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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2023

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

RE: License #: AS590379167
Investigation #: 2023A1029032
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.

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 #:	AS590379167
Investigation #:	2023A1029032
Complaint Receipt Date:	03/23/2023
Investigation Initiation Date:	03/23/2023
Report Due Date:	05/22/2023
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 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:	09/28/2022
Expiration Date:	09/27/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Direct care staff member, Ms. Maloney-DeLong did not administer Resident A's 10:00 p.m. medications on March 11, 2023.	Yes

II. METHODOLOGY

03/23/2023	Special Investigation Intake 2023A1029032
03/23/2023	Special Investigation Initiated – Letter to Milessa Leach ORR
03/24/2023	Contact - Document Received from Ms. Leach ORR
04/04/2023	Inspection Completed On-site - Face to Face with Resident A, Michelle Turner, Kattie Goodrich, Katie Miller at McBride Ferris AFC, and Face to Face with Cathie Griffis at different licensed facility.
04/20/2023	APS Referral made to Centralized Intake, complaint was denied.
04/20/2023	Contact - Telephone call to Sandra Pollock, Mercedes Maloney-Delong -Left message
04/21/2023	Contact – Telephone call to Mercedes Maloney-Delong Left message, Milessa Leach, ORR
04/25/2023	Contact – Telephone call to Mercedes Maloney-Delong
04/25/2023	Exit conference with licensee designee Kent Vanderloon

ALLEGATION:

Direct care staff member, Ms. Maloney-DeLong did not administer Resident A's 10:00 p.m. medications on March 11, 2023.

INVESTIGATION:

On March 23, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system. The complaint included concerns direct care staff member Mercedes Maloney-Delong did not administer Resident A's 10 p.m. medications because his physician recently changed the administration time from 8:00 p.m. to 10:00 p.m. and the Medication Administration Record (MAR) was not updated. According to the complaint, there was also no information in the communication log to

inform direct care staff members of the change in time. Office of Recipient Rights (ORR) Milessa Leach was also assigned to investigate these concerns.

I reviewed an Incident / Accident Report submitted to Montcalm Care Network on March 13, 2023 regarding the incident with the following details.

> *"I, Sandra Pollock was helping Mercedes Moloney-Delong set up her account in Quick MAR. While she was setting it up, I discussed with her after [Resident A] 9:30 PM smoke, she would need to pass his 10:00 PM meds. She said, OK, while still setting up her account and quick MAR. Once finished, she asked me if she would still need to pass the morning medications. There must have been some type of miscommunication, so he did not get his 10:00 PM medications. I thought it was up to her, but she needed to pass his [Resident A's] 10:00 PM meds for that night, she said, OK, I handed her the Med Keys and we walked out of the Med room. [Resident A] did not receive any of his 10:00 p.m. medications."*

On April 4, 2023, I completed an unannounced on-site investigation at McBride Ferris AFC and interviewed Resident A. Resident A stated direct care staff members give his medications to him and he does not remember anytime he missed a medication. Resident A stated he now takes his evening medications at 9 p.m. or 10:00 p.m. and it used to be earlier. Resident A stated McBride Ferris AFC is "the best AFC he has lived in."

I interviewed direct care staff member, whose role is home manager, Anne Turner. Ms. Turner was able to produce the electronic Medication Administration Record (eMAR) for March 2023 which documented Resident A did not receive his 10:00 p.m. medications on March 11, 2023. The medications Resident A did not receive were Eszopiclone 3 MG, Haloperidol 20 MG, Prazosin HCL 1 MG, Quetiapine Fumarate 400 MG, Simvastatin 40 MG, Temazepam 15 MG, and Ziprasidone 60 MG. There were no notations on the eMAR indicating why the medication was not administered.

Ms. Turner stated direct care staff member Mercedes Maloney-DeLong noticed the next day March 12, 2023 when she arrived to work that Resident A's medications were missed in error. Ms. Turner stated Ms. Maloney DeLong works full time at another facility and was just filling in a shift at McBride Ferris AFC and was unaware the time changed from 8:00 p.m. to 10:00 p.m. on March 2, 2023. Ms. Turner stated there were seven medications which were not administered to Resident A but he did not have any side effects from missing these medications. Ms. Turner stated there was also nothing in the communication record noting the change of time. I reviewed the communication log and also observed there were no entries regarding this change to notify the other direct care staff members.

Ms. Turner stated she has implemented a dry erase board in the medication room now where major medication changes can be posted to alert direct care staff of these changes. Ms. Turner stated when she spoke with the direct care staff members

working, Sandy Pollock stated she told Ms. Maloney-Delong that she needed to pass medications but Ms. Maloney-Delong stated she was not told.

I also verified both employees completed training for medication administration. Ms. Pollock completed her training on November 11, 2022 and Ms. Maloney-Delong completed her training on June 6, 2022.

Resident A's resident record included a physician's order from March 2, 2023 which changed his medications from 8:00 p.m. to 10:00 p.m. The notes in the communication log for March 2, 2023 stated "*left at 12:00 p.m. apt. Back at 2:20 p.m*." but there was no information regarding the change in medication times. I reviewed the staffing schedule and Ms. Maloney-Delong worked at McBride Ferris AFC on March 7-9, however she started working at 11:00 p.m. and would not have been present for Resident A's bedtime medication pass.

On April 4, 2023, I interviewed direct care staff member Katie Miller. Ms. Miller stated the evening medications were changed to 10:00 p.m., so Resident A would sleep better. Ms. Miller stated the communication log should have had details regarding the change but she did see the physicians order which informed her of the change. Ms. Miller stated all direct care staff members were also told about the change of time by Ms. Turner.

On April 4, 2023, I interviewed direct care staff member Kattie Goodrich. Ms. Goodrich stated she took Resident A to his medication review on March 2, 2023 and after the medication review, she told everyone working the medication time has changed from 8:00 p.m. to 10:00 p.m. Ms. Goodrich stated she thought she wrote it in the communication log but now realizes that she did not do this. Ms. Goodrich stated Ms. Maloney-Delong was filling in for a shift at McBride Ferris AFC so she was not aware of the time change for Resident A's medication.

On April 20, 2023, I interviewed direct care staff member Sandra Pollock. Ms. Pollock stated she assisted Ms. Maloney-Delong while she was setting her login information for Quick MAR. Ms. Pollock told Ms. Maloney-Delong to administer Resident A's evening medications and reminded her to pass the 10:00 p.m. medications and she said "Okay." Ms. Pollock stated Ms. Maloney-Delong did not seem like she was confused about the medication pass. Ms. Pollock stated this was the first time Ms. Maloney-Delong was there for the 10:00 p.m. medication pass for Resident A. Ms. Pollock stated she also told Ms. Maloney-Delong Resident A's medications had changed earlier in the week.

On April 21, 2023, I interviewed Ms. Leach from Montcalm Care Network. Ms. Leach stated there have been similar medication errors because the staff stated they are short staffed, in a hurry, and the staff need to be reminded to slow down and remember the five rights of administering medication. Ms. Leach stated she is going to have the nurse who runs the medication training for Montcalm Care Network to follow up and assist the direct care staff members at McBride Ferris AFC with their change to the new eMAR system. Ms. Leach stated Ms. Maloney-Delong, Michelle Turner, and Sandra Pollock will be substantiated. Ms. Leach stated Ms. Maloney-Delong failed to go in and check

Quick MAR to see if a medication needed to be administered when she started her shift. Ms. Leach stated the new procedure at McBride Ferris AFC is to log into Quick MAR and look at the medications in the beginning of the shift and review the communication log.

On April 25, 2023, I interviewed direct care staff member Ms. Maloney-Delong. Ms. Maloney Delong stated she only administered medications one time at McBride Ferris AFC. Ms. Maloney-Delong stated it was different than the other homes she worked in because she was not shadowed at McBride Ferris AFC. Ms. Maloney-Delong stated she was tired from picking up a lot of overtime so she does not remember anyone telling her Resident A's medication time had changed and it was not written in the communication log. Ms. Maloney-Delong stated normally at McBride Ferris AFC she is working with a full-time direct care staff member who administers the medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	After reviewing Resident A's electronic medication administration record (eMAR) for March 11, 2023, I confirmed he did not receive his evening medications as prescribed. According to Ms. Turner, Resident A's physician recently changed times from 8:00 p.m. to 10:00 p.m. and this was not written in the communication log. Direct care staff member Maloney-Delong did not administer this medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

Jennifer Browning _____04/25/2023_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 05/18/2023

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Dawn N. Timm
Area Manager
Date