GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 25, 2022

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

RE: License #: AS370319117
Investigation #: 2022A0466018
McBride Stepping Stone AFC Home

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.

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) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AS370319117
Investigation #:	2022A0466018
Complaint Receipt Date:	01/03/2022
Investigation Initiation Date:	01/03/2022
Report Due Date:	03/04/2022
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 Stepping Stone AFC Home
Facility Address:	707 E Vernon Road Rosebush, MI 48878
Facility Telephone #:	(989) 433-0114
Original Issuance Date:	08/09/2012
License **Status:**	REGULAR
Effective Date:	02/09/2021
Expiration Date:	02/08/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
Resident A ran out of medication while staying with her family for the holidays.	Yes

III. METHODOLOGY

01/03/2022	Special Investigation Intake- 2022A0466018.
01/03/2022	Special Investigation Initiated – Telephone call, ORR Katie Hohner interviewed.
01/03/2022	Contact - Document Received email from Katie Hohner.
01/03/2022	Contact - Telephone call made to AHM Donnel Kole interviewed.
01/03/2022	Contact - Telephone call made to Assistant Director Bernie Myers interviewed.
01/03/2022	Contact - Telephone call made to Home Manager Teresa Warner interviewed.
01/03/2022	Contact - Telephone call made to DCW Shelley Housted interviewed.
01/03/2022	Contact - Telephone call made to DCW Crystal Stone, not able to leave a message.
01/04/2022	Contact - Telephone call made to DCW Crystal Stone; message left.
01/04/2022	Contact - Telephone call made to House manager Teresa Warner interviewed second time.
01/04/2022	Contact - Document Received from DCW Crystal Stone, interviewed.
01/07/2022	Contact - Document Received from ORR Katie Hohner, ORR interviewed.
01/25/2022	Inspection Completed On-site.

02/18/2022	Exit Conference with Kent VanderLoon, message left.

ALLEGATION: Resident A ran out of medication while staying with her family for the holidays.

INVESTIGATION:
On 01/03/2022, Complainant reported Resident A was out of the facility on 12/21/2021 through12/31/2021 visiting with relatives. Complainant reported direct care workers (DCW)s at the facility did not provide Resident A with enough of her prescribed medications for the duration of time that she was planned to be out of the facility. Complainant reported Relative A1 contacted the adult foster care (AFC) facility on 12/27/21 and reported Resident A had run out of her nighttime Seroquel (Quetiapine) 100 mg. Complainant reported arrangements were made for a DCW to meet with Relative A1 halfway to obtain the medication on 12/27/21. Complainant reported when Relative A1 returned home she looked at the medications and realized the Seroquel 100 mg had not been provided. Complainant reported Relative A1 called the home and was told they would bring the medication to Relative A1 the following day on 12/28/2021. Complainant reported that because the Seroquel 100 mg was not provided to Relative A1 on 12/27/2021, Resident A missed her nighttime Seroquel 100 mg on 12/27/2021. Complainant confirmed that on 12/28/21, Resident A's Seroquel 100 mg was dropped off to Relative A1, so only one dose was missed.

On 01/03/2022, Katie Hohner, Office of Recipient Rights (ORR) Recipient Rights Advisor and I interviewed assistant home manager (AHM) Donnel Kole who reported Relative A1 called her to report that Resident A ran out of a medication. AHM Kole reported that when resident medications are near the end of the month, it can be difficult as medications can only be refilled a couple days prior to the beginning of the new month. AHM Kole reported that once Resident A's medications were refilled DCW Crystal Stone gathered the medications requested by Relative A1 and delivered them to Relative A1 on 12/27/2021. AHM Kole reported that Relative A1 did not request Seroquel 100 mg so that medication was not provided. AHM Kole reported she was not aware if the DCWs knew which medications Resident A was running low on as they may just have taken the medications that Relative A1 requested. AHM Kole reported that she did not direct any DCW to review Resident A's medication administration record (MAR) nor Resident A's *Leave of Absence Medication In/Out Sheet* to cross reference/determine which medications Resident A needed. AHM Kole reported that after the medications were delivered, Relative A1 called again to report that she did not receive Resident A's evening Seroquel 100 mg. AHM Kole reported that due to the inclement weather conditions that evening, Seroquel 100 mg was not taken to Resident A until the next day on 12/28/2021. AHM Kole reported that she did not realize it at the time but reported that Resident A missed her evening Seroquel 100 mg dose on 12/27/2021 because the evening Seroquel 100mg was not provided to Relative A1 until 12/28/2021.

On 01/03/2022, ORR Hohner and I interviewed Bernie Myers assistant director of services (ADOS) who reported that Resident A missed her evening Seroquel 100 mg on 12/27/2021. ADOS Myers reported that the medication was provided to Relative A1 on 12/28/2021, so only one evening dose was missed.

On 01/03/2022, ORR Hohner and I interviewed home manager (HM) Teresa Warner who reported that Resident A left the facility on 12/21/2021 and reported that she was uncertain when Resident A would return. HM Warner reported that she thought DCW Shelley Housted gathered Resident A's medications for her leave of absence (LOA). HM Warner reported Resident A left the facility prior to medication refills arriving so HM Warner reported that she explained to Relative A1 that once the medication refills were received that they would bring her Resident A's medications. HM Warner reported that Relative A1 called her and reported which medications Resident A needed. HM Warner reported that she made a list of medications that Resident A needed and DCW Stone put the medications together before taking them to Relative A1 on 12/27/2021. HM Warner reported that the next day Relative A1 called to report that Resident A ran out of evening Seroquel 100 mg on 12/27/2021 and therefore she missed her evening Seroquel 100 mg on 12/27/2021. HM Warner reported Resident A's Seroquel 100 mg was delivered to Relative A1 on 12/28/2021 due to a miscommunication. HM Warner reported that she did not direct DCW Stone to review Resident A's MAR nor did she direct DCW Stone to review Resident A's *Leave of Absence Medication In/Out Sheet* to cross reference/determine which medications Resident A needed rather she directed her to follow the list she provided which resulted in a needed medication being omitted.

On 01/03/2022, ORR Hohner and I interviewed DCW Amanda Taylor who reported that she handed Relative A1 Resident A's medications when she picked her up for the holidays on 12/21/2021. DCW Taylor reported that she did the medication count on the *Leave of Absence Medication In/Out Sheet*. DCW Taylor reported that HM Warner had already talked to Relative A1 about the medication refills not arriving so Relative A1 was aware that additional medications would have to brought out to Relative A1 once they arrived.

On 01/03/2022, ORR Hohner and I interviewed DCW Scottie Gonzanlez who reported hearing Relative A1 talking to HM Warner on 12/27/2021 and discussing some miscommunication about medication. DCW Gonzanlez reported that HM Warner told Relative A1 that the facility would get the Seroquel 100 mg to her on 12/28/2021.

On 01/03/2022, HM Warner provided a copy of Resident A's *Leave of Absence Medication In/Out Sheet* which documented that on 12/21/2021, Relative A1 was provided with six Seroquel 100 mg pills.

On 01/03/2022, HM Warner provided a copy of Resident A's December 2021 medication administration record (MAR) which documented that Resident A was prescribed "Quetiapine 100 mg, take 1 ½ tablets by mouth at bedtime brand name

Seroquel." Resident A's MAR documented from 12/21/2021 through 12/28/2021 "LOA."

On 01/03/2022, HM Warner provided a copy of the list she made of the medication that Resident A needed per her phone call with Relative A1. The list stated "Seroquel AM, Melatonin, Depakote, Trileptal AM, Abilify, Stool Softener. Meet at Jared's at 4pm, yellow car."

On 01/04/2021, ORR Hohner and I interviewed HM Warner for a second time and she reported that although additional medications were provided to Relative A1, an *Leave of Absence Medication In/Out Sheet* was not completed on 12/27/2021 nor on 12/28/2021. HM Warner reported that she did not direct DCW Stone to complete the *Leave of Absence Medication In/Out Sheet* when she dropped off additional medications to Relative A1 on 12/27/2021 and again on 12/28/2021.

On 01/04/2021 ORR Hohner and I interviewed DCW Stone who reported that she took medications to Relative A1 on 12/27/2021 and again on 12/28/2021. DCW Stone reported that HM Warner provided her with a list of the medications that were needed on 12/27/2021. DCW Stone reported that she gathered the medications from the list and delivered the medications to Relative A1 on 12/27/2021. DCW Stone reported that on 12/28/2021, she was told that Seroquel 100 mg pills were needed to be delivered to Relative A1 which she did.

On 01/25/2022, I conducted an unannounced investigation and I interviewed Resident A who reported that she missed a dose of her evening Seroquel 100 mg pills on 12/27/2021 because the facility did not bring them to Relative A1 with her other medications. Resident A reported that she did not have any side effects or behavioral issues due to the missed dosage. Resident A1 reported that she takes Seroquel both in the morning and in the evening, but they are different dosages. Relative A1 reported that this medication error could have been avoided had the facility brought all of her medications that she needed on 12/27/2021.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Complainant, ADOS Myers, AHM Kole, HM Warner and Resident A all reported that Resident A missed her evening Seroquel 100 mg on 12/27/2021. Resident A's *Leave of Absence Medication In/Out Sheet* documented that on 12/21/2021, Relative A1 was provided with 6 Seroquel 100 mg pills. Complainant, ADOS Myers, AHM Kole, HM Warner and Resident A all reported that the evening Seroquel 100 mg was provided to Relative A1 on 12/28/2021, therefore one evening dose was missed. Resident A's medication was not taken as prescribed as she did not take the medication on 12/27/2021 at bedtime therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	AHM Kole and HM Warner reported that when Resident A left the facility on 12/21/2021 her medication refills had not arrived, so arrangements were made with Relative A1 for the facility to provide additional medications once received. HM Warner reported that she had been in phone contact with Relative A1 and she made a list of the medications that Relative A1 reported Resident A needed. HM Warner reported that she provided a list of Resident A's medications to DCW Stone for her to gather the medications before taking them to Relative A1 on12/27/2021. HM Warner reported that she did not direct DCW Stone to review Resident A's MAR nor did she direct DCW Stone to review Resident A's *Leave of Absence Medication In/Out Sheet* to ensure that medications were not missed. HM Warner reported that she directed DCW Stone to follow the list she provided. There was no check and balance process in place to assure Resident A received all her medications especially since her leave of absence occurred during a time when medications were due to be refilled.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend the status of the license remains unchanged.

02/18/2022

Julie Elkins Date
Licensing Consultant

Approved By:

02/25/2022

Dawn N. Timm Date
Area Manager