STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 16, 2023

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

RE: License #: AS590084032
Investigation #: 2023A0577039
McBride Todd's Place

Dear Mr. VanderLoon:

Attached is the Special Investigation Report for the above referenced facility. A violation was established; however, a corrective action plan is not required as the corrective action had already been implemented at the time of this report. Specifically, employees have been retrained in medication administration and medication count time has been updated to be completed at the time of administration, had been terminated and termination letter was provided to the department. Documentation of policy/procedure change and verification of staff training on medication administration has been received.

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,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS590084032
Investigation #:	2023A0577039
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/19/2023
Report Due Date:	06/17/2023
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Sarah Nestle
Licensee Designee:	Kent VanderLoon
Name of Facility:	McBride Todd's Place
Facility Address:	107 Charlotte St. Edmore, MI 48829
Facility Telephone #:	(989) 427-2844
Original Issuance Date:	12/30/1998
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On April 09, 2023 Resident A was not administered their evening medications by direct care staff Lori Bailey.	Yes

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0577039
04/19/2023	Special Investigation Initiated – Telephone call made to Angela Loiselle, MCN-ORR.
04/19/2023	APS Referral made to Leslie Brugel, Montcalm Co APS.
04/19/2023	Contact - Telephone call made- Interview with Complainant.
05/02/2023	Inspection Completed On-site- Interviews with staff and observed Resident A.
05/03/2023	Inspection Completed-BCAL Sub. Compliance
05/03/2023	Contact-Telephone call made to DCS Lori Bailey.
05/03/2023	Exit Conference with licensee designee Kent VanderLoon.
05/03/2023	Corrective Action Plan Requested and Due on 05/18/2023
05/03/2023	Corrective Action Plan Received
05/03/2023	Corrective Action Plan Approved

ALLEGATION: On April 09, 2023 Resident A was not administered their evening medications by direct care staff Lori Bailey.

INVESTIGATION:

On April 18, 2023, a complaint was received alleging direct care staff (DCS) Lori Bailey did not pass Resident A's 6:00pm medications to Resident A on April 9, 2023. DCS Bailey admitted that she forgot to pass Resident A's medications on that evening. The

complaint reported Resident A was not passed the following medications: Divalproex 500mg, Quetiapine 400mg, Mirtazapine 30mg and Trazodone 225mg.

On April 19, 2023 I contacted Complainant who provided me with copies of a *Montcalm Care Network Incident Report*, Resident A's *Medication Administration Record* (MAR) for April 2023, Employee Discipline Notice, Staff Meeting Notes/Training, and Medication Administration Policy Change. Complainant reported on April 10, 2023 a *Montcalm Care Network Incident Report* was received, completed by Katelyn Parsons documenting "When I (Katie Parsons) arrived at 6:00am on 04/10/23 for my shift, Tabitha Nielsen told me that on 04/09/23 at 6:00pm [Resident A] did not receive her medications. I (Katie) asked Tabitha if she did her 9:30pm medication count, Tabitha said no, not at 9:30pm, it was later and this is how she realized [Resident A] did not receive her medication. Lori Bailey was the medication passer on 04/09/23 at 6:00pm." I reviewed Resident A's MAR received from Complainant which documented that on April 09, 2023 Resident A was not passed the following medications: Divalproex 500mg, Quetiapine 400mg, Mirtazapine 30mg and Trazodone 225mg at 6:00pm. Per my review, Resident A's April 2023 MAR did not have any direct care staff member initials indicating Resident A's medications were administered as prescribed at 6PM on April 9, 2023.

Complainant reported and provided me with a copy of the Employee Discipline Notice for Lori Bailey completed on April 11, 2023 documenting a written reprimand for failing to pass [Resident A's] medications on April 09, 2023. Complainant reported per Montcalm Care Networks contracts with Adult Foster Care (AFC) Homes stated the AFC homes have a two-hour window in which they can administer medications and has had Dr. Adam, Psychiatrist provide instructions to the facility staff pertaining to Resident A's medication administration times, documenting "Dr. Adam has reviewed the mediation list and is agreeable to allow a two hour window for daily medication distribution and a five hour window for time absent from facility for event or special circumstances." Complainant reported the facility had a staff meeting on April 11, 2023 in which the mediation count procedures happened during the two-hour window of mediations being passed to assist with missed mediations. Complainant provided a staff sign-in sheet for the meeting and meeting notes to verify the training was conducted. Complainant reported interviewing direct care staff member (DCS) Lori Bailey on April 10, 2023 and stated DCS Bailey admitted to mistakenly missing giving Resident A her medications at 6:00, stating, "I must have been in a hurry and skipped over [Resident A]."

On May 02, 2023, I completed an unannounced onsite investigation and interviewed direct care staff member Katelyn Parsons, whose role is Home Manager. Ms. Parsons reported DCS Lori Bailey is a McBride Quality Care Direct Care Staff employee and is a full-time employee at a different facility. Ms. Parsons reported McBride Todd's Place was short staffed on the April 09, 2023 and DCS Bailey covered a shift to resolve the emergency. Ms. Parsons reported when she arrived to work on April 10, 2023, she was notified by another staff member that Resident A did not receive her 6:00pm medications on April 09, 2023. Ms. Parson reported she reviewed Resident A's MAR

and verified all the residents 6:00pm medications were administered except for Resident A. Ms. Parson's reported she contacted Resident A's physician who reported Resident A was okay to miss the medications one time and administer as normal moving forward. Ms. Parsons reported DCS Bailey admitted to accidentally missing Resident A's medications at 6:00pm. Ms. Parsons reported DCS Bailey reported she was not sure how she missed passing Resident A's medications but obviously skipped over them. Ms. Parson's reported she held a staff meeting in which DCS Bailey attended, reviewed proper medication administration and the changed the times for counting medications so missed medications will be caught in the two-hour required administration time frame set by Montcalm Care Network.

On May 02, 2023 I unable to interview Resident A due to her being nonverbal and her cognitive disabilities. However, I observed Resident A sitting in a hammock chair inside the facility and she was smiling and was well groomed and nicely dressed.

I have made multiple attempts to interview DCS Lori Bailey with no success at the time of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Per the investigation, on April 09, 2023, Resident A was not given her Divalproex 500mg, Quetiapine 400mg, Mirtazapine 30mg and Trazodone 225mg at 6:00pm as prescribed by a physician pursuant the label instructions. This appears to be an isolated incident in which the facility handled immediately and appropriately by completing a written reprimand for DCS Lori Bailey and conducting a staff meeting which included medication administration training and review/update of medication administration policy and procedures. A corrective action plan (CAP) is not required as the corrective action has already been implemented at the time of this reported and CAP compliance has been verified.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action has been received to include verification of the corrective action plan. It is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 05/04/2023

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 05/16/2023

Dawn N. Timm Date
Area Manager