GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 24, 2023

Kent Vanderloon
McBride Quality Care Services, Inc.
3070 Jen's Way
Mt. Pleasant, MI 48858

RE: License #: AS590012177
Investigation #: 2023A1029027
McBride Corlisa Jade 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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, 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 #:	AS590012177
Investigation #:	2023A1029027
Complaint Receipt Date:	03/01/2023
Investigation Initiation Date:	03/02/2023
Report Due Date:	04/30/2023
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way, Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Cathie Griffis
Licensee Designee:	Kent Vanderloon
Name of Facility:	McBride Corlisa Jade Home
Facility Address:	610 S Fifth Street, Edmore, MI 48829
Facility Telephone #:	(989) 427-3244
Original Issuance Date:	09/27/1991
License Status:	REGULAR
Effective Date:	04/08/2022
Expiration Date:	04/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Direct care staff member Jodi Grassel made a comment referring to feeding Resident A like a dog and said, “woof, woof” while she was feeding her.	Yes
Resident B did not receive her medications on March 4, 2023 as prescribed because direct care staff member Crystal Almanza clocked out for her shift and told the third shift direct care staff member Amber Buchanan to pass her medication at 9:30 p.m. and this was not done.	Yes

II. METHODOLOGY

03/01/2023	Special Investigation Intake 2023A1029027
03/02/2023	Special Investigation Initiated –Email to complainant.
03/02/2023	APS Referral made to Centralized Intake
03/03/2023	Inspection Completed On-site – face to face with direct care staff members Barbara Baumann and Ann Foster
03/08/2023	Contact - Document Received from ORR Ms. Leach
04/04/2023	Inspection Completed On-site – face to face with home manager, Cassandra Peterson, administrator, Ms. Griffis, Resident A
04/18/2023	Contact - Telephone call made to direct care staff members Samantha Irwin, Crystal Almanza (Left message and sent text), Jodi Grassel (Left message and sent text), Amber Buchanan (Left message and sent text), Danielle Racalla, Michael Mokma Kendra Wood (Left message)
04/19/2023	Contact – Telephone call to Jodi Grassel, Left message.
04/19/2023	Contact – email to Milessa Leach, ORR
04/20/2023	Contact – Telephone call to direct care staff member Kendra Wood
04/20/2023	Exit conference with licensee designee Kent Vanderloon, left a message and sent an email.

ALLEGATION:

Direct care staff member Jodi Grassel made a comment referring to feeding Resident A like a dog and said, "woof, woof" while she was feeding her.

INVESTIGATION:

On March 1, 2023, a complaint was received via Bureau of Community and Health Systems online complaint system alleging that on February 27, 2023, direct care staff member Jodi Grassel threw bits of an apple at Resident A during snack time and said, "it's like feeding a dog" and stated "woof, woof" to her.

On March 2, 2023, I interviewed Montcalm Care Network ORR Resident Rights advisor, Milessa Leach who reported she interviewed direct care staff member Jodie Grassel about this allegation. Ms. Leach stated during the interview, Ms. Grassel admitted to saying, "woof, woof" and throwing the apples to Resident A. Ms. Leach stated Ms. Grassel reported the apples did not hit Resident A but she was tossing them at her while mocking her and talking to her saying she was feeding a puppy. Ms. Leach stated Ms. Grassel told her there was a conversation about dogs before this and then she made this statement. Ms. Leach stated Ms. Grassel informed her in the interview that she asked direct care staff member Kendra Wood to "talk when there were no ears around." Ms. Leach stated Resident A does need her food chopped up in small pieces and given her one at a time. The apple was cut up before this because Ms. Wood cut it up in pieces and tossed them at Resident A. Ms. Leach stated Cathie Griffis sat in on the interview with her and she said it was not like her to say these statements. Ms. Leach stated Resident A is nonverbal but still could understand what was said about her when Ms. Grassel was making those comments. Ms. Leach stated discipline was completed and Ms. Grassel was terminated from her position.

On March 3, 2023, I completed an unannounced onsite investigation at McBride Corlisa Jade Home. I interviewed direct care staff member Barb Baumann who stated Resident A was currently at school as she attended each day arriving home around 4:30 p.m. Ms. Bauman stated she primarily works third shift and did not have many shifts with Ms. Grassel. Ms. Bauman stated she has never observed Ms. Grassel being disrespectful to residents when she has been around her. Ms. Bauman stated all the direct care staff members need to cut Resident A's food into small bites and give her small pieces at a time because she chokes easily by putting too much food into her mouth.

During the onsite investigation, I reviewed Resident A's resident record. I reviewed Resident A's *Treatment Plan* and the *Attestation Form* showing all direct care staff members, including Ms. Grassel, were trained on June 13, 2022. Ms. Grassel completed all required licensing trainings including Working with People on February 15, 2019 and Crisis Prevention Institute (CPI) on February 21, 2019. I also reviewed documentation from a Person Centered Plan (PCP) meeting on May 31, 2022 which states, "[*Resident A] has a history of eating too quickly and of "stuffing" food. To prevent this, staff put only a few bites of food on her plate at a time."*

According to Resident A's *Assessment Plan for AFC Residents* she gets along with others "[Resident A] likes to do things a lot of the time alone or with staff. She follows staff around." Under the section entitled, *A. Eating / Feeding:* "[Resident A] needs her food cut into bite size pieces due to choking" was documented.

I interviewed direct care staff member Ann Foster. Ms. Foster stated she was not present during Ms. Grassel's comments to Resident A. Ms. Foster stated when she worked with Ms. Grassel in the past, she has not had concerns regarding her attitude toward the residents and she described her "pretty quiet" when she was working.

On April 4, 2023, I completed an unannounced onsite investigation at McBride Corlisa Jade Home. During this visit, I observed Resident A however since she is non-verbal, I was not able to interview her. However, I observed she appeared happy and was laughing with the direct care staff members who were working at the time.

I interviewed direct care staff member whose current role is home manager, Cassandra Peterson. Ms. Peterson stated Ms. Grassel admitted to her that she made these statements and it seemed she did not mean to hurt Resident A's feelings but did so with these actions. Ms. Peterson stated Ms. Grassel was terminated from her position effective March 6, 2023.

On April 18, 2023, I interviewed direct care staff member Michael Mokma. Mr. Mokma stated Ms. Grassel "did not seem to be in the right job for her" because she was inpatient with the residents while working there. Mr. Mokma stated he did not remember specific statements she made to the residents but thought her overall demeanor was harsh with them.

On April 18, 2023, I interviewed direct care staff member Crystal Almanza. Ms. Almanza stated she has worked with Ms. Grassel and there are concerns for "dignity and respect" and the other direct care staff members would redirect her and make her aware of her tone with the residents. Ms. Almanza stated Ms. Grassel demeanor "felt kind of mean" with the residents. Ms. Almanza stated she could not think of any specific incidents but there was one issue when Resident C would try to drink her pop. Ms. Almanza stated direct care staff members were not allowed to bring pop into the facility because it upset Resident C. Ms. Almanza stated Ms. Grassel refused to abide by this rule so each time Resident C saw her pop he became upset and started behaviors. Ms. Almanza stated even with Ms. Grassel witnessing how it affected Resident C, she still brought in pop saying it was not fair she could not have her drinks at the facility. Ms. Almanza stated Resident C would slap and pinch the other residents because he would be so upset. Ms. Almanza stated Ms. Peterson tried teaching Ms. Grassel different learning tools for better communication but she would not follow these suggestions.

On April 20, 2020 I interviewed direct care staff member Kendra Wood. Ms. Wood stated she was present for the incident with Ms. Grassel. Ms. Wood stated this was during snack time and Ms. Grassel said to her she wanted to talk to her, "when there

were no ears around" because there was another resident there at the time. Ms. Wood stated once the other resident walked away and Ms. Grassel was still feeding Resident A apple slices she made a "woof, woof" sound, shook the apple slice, and then tossed at her stating, "It's like feeding a dog." Ms. Wood stated Resident A was sitting right there, heard the statement and comment because she put her head down after it was said while waiting for the next apple slice. Ms. Wood stated she has not had other concerns regarding Ms. Grassel and her treatment of the residents.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. **2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A was not treated with consideration and respect after direct care staff member Jodie Grassel made comments about feeding her like a dog, stating "woof woof," and throwing the apple slices toward her. According to Ms. Leach, Ms. Grassel admitted to making the statements and the incident was witnessed by direct care staff member Ms. Wood. Ms. Peterson stated Ms. Grasell was terminated as a result of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B did not receive her medications on March 4, 2023 as prescribed because direct care staff member Crystal Almanza clocked out for her shift and told the third shift direct care staff member Amber Buchanan to pass her medication at 9:30 p.m. and this was not done.

INVESTIGATION:

On March 7, 2023, a new allegation was received alleging Resident B did not receive her 8:00 p.m. medications after returning to McBride Corlisa Jade Home.

On March 8, 2023, I received an email from ORR recipient rights advisor, Milessa Leach stating she interviewed both staff Crystal Almanza and Amber Buchanan and was planning on substantiating both for Neglect class 3 due to their lack of communication

and Resident B not receiving her medication. Ms. Leach stated she spoke with Ms. Griffis who is also aware and Ms. Griffis is planning on both direct care staff members going back through medication training at Montcalm Care Network.

On April 4, 2023, I completed an unannounced onsite investigation at McBride Corlisa Jade Home. I interviewed direct care staff member whose current role is home manager, Ms. Peterson. Ms. Peterson showed me the Medication Administration Record (MAR) and I was able to confirm Resident B did not receive her evening medication on March 4, 2023.

Administrator, Ms. Griffis was also present during the onsite investigation. Ms. Griffis stated they are in the process of switching to electronic medication administration records (eMAR) and she is hoping this will reduce the amount of medication errors.

Ms. Peterson was also able to show verification that Amber Buchanan completed her medication administration training through Montcalm Care Network on September 29, 2021. Ms. Almanza completed her medication administration training on July 24, 2017.

On April 18, 2023, I interviewed direct care staff member Crystal Almanza. Ms. Almanza stated when she returned the medical appointment she told the key holder Amber Buchanan who passed the keys to the next staff and informed Ms. Buchanan Resident B needed Tylenol to be administered with her other medications. Ms. Almanza stated Ms. Buchanan later told her she did not hear her say this. Ms. Almanza stated she was not told to hold the medications at all. Ms. Almanza stated she was disciplined because she did not give Resident B her medications but the reason she did not do so was because she did not have the medication keys and was not the assigned medication passer for that shift. Ms. Almanza stated direct care staff members are a "dime a dozen and it does not matter if they are fired." Ms. Almanza specifically told Ms. Buchanan Resident B needed the Tylenol passed to her and Ms. Buchanan stated, "she didn't think of it" but Resident B was "tossing and turning all night because she was in pain." Ms. Almanza stated Ms. Buchanan stated she counted the medications at 11:00 p.m. and then realized the numbers were off. Ms. Almanza stated Resident B did not have any side effects or any issues for not receiving her medications on the evening of March 4, 2023.

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

ANALYSIS:	Upon review of Resident B's medication administration record for March 4, 2023, I confirmed she did not receive her evening medications as prescribed. Ms. Almanza stated she did not administer Resident B's medications because she did not have the medication keys and she was not the medication passer.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

Jennifer Browning _____04/20/2023_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 04/24/2023

_____

Dawn N. Timm
Area Manager
Date