GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 18, 2024

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

RE: License #: AS540074861
Investigation #: 2025A1033001
Pineport Home

Dear Ms. Riley:

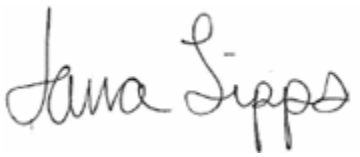
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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) 284-9730.

Sincerely,



Jana Lipps, 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

License #:	AS540074861
Investigation #:	2025A1033001
Complaint Receipt Date:	10/01/2024
Investigation Initiation Date:	10/01/2024
Report Due Date:	11/30/2024
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Dawn Vallad
Licensee Designee:	Stephanie Riley
Name of Facility:	Pineport Home
Facility Address:	915 North DeKraft Big Rapids, MI 49307
Facility Telephone #:	(231) 796-3993
Original Issuance Date:	02/12/1997
License **Status:**	REGULAR
Effective Date:	10/16/2023
Expiration Date:	10/15/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
It was discovered, during a monthly audit, that Resident A and Resident B's cash funds were both missing monies.	Yes

III. METHODOLOGY

10/01/2024	Special Investigation Intake 2025A1033001
10/01/2024	Special Investigation Initiated - On Site
10/02/2024	APS Referral- Referral made per protocol.
10/09/2024	Contact - Telephone call made Interview conducted with direct care staff, Kerri Sarns, via telephone.
10/15/2024	Contact - Telephone call made Attempt to interview direct care staff, Kandra McDonald. Voicemail message left and awaiting a response.
10/15/2024	Contact - Telephone call made Attempt to interview direct care staff, Rebecca Hayner. The telephone number provided was not a working number.
10/16/2024	Contact – Telephone call made Interview conducted with direct care staff, Kandra Donald, via telephone.
10/21/2024	Exit Conference Conducted via telephone with licensee designee, Stephanie Riley. Voicemail message left.

ALLEGATION:

It was discovered, during a monthly audit, that Resident A and Resident B's cash funds were both missing monies.

INVESTIGATION:

On 10/1/24 I received an online complaint regarding the Pineport Home, adult foster care facility (the facility). The complaint alleged that cash was missing from Resident A and Resident B's resident funds. I conducted an unannounced, on-site investigation on this date. I interviewed Administrator, Dawn Vallad, regarding the complaint. Ms. Vallad reported that at the end of each month she has a protocol where she counts all resident funds and verifies that the funds are correct and that the receipts match the tracking logs for each resident. She reported resident funds were counted on 8/28/24 by herself and Rachel Shaffer. She reported that all funds were accounted for on this date and there were no discrepancies. Ms. Vallad reported that on 9/27/24 while completing her monthly funds audit, she noted that Resident A's funds were missing $10, and Resident B's funds were missing $5. Ms. Vallad reported that she counted the funds several times and had others verify the count as she could not find the missing $15. Ms. Vallad reported resident funds monies are kept in a filing cabinet in her office, which is to be kept locked. She reported that the only individuals who have access to this filing cabinet keys are herself, direct care staff, Kandra Donald, and direct care staff, Erinn Noland. Ms. Vallad reported that there have been a couple of occasions where she has found that the file cabinet was left unlocked. She is not certain who left the file cabinet unlocked on these occasions. Ms. Vallad reported that the practice at the facility is that if a direct care staff is taking a resident on an outing and needs access to resident funds that one of the three individuals noted to have keys will access the funds and provide the cash to the direct care staff member. She reported direct care staff member will then take the resident out, obtain receipts for any purchases made with the funds, and return to the facility to record the transactions and return the remaining funds to the file cabinet. Ms. Vallad reported facility management are replacing the missing money for Resident A and Resident B.

While conducting the on-site investigation I reviewed the resident funds for Resident A and Resident B. I reviewed the *Resident Funds Part II* tracking forms, receipts, and cash available in the resident funds pouches. I verified that Resident A's funds were missing $10, and Resident B's funds were missing $5.

During the on-site investigation on 10/1/24, I reviewed the following documents:

- *Resident Funds Part II,* for Resident B, dated September 2024. This document indicated that Resident B has $62.36 cash funds available to Resident B. There were no transactions recorded on this document. I counted Resident B's funds and there was $57.36 available at the time of this investigation.

- *Resident Funds Part II,* for Resident B, dated August 2024. This document indicates that as of 8/23/24 Resident B's funds available was $62.36. There were four purchases recorded on this document. I reviewed the receipts for these purchases. The last purchase was made on 8/14/24 in the amount of $15.52 and was paid with $20.52 in cash. The receipt notes that $5 change was provided. The receipt is signed by Ms. Vallad. This transaction is signed for on the document by R. Shaffer.
- *Resident Funds Part II,* for Resident A, dated August 2024. This document indicates that as of 8/23/24 Resident A's funds available was $118.01. There was one purchase recorded on this document. I reviewed the receipt for this purchase. The purchase was made on 8/7/24 in the amount of $20 for a haircut. This purchase was paid in cash. The receipt is signed by Ms. Vallad. This transaction is signed for on the document by R. Shaffer.
- *Resident Funds Part II,* for Resident A, dated September 2024. This document had no entries recorded and did not include a balance forward amount. I counted Resident A's funds and there was $108.01 available at the time of this investigation.

On 10/9/24 I interviewed direct care staff, Kerri Sarns, via telephone. Ms. Sarns reported that resident funds are kept in a locked file cabinet in Ms. Vallad's office. She reported that there were two individuals who had keys to this filing cabinet, Ms. Vallad and Ms. Donald. Ms. Sarns reported that when a direct care staff member would take a resident to the store, either Ms. Vallad or Ms. Donald would give the direct care staff money from the resident's funds pouch and the direct care staff would track all money spent that day. She reported direct care staff obtain receipts for items purchased and bring back any remaining monies to the facility. She reported that the direct care staff would write the expenses on the tracking sheet and return the money to Ms. Vallad or Ms. Donald. Ms. Sarns reported that she has never taken money from any of the residents, and she has no knowledge of another direct care staff member taking resident funds. Ms. Sarns reported that when Ms. Vallad or Ms. Donald were not available to open the file cabinet for direct care staff to deposit funds after an outing, she would lock the funds and documentation in Resident C's lockbox where her Coumadin testing supplies are kept. She reported that she is certain she did not leave any funds in this lockbox.

On 10/16/24 I interviewed Ms. Donald regarding the allegation. Ms. Donald reported that the resident funds were kept in a filing cabinet in Ms. Vallad's office, prior to the recent discovery that funds are missing from Resident A and Resident B's pouches. Ms. Donald reported that she and Ms. Vallad were the only ones who had keys to the filing cabinet and access to the resident funds. Ms. Donald reported that direct care staff would request monies from the resident funds pouches when they would take residents to the store. She reported direct care staff keep a receipt for items purchased and bring the receipts and the change back to the facility for Ms. Vallad or Ms. Donald to record on the tracking logs. Ms. Donald reported that she has no knowledge of any direct care staff member who would have stolen monies from Resident A or Resident B's funds. Ms. Donald reported that now the facility is using

a lockbox which they keep in the same filing cabinet. She reported that Ms. Vallad is the only direct care staff member who has access to this lockbox, and she manages all resident funds at this time. Ms. Donald reported that the management at the facility are developing ways to increase security around the resident funds since Resident A and Resident B's funds were discovered to be missing. Ms. Donald reported that prior to the funds being reported as missing, they had a back up plan for where to store resident funds should a direct care staff member return from an outing and Ms. Vallad or Ms. Donald were not available. She reported that Ms. Sarns would lock the excess funds in another lockbox which holds Resident C's Coumadin testing supplies until Ms. Vallad or Ms. Donald could place the funds in the correct pouches. Ms. Donald reported that they did search this box and did not find the missing resident funds.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based upon interviews conducted with Ms. Vallad, Ms. Sarns, & Ms. Donald, as well as review of Resident A and Resident B's cash funds and funds documentation, it can be determined that Resident A is missing $10 and Resident B is missing $5 from their resident funds. The direct care staff were not able to identify where the missing funds were to account for these monies. Although it cannot be identified how and why the cash funds are missing, the direct care staff are responsible to keep these monies safe and accounted for at the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

 10/16/24

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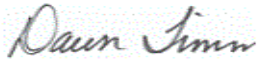
Jana Lipps Date
Licensing Consultant

Approved By:

 10/18/2024

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Dawn N. Timm Date
Area Manager