GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2024

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

RE: License #: AS370088019
Investigation #: 2024A1029041
McBride #1

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. 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

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 #:	AS370088019
Investigation #:	2024A1029041
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/12/2024
Report Due Date:	06/11/2024
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 #1
Facility Address:	235 S. Bamber Road, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-7058
Original Issuance Date:	10/01/1999
License Status:	REGULAR
Effective Date:	04/01/2024
Expiration Date:	03/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Sarah Krapohl pulled Resident A down the ramp after Resident A crawled up the ramp toward the office which caused a large injury on her back right shoulder blade.	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A1029041
04/12/2024	Special Investigation Initiated – Telephone to ORR Katie Hohner
04/12/2024	Contact - Document Received from Katie Hohner
04/12/2024	APS Referral to Centralized Intake
04/17/2024	Contact - Face to Face with direct care staff members Katlynn Martin, Brandt Montague, Lalita Kennedy, Hnin Khine, JaNessa Keener, Sara Krapohl, Hannah Huber, Arica Quesnel, Kent Vanderloon, Sarah Nestle at McBride Quality Care Offices
04/18/2024	Contact - Telephone call made to Kent Vanderloon.
04/19/2024	Contact - Document Received from Arica Quesnel
04/19/2024	Inspection completed On-site – face to face with direct care staff member Arica Quesnel and Resident A at McBride 1.
04/23/2024	Contact - Telephone call made to licensee designee Kent Vanderloon.
05/30/2024	Contact – Telephone call to ORR Katie Hohner
05/30/2024	Exit conference with licensee designee Kent Vanderloon.

ALLEGATION:

Direct care staff member Sarah Krapohl pulled Resident A down the ramp after Resident A crawled up the ramp toward the office which caused a large injury on her back right shoulder blade.

INVESTIGATION:

On April 12, 2024, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that direct care staff member Sarah Krapohl pulled Resident A down a ramp after Resident A crawled up the ramp toward the office area which caused a large scratch on her back right shoulder blade. Office of Recipient Rights (ORR) advisor, Katie Hohner was also assigned to investigate the concerns.

On April 17, 2024, ORR Katie Hohner and I interviewed direct care staff member Katlynn Martin. Ms. Martin stated she did not see Ms. Krapohl drag Resident A however Ms. Krapohl told her Resident A was crawling up the ramp to the office area and she "drug her back down to her chair" on April 5, 2024. Ms. Martin stated she initially thought Ms. Krapohl would have put her arms underneath Resident A and assisted her back to her wheelchair. Ms. Martin then demonstrated on Ms. Hohner hooking her arms underneath her to show how Resident A will walk with someone if they are behind her assisting. Ms. Martin stated direct care staff member Lalita Kennedy had taken Resident A to the bathroom before lunch and she observed the mark on Resident A's back. Ms. Martin stated Ms. Kennedy asked her if she knew how Resident A received this injury and then informed her that she watched Ms. Krapohl drag Resident A by the ankle and pull her down the ramp. Ms. Martin stated Resident A had a mark showing a large scratch down her back which she photographed. Ms. Martin showed Ms. Hohner and I the picture then deleted it off her phone. Ms. Martin stated she did not report it because she did not want to get in trouble and thought she was going to lose her job because direct care staff member, whose role is home manager, Ms. Quesnel, and Ms. Krapohl (assistant manager) are close friends and she did not think they would believe her. Ms. Martin stated she did take the photo of Resident A's injury however she did not write any progress notes or complete an *AFC Incident / Accident Report*. Ms. Martin stated she and Ms. Kennedy initially did not think the mark was from Resident A being dragged down the ramp because when Ms. Kennedy asked Ms. Krapohl about Resident A's injury and was told it occurred when Resident A threw herself down on the floor.

Ms. Martin stated she provided personal care to Resident A in the bathroom before the incident and never saw any marks on her so she knew the injuries were from this incident. Ms. Hohner informed Ms. Martin failure to report was also a "Neglect 2" violation with Recipient Rights. Ms. Martin stated Ms. Krapohl likes to "play with the residents" and will hit the residents with a pool noodle while they are laughing but she has never seen her have a mean demeanor with the residents or physically assault any resident. Ms. Martin stated Ms. Quesnel went over the Recipient Rights reporting forms

and trained direct care staff members on the process of reporting during a staff meeting on April 16, 2024. Ms. Martin stated prior to this training, she did not know how to report to Recipient Rights.

On April 17, 2024, ORR Ms. Hohner and I interviewed direct care staff member, whose role is home manager at another licensed AFC owned by McBride Quality Care, Brandt Montague. Mr. Montague stated he called direct care staff member Hannah Huber for coverage and during the shift report on April 10, 2024, Ms. Huber expressed frustration with McBride 1 and told him about Resident A's injury. Mr. Montague stated he told her to type up this information into an email and sent it to McBride Associate Director of Services (ADOS) Jackie Brown to report the allegations. Mr. Montague stated he spoke with Mr. Brown on April 11, 2024, and asked if he knew about the incident and Mr. Brown replied he was not aware of this incident and he had not received an email documenting the incident from Ms. Huber. Mr. Montague stated in the future, he would call Mr. Brown or report to Office of Recipient Rights immediately instead of only directing the direct care staff member to report the concerns.

On April 17, 2024, ORR Ms. Hohner and I interviewed direct care staff member Lalita Kennedy. Ms. Kennedy stated she was working at McBride #1 on April 5, 2024 and noticed Resident A was down in the sunken living room area. Ms. Kennedy stated around 9-10 AM, she observed Ms. Krapohl dragging Resident A by one of her legs near her ankle. Ms. Kennedy stated she asked Ms. Krapohl if she needed assistance with Resident A, but Ms. Krapohl declined and stated she would have found another direct care staff member to help. Ms. Kennedy stated she could not assist due to recently having surgery but she was cleared to work with no restrictions. Ms. Kennedy stated Ms. Krapohl dragged Resident A down very slowly and neither Ms. Krapohl nor Resident A appeared to be upset while this was happening. Ms. Kennedy stated Ms. Krapohl did not say anything to Resident A when she was dragging her. Ms. Kennedy stated she wondered why Ms. Krapohl would do this especially knowing that she was watching. Ms. Kennedy stated she believed this was wrong for her to do. Ms. Kennedy stated she found the injuries on Resident A around 11 AM when she took her to the bathroom and she saw the injury on her back. Ms. Hohner showed her a picture of the injury and she stated it was the same but it was redder at the time. Ms. Kennedy stated she did not see the injury before this occurred. Ms. Kennedy stated after she saw the injury, she did not call Recipient Rights or report to Ms. Quesnel but she called direct care staff member Ms. Martin to tell her about it and took a picture of the injury because she "wanted to have proof of the incident." Ms. Kennedy stated she was afraid that no one would believe her if she said something. Ms. Kennedy stated she has a picture on her phone of the back injury which she showed Ms. Hohner and I then deleted off her phone. Ms. Kennedy stated she reported the injury to Ms. Krapohl but Ms. Krapohl responded that Resident A had falls in the past and she would be okay. Ms. Kennedy stated she did have Recipient Rights training in the past and she knows that she should have reported it. Ms. Kennedy stated she did not want to report to Recipient Rights because she did not want to get in trouble in the house and lose her job because she likes working for McBride Quality Care Services. Ms. Kennedy stated Resident A did say "Ow" when she picker her shirt up but otherwise did not appear to be in pain. Ms.

Kennedy admitted she told other direct care staff members about the incident but did not report it as required.

On April 17, 2024, ORR Ms. Hohner and I interviewed direct care staff member Hnin Khine. Ms. Khine stated she worked the previous night on third shift and was in the bathroom providing personal care to Resident A when she noticed the marks on her back. Ms. Khine stated she asked the other direct care staff member (she could not recall who) who told her Resident A has been throwing herself off the bed and she likely injured herself while doing so. Ms. Khine stated she knows when she sees an injury on a resident, she is supposed to report it but she did not report the injury in this situation. Ms. Khine stated she was recently trained on how to report incidents to Recipient Rights and about filling out the *AFC Incident / Accident Reports*. Ms. Hohner stated there needed to be a record of the incident and injury when it is first noticed.

On April 17, 2024, ORR Ms. Hohner and I interviewed direct care staff member JaNessa Keener. Ms. Keener stated she completed Recipient Rights training when she started. Ms. Keener stated she was not on shift when the allegation allegedly occurred but she did see the injury on Resident A the following morning when Resident A woke up. Ms. Keener stated she did not see any documentation about the injury or that it was reported. Ms. Keener stated she did not know if an *AFC Incident / Accident Report* was completed yet and she also did not complete one when she observed the injury.

On April 17, 2024, ORR Ms. Hohner and I interviewed direct care staff member whose current role is assistant home manager, Sara Krapohl. Ms. Krapohl stated Resident A has had injuries in the past because she throws herself onto the floor. Ms. Krapohl did not remember the exact date Resident A last had a behavior but stated Resident A recently threw herself on the floor when she was at breakfast with another resident. Ms. Krapohl stated she observed the injury on Resident A as did Ms. Martin and Ms. Kennedy, however none of them completed an *AFC Incident / Accident Report* or any progress notes for that day. Ms. Krapohl stated Ms. Martin told Ms. Krapohl Resident A had thrown herself and this was how she got the injury. During that same day, Ms. Krapohl stated Resident A crawled up the ramp but denied that she dragged Resident A in any way. Ms. Krapohl stated Ms. Kennedy helped Resident A to stand up and then Ms. Krapohl walked her with her by her side. Ms. Krapohl denied dragging Resident A down the ramp. Ms. Krapohl stated she did not notify Ms. Quesnel because she was out that day and she also did not write an *AFC Incident / Accident Report* or progress notes because she was not sure if she should. Ms. Krapohl stated she has not witnessed any of the direct care staff member dragging Resident A at any point in time. Ms. Krapohl stated she does not know why someone would say that she dragged Resident A down the ramp.

On April 17, 2024, ORR Katie Hohner and I interviewed direct care staff member Hannah Huber. Ms. Huber stated she was aware of the injury to Resident A. Ms. Huber stated she was told by Ms. Kennedy that Ms. Krapohl dragged her down the ramp by her leg, all the way to her wheelchair, and then dropped her into her wheelchair but did not witness this occurring. Ms. Huber stated this incident occurred on a Friday and she

was informed about it on Monday when she came back to work. Ms. Huber stated Ms. Quesnel was told about it by Ms. Martin and she just said “Okay” and Ms. Quesnel saw the injury six days later on April 11, 2024. Ms. Huber stated she knew it was not reported but she was scared to because of the “backlash in the house” and she did not know what would happen with her job. Ms. Huber stated she completed Recipient Rights training when she started but stated she did not know how to report an incident. Ms. Huber stated no one did an *AFC Incident / Accident Report* or documented the injury. Ms. Huber stated she did not feel comfortable reporting it because it was the assistant manager and Ms. Quesnel and Ms. Krapohl are best friends. Ms. Hohner again reiterated to Ms. Huber that she was required to report an incident such as this in the future.

On April 17, 2024, ORR Katie Hohner and I interviewed direct care staff member whose role is home manager, Arica Quesnel. Ms. Quesnel stated she did not know about the injury until April 11, 2024, because she was informed about the allegations by Mr. Brown. Ms. Quesnel denied that Ms. Martin reported the incident to her. Ms. Quesnel stated she observed Resident A’s injuries on April 11, 2024. Ms. Quesnel stated she completed an *AFC Incident / Accident Report* and reported the concerns to Recipient Rights. Ms. Quesnel stated the injury did not have a bandage on it when she saw her but stated the picture provided by Ms. Hohner was accurate. Ms. Quesnel stated the injury was still bleeding days after it occurred. Ms. Quesnel stated she provided training to direct care staff members on how to report incidents to Recipient rights during a staff meeting on April 16, 2024. Ms. Quesnel stated Resident A does have a history of throwing herself on the floor resulting in injuries however she has never observed an injury like this when she has thrown herself on the floor, and stated this one did look like a scrape.

Ms. Quesnel stated she has never observed any aggressive behaviors from Ms. Krapohl toward Resident A but she also does not believe she would do anything like this in front of her. Ms. Quesnel stated she had no doubt the incident occurred and upon hearing about the incident she sent Mr. Brown a picture of the injuries and Ms. Krapohl was taken off the schedule. Ms. Quesnel stated she felt horrible she did not realize what occurred until much later but between being off work, a training, and a celebration of life she had to attend she did not have contact with Resident A.

On April 17, 2024, I interviewed Associate Director of Services (ADOS) Mr. Brown who stated he spoke with Ms. Quesnel on April 11, 2024, and had her do a body check for Resident A which was when Ms. Quesnel saw the injuries. Mr. Brown stated he could hear Resident A whimpering about the injury and Ms. Quesnel provided first aid to the injury. Mr. Brown stated Ms. Kennedy came back to work on April 2, 2024 but did not have any work-related restrictions, however, she was still healing and was likely not comfortable lifting Resident A at this time. Mr. Brown stated Ms. Quesnel also told him she knew Ms. Kennedy was not comfortable with lifting.

On April 19, 2024, I completed an unannounced on-site investigation at McBride 1 and met with Ms. Quesnel and reviewed Resident A’s resident record. I also observed

Resident A however because she is non-verbal, she was not able to complete an interview regarding the allegations. I was able to observe the metal ramp that is in the living room area. The facility has a sunken living room and the metal ramp provides the ability to traverse into the living room in a safe manner. During the on-site, I was able to observe several of the residents utilizing the ramp safely.

I reviewed the direct care staff member staff meeting sign off from April 20, 2023 where Ms. Quesnel reviewed how to fill out an *AFC Incident / Accident Report* with the direct care staff members which was signed by Lalita Kennedy, Nancy Johnston, Kimberly Johson, Jaedin Martinez, Madelyn Crane, Sara Krapohl, Natalie Wagner, and Talia Kyle. There was a Rights Refresher training attestation completed on September 15, 2023 which was signed by Ms. Krapohl, Ms. Martin, and Ms. Kennedy confirming they understood the Recipient Rights refresher.

Ms. Nestle also sent training documentation for all direct care staff members involved showing they completed training for Recipient Rights on the following dates:

- Ms. Martin January 17, 2024
- Ms. Kennedy March 10, 2022
- Ms. Kline May 22, 2023
- Ms. Keener February 13, 2024
- Ms. Krapohl November 15, 2021
- Ms. Huber October 20, 2023

I reviewed a work release letter for Ms. Kennedy verifying she was off work for 14 days and returned to work without restrictions on April 2, 2024.

I reviewed Resident A's resident record. I reviewed Resident A's *Assessment Plan for AFC Residents.* Resident A's Assessment Plan for AFC Residents documented the following: "[Resident A] uses a walker and wheelchair. She needs full assistance going up stairs and steps and getting into the van. She needs supervision while in public. She is a fall risk." Resident A's *Health Care Appraisal* documented the following: Resident A utilizes a wheelchair as an assistive device, has a diagnosis of cognitive impairment, developmental delay, PD, and RLS, and she can be agitated and non-communicative.

On April 23, 2024, I interviewed licensee designee Kent Vanderloon who stated he did not know how Resident A incurred the injuries to her back but confirmed Resident A has a history of throwing herself on the floor causing injury when she is upset. Mr. Vanderloon stated he has never had concerns regarding Ms. Krapohl mistreating residents in the past. Mr. Vanderloon also confirmed there will be additional trainings on reporting because it appears several of the direct care staff members knew about Resident A's injuries and the alleged incident but did not report the concerns.

On May 30, 2024, I interviewed ORR Ms. Hohner. Ms. Hohner stated she will be substantiating Abuse 2 for Ms. Krapohl and failure to report for the direct care staff members that did not report.

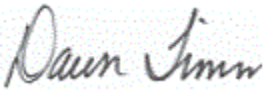
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on interviews with direct care staff members Ms. Krapohl, Ms. Quesnel, Ms. Keener, Ms. Kennedy, Mr. Montague, and Ms. Huber, Resident A incurred injuries to her back right shoulder on April 5, 2024. Although direct care staff member Lalita Kennedy reported observing direct care staff member Sara Krapohl drag Resident A down the metal ramp, she did not take any action to stop Ms. Krapohl nor did she report this behavior to any supervision or administrative staff. None of the direct care staff members who observed Resident A's injury documented or reported it. I observed a picture of the injury and it appeared to be a large wound that was still reddened and bleeding near the bottom with scratch marks underneath the wound that would be consistent with Resident A being dragged. Although the direct care staff members involved all completed Recipient Rights training and there were two Recipient Rights refreshers on April 20, 2023 and September 15, 2023, none of the direct care staff members involved reported the incident to Recipient Rights, Adult Protective Services or the licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning _____05/30/2024_____
Jennifer Browning Date
Licensing Consultant

Approved By:



06/04/2024
_____
Dawn N. Timm Date
Area Manager