GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 18, 2023

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

RE: License #: AS340397979
Investigation #: 2023A1033049
McBride Pearl Street 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 (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340397979
Investigation #:	2023A1033049
Complaint Receipt Date:	06/06/2023
Investigation Initiation Date:	06/08/2023
Report Due Date:	08/05/2023
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 Pearl Street AFC
Facility Address:	1332 Pearl Street Lake Odessa, MI 48849
Facility Telephone #:	(989) 772-1261
Original Issuance Date:	04/04/2019
License **Status:**	REGULAR
Effective Date:	10/04/2021
Expiration Date:	10/03/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/31/23 direct care staff, Dana Whitecotton, attempted to redirect Resident A and grabbed his wrists behind his back and pushed his arms upward and forced him to his bedroom. Three additional direct care staff observed the incident and did not intervene.	Yes

III. METHODOLOGY

06/06/2023	Special Investigation Intake 2023A1033049
06/08/2023	Special Investigation Initiated - Face to Face Interview with AFC Licensing Consultant, Jennifer Browning.
06/14/2023	Inspection Completed On-site- Interview with home manager/direct care staff, Klista Plett. Review of Resident A's resident record and direct care staff, Dana Whitecotton, employee file.
07/11/2023	Contact - Telephone call made Interview with direct care staff, Samantha Kinsman, via telephone.
07/11/2023	Contact - Telephone call made Interview with former direct care staff, Dana Whitecotton, via telephone.
07/11/2023	Contact - Telephone call made Attempt to interview direct care staff, Brooklynn Johnson, via telephone. Voicemail message left.
07/11/2023	Contact - Telephone call made Attempt to interview direct care staff, Ann Swift, via telephone. Wrong number provided.
07/11/2023	Inspection Completed-BCAL Sub. Compliance
07/11/2023	APS Referral- Referral made per protocol.
07/17/23	Exit Conference- Telephone call made to licensee designee, Kent Vanderloon. Voicemail message left.

ALLEGATION:

On 5/31/23 direct care staff, Dana Whitecotton, attempted to redirect Resident A and grabbed his wrists behind his back and pushed his arms upward and forced him to his bedroom. Three additional direct care staff observed the incident and did not intervene.

INVESTIGATION:

On 6/6/23 I received a complaint regarding the McBride Pearl Street AFC (the facility). An *AFC Licensing Division – Incident/Accident Report (IR)* for Resident A, dated 6/1/23, was received by Adult Foster Care Licensing Consultant, Jennifer Browning. This IR contained a written narrative completed and signed by direct care staff, Brooklynn Johnson. This narrative stated, "[Resident A] came home from a walk and tried to go into laundry room. [Dana Whitecotton] told [Resident A] "no thank you" and when he went to go out of laundry room he raised his hand and Dana grabbed his hands and put them behind his back and walked him to the hallway entrance."

There was a second written statement attached to the IR dated 6/1/23 signed by direct care staff, Samantha Kinsman, which stated, "At work on May 31st at 3:20pm Brooklynn Johnson and I (Samantha Kinsman) got off the clock but we stayed back for a little bit to talked *[sic]* with Dana Whitecotton and Ann Swift about the schedule and during that [Resident A] went up to Brooklynn Johnson and asked for help. Since Brooklynn Johnson was off the clock she stated to [Resident A] she was unavailable. Then [Resident A] was going in the laundry room where he had clothes folded at *[sic].* Dana Whitecotton went to grabbed *[sic]* [Resident A] arm to have him not go in the laundry room. Then [Resident A] got upset then tried to grabbed *[sic]* Dana Whitecotton. Then Dana Whitecotton was trying not to get grabbed, so she then grabbed [Resident A] wrist and put his arms behind his back and she pulled his arms up towards his head so he is somewhat bent down and pushed him towards his bedroom. [Resident A] then said "help me." I was off the clock so I didn't now if I could helped *[sic]* him so I looked at Ann Swift who was on the clock and watching what was going on. Ann Swift didn't help [Resident A] at all she just stood back and watch [Resident A] and Dana Whitecotton. Once Dana Whitecotton got him near his bedroom she told him to get in his room where then [Resident A] stayed and after Dana Whitecotton was done with [Resident A] she came back to the kitchen and finished up the schedule then Brooklynn Johnson and I left at the same time."

On 6/14/23 I completed an on-site investigation at the facility. I interviewed direct care staff/Home Manager, Klista Plett. Ms. Plett reported she was aware of the allegation against direct care staff Dana Whitecotton regarding the alleged incident on 5/31/23. Ms. Plett reported she was not present in the facility at the time of the reported event. Ms. Plett reported she received a text message from Ms. Kinsman on 5/31/23 reporting she needed to discuss what had transpired. Ms. Plett reported that on 6/1/23 Ms. Kinsman physically demonstrated the physical hold Ms.

Whitecotton had placed on Resident A on 5/31/23. Ms. Plett reported she had also spoken with Ms. Johnson, who had confirmed she also witnessed Ms. Whitecotton grab Resident A by his wrist, hold his wrist behind his back and walk him to his bedroom. Ms. Plett reported she did a physical assessment of Resident A and he had no visible bruising or marks on his arms or wrists from the alleged incident. Ms. Plett reported that Ms. Whitecotton has been suspended as of this date pending investigation of the allegations. Ms. Plett reported direct care staff at the facility are not trained to use any type of restraint hold with any of the current residents. She reported this type of intervention is not in Resident A's assessment plan. Ms. Plett reported no other residents were witness to this alleged incident. Resident A was not available to be interviewed at the time of this on-site investigation.

During on-site investigation Ms. Plett provided me with written statements from Ms. Johnson, Ms. Kinsman, and direct care staff, Ann Swift. Ms. Swift was also reported as being present for this alleged event and reported the following, "Ann dsp, Sam dsp, Brooklynn dsp, Dana ahm were standing at the counter June 1 at about 3pm talking about the schedule [Resident A] came up to us and asked for help and dana said just a min please and he got a little upset and try to go to the laundry room and dana stop him and [Resident A] was grabbing at her and she took his arms and put them behind his back and walked him to his room. The dsps look at each other and they said they were leaving as there *[sic]* shift was over. I feel and know we were not trained like that and after the girls left and I told dana she should not have done that. that is when she said I didn't do nothing I wasn't trained to do and she didn't care."

On 7/11/23 I interviewed Ms. Kinsman via telephone. Ms. Kinsman reported that she had completed a written statement and everything in her written statement is accurate as to the incident on 5/31/23 concerning Resident A and Ms. Whitecotton. She further reported that Ms. Whitecotton had arrived for her scheduled shift on 5/31/23 and was upset that Ms. Johnson had taken Resident A for a walk that afternoon. Ms. Kinsman reported that it is normal practice for the direct care staff to go for walks with Resident A. Ms. Kinsman reported that when Resident A returned from his walk, he was walking toward the laundry room, as he enjoys doing his laundry and had folded clothes in the laundry room. Ms. Kinsman reported that Ms. Whitecotton had attempted to redirect Resident A as she did not want him in the laundry room, and he grabbed at Ms. Whitecotton. Ms. Kinsman reported Ms. Whitecotton took Resident A by his arms, held them behind his back, and forced him to his bedroom. She reported as Ms. Whitecotton was walking Resident A to his bedroom, she was pulling up on his wrists causing him to walk in a hunched position. Ms. Kinsman reported that Resident A said, "help me", but Ms. Kinsman was not sure she could intervene as she was not currently punched in as her shift had ended.

On 7/11/23 I interviewed Ms. Whitecotton via telephone. Ms. Whitecotton reported she no longer is employed at the facility. She reported that she was recently terminated from her position as the Assistant Home Manager (AHM)/direct care staff. Ms. Whitecotton reported that she does recall the incident from 5/31/23

regarding Resident A. She reported that Resident A was trying to enter the laundry room and she was trying to redirect him as she did not want him to interfere with the washer and dryer cycles as they were both currently running. She reported Resident A tends to stop these machines and add soiled clothing. She reported that she took his right arm and put it behind his back and asked him to go to his room. Ms. Whitecotton reported she was trained to use this intervention with Resident A when she hired into the facility in 2021. She further reported that she was recently told not to handle Resident A in this manner, and she was terminated due to this issue.

During on-site investigation on 6/14/23 I reviewed Resident A's resident record. I reviewed the following documents, *BTC Behavior Support Plan*, dated 8/2/21. This document addressed interventions such as verbal redirection and using hand gestures to provide direction to Resident A (such as pointing to his bedroom when this is the desired location for Resident A), but did not address the use of physical holds in an attempt to provide redirection to Resident A. I also reviewed the documents, *PCP Meeting & Treatment Plan*, dated 4/28/23, and *Assessment Plan for AFC Residents*, dated 4/6/23. Neither of these documents indicated the use of a physical hold when attempting an intervention for behavior management with Resident A.

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:	Based upon interviews with Ms. Plett, Ms. Kinsman, & Ms. Whitecotton, as well as personal written statements of the events of 5/31/23, by Ms. Swift and Ms. Johnson, in addition to review of Resident A's resident record, it can be determined that the direct care staff did not provide for Resident A's protection and safety on 5/31/23. Ms. Whitecotton verbally reported that she held Resident A's wrist behind his back and led him away from the laundry room. Three additional witnesses reported that they observed this incident and noted feeling uncomfortable with the way Ms. Whitecotton handled Resident A physically yet did not assist. Furthermore, Ms. Kinsman reported that she was unaware she could intervene as she was not currently on shift at the time of the incident, however observed Resident A asking, "help me". Resident A's current assessment plan and behavior plan do not document the support of using physical holds in redirecting his behaviors. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

07/17/23

Jana Lipps Date
Licensing Consultant

Approved By:

07/18/2023

Dawn N. Timm Date
Area Manager