



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

September 6, 2022

Stephanie Riley  
Valley Residential Serv Inc.  
P O Box 186  
St Charles, MI 486550186

RE: License #: AS730094689  
Investigation #: 2022A0580052  
Southport Home

Dear Ms. Riley:

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. violations of any licensing rules are also violations of the MSA and your contract.

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 "Sabrina McGowan". The signature is written in black ink on a white background.

Sabrina McGowan, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 835-1019

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS730094689
<b>Investigation #:</b>	2022A0580052
<b>Complaint Receipt Date:</b>	08/19/2022
<b>Investigation Initiation Date:</b>	08/23/2022
<b>Report Due Date:</b>	10/18/2022
<b>Licensee Name:</b>	Valley Residential Serv Inc.
<b>Licensee Address:</b>	300 S Saginaw St. Charles, MI 48655
<b>Licensee Telephone #:</b>	(231) 580-5204
<b>Administrator:</b>	Candace Wilson
<b>Licensee Designee:</b>	Stephanie Riley
<b>Name of Facility:</b>	Southport Home
<b>Facility Address:</b>	2950 Briarwood Saginaw, MI 48601
<b>Facility Telephone #:</b>	(989) 777-5165
<b>Original Issuance Date:</b>	10/24/2000
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/09/2021
<b>Expiration Date:</b>	11/08/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Complaint alleges Resident A assaulted staff and staff, Ms. Rosie Bullock responded by grabbing resident.	Yes

## III. METHODOLOGY

08/19/2022	Special Investigation Intake 2022A0580052
08/19/2022	APS Referral This complaint was denied by APS for investigation.
08/22/2022	Contact - Document Received An emailed copy of the incident report was received from Ms. Christina Garza, assigned AFC Consultant
08/23/2022	Special Investigation Initiated - On Site An onsite inspection was conducted. Contact was made with Ms. Aeriell Scott, staff.
08/23/2022	Contact - Face to Face An in-person observation was made regarding Resident A.
08/23/2022	Contact - Telephone call made A call was made to Ms. Candace Wilson, Home Manager.
08/24/2022	Contact - Telephone call made A call was made to Ms. Tonya Bentley, Staff.
08/26/2022	Contact - Telephone call made I spoke with Ms. Jamie Zimmer, Saginaw County CMH Case Manager for Resident A.
08/30/2022	Contact - Telephone call made A call was made to Ms. Rosie Bullock, Direct Staff.
08/30/2022	Contact - Telephone call made A call was made to Ms. Aeriell Scott, Assistant Mgr.

09/06/2022	Contact - Telephone call made A call was made to Ms. Parlee Ealy, Direct Staff.
09/06/2022	Exit Conference An exit conference was held with the licensee designee.

**ALLEGATION:**

Complaint alleges Resident A assaulted staff and staff, Ms. Rosie Bullock responded by grabbing resident.

**INVESTIGATION:**

On 08/19/2022, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 08/22/2022, I received a copy of the incident report related to the allegations from Ms. Christina Garza, the consultant assigned to the home. The incident report, completed by staff, Ms. Rosie Bullock. It indicates that on 08/17/2022, she was cleaning the dining room and Resident A pushed her. She grabbed him by his shirt and took him to his room. She then noticed a scratch on his neck and left arm. Actions taken by staff include redirecting Resident A to his room. Corrective measures indicate that staff will continue to monitor the scratch. Staff, Ms. Tonya Bentley, and Ms. Parlee Ealy were also working that evening.

On 08/23/2022, I conducted an onsite inspection at Southport Home. Contact was made with the assistant manager, Ms. Aeriell Scott, who provided phone numbers for the staff identified on the incident report.

On 08/23/2022, I conducted an observation of Resident A while in his room. Resident A was observed neat, clean, and appropriately dressed while sitting on his bed playing with books. Ms. Scott showed me the area on the left side of Resident A's neck where the scratch was located. Resident A's neck has since healed. No scratch was observed. Resident A is nonverbal and unable to participate in an interview.

On 08/23/2022, I spoke with Ms. Candance Wilson, home manager at Southport Home. She indicated that when she arrived to work on 08/18/2022, she read the incident report completed by Ms. Bullock. When she asked Ms. Bullock what happened, she indicated that she had a lot going on. She never told her what happened. Upon contacting the other staff working that shift, Ms. Tonya Bentley and Ms. Rosie Ealy, Ms. Ealy indicated that she did not observe the incident. Staff, Ms. Bentley indicated that when Resident A would not move while Ms. Bullock was sweeping, Ms. Bullock grabbed him by the neck and Resident A dropped to the floor. Ms. Bullock then pushed him to his room.

On 08/24/2022, I spoke with direct staff, Ms. Tonya Bentley. She recalled that staff, Ms. Ealy was in the bathroom preparing a bath for a resident while staff Ms. Rosie Bullock was sweeping. Ms. Bullock had requested for Resident A to move while she was sweeping the floor, however, Resident A just stood there and grunted. After asking him to move a couple of more times, Resident A still did not move. Ms. Bullock then proceeded to grab Resident A by the collar and bottom of his shirt and took him to his room. Ms. Bentley observed the scratch on Resident A's neck and proceeded to inform Ms. Ealy of what had just occurred.

On 08/26/2022, I spoke with Ms. Jamie Zimmer, assigned Saginaw County CMH worker for Resident A. She shared that Resident A is diagnosed with Moderate Intellectual Disability and Trisomy 21. He is nonverbal. She shared that staff, Ms. Rosie Bullock left her a voice mail of what occurred that evening, however, upon receiving the incident report from Ms. Wilson, the story did not match. She is aware that the staff has been suspended. Ms. Zimmer reports no prior concerns regarding his care in the home.

On 08/30/2022, I spoke with staff, Ms. Rosie Bullock, the alleged perpetrator. She shared that she has worked at the home for 1 ½ years. She enjoys and has never had any issues with the residents. She recalled that on the day in question she was sweeping while Resident A was standing in the way. She asked Resident A to move. Resident A responded by grunting and pushing her. She asked Resident A to move again, he responded by pushing her again. She then grabbed him by his shirt and proceeded to guide him in his room. She indicated that she did not initially observe a scratch, however, when staff, Ms. Ealy gave him his bath later that evening, she observed a scratch and showed it to her.

On 08/30/2022, I spoke with Ms. Scott, requesting a copy of the AFC Assessment Plan and Individual Plan of Service (IPOS) for Resident A. The assessment plan indicates that Resident A is able to follow instructions and may need redirection when dealing with aggressive behaviors. The Saginaw County Community Mental Health Individual Plan of Service (IPOS) for Resident A states that if Resident A becomes physically aggressive, staff will firmly prompt him to stop. Staff will remind Resident A that violence is not the answer and staff want to help. If Resident A becomes physically aggressive and his behavior becomes a danger to himself or others, staff will immediately evacuate the area. Staff will verbally acknowledge his emotions and tell him they are going to give him time to calm down.

On 09/06/2022, I spoke with staff, Ms. Parlee Ealy. She shared that while preparing Resident A's bath, she heard a loud thud. When she went to find out what had occurred, she observed Resident A on the floor. Ms. Bullock began trying to explain what occurred. She explained to Ms. Bullock that Resident A has rights and did not have to move if she did not want to. Ms. Ealy stated that when she began bathing Resident A she observed a scratch on the left side of his neck. She indicated that she made Ms. Bullock come observe the scratch. She then informed Ms. Bullock that she would need to complete an incident report to explain how the scratch occurred as she did not want to be blamed.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:</b> <b>(b) Use any form of physical force other than physical restraint as defined in these rules.</b>
<b>ANALYSIS:</b>	Based on my investigation, which included interviews with multiple direct staff members, Saginaw County CMH Case Manager, Jamie Zimmer, an observation of Resident A, and a review of Resident A's AFC Assessment Plan, there is evidence to substantiate the allegation that staff, Ms. Rosie Bullock used physical force in response to Resident A.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 09/06/2022, I conducted an exit conference with the licensee designee, Ms. Stephanie Riley. Ms. Riley was informed of the findings of this investigation.

#### IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

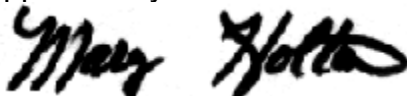


September 6, 2022

Sabrina McGowan  
Licensing Consultant

Date

Approved By:



September 6, 2022

Mary E. Holton  
Area Manager

Date