



STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

GRETCHEN WHITMER  
GOVERNOR

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 #:	AS440400086
Investigation #:	2026A1039023
	Oregon 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,

A handwritten signature in cursive script, appearing to read "Martin Gonzales".

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**

<b>License #:</b>	AS440400086
<b>Investigation #:</b>	2026A1039023
<b>Complaint Receipt Date:</b>	02/24/2026
<b>Investigation Initiation Date:</b>	02/24/2026
<b>Report Due Date:</b>	04/25/2026
<b>Licensee Name:</b>	Central State Community Services, Inc.
<b>Licensee Address:</b>	Suite 201 2603 W Wackerly Rd Midland, MI 48640
<b>Licensee Telephone #:</b>	(989) 631-6691
<b>Administrator:</b>	Dana Marshall
<b>Licensee Designee:</b>	Paula Barnes
<b>Name of Facility:</b>	Oregon Home
<b>Facility Address:</b>	1568 W. Oregon Lapeer, MI 48446
<b>Facility Telephone #:</b>	(989) 513-7503
<b>Original Issuance Date:</b>	10/01/2019
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/01/2024
<b>Expiration Date:</b>	03/31/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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**II. ALLEGATION(S)**

	<b>Violation Established?</b>
<b>Staff Avionna Laboy threw Resident A on the ground and he hit his head on a vent causing redness.</b>	Yes

**III. METHODOLOGY**

02/24/2026	Special Investigation Intake 2026A1039023
02/24/2026	APS Referral called in via telephone.
02/24/2026	Special Investigation Initiated - Letter Emailed ORR Kelly North regarding complaint.
02/24/2026	Contact - Document Received ORR Kelly North sent additional information concerning allegations.
02/24/2026	Contact - Document Received APS worker Janetsky sent information regarding allegations.
03/05/2026	Inspection Completed On-site Interviewed Home Manager and Direct Care Worker.
04/06/2026	Contact - Telephone call made APS worker Janetsky informed me that he did substantiate on the complaint.
04/06/2026	Contact - Telephone call made Completed with Guardian A1.
04/06/2026	Contact – Telephone call made Attempted phone contact with DCW Laboy. No answer left message.
04/07/2026	Contact - Face to Face FF with Resident A at his day program.
04/07/2026	Contact – Telephone call made

	Attempted phone contact with DCW Laboy. No answer left message.
04/07/2026	Exit Conference Completed with Licensee Designee Paula Barnes.
04/07/2026	Inspection Completed-BCAL Sub. Compliance
04/08/2026	Contact – Telephone call made Attempted phone contact with DCW Laboy. No answer left message.

**ALLEGATION:**

**Staff Avionna Laboy threw Resident A on the ground and he hit his head on a vent causing redness.**

**INVESTIGATION:**

On 02/24/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Staff Avionna Laboy allegedly threw Resident A on the ground and he hit his head on a vent causing redness.

On 03/05/2026, I completed an unannounced investigation at Oregon Home concerning the allegations. I interviewed the following people: Home Manager John Lokken and Medical Coordinator Shaniya Majied. There were no residents at the home at the time of the investigation. The residents were all at Stepping Stone day program.

On 03/05/2026, I interviewed Home Manager (HM) John Lokken concerning the allegations. HM Lokken stated that he was aware of the allegations but that he was not working at the time the incident occurred. HM Lokken stated that he believed the allegations were true as another staff member witnessed the incident. HM Lokken stated that the staff member that allegedly pushed Resident A was Direct Care Worker (DCW) Avionna Laboy. HM Lokken stated from what he understands, DCW Laboy was frustrated with Resident A because he was refusing to eat his food and she pushed him and he fell back and hit his head on the vent that was located along the floor on the kitchen wall. HM Lokken stated that it was reported that Resident A had some redness on the back of his head from hitting the vent. HM Lokken stated that Direct Care Worker (DCW) Shaniya Majied witnessed the incident and reported it to supervision and DCW Laboy was immediately taken off of the schedule and has not returned to work. HM Lokken stated that Resident A is non-verbal and was unable to verbalize what happened to him. HM Lokken stated that Resident A was moved out of the home by his guardian. HM Lokken stated that there are currently five residents in the home. HM Lokken stated that all of the residents in the home are non-verbal and they were all at a

day program. HM Lokken took me to the kitchen where the incident occurred and showed me where Resident A hit his head and there appeared to be a dent in the vent.

On 03/05/2026, I completed an interview with Direct Care Worker (DCW) Shaniya Majied concerning the allegations. DCW Majied stated that she was aware of the allegations and believes they are true. DCW Majied stated that she was working when the incident happened. DCW Majied stated that she witnessed DCW Laboy yell at Resident A multiple times that day. DCW Majied stated that earlier in the day she witnessed DCW Laboy yell at Resident A for soiling himself. DCW Majied stated that Resident A is non-verbal and needs assistance with the bathroom and that there was no reason for DCW Laboy to yell at Resident A. DCW Majied stated that she informed supervision of DCW Laboy yelling at Resident A about soiling himself but is not sure what happened regarding that.

DCW Majied stated that later that same day, DCW Majied was feeding Resident A and he did not want to eat his food. It appeared that DCW Laboy was getting frustrated with Resident A because she heard DCW Laboy begin to yell at Resident A for not eating. DCW Majied stated that Resident A was sitting at the island in the kitchen and that DCW Laboy came around and grabbed Resident A by the shirt and pushed Resident A down. DCW Majied stated that Resident A fell to the ground and hit his head on a vent when he fell. DCW Majied stated that DCW Laboy kept calling Resident A names and cursing at him and pushed him towards his room. DCW Majied stated that Resident A then went into his room. DCW Majied stated that she notified her supervisor of the incident. DCW Majied stated that DCW Laboy has been working at the home and believes she was suspended but is unsure.

On 04/06/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations and believed they were true. Guardian A1 stated that she believed that DCW Laboy lost her temper with Resident A and threw him down on the ground and Resident A hit his head on a vent. Guardian A1 stated that there was another staff member there that was a witness to the incident. Guardian A1 stated that she believes that there have been other incidents with staff and Resident A but does not know for sure. Guardian A1 stated that she thinks that staff tried to cover the incident up. Guardian A1 stated that she removed Resident A from the home on 02/20/2026 when she found out about it. Guardian A1 stated that Resident A is now at Woodlawn AFC home. Resident A continues to attend Stepping Stone day program in Lapeer, MI. Guardian A1 stated that the way Resident A was treated at Oregon Home is unacceptable.

On 04/06/2026, Department of Health and Human Services Adult Protective Services (APS) Worker Eric Janetsky confirmed that he had completed his investigation. APS Janetsky stated that he substantiated the complaint.

On 04/06/2026, Lapeer County Community Mental Health Office of Recipient Rights (ORR) Worker Kelly North confirmed that they completed their investigation. ORR North stated that they substantiated the complaint as an Abuse II: non accidental act.

On 04/07/2026, I completed an unannounced visit to Stepping Stone day program in Lapeer, MI. I completed an interview with Stepping Stone Supervisor Andrea Casler concerning the allegations. Supervisor Casler stated that she was aware of the allegations but was unsure what exactly happened to Resident A at the Oregon Home. Supervisor Casler stated that she did see the redness on the head of Resident A after the incident happened. Supervisor Casler stated that there is not a past history of injuries and that Resident A does have a past history of self-injurious behavior. Supervisor Casler stated that she has spoken to Lapeer ORR, Oregon Staff and Guardian A1 concerning the incident. Supervisor Casler stated that Resident A is no longer in the home and that he has moved to a new AFC home. Supervisor Casler stated that there has been no change in Resident A's behaviors since he was moved to a new home.

Supervisor Casler informed me that Resident A was currently in a classroom and that we could go see him. Resident A was in his classroom sitting at a desk when I viewed him. Resident A appeared neat and clean but is non-verbal and was unable to speak. Supervisor Casler was able to have Resident A stand up and let me view the area of his head that he hit on the vent. There was no longer any redness or signs of distress in the area that Resident A hit on the vent. Resident A appeared happy and gave Supervisor Casler a hug as we exited the classroom.

I viewed Resident A's Assessment Plan dated 02/18/2025. Resident A is diagnosed with the following: Autism disorder, Cerebral palsy and Bi-lateral hearing loss non-verbal. The plan notes that Resident A is non-verbal and requires assistance with his communication needs. Resident A requires assistance with understanding verbal communication, eating/feeding, toiletry, bathing, grooming, dressing and personal hygiene. Resident A may hit staff and requires redirection. Resident A exhibits self-injurious behaviors such as biting his hand and smacking his face.

I attempted to contact Direct Care Worker (DCW) Avionna Laboy on 04/06/2026, 04/07/2026 and 04/08/2026 by phone with no success.

I reviewed a Notice of Termination that DCW Avionna Laboy was separated from employment on 03/03/2026. The Notice of Termination states that following an investigation by Lapeer CMH Right department, it was determined that an incident occurred on 02/14/2026, resulted in a substantiated Recipient Rights violation for Abuse-Class II (Non-Accidental Act).

I reviewed a Notice of Termination that DCW Shaniya Majied was separated from employment on 03/11/2026. The Notice of Termination states that DCW Majied failed to report to Recipient Rights violation in a timely manner. The Notice of Termination states that on 02/14/2026, DCW Majied witnessed an incident involving abuse towards

a resident. As a direct care staff member, she is required to report any suspicious or observed abuse, neglect, exploitation, or right violation in accordance with Recipient Rights regulations, agency policy, and applicable state licensing requirements. The investigation determined that DCW Majied witnessed the incident on 02/14/2026 and did not report it until 02/19/2026. The delay is a violation of agency policy and Recipient Rights requirements. Failure to report incidents of abuse in a timely manner places residents at risk and is considered a serious violation of professional responsibilities.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>It was alleged that Staff Avionna Laboy allegedly threw Resident A on the ground and he his head on a vent causing redness.</p> <p>I interviewed the Home Manager, Direct Care Worker, Stepping Stone Supervisor and Guardian A1 concerning the allegations. The parties interviewed believe the allegations are true</p> <p>Department of Health and Human Services Adult Protective Services (APS) Worker Eric Janetsky confirmed that he had completed his investigation. APS Janetsky stated that he substantiated the complaint for abuse.</p> <p>Lapeer County Community Mental Health Office of Recipient Rights (ORR) Worker Kelly North confirmed that she completed her investigation. ORR North stated that she substantiated the complaint regarding Avionna Laboy as an Abuse II: non accidental act.</p> <p>I viewed the Notice of Termination of DCW Laboy for Abuse II: non accidental act.</p> <p>I viewed the Notice of Termination of DCW Majied for witnessing an incident of abuse towards a resident and not reporting it immediately in accordance with Recipient Rights regulations, agency policy, and applicable state licensing requirements.</p> <p>Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.629</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(4) Direct care staff shall possess all of the following qualifications before working independently: (a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.</b>
<b>ANALYSIS:</b>	<p>Avionna Laboy is not capable of meeting the physical, emotional, intellectual and social needs of residents.</p> <p>Lapeer County Community Mental Health Office of Recipient Rights (ORR) Worker Kelly North confirmed that she completed her investigation. ORR North stated that she substantiated the complaint regarding Avionna Laboy as an Abuse II: non accidental act.</p> <p>I viewed the Notice of Termination of Aviona Laboy for Abuse II: non accidental act.</p> <p>Upon completion of my investigation it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 04/07/2026, I completed an exit conference with Licensee Designee (LD) Paula Barnes. I informed LD Barnes of the results of my investigation.

**IV. RECOMMENDATION**

Upon receipt of an approved corrective action plan, I recommend no change in licensure status.

*Martin Gonzales*

04/10/2026

Martin Gonzales Licensing Consultant	Date
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Approved By:

*Mary Holton*

04/10/2026

Mary E. Holton Area Manager	Date
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