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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 27, 2021

Kent VanderLoon
McBride Quality Care Services, Inc.
P.O. Box 387
Mt. Pleasant, MI 48804-0387

RE: License #: AS370088019
Investigation #: 2021A1029006
McBride #1

Dear Mr. VanderLoon:

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. Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010

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

I. IDENTIFYING INFORMATION

License #:	AS370088019
Investigation #:	2021A1029006
Complaint Receipt Date:	03/30/2021
Investigation Initiation Date:	03/30/2021
Report Due Date:	05/29/2021
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way, Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent VanderLoon
Licensee Designee:	Kent VanderLoon
Name of Facility:	McBride #1
Facility Address:	235 S. Bamber Road Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-7058
Original Issuance Date:	10/01/1999
License **Status:**	REGULAR
Effective Date:	04/01/2020
Expiration Date:	03/31/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S):

	Violation Established?
Resident A's Hydrocodone Elixir medication was missing from the medication cabinet at McBride #1 facility. A week passed before the home manager noticed the medication was missing. There is no information who took the missing narcotics.	Yes

II. METHODOLOGY

03/30/2021	Special Investigation Intake 2021A1029006
03/30/2021	Special Investigation Initiated - Bridget Vermeesch initiated the complaint. Telephone call to Jackie Brown Assistant Director of Services for McBride.
04/13/2021	Contact - Telephone call made to Jackie Brown, ADOS
04/16/2021	Contact - Face to Face with home manager, Tiffany Giles
04/16/2021	Contact - Face to Face with direct care staff member, Nancy Johnston
04/16/2021	Contact - Face to Face with direct care staff members Alyssa Margiotta, Elaine Alexander, Tiffany Giles at McBride home.
04/16/2021	Inspection Completed-BCAL Sub. Compliance
04/23/2021	Contact - Telephone call received from Angela Wend, CMH
05/04/2021	Contact - Telephone calls made to Eileen Cotter, Vincent Cruz, Taniya Laury, Courtney Nelson, and former staff Chantel Tryon (her number is invalid). Left messages for all other staff.
05/04/2021	Contact - Telephone call made to Jackie Brown, ADOS
05/04/2021	Contact - Telephone call made to Tiffany Giles, home manager.
05/18/2021	Contact - Telephone call received to Angela Wend, CMH
05/18/2021	Contact – Telephone call to Kent VanderLoon, licensee for Exit Conference. Left a message for him.

ALLEGATION:

Resident A's Hydrocodone Elixir medication was missing from McBride #1 facility. A week passed before home manager noticed the medication was missing. There is no information who took the missing narcotics.

INVESTIGATION:

On 3/30/2021, a complaint was received that the liquid narcotic Hydrocodone Elixir prescribed to Resident A as a PRN or as needed medication was missing from the medication cabinet at McBride #1.

On 3/30/2021, I reviewed the *Adult Foster Care (AFC) incident/accident report* that was authored and received from direct care staff member and home manager Tiffany Giles on 3/30/21 that stated:

> *"Staff counted medication after passing PM medications. Staff checked all pills, liquids and topicals including PRN medications. Staff noticed that Hydrocodone Elixir PRN medication was missing from the box in cabinet. Staff searched for it and did not find it."*

The AFC Incident / Accident Report under action taken documented:

> *"Staff searched entire medication cabinet and extra medication cabinet for missing medication. Last check and confirmed presence was Monday, 3/22/21 around 9 am. Staff completed IR. Notified ADOS. ADOS notified licensing consultant and waiting to hear back."*

The AFC Incident Report under corrective measures documented:

> *"Continue to practice safeguarding medications."*

On April 13, 2021, I interviewed Jackie Brown, Assistant Director of Services, for McBride #1. Mr. Brown stated that he interviewed all direct care staff members and no one knows where the medication went. There was one direct care staff member, Chantel Tryon, who terminated her employment shortly after the medication went missing. She had three no call, no shows in the week prior to the missing medication. Mr. Brown stated there are seven staff that have access to resident medications. Mr. Brown stated the facility has not had any missing medications in the past. Resident A was hospitalized last year, and the narcotic medication was prescribed as a PRN for pain. The medication, Hydrocodone Elixir, expires in May 2021 and was always locked in the medication cabinet. Mr. Brown stated direct care staff members complete medication checks for the liquid medications once per week. Mr. Brown stated the prescription was not refilled since Resident A had not used the medication and does not appear to be needed for pain. I confirmed this to be accurate by reviewing the medication label.

On April 16, 2021, I conducted an unannounced investigation at McBride #1. I observed the medication cabinet, medication count sheets, and the Medication Administration Records (MAR) for the home. The medication cabinet is a large cabinet

in the office located off the entry way of the home. There is a large desk in the office, and it is in an area of the home that is accessible to all direct care staff and residents. The medication cabinet remains locked and only direct care staff members that are trained to pass medications have keys to the cabinet. All the medications are on the top shelf that the residents take daily. On the shelf underneath there are liquid medications and medications that are not given daily. Resident A had a box on that shelf which kept her one medication she receives weekly on Mondays, Polyethylene Glycol, and the Hydrocodone since May 2020 when it was prescribed. No one was going into that box except for Monday mornings and there is no procedure to count the liquid medications. Nancy Johnston is the direct care staff member that typically would give Resident A the Polyethylene on Mondays.

In the medication administration record for Resident A, there is a row for the Hydrocodone with the instructions to give 5 ml via tube every four hours as needed for pain. There is no documentation in the MAR that this medication has ever been given to her. This is consistent with the reports from all employees that the medication was a PRN, was not needed, and had never been given to Resident A. I also reviewed the medication count sheets for the pills she was prescribed for March and April 2021. Each of the medications prescribed: Calcium, Bisoprolol, Vitamin D2, Ipratropium, and Bumetanide were counted three times daily at the start of the day, afternoon, and evening shift.

I interviewed home manager, Tiffany Giles who has worked at this home for 2.5 years but has been with McBride homes since 2014. She stated she was counting the medications with the assistant manager, Elaine Alexander when they both noticed that it was missing on March 29, 2021. Ms. Giles stated the last time she saw the medication was the week before on March 22, 2021 because she had given Resident A her Polyethylene Glycol. Ms. Giles stated she was aware the Hydrocodone narcotic was in the box because she was waiting to discard of it because she knew it was going to expire in May 2021. Ms. Giles stated there are seven employees total that have the medication key. Ms. Giles was able to simulate a medication pass and explained the procedure that the medications are prepared on a plate for Resident A and then taken back to her room. There is a witness while doing medications. While Resident A is taking her medications, the medication cabinet is locked until the direct care staff member returns to the medication room.

I interviewed Nancy Johnston who has been employed at McBride #1 home for 34 years. She was trained to give medications at CMH before starting in this home. She counts the medications with Ms. Giles. Since there is no way to count the liquids, they just check them to make sure they are not running low. Ms. Johnston stated she did not take the missing medication and has no knowledge of who took the medications. She stated when she works, she always keeps the keys on her.

I interviewed Alyssa Margiotta, Assistant Manager at McBride #1. She stated that she passes medications usually every other day. She said that all the residents come into the medication room / office to take their medications except for Resident A who takes them in her room. She stated the medication passing process includes that she prepares the medication, lock up the cabinet and they have a witness that observes the

passing of the medications. She did not know that the medication was missing until the other staff told her. She is surprised that someone would take the medication. She has never had any suspicion of anyone having concerns with substance abuse or information who took the medication. She is concerned that it was not noticed until a week had passed and feels they need to monitor the liquid medications better.

I interviewed assistant manager, Elaine Alexander. She stated she is trained to pass medications and works on second shift. On her shift, Ms. Alexander stated it is typically just her passing medications because her shift partner is not trained as a med passer. The only resident that gets the medication in her room is Resident A and she locked the medication cabinet while passing medication to Resident A. The witness stays in the medication room during this time. She also described that the liquid medications do not get counted, just looked over to make sure they are there. Since it was a PRN and never needed, she just knew the medication was in the box that gets pulled one time per week for Polyethylene Glycol which Resident A takes on Mondays. Therefore, the missing medication was noticed on the following Monday. Ms. Alexander denied taking the medication and has no information who could have done so.

On April 23, 2021 Angela Wend from Recipient Rights contacted me to report that she spoke with most of the direct care staff member. She was told there was an extra set of keys in an unlocked drawer in the office. These are the master keys for the medication cart in case anyone needs to access them in case something happens to their keys.

On 5/4/2021, I made telephone calls and left messages to direct care staff members, Eileen Cotter, Vincent Cruz, Taniya, Courtney Nelson. Chantel Tryon was also called but her number was invalid, and I was unable to leave a message. Ms. Tryon was also the employee that terminated her employment after several no call / no shows around the same time the medication was missing. This was the only number available for Ms. Tyron and I was unable to interview her.

I spoke with Associate Director of Services at McBride Homes, Jackie Brown and he stated that there is a spare key for the medication cabinet, but it is in the medication cabinet or with the home manager Tiffany Giles. He stated they do not know what happened with the missing medication or who took the medication. He was informed there was a spare key in the drawer of the desk from recipient rights officer, Angela Wend but was not aware of this previously.

On 5/4/2021, I interviewed home manager, Tiffany Giles again. She stated that she does have another set of keys, but she did not know they were in the drawer. Ms. Giles stated usually she keeps them on her when she is not there. In the past, if they needed the second set, they would call her, and she will bring them. If she knows she is not going to be there, she will give them to one of the assistant managers. They have to be part of management to have the second set of keys. If they were in an unlocked drawer, it would be because she was at the home and she does not want to keep them on the desk in plain sight.

On 5/5/2021, I interviewed direct care staff member, Vincent Cruz who has worked at McBride #1 for three years. He explained the same medication procedure as the other

direct care staff member previously. He stated he typically works third shift and there are always two direct care staff members working. He also confirmed there was a second set of keys that was kept in the drawer in the office. He does not know if the drawer is locked or not because he has never used the keys and has not seen them in a long time. He does not have any information of who would have taken it and denied taking any medication that belongs to a resident.

On 5/5/21, I interviewed direct care staff member, Eileen Cotter. She also described the same medication process as previous employees. She stated she does not count the PRN medications in the daily medication counts unless they are needed. She did not know what type of medication was missing or if it was a pill form or liquid. Ms. Cotter stated there is an extra set of keys and Ms. Giles keeps them in the top drawer of her brown L-shaped desk. They are in the right-hand side of the drawers in the top drawer. These keys are not locked up and a lot of people know where they are. On one occasion, she needed the keys and she called Ms. Giles who told her where they were. They were not locked up at that time. Recently, Ms. Giles started taking the extra set home with her when she leaves at night. She has no information who took the medications.

On 5/5/21, I interviewed direct care staff member, Taniya Laury. She was not trained to pass medications at the time of the medication was missing so she did not have access to the medication cabinet. She did not know if there was a separate set of keys or the procedure for counting medications. She only knew of the missing medication because the home manager, Ms. Giles, told her she went through the cabinet and it was missing.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Resident A's Hydrocodone Elixir medication was found missing from the medication cabinet at McBride #1 facility. Ms. Giles reported that the medication was observed in the box on March 22, 2021 and was not noticed missing until a week later March 29, 2021. There is no procedure to check the liquid medications on a regular basis and there was a spare set of keys anyone could access in an unlocked drawer. Consequently, the measures being taken to ensure Resident A's narcotic medication was not used or taken by another individual were not successful.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

05/18/2021

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Jennifer Browning
Licensing Consultant

Date

Approved By:

05/27/2021

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Dawn N. Timm
Area Manager

Date