



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

May 31, 2023

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

RE: License #: AS590379167  
Investigation #: 2023A1029036  
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,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid.

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**

<b>License #:</b>	AS590379167
<b>Investigation #:</b>	2023A1029036
<b>Complaint Receipt Date:</b>	04/18/2023
<b>Investigation Initiation Date:</b>	04/18/2023
<b>Report Due Date:</b>	06/17/2023
<b>Licensee Name:</b>	McBride Quality Care Services, Inc.
<b>Licensee Address:</b>	3070 Jen's Way, Mt. Pleasant, MI 48858
<b>Licensee Telephone #:</b>	(989) 772-1261
<b>Administrator:</b>	Kent Vanderloon
<b>Licensee Designee:</b>	Kent Vanderloon
<b>Name of Facility:</b>	McBride Ferris AFC
<b>Facility Address:</b>	5075 S. Ferris Road, Sheridan, MI 48884
<b>Facility Telephone #:</b>	(616) 255-8916
<b>Original Issuance Date:</b>	03/28/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/28/2022
<b>Expiration Date:</b>	09/27/2024
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Direct care staff member Ms. Miller did not administer Resident A's 10:00 p.m. medications on April 10, 2023 because the medication was not available at McBride Ferris AFC.	Yes

## III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A1029036
04/18/2023	Special Investigation Initiated – Letter Email to M. Leach ORR
04/19/2023	Inspection Completed On-site – face to face with Anne Turner, Marissa Hemmes, and Resident A
04/20/2023	APS Referral made to Centralized Intake, complaint was denied.
04/20/2023	Contact - Telephone call made to Sandra Pollock and Katie Miller (Left message)
04/21/2023	Contact - Telephone call made to Ms. Leach Montcalm Care Network and Katie Miller.
04/25/2023	Exit Conference with licensee designee Kent Vanderloon

### **ALLEGATION:**

**Direct care staff member Ms. Miller did not administer Resident A's 10:00 p.m. medications on April 10, 2023 because the medication was not available at McBride Ferris AFC.**

### **INVESTIGATION:**

On April 18, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns direct care staff member Katie Miller did not administer Resident A's 10 p.m. medication on April 10, 2023 because she did not have the medication to pass. According to the complaint, earlier in the day on April 10, 2023 Michelle Anne Turner ordered the medication from pharmacy with directions to deliver the medication to a different location for someone to pick up but when it was realized, there was not enough staff at McBride Ferris AFC for the direct care staff member to leave and pick up the medication.

On April 19, 2023, I completed an unannounced on-site investigation at McBride Ferris AFC. I interviewed direct care staff member whose current role is home manager, Ms. Turner who was able to produce the electronic Medication Administration Record (eMAR) for April 2023 showing Resident A did not receive his 10:00 p.m. medication Benztropine Mesylate on April 10, 2023. The notation regarding the missed medication in the eMAR stated *“physically unable to take – KM, I was not here when the call came in from the other house that the medication was there to be picked up. I was out picking up another consumer up from school. The message wasn’t relayed so the med wasn’t picked up. I called home manager and left voicemail.”*

Ms. Turner stated all medications are delivered from Downtown Drugs in Mt. Pleasant and since there was only one medication arrangements were made to deliver the medication to another licensed AFC which is also owned by McBride Quality Care in Stanton, MI. Ms. Turner stated the other AFC called McBride Ferris AFC to let them know the medication was ready to be picked up but the message was not relayed to Ms. Miller. Ms. Turner stated direct care staff member Marissa Hemmes received the call around 5:00 p.m. and Ms. Turner did not realize the medication was there to administer until 10:00 p.m. when she went to administer the medication. Ms. Turner stated there were two direct care staff members working and they did not feel comfortable going to pick up the medication and leaving one direct care staff member present with the five residents. Ms. Turner stated she does not think Ms. Turner called the other AFC when she realized this to see if they had a direct care staff member who could deliver the medication. Ms. Turner stated they have resolved the concern and have arranged for Downtown Drugs to deliver all medications to McBride Ferris AFC and not deliver any medication to other locations.

On April 19, 2023, I interviewed Marissa Hemmes. Ms. Hemmes stated she received a call around 5:00 p.m. from the other AFC informing her the medications were there. Ms. Hemmes did not recall who she spoke to but stated she told Ms. Miller who was standing nearby and she said “okay.” Ms. Hemmes stated shortly after Ms. Miller went to pick up another resident but did not pick up the medication. Ms. Hemmes stated Ms. Turner mentioned to them a medication would be delivered to the other AFC. Ms. Hemmes denied forgetting to relay the message.

On April 19, 2023, I interviewed Resident A who stated he missed his medication because the pharmacy delivered the medication to a different house. Resident A stated he does not recall this happening before but he has never observed medications delivered to McBride Ferris AFC in the past.

On April 20, 2023, I contacted direct care staff member, Sandra Pollock. Ms. Pollock stated most of the time the medications are delivered to a different facility and one of the direct care staff members will leave and pick the medication up at one of the other three licensed facilities owned by McBride Quality Care once they are notified.

On April 21, 2023 I interviewed direct care staff member Katie Miller. Ms. Miller stated the medication was supposed to be delivered to another licensed adult foster care

(AFC) in Stanton, MI and when the call came in to notify her it was available, she was not at the facility. Ms. Miller did not receive the message and no one reached out to her when she went to pick up a resident from school because she could have picked it up then since she was near the other AFC. Ms. Miller stated once she realized the medication was not at McBride Ferris AFC a direct care staff member already left work at 9:00 p.m. so she could not leave. Ms. Miller stated she asked Kara Denman if the other AFC called and she said she did not know. Ms. Miller stated Ms. Hemmes is the one who took the call from the other AFC and did not relay the message or make a note in the communication log. Ms. Miller stated she realized the medication was not available when she went to administer the medication. Ms. Miller stated she did not feel comfortable leaving the five residents alone with one direct care staff member in order to pick up the medication. Ms. Miller stated this issue has been resolved because now the medication will be delivered straight to McBride Ferris AFC by Downtown Drugs. Ms. Miller stated the medications have always been delivered to a different facility and this issue has never occurred before.

On April 21, 2023, I interviewed Ms. Leach from Montcalm Care Network. Ms. Leach stated she will be substantiating these concerns and plans to have the nurse who runs the medication training to follow up with McBride Ferris AFC as well since they are changing to a new eMAR system. Ms. Leach stated also interviewed Ms. Miller who stated she did not think to contact Downtown Drugs or the other AFC herself. Ms. Leach stated the error could have been caught earlier but Ms. Miller informed her there were 14 pills of the Benztropine Mesylate left when she counted two weeks ago so she thought he had two weeks left but she did not realize he took them twice per day and would only have one week.

Special Investigation Report #2023A1029032 cited Rule 400.14312 (2) on April 25, 2023, after a resident did not receive a medication per the physician instructions due to a change in time for the medication to be administered. The licensee designee has submitted an acceptable corrective action plan.

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

<b>ANALYSIS:</b>	<p>After reviewing the electronic medication administration record (eMAR) for April 10, 2023 for Resident A, I was able to confirm he did not receive his evening medication, Benztropine Mesylate as prescribed. According to Ms. Turner, Resident A's medication were delivered to another licensed facility and a direct care staff member was going to pick it up, however, the message was not relayed from Ms. Hemmes to pick up the medication.</p> <p><b>REPEAT VIOLATION: SEE SIR 2023A1029032 DATED APRIL 25, 2023. CAP COMPLETED.</b></p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*Jennifer Browning*

Jennifer Browning  
Licensing Consultant

05/04/2023

Date

Approved By:

*Dawn Timm*

05/31/2023

Dawn N. Timm  
Area Manager

Date