STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

April 22, 2026

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

RE: License #: AS250010863
Investigation #: 2026A0569018
Sycamore House

Dear Paula Barnes:

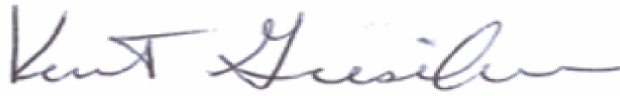
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010863
Investigation #:	2026A0569018
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/12/2026
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:	Sharon Williams
Licensee Designee:	Paula Barnes
Name of Facility:	Sycamore House
Facility Address:	11170 Linden Rd Clio, MI 48420
Facility Telephone #:	(810) 564-1699
Original Issuance Date:	03/03/1989
License Status:	REGULAR
Effective Date:	02/10/2026
Expiration Date:	02/09/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The residents were left unsupervised in the facility on 03/08/2026.	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake 2026A0569018
03/12/2026	APS Referral Referral to APS.
03/12/2026	Special Investigation Initiated - Letter Email to Pat Shepard, RRO.
04/14/2026	Contact - Telephone call made Contact with Pat Shepard.
04/14/2026	Inspection Completed On-site
04/14/2026	Contact - Face to Face Contact with Sharon Williams, administrator.
04/15/2026	Contact - Telephone call made Attempted contact with Jamari Sanders, staff person.
04/20/2026	Contact - Telephone call made Contact with Jamari Sanders.
04/20/2026	Inspection Completed-BCAL Sub. Compliance
04/20/2026	Exit Conference Exit conference with Paula Barnes, licensee designee.
04/20/2026	Corrective Action Plan Requested and Due on 05/10/2026
04/20/2026	Contact- Telephone call made. Attempted contact with Michelle Stinson, staff person. No voicemail available.
04/21/2026	Contact - Telephone call made.

	Attempted contact with Michelle Stinson, staff person. No voicemail available.
04/22/2026	Contact - Telephone call made. Contact with Sharonda Williams, staff person.

ALLEGATION:

The residents were left unsupervised in the facility on 03/08/2026.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that Jamari Sanders, staff person, left the facility on 03/08/2026 before other staff arrived. The complainant reported that the residents were left alone in the facility with no supervision as a result.

Pat Shepard, recipient rights officer, stated on 04/14/2026 that she investigated this allegation. Pat Shepard stated that she interviewed Jamari Sanders, staff person. Jamari Sanders admitted that she had left the facility before the next shift staff arrived, leaving the residents in the facility with no supervision for approximately 15 to 20 minutes. Pat Shepard stated that none of the residents are capable of moving independently in the community or being left unsupervised. Pat Shepard stated that no residents were injured as a result of having no supervision. Pat Shepard stated that she has substantiated a violation of resident rights and that Jamari Sanders has been terminated from employment.

An unannounced inspection of this facility was conducted on 04/14/2026. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he did not recall any incident when the residents were left unsupervised in the facility.

Five residents were present during the inspection on 04/14/2026 and all of the residents were observed. All of the residents were observed to be appropriately dressed and groomed with no visible injuries. None of the residents currently residing in this facility are capable of moving independently in the community per the written resident assessments.

Sharon Williams, administrator, stated on 04/14/2026 that Jamari Sanders admitted to leaving the facility on 03/08/2026 prior to the incoming shift staff arriving at the facility, leaving the residents unsupervised in the facility. Sharon Williams stated that none of the residents residing in this facility can move independently in the community and none

of the residents can be left unsupervised. Sharon Williams stated that the second shift staff, Sharonda Williams, arrived at the facility and reported that Jamari Sanders was not present and there were no staff in the facility. Sharon Williams stated that Jamari Sanders has been terminated from employment.

Jamari Sanders, staff person, stated on 04/20/2026 that he was working on 03/08/2026 and needed to leave the facility for another appointment. Jamari Sanders stated that the staff for the next shift were running late and he could not stay until they arrived for their shift. Jamari Sanders stated that the end of his shift was 5:00pm and he left “shortly after 5:00pm” but did not know how long the residents were left alone before Michelle Stinson, staff person, arrived for the next shift. Jamari Sanders stated that he did not notify a manager or any other staff to inform them that he could not stay past his shift time. Jamari Sanders stated that he did leave the residents in this facility with no supervision. Jamari Sanders stated that he was terminated from employment following this incident.

Sharonda Williams, staff person, stated on 04/22/2026 that she received a text message from Jamari Sanders at 5:20pm on 03/08/2026 stating that he could not stay any longer at the facility. Staff Williams stated that she told Staff Sanders that he could not leave the residents without a staff person present, but he responded that he had to go somewhere and was leaving the facility. Staff Willams stated that staff arrived at the facility 10 to 15 minutes after the final text from Staff Sanders so the residents were left in the facility with no supervision for 10 to 15 minutes. Staff Willams stated that none of the residents were injured or harmed and that she then reported that staff Sanders left the residents unsupervised to management.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	The complainant reported that Jamari Sanders, staff person, left the residents in this facility unsupervised on 03/08/2026. Jamari Sanders admitted to leaving the residents unsupervised before

	the incoming shift staff arrived at the facility on 03/08/2026. Based on the statements given it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Paula Barnes, licensee designee, on 04/20/2026. The findings in this report were reviewed, and a written corrective action plan was requested.

IV. RECOMMENDATION

I recommend that the status of this license remains unchanged with the receipt of an acceptable corrective action plan.

04/22/2026

Kent W Gieselman
Licensing Consultant

Date

Approved By:

04/22/2026

Mary E. Holton
Area Manager

Date