genesee County Office of Recipient Rights (ORR) Patricia Shepard informed me that she completed her investigation and substantiated the complaint.

I attempted to contact Direct Care Worker Jonathon Groves on his last reported phone number for an interview on 01/06/2026, 01/08/2026 and 01/13/2026 with no success.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that Staff showed residents pornography on his phone. I interviewed the following people concerning the allegations: Program Coordinator, Home Manager, Direct Care Worker, Resident A and Resident B. The parties interviewed believe the allegations to be true. I attempted to interview the Direct Care Worker identified as the possible perpetrator but he did not answer any phone calls and make himself available for an interview. The Direct Care Worker in question quit after he was placed on suspension pending an investigation into the allegations. Genesee Health Systems ORR Shepard completed her investigation and substantiated the complaint. Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff does not give residents medication as prescribed.

INVESTIGATION:

On 11/20/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Staff does not give residents medication as prescribed.

On 11/21/2025, The Department of Health and Human Services Centralized Intake denied the complaint and did not assign for investigation.

On 01/06/2026, I completed an unannounced onsite investigation at Wilson Road Home and interviewed the following people: Direct Care Worker Phillip Parrish, Resident A and Resident B.

On 01/06/2026, I completed an interview with Direct Care Worker (DCW) Phillip Parrish concerning the allegations. DCW Parrish stated that he was familiar with the allegations but did not believe they were true. DCW Parrish stated that the residents get their medication timely every day. DCW Parrish stated that sometimes the residents will get up early and want their morning medication earlier than their prescribed time and the staff will make them wait until a certain time to ensure they get their medication at the same time as prescribed. DCW Parrish stated that residents always get their medication and the residents get their medication in the medication room every day.

On 01/062026, DCW Parrish was able to show me the medication room, Medication Administration Reports (MARs) and the medication for each resident. The medication and log were consistent with each other and there did not appear to be any issues with the medications.

On 01/06/2026, I completed an interview with Resident A in the staff office. Resident A appeared neat and clean and was able to communicate with no issues. Resident A is diagnosed with the following: Bipolar disorder, Unspecified paraphilic disorder and Antisocial personality disorder. Resident A stated that he was not familiar with the allegations but did not believe they were true. Resident A stated that all of the residents receive their medication daily and has not heard of anyone not getting their medication. Resident A stated that he receives medication three times daily and that staff never forget to give him his medication. Resident A stated that the residents get their medication in the medication room and that sometimes it takes like 20 or 30 minutes to get them if one of the other residents takes a long time to take their medication.

On 01/06/2026, I completed an interview with Resident B in the staff office. Resident B appeared neat and clean and was able to communicate with no issues. Resident B is diagnosed with the following: Unspecified bipolar disorder, Cannabis disorder, Intellectual disability and Localization-related idiopathic epilepsy. Resident B stated that

he was not familiar with the allegations but did not believe they were true. Resident B stated that the staff give them their medication every day. Resident B stated that sometimes the residents get upset if it takes a couple minutes longer cause everyone gets them at the same time but they always get their medication. Resident B stated that they get their medication in the medication room and whoever is working that day gives them their medication. Resident B stated that staff have never forgotten to give him his medication.

On 01/06/2026, I completed a phone interview with Home Manager (HM) Tameka Miller concerning the allegations. HM Miller stated that she was not aware of the allegations but did not believe they were true. HM Miller stated that she had not heard of any issues with medication so she could not speak to the allegations. HM Miller stated that residents get their medication daily and that all staff are trained to administer medication.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	It was alleged that Staff does not give residents medication as prescribed. I interviewed the following people concerning the allegations: Home Manager, Direct Care Worker, Resident A and Resident B. The parties interviewed believe the allegations are not true. The residents stated that they receive their medication timely and accurately and they are not aware of any issues concerning residents not getting their prescribed medication. I reviewed the medication and the Medication Administration Report (MARs) and they appear to be up to date with no discrepancies. Upon completion of my investigation, it has been determined that there is no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 01/13/2026, I completed an exit conference with Licensee Designee (LD) Paula Barnes. I explained the results of this investigation to LD Barnes.

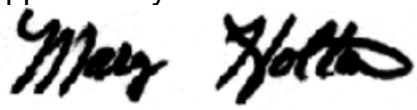
IV. RECOMMENDATION

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

01/14/2026

Martin Gonzales Licensing Consultant	Date

Approved By:



01/16/2026

Mary E. Holton Area Manager	Date