GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 8, 2022

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

RE: License #: AS370011303
Investigation #: 2022A1029041
McBride #7

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. In the event that 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
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011303
Investigation #:	2022A1029041
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	07/19/2022
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 #7
Facility Address:	501 N. Coldwater Weidman, MI 48893
Facility Telephone #:	(989) 644-3627
Original Issuance Date:	06/18/1991
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was unsupervised for about two hours during a medical appointment.	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A1029041
05/20/2022	Special Investigation Initiated – Telephone to complainant
05/20/2022	Contact - Telephone call made to Danielle at Asleep Lab in Mt. Pleasant with ORR Katie Hohner.
05/23/2022	Contact - Document Received - reviewed a video recording sent by Katie Hohner
05/23/2022	Contact - Telephone call made Sound aSleep Lab staff member, Amanda King, and completed an interview along with Katie Hohner from Recipient Rights.
05/24/2022	Contact - Telephone call made - Microsoft Teams interview with Alyssa Miller, Jovani McKinney, Ms. Marek, Resident A and Katie Race with Recipient Rights advisors Sarah Watson and Katie Hohner
05/25/2022	Contact - Face to Face - Completed onsite investigation at McBride #7. Interviewed Alyssa Miller.
06/30/2022	Exit conference with licensee designee Kent VanderLoon.

ALLEGATION:

Resident A was unsupervised for about two hours during a medical appointment.

INVESTIGATION:

On May 17, 2022, a complaint was received via the Bureau of Community Health Systems online complaint system. The complaint included concerns Resident A had been left alone during a sleep study by direct care staff member Jessica Marek and did not have the required supervision while the testing was done. According to the complaint, Ms. Marek left the facility to sit in her car for two hours which left Resident A without supervision.

On May 23, 2022, I reviewed a video recording phone conversation sent to me by Katie Hohner, Office of Recipient Rights, between Sound aSleep Lab staff member, Amanda King at the sleep center and direct care staff member Jovani McKinney at McBride #7. Ms. King called McBride #7 to notify the AFC facility that direct care staff member Jessica Marek was not at the sleep lab while Resident A was in the sleep lab doing the sleep study. Ms. King stated she told Ms. Marek she needed to remain in the facility while he was doing the study so Ms. King was upset and was stating the sleep center is a non-caregiving facility and Ms. Marek was out in her car not providing supervision. Ms. King stated she was concerned for abandonment of Resident A while he was completing the sleep study.

On May 23, 2022, I interviewed Sound aSleep Lab staff member, Amanda King, along with Recipient Rights officer, Katie Hohner. According to Ms. King, direct care staff member Jessica Marek brought Resident A for the sleep study and was informed the lab was not a caregiving facility rather they are a testing facility. Ms. Marek was informed there would be about thirty different wires on Resident A tracking data while he slept. The direct care staff member, Jessica Marek, stated to Ms. King she was going to leave and she was told again by Ms. King the sleep lab staff do not provide care and she cannot leave. The direct care staff member, Ms. Marek, did not want to stay during the sleep study according to Ms. King. Ms. King was informed prior to the appointment Resident A has violent tendencies and was concerned because during the night, she has to put a mask on him, and make sure he is okay during the night. Ms. King stated Ms. Marek reported to her Resident A he did not want her to be in the room while he was sleeping. Ms. Marek stated to Ms. King she was going to go to her car and Ms. King could come out and get her during that time if she was needed.

Ms. King stated Ms. Marek called the assistant home manager, Katie Race who told Ms. King she could leave and go out to her car. Ms. Marek went out to her car for 3.5 hours (left around 11:00 p.m.) and did not come back until Ms. King called McBride #7 around 2:30 am. to say Resident A was abandoned at the sleep center. Ms. King had to fix his wires, put a mask on him, and take him to the bathroom during the sleep study as direct care staff member Jessica Marek was not available. Ms. King stated Ms. Marek told her before the appointment started, Resident A was a 1:1 for supervision and he needed 24/7 care because he has violent episodes making it all the more necessary for him to be supervised by someone familiar with his needs not a sleep lab staff member. Ms. King stated could not walk outside to look for Ms. Marek or get Ms. Marek from her car because there were two other patients at the sleep center during the time of Resident A's sleep study. Ms. Marek was aware of the fact she was staying during the night for the sleep study but stated she would not have been able to stay alert while she was in the room.

On May 24, 2022, I participated in a Microsoft Teams interview with direct care staff members Alyssa Miller and Katie Race, conducted with Office of Recipient Rights Advisors, Sarah Watson and Katie Hohner. According to Ms. Race, Resident A had an

appointment at the Sound aSleep Lab on May 17, 2022. According to Ms. Race, Ms. Marek took Resident A to the appointment leaving McBride #7 around 8:30 p.m. Ms. Race received a call from direct care staff member Jessica Marek around 9:00 p.m. because she felt the staff at the Sound aSleep Lab (Ms. King) was rude to her because she knocked on the window instead of the door. Ms. King stated shortly after the first call, she received another call from Ms. Marek because she wanted to leave the building and go into the car. Ms. Race stated she felt Ms. King and Ms. Marek seemed to be in an argument. Ms. Race told her she could step out if she was allowed to and it was okay with Ms. King. Ms. Race thought she was stepping out because she is a smoker and she thought it would be okay. Ms. Race was woken up by a phone call at 2:40 a.m. from third shift direct care staff member, Jovani McKinney asking for Ms. Marek's cell phone number because she was not responding to Ms. King and was no longer in the lab.

Ms. Race stated she was on Facetime with Ms. Marek and heard Ms. King state she had to keep the door locked because there were three other patients to care for during the sleep studies around 11:00 p.m. Ms. Race stated she thought Ms. Marek asked she could step out. Ms. Race stated Resident A's oxygen began to drop during the study and Ms. King wanted to speak with Ms. Marek about this. Ms. Race stated Ms. Marek was panicked and stated they were filing a police report for neglect because they could not reach her.

Ms. Race came to the Sound aSleep Lab and Ms. Marek was crying when she arrived and was upset about them filing neglect charges against her because she left the building. Ms. Race sent Ms. Marek home and took over the rest of the shift at the Sound aSleep Lab.

Ms. Race stated Resident A's level of supervision is 1:1 supervision and they are not allowed to leave him alone. Ms. Race stated Ms. Marek should not have been allowed to go outside at all because when he is 1:1 in the community. According to Ms. Race, Ms. Marek has worked at McBride #7 since July 2021 and had knowledge of Resident A's supervision guidelines. Ms. Marek was told by home manager, Alyssa Miller multiple times she was going to be required to stay at Sound aSleep Lab for the duration of Resident A's sleep study.

I interviewed direct care staff member, Alyssa Miller whose current role is a home manager. Ms. Miller stated Ms. Marek asked her while she was working with her earlier in the day around 2:50 p.m. if she was able to sit in the car and she told Ms. Marek she was not able to do so. Ms. Miller stated she told Ms. Marek she could use the bathroom briefly during the sleep study but needed to quickly return and could not sit in the car. Ms. Miller also told Ms. Marek she needed to clear it with sleep center staff if she needed to leave for any reason.

I interviewed direct care staff member, Jovani McKinney. Mr. McKinney stated he received a call from Ms. King from the sleep lab stating Ms. Marek had not been in the sleep lab with Resident A and Ms. King could not reach Ms. Marek. Mr. McKinney

stated he heard Ms. Race tell Ms. Marek she could step out for a second, but she needed to return quickly and stay in the facility. Mr. McKinney stated Resident A always required someone to be with him all times in the community.

Resident A was then interviewed. He stated he had a sleep study and he was on oxygen and his O2 went to 75 and when they put his oxygen back on he went back to the 90's. He stated he did not receive his CPAP machine yet but he is hoping this will help him. Resident A stated Ms. Marek went to the sleep study with him but she did not stay in the building because she yelled at the staff about leaving. Resident A stated they were arguing before he went to sleep as well as while he was trying to sleep he could hear Ms. King and Ms. Marek arguing in the lobby.

On May 24, 2022, I interviewed direct care staff member Jessica Marek along with Recipient Rights Advisors Ms. Hohner and Ms. Watson using Microsoft Teams. Ms. Marek stated Ms. King had an "attitude" with her when she walked in and was uncomfortable at the appointment. Ms. Watson asked what she meant by "aggressive" but Ms. Marek could not give details regarding this description of Ms. King. Ms. Marek said she "checked her attitude" and asked Ms. King who owned the building she was working in. Ms. Marek stated she told Ms. King she was not there to argue. Ms. King insulted her and said she said neglected the patient (Resident A). Ms. Marek stated she was on the phone with her assistant manager, Katie Race, the whole time Ms. King was giving her a "hard time." The next morning, Ms. Race stated to Ms. Marek she did not need to come to the manager meeting and she was under the impression she was going to be fired, so she resigned from the position. Ms. Marek denied she was advised she had to stay in the building when she was there however, Ms. Marek stated Resident A is on 1:1 supervision / line of sight supervision. Ms. Marek was aware of the fact she was staying during the night for the sleep study but stated she would not have been able to stay alert while she was in the room. Ms. Watson explained to her leaving the building did not follow the supervision guidelines because the sleep center staff were not aware of the *Treatment Plan* and would not know how to handle Resident A if he had behaviors during the sleep study.

On May 25, 2022, I conducted an unannounced investigation and interviewed direct care staff member Alyssa Miller who stated Ms. Marek resigned from her direct care staff member position. Ms. Miller stated the incident date was only the second day Ms. Race worked as a home manager and Ms. Race told Ms. Miller she did not think Resident A required 1:1 supervision while in the community. was a one on one if he was not at the facility. According to Ms. Miller, Ms. Marek has taken Resident A on many outings in the community and should have known what was required of her.

During the onsite investigation, I reviewed the employee record for Jessica Marek which included documentation she reviewed and understood Resident A's *Person Centered Plan* on October 9, 2021. Ms. Marek reviewed Resident A's *Treatment Plan* from Community Mental Health on March 17, 2022. Ms. Race's employee record included documentation she reviewed and understood Resident A's *Person Centered Plan* and *Treatment Plan* on March 17, 2022.

During the onsite investigation, I reviewed Resident A's resident record. According to the *Assessment Plan for AFC Residents* for Resident A, Moves Independently in the Community is marked "No- Needs supervision in the community at all times by staff. He is to have 1:1 staffing in the community. History of being inappropriate in the community." Under Controls Sexual Behavior is marked "No-Resident A can be inappropriate in the community and on the phone with actions and words. Staff monitor in the community and on the phone, see his plan." According to Resident A's *Health Care Appraisal*, he is diagnosed as bipolar, intellectual disability, hypothyroidism, hypertension, and hyperlipidemia. The *Behavior Treatment Plan* revised on May 28, 2021, Resident A requires staff supervision in the community due to historical records of perpetrating inappropriate sexual contact with minors and making false accusations against others.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Direct care staff member Jessica Marek did not follow the personal care and supervision guidelines set forth by Resident A's *Treatment Plan* from Community Mental Health and his *Assessment Plan for AFC Residents.* According to the *Assessment Plan for AFC Residents,* Resident A receives 1:1 supervision while in the community. Ms. Marek did not ensure Resident A was provided this level of supervision by going out to her car for an extended period of time while Resident A underwent a sleep study unsupervised. Sleep study staff were not able to reach Ms. Marek during the sleep study to discuss concerns regarding Resident A's testing. Resident A was not provided the one on one level of supervision he requires which could have resulted harm to himself or the sleep center staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_ _____7/1/2022

Jennifer Browning Date
Licensing Consultant

Approved By:

07/08/2022

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Dawn N. Timm Date
Area Manager