GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

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

RE: License #: AS590012177
Investigation #: 2023A1029052
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.
- 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
THIS REPORT CONTAINS QUOTED DEROGATORY LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS590012177
Investigation #:	2023A1029052
Complaint Receipt Date:	08/02/2023
Investigation Initiation Date:	08/02/2023
Report Due Date:	10/01/2023
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?
Resident A accessed expired medications, which were not locked, and attempted to drink Milk of Magnesia which was not prescribed to him.	Yes
Direct care staff member Lori Bailey told Resident B to “turn down his nigger music.”	Yes

II. METHODOLOGY

08/02/2023	Special Investigation Intake 2023A1029052
08/02/2023	Contact - Document Sent to Angela Loiselle ORR
08/02/2023	Special Investigation Initiated – Letter to ORR Angie Loiselle
08/24/2023	Inspection Completed On-site – face to face with Crystal Almanza, Ann Foster, and Resident B and Resident C
08/24/2023	Contact - Telephone call made to Cassie Peterson
09/12/2023	APS Referral - Made APS referral to Centralized Intake
09/12/2023	Contact - Telephone call made to Brad Devries (# d/c), Mike Mokma, Leigha Allen
09/18/2023	Contact - Telephone call made to Leigha Allen and Mike Mokma
09/19/2023	Contact – Telephone call to Lori Bailey, Licensee designee Kent Vanderloon (also sent email), administrator Cathie Griffis, Brad Devries, Cassandra Peterson, Mary Wotring
09/20/2023	Exit conference with licensee designee Kent Vanderloon.

ALLEGATION: Resident A accessed expired medications, which were not locked, and attempted to drink Milk of Magnesia which was not prescribed to him.

INVESTIGATION:

On August 1, 2023, I received a complaint via the Bureau of Community and Health Systems online complaint system indicating expired medications were not being destroyed in a timely manner nor were they maintained in a locked cabinet. According to the complaint, Resident A grabbed a bottle of expired Milk of Magnesia (expired date 2020) and attempted to ingest it however direct care staff member Mary Wotring intervened and dumped it out in the sink. The complaint also included concerns expired medications had been left unsecured in both the manager's office, laundry room cabinet, and cleaning closet.

On August 3, 2023, I spoke to Office of Recipient Rights (ORR) advisor, Angela Loiselle who stated she interviewed most direct care staff members regarding these allegations. Ms. Loiselle stated she learned the Milk of Magnesia was the only medication not disposed of as required because it was already expired when it was received by the resident's family. Ms. Loiselle stated ORR advisor Cece McIntyre went to McBride Corlisa Jade Home and did not find any other expired medications.

On August 24, 2023, I completed an unannounced on-site investigation at McBride Corlisa Jade Home. I interviewed direct care staff members Crystal Almanza and Ann Foster. Ms. Almanza and Ms. Foster both denied ever observing any medications left accessible to residents or maintained in an unlocked cabinet. Neither direct care staff member interviewed was working the day Resident A attempted to drink the expired Milk of Magnesia.

I was able to verify via inspection of the facility there were no medications left out or unlocked at the time of the on-site investigation. Ms. Peterson sent me the *Medication Disposal Procedure* followed at McBride Corlisa Jade Home which outlined how to put medication in ground coffee grounds in a wet zip lock bag to disintegrate the medications and taking them to the dumpster. However, in this policy, there was no indication where expired medications are kept before disposal. Ms. Peterson provided a signed attestation form which all the direct care staff members signed off on February 26, 2023 confirming they were trained on medication disposal procedures.

On August 24, 2023, I interviewed direct care staff member, whose current role is home manager, Cassandra Peterson. Ms. Peterson stated all expired are currently in the cleaning closet locked until she can dispose of them. Ms. Peterson stated the medication found by Resident A was Milk of Magnesia which expired in 2019 but denied knowing it was in her office. Ms. Peterson stated Resident A did not drink the medication because a direct care staff member was able to get it away from him before

he took a drink. Ms. Peterson stated they have a written policy for disposing of medications.

On August 24, 2023, I interviewed Resident C at McBride Corlisa Jade Home. Resident C stated he has resided in the home for almost three months and he has never observed any medications out because they keep them all locked up. Resident C stated he has never observed Resident A get a hold of medications and try to drink anything.

On September 18, 2023, I interviewed direct care staff member Mike Mokma. Mr. Mokma stated there was expired Milk of Magnesia in the manager's office and when he was administering medications he noticed Resident A was holding it, uncapped it, and brought it to his mouth like he wanted to drink it. Mr. Mokma stated direct care staff members were able to get this medication from him and dump it in the sink. Mr. Mokma stated there were other expired medications in a gallon zip lock bag along with another expired bottle of Milk of Magnesia which he locked up after they were found. Mr. Mokma stated typically the medications are locked up when they are expired so he was not sure why those were in Ms. Peterson's office unlocked.

On September 19, 2023, I interviewed direct care staff member Lori Bailey. Ms. Bailey stated she did not know medications were in the office. Ms. Bailey stated medications are kept in the locked closet in the laundry room area where only Ms. Peterson and her have the keys. Ms. Bailey stated she has never observed residents obtain expired medications.

On September 19, 2023, I interviewed administrator Cathie Griffis. Ms. Griffis stated the expired medications were underneath the office cabinet but she had no knowledge of how the medications got there as this was not protocol. Ms. Griffis stated Resident A picked it up but direct care staff members were able to get it from Resident A before he ingested any of the Milk of Magnesia. Ms. Griffis stated they used to keep them in a locked cabinet in the office however Ms. Peterson moved them into the laundry room. Ms. Griffis stated Resident A will look for drinks around the home and because direct care staff put their drinks in the office, she believes that's why he tried to drink it thinking it was a pop.

On September 19, 2023, I interviewed direct care staff member Mary Wotring. Ms. Wotring stated she was there at the time of the incident. Ms. Wotring stated direct care staff member Mr. Mokma took the medication away from Resident A, not her, but they were able to successfully do so before Resident A ingested any and dumped it immediately after taking it from him. Ms. Wotring stated she has never observed unlocked medications in the office.. Ms. Wotring stated she does not know how the Milk of Magnesia got there because it was so old.

On September 19, 2023, I contacted licensee designee Kent Vanderloon. Mr. Vanderloon emailed to state Resident A did not ingest the medication because the direct care staff member was able to get it away from them.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Although Resident A did not ingest any of the expired Milk of Magnesia, he was able to access this medication because it was not kept locked in a cabinet or drawer as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	The Milk of Magnesia expired in 2019 or 2020 and had not been disposed of as required. Direct care staff members interviewed did not have an explanation why this expired medication remained in the facility accessible to residents or why the licensee's medication disposal protocol had not been followed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff member Lori Bailey told Resident B to "turn down his nigger music."

INVESTIGATION:

On August 1, 2023, I received a complaint via the Bureau of Community and Health Systems online complaint system alleging direct care staff member Lori Bailey yells at Resident B when he has his music/tv up too loud shouting "turn down that nigger music." According to the complaint, direct care staff members Ms. Wotring, Mr. Devries, and Mr. Mokma witnessed these incidents.

On August 3, 2023, I interviewed Office of Recipient Rights (ORR) advisor, Angela Loiselle who stated she interviewed direct care staff members regarding these allegations. Ms. Loiselle stated this was said to Resident B because his music was too loud. Ms. Loiselle stated there were other direct care staff members who heard her say this.

On August 24, 2023, I completed an unannounced on-site investigation at McBride Corlisa Jade Home. I interviewed direct care staff members Crystal Almanza and Ann Foster. Ms. Almanza and Ms. Foster both denied ever observing any direct care staff member, including Lori Bailey, use derogatory language toward a resident or their music. Ms. Almanza stated she heard about the incident and stated Ms. Bailey has "loose lips" but she has never heard her make any racial comments but has heard her swear before. Ms. Almanza stated she has heard direct care staff members ask Resident B to turn down his music because he likes it as loud as possible. Ms. Foster stated she did not think Resident B had the physical capability to turn the music knob up or down by himself so she was not sure how it ended up that loud.

On August 24, 2023, I interviewed direct care staff member, whose current role is home manager, Cassandra Peterson. Ms. Peterson stated she has never heard Ms. Bailey say anything like what was alleged. Ms. Peterson stated Resident B has not expressed any fear of Ms. Bailey when she works with him.

During the onsite investigation I observed Resident B positively interact with direct care staff members. I was not able to interview Resident B as he is non-verbal and unable to answer specific questions about the incident.

I reviewed training records showing Ms. Bailey completed *Person Centered Planning* on January 7, 2022 and *Positive Approach to Challenging Behaviors Non-Aversive* on January 17, 2021.

On August 24, 2023, I interviewed Resident C at McBride Corlisa Jade Home. Resident C stated he thinks direct care staff members interact well with Resident B. Resident C stated he has never heard anything mean or derogatory about the music. Resident C stated he has only heard people tell Resident B to turn down his music but they are polite about it.

On September 18, 2023, I interviewed direct care staff member Mike Mokma. Mr. Mokma stated Resident B had his music loud and Ms. Bailey told Resident B to "turn your nigger music" off which he thought was inappropriate but even more so because there is an African American resident living in the facility. Mr. Mokma stated he does not believe this was said accidentally as Ms. Bailey is a "grown adult, not someone who does not know better." Mr. Mokma stated he was on his way outside because Resident A was eloping at the time of the incident, so he was working to address Resident A's behavior. Mr. Mokma stated Ms. Allen was also working at the time of the incident. Mr. Mokma stated he has mentioned concerns to management before but nothing is done to rectify the situation. Mr. Mokma stated he has never heard her make racial

comments but “Ms. Bailey always has an attitude with the residents” when she is trying to redirect them.

On September 18, 2023, I interviewed direct care staff member Leah Allen. Ms. Allen stated she was heading outside to the porch when she heard Ms. Bailey say “turn down your nigger music” to Resident B and after she heard this, Ms. Allen stated Mr. Mokma turned down the music for Resident B while she went back inside to resume cooking. Ms. Allen stated she had never heard Ms. Bailey say something like this in the past and she is typically good with the residents. Ms. Bailey stated there were some residents awake who heard this statement.

On September 19, 2023, I interviewed direct care staff member Lori Bailey. Ms. Bailey stated she has never spoken to Resident B in a disrespectful manner and she stated she has the same relationship with all the residents. Ms. Bailey stated, “she absolutely did not” tell him to turn down his “nigger music.” Ms. Bailey stated she would not say this word so she does not know where this came from and she was dumbfounded when she went to see Ms. Loiselle about the allegation.

On September 19, 2023, I interviewed administrator Cathie Griffis. Ms. Griffis stated she has not heard Ms. Bailey say anything derogatory around the residents. Ms. Griffis stated there were other direct care staff members who were on the porch when she said that and there were two direct care staff members who heard her say this. Ms. Griffis stated Ms. Bailey received a three day suspension as discipline for this incident and there have been no issues with her since she was back.

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 B was not treated with dignity and respect when Ms. Bailey told him to “turn down his nigger music” as she was walking out of the facility. Although Ms. Bailey denied saying this, Ms. Allen and Mr. Mokma both stated they overheard Ms. Bailey say to Resident B to turn down his “nigger” music. According to administrator, Ms. Griffis because there were two other direct care staff members who stated they heard this incident and as a result Ms. Bailey received a three day suspension as discipline.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

Jennifer Browning _____09/20/2023_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 09/25/2023

_____

Dawn N. Timm Date
Area Manager