GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 17, 2021

Nancy Beach
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS730016089
Investigation #: 2021A0233010
Navaho Trail Home

Dear Ms. Beach:

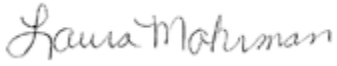
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (906) 226-4171.

Sincerely,



Laura Mohrman, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 290-3428

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730016089
Investigation #:	2021A0233010
Complaint Receipt Date:	05/24/2021
Investigation Initiation Date:	05/25/2021
Report Due Date:	06/23/2021
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(989) 860-7904
Administrator:	Diane Carrillo
Licensee Designee:	Nancy Beach, Designee
Name of Facility:	Navaho Trail Home
Facility Address:	3161 Navaho Trail Hemlock, MI 48626
Facility Telephone #:	(989) 642-3603
Original Issuance Date:	08/01/1994
License **Status:**	REGULAR
Effective Date:	02/22/2021
Expiration Date:	02/21/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/6/2021 staff Kathleen Ray was swearing, and threatening Resident A. Ms. Ray yanked Resident A's pants and underwear down off her body as she was lying in bed. Ms. Ray was also degrading towards Resident B who is Resident A's roommate.	Yes
Additional Findings	No

III. METHODOLOGY

05/24/2021	Special Investigation Intake 2021A0233010
05/24/2021	APS Referral This complaint came in as a denied APS referral.
05/25/2021	Special Investigation Initiated – Letter I emailed the Administrator Diane Carrillo and requested documents.
05/26/2021	Contact - Document Received I received Resident A's assessment, progress notes and a list of staff names. I also received information from Ms. Rays personnel file that I requested.
06/01/2021	Contact - Telephone call made I called staff person Nakella Williams
06/01/2021	Contact - Telephone call made I called staff person Kathleen Ray
06/03/2021	Contact - Telephone call made I called the facility and spoke to staff person Victoria Wale and Resident A
06/03/2021	Inspection Completed On-site This inspection was completed virtually
06/04/2021	Contact - Telephone call made I spoke to Diane Carrillo (Administrator)
6/11/2021	Contact - Telephone call made

	I spoke to the Guardian of Resident A and Resident B
6/16/2021	Exit conference I spoke to Ms. Carrillo

ALLEGATION:

On 5/6/2021 staff Kathleen Ray was swearing, and threatening Resident A. Ms. Ray yanked Resident A's pants and underwear down off her body as she was lying in bed. Ms. Ray was also degrading towards Resident B who is Resident A's roommate.

INVESTIGATION:

On May 24, 2021, I received a complaint from adult protective services who denied the intake.

The complaint states that on May 6, 202, staff person Kathleen Ray was swearing and threatening Resident A. It states that Ms. Ray yanked Resident A's pants off while she was lying in bed. The complaint also states that Ms. Ray told Resident B (Resident A's roommate) not to laugh and threatened to take her snack away. The complaint also states that Ms. Ray was taken off the schedule.

On May 25, 2021, I email Diane Carrillo (Administrator). I requested Resident A and B's assessment, progress notes, a list of staff names/phone numbers and any written discipline in Ms. Rays employee file.

On May 26, 2021, I received the requested documentation and reviewed them. The progress notes did not indicate an altercation between the residents and staff. It does state that Resident A was yelling at staff and refused to eat her dinner. It does not indicate that Resident B had any issues on 5/6/2021. Ms. Ray has been employed for 1 year and has received verbal and written warnings. The written and verbal warnings include: 1/5/2021 verbal counseling on gossiping, 3/29/2021 was given a counseling on neglect and reporting suspected abuse/ neglect. (This incident is still being investigated by CMH), 4/12/2021 verbal on weights and vitals documentation and 4/16/2021 she had 3 counseling's for a medication errors that occurred on 4/14/2021.

On May 26, 2021, I spoke to Ms. Carrillo. She stated that Ms. Ray was suspended when the allegation was received, and the facility plans to terminate her when the investigation is closed.

On June 1, 2021, I interviewed Nakella Williams by phone. Ms. Williams stated she was working the afternoon of 5/6/2021. She stated she was passing medications and she heard yelling and cursing. Ms. Williams thought Ms. Ray was on the phone but then realized that she was speaking to the residents this way. She stated she went to the

resident's room and let Ms. Ray know that what she was doing was not okay. Ms. Williams stated she recorded what was happening on her phone. Ms. Williams stated she that the incident occurred on Thursday May 6th, but she did not report it to Ms. Carrillo until the following Tuesday May 11th when she returned to work. Ms. Williams stated that she has never witnessed Ms. Ray treating the residents this way prior to 5/6/2021.

On June 1, 2021, I called Kathleen Ray. She stated that she was not working on 5/6/2021. Ms. Ray stated she thought she was suspended on 5/4/2021, due to an investigation in March. She stated that she reported a staff in March for swearing at Resident A and that staff was terminated. She stated that the staff that was terminated said it was Ms. Ray that was swearing at Resident A and that is why she was suspended. I explained to her that I am not aware of the investigation in March and that I am investigating what happened on 5/6/2021. Ms. Ray stated if she was working on 5/6/2021 she did not mistreat any of the residents at the facility and denied ever mistreating the residents. She stated that no one has contacted her regarding either allegations.

On June 3, 2021, I interviewed Victoria Wale over the phone. Ms. Wale stated that she has worked many shifts with Ms. Ray and has never witnessed her mistreat a resident. She stated that Resident A can be verbally aggressive at times and the staff will switch off with giving cares if she is targeting that staff person.

On June 3, 2021, I interviewed Resident A over the phone. She stated that she does not remember a staff person yelling at her or threatening her. She stated that the staff have not yelled at her. I assured Resident A that she is not in trouble and that she can tell me what happened. She again stated that the staff have not sworn at her or threatened her. She then stated if she told anyone they would not believe her. I told her I would believe her and that I would make sure it did not happen again. Resident A again said she does not remember a staff yelling at her.

On June 4, 2021, I spoke to Ms. Carrillo. I let her know that based on the information I gathered I believe it to be true. I let her know that the facility clearly took it seriously and suspended the employee and the other employee reported it but should have reported it immediately. I asked Ms. Carrillo about the recording on the phone. She stated she was not told about the recording when it was first reported to her. Ms. Carrillo stated she heard about the recording from recipient rights. She stated that Ms. Williams will be receiving a written warning regarding having her phone and recording a resident.

On June 11, 2021, I spoke to Resident A and B's guardian who is the same person. He stated he was not aware of this investigation. He stated that he has not had any concerns about the staff at the facility. He stated that he thinks they do a good job caring for the residents. I asked him about interviewing Resident B, and he stated she is very difficult to understand, and that Ms. Carrillo is very good at interpreting what she is saying. I let him know that I did interview Resident A and she denies any mistreatment from the staff. He stated that she will often deny things in fear of getting into trouble. I let

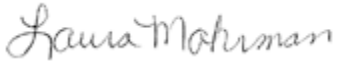
him know that I felt she was not being truthful with me in fear of “getting into trouble” even after I assured her that she was not in trouble.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information gathered Ms. Ray was swearing at Residents A and B and was threatening to take away their privileges. The facility took appropriate action and suspended Ms. Ray as soon as they were made aware of the incident. Ms. Williams is also receiving written discipline for using her phone to record a resident and not reporting the incident immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

Exit conference: On June 16, 2021, I called Ms. Carrillo and went over my findings I found the allegation to be true.

IV. RECOMMENDATION

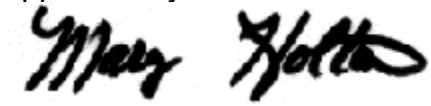
Contingent upon an acceptable corrective action plan I recommend no change to the status of this license.



06/16/2021

Laura Mohrman Date
Licensing Consultant

Approved By:



06/17/2021

Mary E Holton Date
Area Manager