GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2021

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

RE: License #: AS590379167
Investigation #: 2021A1030007
McBride Ferris AFC

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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www.michigan.gov/lara • 517-335-1980

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,

Nile Khabeiry, 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 #:	AS590379167
Investigation #:	2021A1030007
Complaint Receipt Date:	04/19/2021
Investigation Initiation Date:	04/27/2021
Report Due Date:	06/18/2021
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 Ferris AFC
Facility Address:	5075 S. Ferris Road Sheridan, MI 48884
Facility Telephone #:	(616) 255-8916
Original Issuance Date:	03/28/2016
License **Status:**	REGULAR
Effective Date:	09/28/2020
Expiration Date:	09/27/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION:

	Violation Established?
Resident A and Resident B were not given medications as prescribed by a licensed physician.	Yes

II. METHODOLOGY

04/19/2021	Special Investigation Intake 2021A1030007
04/27/2021	Special Investigation Initiated - Telephone call with complainant
05/06/2021	Contact - Document Received Received MARS for Resident A and Resident B from AFC
05/06/2021	Contact - Telephone call Interview with assistance Home Manager, Tom Borkowski
05/10/2021	Contact - Telephone call- Interview with Resident A
05/10/2021	Contact - Telephone call- Interview with Resident B
05/20/2021	Contact - Telephone call - Interview with RN Shelly Springsteen
05/21/2021	Exit Conference with Licensee Designee

ALLEGATION:

Resident A and Resident B were not given medications as prescribed by a licensed physician.

INVESTIGATION:

On 04/27/2021, I interviewed Complainant regarding the allegation. Complainant reported Resident A's Seroquel was discontinued during a medication review on 03/27/2021 due to excessive drowsiness. Complainant reported the order was sent to the pharmacy who then delivered it to the AFC however the facility direct care staff claimed to have never received the order to discontinue. Complainant reported direct care staff members stopped giving the medication to Resident A on 04/19/2021. Complainant reported the AFC does not have a fax machine which makes communication more difficult. Complainant reported new supervisor Tom Borkowski took responsibility for the mistake and is working to correct it. Complainant reported Resident B is prescribed Trintellix and had the milligrams increased from 15 mg to 20

mg on 03/18/2021, however the AFC was unaware of the change in the prescription. Complainant reported the same pharmacy informed the AFC of the change. Complainant reported the error was caught on 04/14/2021.

On 05/06/2021 I requested and received the medication administration records (MARS) for Resident A and Resident B for March 2021, April 2021 and May 2021. Resident A's MAR indicated his prescribed Seroquel was discontinued on 03/27/2021. Resident A's March 2021 and April 2021 also indicated, via direct care staff initials which documented the medication as having been passed, that Resident A continued to receive the medication until 04/19/2021. This was 23 days past the date the medication was discontinued by Resident A's physician. My review of Resident B's March 2021 MAR indicated that Resident B Trintellix was increased from15mg to 20mg on 03/18/2021. However, my review of Resident B's March 2021 MAR found that Resident B continued to receive 15mg per day until 04/14/2021 based on direct care staff members initialing the medication as passed on those days. This was 27 days past the date the medication was increased from 15mg to 20 mg.

On 05/06/2021, I interviewed Tom Borkowski regarding the allegations. Mr. Borkowski acknowledged the mistake and reported he is new to the agency. Mr. Borkowski reported he is willing to correct the problem and has been in contact with Montcalm Care Network RN, Shelly Springsteen who will be assisting them to ensure all medications are correct and administered properly.

On 05/10/2021 I interviewed Resident A and Resident B regarding the allegations. Neither resident was aware of the medication errors. Both reported they were satisfied with the care they receive at the AFC home.

On 05/20/2021, I interviewed Shelly Springsteen RN from Montcalm Care Network regarding the allegations. Ms. Springsteen was aware of the medication error for Resident A and Resident B at the McBride-Ferris AFC home. Ms. Springsteen reported that there was some confusion by the doctor who made the changes to the prescriptions as to who the emails reporting the medications should be emailed to at the facility. Ms. Springsteen reported there was also a change in leadership at the facility which may have led to an additional lack of communication. Ms. Springsteen reported that once the error was discovered, it was corrected, and she is now going to the facility once per month to ensure medication compliance.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled

	for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. **(2) Medication shall be given, taken, or applied pursuant to label instructions.**
ANALYSIS:	Based on the investigation, which included interviews with the complainant, assistance home manager Tom Borkowski, Resident A, Resident B, and Shelly Springsteen RN, Resident A continued to receive medication 23 days past the date the medication had been discontinued and was no longer prescribed to Resident A. Resident B was not given medication per the label instruction as his medication dosage had been increased but Resident B continued to receive the incorrect dosage of medication for a period of 27 days.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

Nile Khabeiry, LMSW 6/8/2021

Nile Khabeiry Date
Licensing Consultant

Approved By:

Dawn Timm 06/08/2021

Dawn N. Timm Date
Area Manager