



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2025

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

RE: License #: AS230068521
Investigation #: 2025A1024033
Mulliken Afc Home

Dear Stephanie 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 (616) 356-0183.

Sincerely,

A handwritten signature in dark ink, reading "Ondrea Johnson". The signature is written in a cursive, flowing style.

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230068521
Investigation #:	2025A1024033
Complaint Receipt Date:	05/17/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/16/2025
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Geraldine Bearden
Licensee Designee:	Stephanie Riley
Name of Facility:	Mulliken Afc Home
Facility Address:	9120 E Eaton Hwy Mulliken, MI 48861
Facility Telephone #:	(517) 649-2377
Original Issuance Date:	11/01/1995
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not provided with supervision and protection as he continues to leave the facility property without staff knowledge in attempts to get inside the neighbor's house.	Yes

III. METHODOLOGY

05/17/2025	Special Investigation Intake 2025A1024033
05/22/2025	Special Investigation Initiated – Telephone left voicemail for Citizen 1
05/22/2025	Contact - Telephone call received-with Citizen 1
05/22/2025	Contact - Telephone call made with administrator Geraldine Bearden
05/22/2025	Contact - Document Received-AFC <i>Licensing Division-Incident/Accident Report</i> and Resident A's <i>Behavior Treatment Plan</i> (BTP) emailed from Geraldine Bearden
05/23/2025	Contact - Document Received-Michigan State Police (MSP) <i>911 Event</i> emailed from Citizen 1
05/23/2025	APS Referral not warranted
05/28/2025	Contact - Telephone call made with direct care staff member Richard Paul
05/29/2025	Contact - Telephone call made direct care staff member Kendra Dunn
06/22/2025	Contact - Document Received-email correspondence from Citizen 1
06/23/2025	Contact - Document Received- AFC <i>Licensing Division-Incident/Accident Report</i> emailed from Geraldine Bearden
06/24/2025	Contact - Telephone call made with direct care staff member Richard Paul

06/25/2025	Contact - Telephone call made with direct care staff member Joe Shaddock
06/26/2025	Inspection Completed On-site with direct care staff members Jessica Triplet and Nichole Costello
06/26/2025	Exit Conference with licensee designee Stephanie Riley
07/03/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A is not provided with supervision and protection as he continues to leave the facility property without staff knowledge in attempts to get inside the neighbor's house.

INVESTIGATION:

On 5/17/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint stated Resident A is not provided with supervision and protection as he continues to leave the facility property without staff knowledge in attempts to get inside the neighbor's house. This complaint further stated that Resident A has attempted to get inside the neighbor's property four times in the last year and will repeatedly bang on his door, ring his doorbell multiple times and has taken off his clothes in front of his five-year-old daughter while urinating on his porch.

On 5/22/2025, I conducted an interview with Citizen 1 who stated that he lives near the facility and Resident A continues to come to his house without staff being present or even knowing that he has left the facility. Citizen 1 stated a few months ago Resident A came to his home unattended to by staff, attempted to open his front door and urinated on his front porch while getting naked in front of his five-year-old daughter. Citizen 1 stated recently Resident A came to his house again, attempting to open his front door at which time he walked over to the facility and notified the staff members. Citizen 1 stated he is very concerned that Resident A is not provided with adequate protection and supervision to keep him from trespassing onto his property. Citizen 1 further stated that staff has informed him that Resident A is a violent resident therefore he is very concerned for his daughter, and he will take all measures to keep his daughter safe from Resident A.

On 5/22/2025, I conducted an interview with administrator Geraldine Bearden who stated that Resident A eloped from the facility to the neighbor's house around October 2024 when the neighbor contacted police however, she has no knowledge of Resident A eloping from the facility recently. Geraldine Bearden stated staff members usually monitor Resident A closely to keep him from going outside to leave the property, which is why there has not been any occurrences, to her knowledge, of Resident A eloping from the facility since October 2024.

On 5/22/2025, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 10/5/2024 which stated that Resident A walked over to the neighbor's house and the neighbor called the police. Staff attempted to get Resident A to go back to the facility, but it was not successful therefore the police had to escort him back to the facility.

I also reviewed Resident A's Behavior Treatment Plan (BTP) dated 9/26/2024 which stated that Resident A may elope, which has been an issue in the past and staff should be prepared to follow him outside and redirect him back home.

On 5/23/2025, I reviewed *MSP 911 Event* dated 10/5/2024. According to this *MSP 911 Event* report Citizen 1 called to report that a resident from Mullikan AFC is currently at his door ringing the doorbell, attempting to open his front door and Citizen 1 believes the resident has a mental condition and is reportedly violent. The *MSP 911 Event* report documented that Citizen 1 stated that this is an ongoing issue and attempted contact was made to the facility.

I also reviewed *MSP 911 Event* dated 5/8/2025. According to this *MSP 911 Event* report, Citizen 1 called and stated that he keeps having an ongoing issue with a violent resident from Mullikan AFC coming to his house and trying to get inside. The *MSP 911 Event* report documented this resident also has a history of coming to Citizen 1's house, taking his clothes off, and urinating on his porch and he needs assistance in dealing with this matter.

On 5/28/2025, I conducted an interview with direct care staff member Richard Paul who stated he was working on 5/8/2025 when Resident A left the facility property without staff's knowledge and went over to the neighbor's house at which time the neighbor called police. Richard Paul stated he was in the back of the home assisting other residents when direct care staff member Joe Shaddock informed him that Citizen 1 came to the facility and notified him that Resident A was at his house on his front porch. Richard Paul stated he did not see Resident A leave the facility however he saw Joe Shaddock and Resident A walking in the driveway coming back from the neighbor's house which is when he was notified that Resident A had eloped. Richard Paul stated he is not aware of any other occurrences involving Resident A leaving the facility without staff knowledge.

On 5/29/2025, I conducted an interview with direct care staff member Kendra Dunn who stated that she was working on 5/8/2025 when she heard the neighbor come over to complain about Resident A. Kendra Dunn stated she was in the back of the home cleaning and working with other residents and had no knowledge Resident A had eloped from the facility. Kendra Dunn stated she works regularly with Resident A who will leave the facility if staff are not paying attention to him therefore, she always tries to make sure a staff member is nearby to ensure Resident A does not try to leave the property. Kendra Dunn stated Resident A has eloped in the past but it is not a regular behavior.

On 6/22/2025, I received email correspondence from Citizen 1 who stated that Resident A came over to his house again at 8:14pm and was ringing his doorbell and banging on his door repeatedly which woke up his daughter. Citizen 1 stated he called the police, and they escorted him back to the facility and again staff members had no idea that Resident A had left the facility. Citizen 1 stated the police report number for this incident is 11-2666-25.

On 6/23/2025, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report (incident report)* dated 6/22/2025 written by Zerrick Daniels which stated that Resident A walked to the house next to the facility and the neighbor called the police. The incident report stated when staff members noticed Resident A was gone, the neighbor was already at the home informing staff that Resident A was at his house. The incident report stated staff went to the neighbor's house but Resident A refused to leave the home with staff because he wanted to wait for the police to arrive. The incident report further stated Resident A loves calling 911 and getting a reaction from new people therefore Resident A will continue to elope to the neighbor's house even with redirection. The incident report stated that a fence is needed otherwise Resident A will continue to go over to the neighbor's house as staff has tried everything to redirect him.

On 6/24/2024, I conducted an interview with direct care staff member Richard Paul who stated that he was working on 6/22/2025 when Resident A eloped again to the neighbor's house. Richard Paul stated he was helping another resident when he received a knock on the facility door from the neighbor informing staff members that Resident A had walked over to his home again and was on his front porch without staff being present. Richard Paul stated the other staff member Zerrick Daniels was in the laundry room when this incident occurred which is the reason Resident A was able to leave the facility without staff's knowledge. Richard Paul stated staff were not able to get Resident A back to the facility therefore he was escorted back by the police. Richard Paul stated this is the second time Resident A has eloped to the neighbor's home without staff knowledge in the last two months.

On 6/25/2025, I conducted an interview with direct care staff member Joe Shaddock who stated that on 5/8/2025 he was working when Resident A eloped to the neighbor's house without staff knowledge. Joe Shaddock stated he immediately went after Resident A when he realized that Resident A was no longer in the garage, which is where he last saw Resident A. Joe Shaddock stated he was inside doing dishes in the kitchen and by the time he went outside, the neighbor was already walking to the facility to notify staff that Resident A was at his property. Joe Shaddock stated Resident A will leave the property if he is not engaged therefore staff members must keep him engaged and monitor him at all times.

On 6/26/2025, I conducted an onsite investigation at the facility with direct care staff member Jessica Tripplet who stated that Resident A has not tried to elope on her shift however she has heard that the police were called on more than one occasion due to Resident A eloping to the neighbor's house. Jessica Tripplet stated that when she works with Resident A, she makes sure that Resident A is getting attention and can be seen at

all times to keep him from leaving out of the facility. Jessica Tripplet stated she believes if Resident A is attended to, he will not leave the facility.

I also interviewed direct care staff member Nichole Costello who stated that Resident A has never tried to elope on her shift, however, it has been reported to her by other staff members that Resident A has left the facility to go to the neighbor's house on more than one occasion, which is something that happens on the second shift later in the day. Nichole Costello stated that Resident A likes to keep busy and staff members must keep him engaged to prevent him from leaving the facility.

It should be noted that Resident A was asleep during this visit therefore an interview was not conducted.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	<p>Based on my investigation which included interviews with direct care staff members Richard Paul, Joe Shaddock, Jessica Triplet, and Nichole Costello, administrator Geraldine Bearden, and Citizen 1 along with my review of <i>MSP 911 Event</i> records, Resident A's BTP, and facility's incident reports, there is evidence that Resident A was not provided with supervision and protection as he continues to leave the facility property without staff knowledge in attempts to get inside the neighbor's house. According to Citizen 1, Resident A has repeatedly eloped to his house without staff being present or even knowing that he has left the facility. I reviewed two <i>MSP 911 Event</i> records that documented Citizen 1's need for police assistance due to Resident A being at his home without supervision and attempting to enter Citizen 1's home. These incidents occurred on 10/4/2024 and 5/8/2025. I reviewed two facility <i>AFC Incident/Accent Reports</i> dated 10/5/2024 and 6/22/2025 which stated that Resident A eloped to the neighbor's house without staff knowledge, the neighbor called the police, and police had to escort Resident A back to the facility. In addition, Richard Paul and Joe Shaddock both stated that Resident A eloped from the facility on 5/8/2025 without staff knowledge and staff were notified of the elopement by the neighbor. Geraldine Bearden, Jessica Triplet, and Nichole Costello all stated that staff members must attend to Resident A at all times to keep him from leaving the facility, however Resident A has had three incidents of leaving the facility without staff knowledge within the last eight months. In addition, according to Resident A's BTP, Resident A has a history of elopement therefore staff should be aware that elopement is a target behavior for Resident A. I reviewed an incident report written by staff Zerrick Daniels, stated that the facility and staff members are not equipped to keep Resident A from leaving the facility because there is no fence installed and redirection from staff has not been effective. Therefore, Resident A has not been provided protection and safety at all times to keep him from eloping from the facility to the neighbor's property.</p>
CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference with licensee designee Stephanie Riley. I informed Stephanie Riley of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action, I recommend the current license status remain unchanged.



Ondrea Johnson
Licensing Consultant

07/03/2025
Date

Approved By:



07/07/2025

Dawn N. Timm
Area Manager

Date