



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2026

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

RE: License #: AM250083741
Investigation #: 2026A0779020
Lara House

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,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

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 #:	AM250083741
Investigation #:	2026A0779020
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/11/2026
Report Due Date:	05/10/2026
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dale McAlpine
Licensee Designee:	Paula Barnes
Name of Facility:	Lara House
Facility Address:	6151 W. Lake Road Clio, MI 48420
Facility Telephone #:	(810) 687-2350
Original Issuance Date:	06/22/2001
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/4/2026, Resident A sustained a burn on his thigh from an unknown source or incident.	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake 2026A0779020
03/11/2026	Special Investigation Initiated - Telephone Voicemail left for ORR investigator.
03/12/2026	Contact - Telephone call received Spoke to ORR.
03/17/2026	Inspection Completed On-site
03/17/2026	Contact - Telephone call made Spoke to staff person, Lisa Pennyman.
03/17/2026	Contact - Telephone call made Spoke to staff person, Dalisha Redrick.
03/17/2026	Contact - Telephone call made Spoke to Hospice nurse.
03/17/2026	APS Referral Confirmed with APS they already received this complaint.
04/07/2026	Contact - Telephone call made Spoke to home manager.
04/09/2026	Exit Conference Held with licensee designee, Paula Barnes.

ALLEGATION:

On 3/4/2026, Resident A sustained a burn on his thigh from an unknown source or incident.

INVESTIGATION:

On 3/12/2026, a phone was made to recipient rights investigator, Pat Shepard, who confirmed that she was investigating the same allegations. ORR Shepard stated that she had already spoken to several staff and they all said that they do not know how the red mark got there. ORR Shepard stated that staff claim that Resident A does not drink hot coffee/liquids that would have spilled on him. ORR Shepard reported that staff person, Miracle Horne was the staff assigned to provide personal care for Resident A and he was the one that noticed the red mark on 3/4/2026. ORR Shepard stated that Resident A receives Hospice services and that the Hospice nurse thinks the red mark is some type of burn.

On 3/17/2026, an on-site inspection was conducted. Resident A was observed to be clean and well-groomed. Resident A was observed to have a large burn on his right thigh that appeared to be healing and starting to scab over. Due to his cognitive deficiencies, Resident A was not able to be interviewed.

This home serves the mentally ill and developmentally disabled populations. No other residents were able to provide any information related to how Resident A obtained his burn.

A review of Resident A's record was completed and Resident A does not require any enhanced supervision. Resident A is non-mobile, utilizes a wheelchair, has a puree diet, and requires full assistance from staff to complete all his activities of daily living, except eating.

On 3/17/2026, staff person, Rotishelle Person, stated that she worked 1st and 2nd shift from 5:30am-9:30pm on 3/4/2026. Staff Person stated that she changed Resident A's brief at 5:40am and Resident A did not have any red marks or burns at that time. Staff Person stated that she did not provide any further personal care to Resident A that day and did not interact with Resident A during any meals. Staff Person reported that, from what she saw, Resident A seemed normal all day, but that Resident A does not seem to express pain.

On 3/17/2026, staff person, Kanquasha Stevenson, reported that she worked 1st shift from 8:30am-5:30pm. Staff Stevenson stated that she did not do any personal care for Resident A that day and that she has no idea how Resident A obtained the burn. Staff Stevenson stated that she is not aware of any incidents involving Resident A during her shift.

On 3/17/2026, staff person, Miracle Horne, reported that he worked 2nd shift on 3/4/2026 from 1:30pm-9:30pm and that he was assigned to complete all of Resident A's personal care that shift. Staff Horne stated that he checked and/or changed Resident A's brief multiple times between 1:30 and 7:30pm, and did not see any red mark or burn. Staff Horne reported that at 8:30pm, he was getting Resident A ready for bed and decided to give Resident A a shower. Staff Horne stated that when he undressed Resident A for the shower, he noticed a big red spot on his leg, sort of like a blister, so he went and got his home manager and they decided to not shower Resident A at that time. Staff Horne stated that there was a dark colored dry stain on Resident A's pants, that was located where the red mark was, but there was no hole in Resident A's pants. Staff Horne reported that Resident A never expressed any pain. Staff Horne stated that he is not aware of any incidents involving Resident A on 3/4/2026 and claimed that he has no idea how Resident A obtained the burn on his leg.

The facility provided a copy of an Incident/Accident Report (IR) regarding the injury to Resident A. The IR was completed by Staff Horne and matched the information that Staff Horne provided when interviewed. The IR stated that Resident A was checked and/or changed multiple times throughout the day on 3/4/2026. It stated that at 6:30pm and 7:30pm, Resident A was dry and was not changed. The IR reported that Resident A was wet after Staff Horne passed medications at 7:30pm and Staff Horne started to give Resident A a shower and the red mark was noticed before the shower took place. The corrective measures on the IR were to continue to closely monitor Resident A.

On 3/17/2026, a phone call was made to staff person, Lisa Pennyman, who stated that she worked 5:30am-1:30pm on 3/4/2026. Staff Pennyman stated that she completed all of Resident A's personal care on 1st shift, changed him multiple times, and never saw any red marks or burns. Staff Pennyman reported that Resident A did not have any unusual incidents during her shift and never expressed having any pain. Staff Pennyman stated that Resident A is on a pureed diet and does not drink any hot beverages. Staff Pennyman stated that she last changed Resident A at 1:10pm and he did not have a red mark or burn.

On 3/17/2026, a phone call was made to staff person, Dalisha Redick, who stated that she worked 9:00am-5:30pm on 3/4/2026. Staff Redick stated that she had kitchen duties that day and did not complete any personal care for Resident A. Staff Redick confirmed that Resident A is on a pureed diet and does not drink hot liquids. Staff Redick stated that she interacted with Resident A during lunch and dinner and that Resident A had no incidents during either meal. Staff Redick stated that Resident A had no known spills or food on his clothing and appeared to be fine when she left work at 5:30pm.

On 3/17/2026, a phone call was made to Resident A's Hospice nurse, Heather Rinks, who stated the home called her to report the red mark and that she saw Resident A the next morning. Nurse Rinks stated that Resident A definitely has a burn on his right thigh and that they started treating the burn with anti-biotic cream and then switched to a prescribed cream. Nurse Rinks reported that it looks like something hot landed on

Resident A left thigh and then ran down the side of his leg. Nurse Rinks stated that no one at this home had any explanation for how Resident A obtained the burn and that Resident A is not able to verbalize any incident that may have happened.

On 4/7/2026, a phone call was to home manager, Tamika Miller, who stated that she was at the home when the red mark was first noticed. HM Miller stated that Staff Horne called her into the bathroom and Resident A was standing in the shower with the water running and Resident A had the red mark on his leg. HM Miller reported that no staff reported that Resident A had any incidents that day and claimed that they did not know how Resident A got the red mark. HM Miller stated that Staff Horne was assigned to do all of Resident A's personal care during 2nd shift and that she does not understand how Staff Horne could not know how Resident A was injured.

On 4/9/2026, an exit conference was held with licensee designee, Paula Barnes, who stated that she will conduct her own internal investigation to try and obtain more detailed information to determine how Resident A got burned. Admin Barnes was informed of the outcome of the investigation and that a written corrective action plan is required.

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:	Sometime on 3/4/2026, Resident A suffered a rather large burn on his right thigh. All staff who worked 1 st and 2 nd shift on 3/4/2026 stated that they do not know how Resident A obtained the burn and due to his cognitive deficiencies, Resident A was not able to communicate what had happened. No explanation has been given. There was sufficient evidence found to prove that Resident A was not adequately protected and kept safe.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Christopher A. Holvey

4/10/2026

Christopher Holvey
Licensing Consultant

Date

Approved By:

Mary Holton

4/10/2026

Mary E. Holton
Area Manager

Date