GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

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

RE: License #: AS370088019
Investigation #: 2025A0577005
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. 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) 284-9727.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AS370088019
Investigation #:	2025A0577005
Complaint Receipt Date:	11/04/2024
Investigation Initiation Date:	11/04/2024
Report Due Date:	01/03/2025
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 were not trained in Resident A's colostomy care.	Yes
Direct care staff Kimberly Johnson yelled at Resident A.	No

III. METHODOLOGY

11/04/2024	Special Investigation Intake 2025A0577005
11/04/2024	Special Investigation Initiated – Telephone call to Katie Hohner, CMHCM-ORR.
11/04/2024	Referral - Recipient Rights CMHCM
11/05/2024	Contact - Document Received- Incident Report received.
11/06/2024	APS Referral completed.
11/07/2024	Contact - Face to Face- Interviews with DCS at office.
11/12/2024	Contact - Document Received- Screen shot of physician contacts for Resident A.
11/19/2024	Inspection Completed On-site- Interview of resident.
11/19/2024	Inspection Completed-BCAL Sub. Compliance
11/19/2024	Exit Conference with licensee designee Kent VanderLoon.

ALLEGATION: Direct care staff were not trained in Resident A's colostomy care.

INVESTIGATION:

On November 04, 2024, the complaint alleged direct care staff have not been properly trained on Resident A's colostomy bag care.

On November 04, 2024, I interviewed Katie Hohner, Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM) who reported it has been brought to her attention that direct care staff have not been properly trained in Resident A's colostomy care. Ms. Hohner provided a copy of an *AFC Licensing Division - Incident*

/ Accident Report (IR) dated October 31, 2024, completed by Arica Quesnel, home manager (HM), which documented, in part the following, that Resident A woke up during the early morning hours and realized her colostomy bag had leaked and went into the bathroom to fix this. According to the IR, Resident A requested help from direct care staff (DCS) Kimbery Johnson with getting cleaned up and changing her colostomy bag, while DCS Katherine Middleton contacted HM Arica Quesne via phone at 4:59AM stating direct care staff could not locate the colostomy bags. The IR documented Ms. Quesnel asked what had happened to the bag Resident A had on and was informed DCS Johnson had thrown it away and they could not locate the colostomy supplies. Ms. Quesnel asked for a photo of the stoma and colostomy bag. DCS Johnson sent a photo by text message showing the colostomy port patch being directly placed over the stoma, with no hole cut in it, completely flat indicating the stoma has been pushed inside, and a glove sticking out of the port in lieu of the required colostomy bag. Ms. Quesnel advised DCS Middleton to call for an ambulance and have Resident A taken to the hospital due to the stoma being pushed in. According to the IR, while at the emergency room, Resident A's stoma was extended, colostomy bag was placed appropriately, and Resident A was discharged back to the facility. Ms. Hohner also provided me with a photo of the port with a rubber glove being used instead of the required colostomy bag.

On November 07, 2024, Katie Hohner, ORR-CMHCM and I interviewed DCS Nancy Johnston who reported she believes about 35 years ago she was trained in colostomy care. Ms. Johnston reported she was recently trained Resident A's colostomy care, but prior to this incident she was not trained in Resident A's colostomy care and provided care to Resident A with no updated training.

On November 07, 2024, we interviewed DCS Katherine Middleton who reported she was not trained in Resident A's colostomy care. Ms. Middleton reported she has worked with other residents who have had colostomies in the past. Ms. Middleton reported she has provided colostomy care to Resident A without current training. Ms. Middleton reported on October 31, 2024, DCS Johnson provided colostomy care to Resident A and placed a latex glove in the port in place of the colostomy bag to prevent the port from leaking and in attempt to gather the fecal matter inside of the glove. Ms. Middleton reported herself and DCS Johnson did not know the location of Resident A's colostomy supplies and could not locate a colostomy bag. Ms. Middleton reported she sent HM Quesnel a photo of Resident A's colostomy and HM Quesnel advised Resident A to be taken to the hospital because per the photo it appeared Resident A's stoma had been pushed in.

On November 07, 2024, we interviewed DCS Arica Quesnel, HM, who reported Resident A was admitted to the facility on October 25, 2024, from a long-term care facility. Ms. Quesnel reported a nurse from the long-term care facility was supposed to come the Adult Foster Care Home and train Ms. Quesnel and staff members upon Resident A's admission but did not. Ms. Quesnel reported DCS Lalita Kennedy is a nursing student and has been trained on colostomy bag care, therefore Ms. Quesnel stated she allowed Ms. Kennedy to train her on Resident A's colostomy care upon Resident A's admission. Ms. Quesnel reported she was only able to train three staff

members in Resident A's colostomy care. Ms. Quesnel reported there is a booklet on the back of the toilet in Resident A's bedroom that provides direct care staff with a step-by-step process to Resident A's colostomy care. Ms. Quesnel reported on October 28, 2024, a nurse from the long-term care facility came to the facility to train Ms. Quesnel in Resident A's colostomy bag care. During the interview Ms. Quesnel was asked to provide documentation of herself and staff members being trained in Resident A's colostomy bag care and Ms. Quesnel reported most staff members have not been trained and there is no documentation to verify which direct care staff members and management have been trained in Resident A's colostomy care.

On November 07, 2024, Ms. Hohner, CMHCM-ORR and myself interviewed DCS Kimberly Johnson who reported she was trained by the American Red Cross years ago in colostomy care. Ms. Johnson reported she has not been specifically trained in the colostomy care of Resident A. Ms. Johnson reported on October 31, 2024, she found Resident A in her bedroom covered in feces due to Resident A's colostomy bag breaking open. Ms. Johnson reported she told Resident A to get into the shower while Ms. Johnson looked for supplies. Ms. Johnson reported the colostomy bags could not be found so she remembered being trained in using a latex glove as a temporary solution in place of the colostomy bag which was what she did. Ms. Johnson reported DCS Middleton was on the phone with HM Quesnel during this process and HM Quesnel advised that Resident A be taken to the hospital because Resident A's stoma appeared to be pushed in per a photograph DCS Middleton sent HM Quesnel.

On November 19, 2024, I completed an unannounced onsite investigation and interviewed Resident A who reported she does not know how to change her colostomy bag, but she does know where her supplies are kept. Resident A reported she does not know if direct care staff have been trained in colostomy care. Resident A reported she did have to go to the hospital by ambulance one night due to issues with her colostomy.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Based on the information gathered during the investigation, there is sufficient evidence to support that direct care staff were not appropriately trained in Resident A's colostomy care yet provided this care to Resident A. It has been found the home was not able to provide the services and skills needed to meet Resident A's colostomy care needs at the time of admission on October 25, 2024, and thereafter. Specifically on October 31, 2024, DCS Kimberly Johnson and Katherine Middleton provided care to Resident A's colostomy, using a latex glove as a colostomy bag and to plug the hole of the port to prevent the feces from leaking. The lack of training required Resident A to go to the hospital because Resident A's stoma was pushed too far in so a colostomy bag could not be attached.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Staff, Kimberly Johnson yelled at Resident A.

INVESTIGATION:

On November 04, 2024, a complaint was received alleging DCS Kimberly Johnson made derogatory remarks to Resident A after Resident A's colostomy bag broke open.

On November 04, 2024, I interviewed Katie Hohner, Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM) who reported she received information that DCS Kimberly Johnson found Resident A in her bedroom covered in feces and DCS Johson started yelling at Resident A stating, "you have made a mess, get in the shower right now because you made a mess."

On November 07, 2024, we interviewed DCS Katherine Middleton who reported she was working on October 31, 2024, with DCS Kimberly Johnson when Resident A's colostomy bag fell off. Ms. Middleton reported DCS Johnson called Ms. Middleton into Resident A's bedroom when Ms. Middleton heard DCS Johnson say to Resident A in a raised voice, "you know better, you know when to get out of bed, now you are going to have to clean up your bedroom." Ms. Middleton reported Resident A kept apologizing to staff members. Ms. Middleton reported she heard DCS Johnson tell Resident A she did it on purpose because she did not get out of bed in time causing her colostomy bag overflowed.

On November 07, 2024, Ms. Hohner, ORR-CMHCM and I interviewed HM Arica Quesnel who reported she has no concerns with DCS Kimberly Johnson and the care she provides to the residents or how she verbally interacts with residents. Ms. Quesnel

reported she has not witnessed DCS Johnson being rude or inappropriate to residents when Ms. Quesnel has worked third shift with DCS Johnson.

On November 07, 2024, we interviewed DCS Kimberly Johnson who reported on October 31, 2024, around 4:00am Ms. Johnson was doing rounds and upon entering Resident A's bedroom, Resident A had gotten out of bed and the colostomy bag had burst open spreading feces all over the bedroom and Resident A. Ms. Johnson reported she did not yell or scream, but did raise her voice saying, "get into the bathroom, get into the bathroom fast." Ms. Johnson reported this was not out of punishment but out of alarm so fecal matter did not continue to spread all over the bedroom. Ms. Johnson stated, "I had just come from another resident's bedroom who was having diarrhea, cleaned them up and then entered [Resident A's] bedroom to find a busted colostomy bag. I was freaking out because feces were all over the bed, the bedroom floor, [Resident A], and continued to poor out of the busted bag." Ms. Johnson reported she did not tell Resident A she would have to clean the mess up herself, nor did she tell Resident A it was Resident A's fault. Ms. Johnson reported she told Resident A this is natural, accidents happen, and not to worry.

During the onsite investigation on November 19, 2024, I interviewed Resident A who reported DCS Kimberly Johnson yelled at her in a mean tone. Resident A was not able to provide specific information of what DCS Johnson said, but stated, "it was on the night I had to ride in the ambulance." Resident A reported this has been the only time DCS Johnson yelled at Resident A.

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:	During the investigation there was insufficient evidence to support the allegations of DCS Kimberly Johnson yelling at Resident A in an inconsiderate or disrespectful manner. DCS Johnson did report of yelling to Resident A to get into the bathroom due to Resident A's colostomy bag breaking and leaking feces over Resident A and the bedroom. DCS Johnson reported the yelling was due to urgency and not to disrespect or be inconsiderate.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues regular status.

Bridget Vermeesch

11/25/2024

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 11/26/2024

_____

Dawn Timm Date
Area Manager