



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2025

Kent Vanderloon
McBride Quality Care Services, Inc.
P.O. Box 387
Mt. Pleasant, MI 48804-0387

RE: License #: AS430088209
Investigation #: 2025A0230014
Beech Street

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 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,



Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS430088209
Investigation #:	2025A0230014
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	05/17/2025
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:	Beech Street
Facility Address:	610 Fifth Street, Baldwin, MI 49304
Facility Telephone #:	(989) 772-1261
Original Issuance Date:	07/01/2000
License Status:	REGULAR
Effective Date:	09/03/2023
Expiration Date:	09/02/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Inel George was observed yelling at Resident A and twisting his ear to get him to open his mouth.	Yes

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A0230014
03/19/2025	Special Investigation Initiated - On Site Interview Resident A and staff members Christinia Burke and Mary Johnson as well as nurse Megan Spencer
03/19/2025	APS Referral
03/19/2025	Contact - Telephone call received Kara Rose Recipient Rights Officer
03/21/2025	Contact - Telephone call made staff member Inel George
03/28/2025	Contact-Telephone call received from Adult Protective Service Worker Brooke Seaman
04/29/2025	Contact - Telephone call made staff member Kim Dalstra
04/30/2025	Contact - Telephone call made staff member Brandy Bentley
05/01/2025	Contact - Telephone call received RRO Kara Rose
05/05/2025	Exit Conference With Administrator Sarah Nestle

ALLEGATION: Staff member Inel George was observed yelling at Resident A and twisting his ear to get him to open his mouth.

INVESTIGATION: On 03/19/2025, I conducted an unannounced on-site investigation at the facility and interviewed Resident A and staff members Christinia

Burke and Mary Johnson. I also spoke with Community Mental Health nurse Megan Spencer.

Ms. Johnson stated that she has not observed any abuse toward Resident A by Ms. George as she was not working when the alleged incident occurred.

Ms. Burke stated that she is the home manager for the facility and had received a call from staff member Charlene Powers who stated that staff member Kimberly Dalstra told her that she had observed an incident that she was upset by and it involved staff member Inel George yelling at Resident A and pulling his ear. Ms. Dalstra was told to report immediately to the Recipient Rights Officer (RRO) at community Mental Health (CMH). Ms. Burke stated Ms. George is currently not working in the facility pending the investigation.

While at the facility CMH nurse Megan Spencer was also present. She was aware of the allegation but did not know much. She stated she had looked at Resident A's ear but did not observe any marks.

I attempted to interview Resident A but due to cognitive limitations I was not able to obtain any information other than he pointed to his ear and when I asked what happened he stated "her." He was laughing and nodding his head up and down. I did not observe any marks or injuries to his ear.

On 03/19/2025, I spoke with Kara Rose who is the RRO for CMH. She interviewed Resident A and staff members Brandy Bentley and Kim Dalstra via zoom. She stated the only information she was able to obtain from Resident A was that someone hurt him and he pointed to his left ear. He did not give a name but stated it was a woman. She stated that staff member Kimberly Dalstra stated she observed Ms. George twist Resident A's ear, scream at him and shove food in his mouth. Staff member Brandly Bentley told Ms. Rose she did not witness the incident but overheard Ms. George screaming and swearing at Resident A.

On 03/21/2025, I interviewed staff member Inel George regarding the allegation. She stated that Resident A had been "having an outburst at dinner time." Ms. George stated she told him, "Let's eat some more." She continued to attempt to assist in feeding him. Ms. George denied that she forced food in Resident A's mouth or yelled. She stated, "I didn't swear." And I would never twist his ear. I am a mother figure to these people." Ms. George indicated she had planned to retire in two weeks but now was forced to leave early due to the allegation.

On 03/28/2025, I received a telephone call from Adult Protective Services (APS) worker Brooke Seaman who reported that she had investigated the case and would be substantiating the allegations. She also stated that the police had investigated this case and would be charging Ms. George with abuse.

On 04/29/2025, I interviewed staff member Kim Dalstra who stated that on 3/13/25

at dinnertime Resident A was “having a behavior and did not want to eat.” she observed Ms. George yelling at Resident A and swearing and stating, “You want to eat?!” Ms. Dalstra stated Ms. George shoved a spoon in Resident A’s mouth and she observed Ms. George twisting Resident A’s ear twice. She stated she was “shocked” and she reported the incident to her manager and CMH Recipient Rights.

On 04/30/2025, I interviewed staff member Brandy Bentley who stated she was working on 03/13/2025 with Ms. George and Ms. Dalstra. Ms. Bentley stated she was in the staff office completing online training so she did not see what was going on. She overheard Resident A yelling and then she heard Ms. George yelling back at him. “She got very loud and told him to shut up. She used the F word.”

On 05/01/2025, I spoke with RRO Kara Rose. She stated she is substantiating her complaint under the category of unreasonable force and lack of dignity and respect.

On 05/05/2025, I conducted an exit conference with Administrator Srah Nestle and reviewed the findings of the investigation. She stated she believed that the incident occurred as alleged. McBride Services terminated Ms. George’s employment. Additionally, she stated there are upcoming court hearings regarding the case and she or another staff member from the facility will attend those hearings. Ms. Nestle will be providing a plan of correction.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>Ms. George denied that she yelled, swore, shoved a spoon in Resident A’s mouth or twisted his ear.</p> <p>Resident A was unable to provide a clear interview regarding the allegation due to cognitive limitations.</p> <p>Ms. Dalstra stated she observed Ms. George yelling at Resident A and shoving food in his mouth and twisting his ear.</p> <p>Ms. Bentley stated she was in another room and overheard Ms. George yelling loudly, telling him to shut up and swearing at him.</p> <p>RRO Ms. Rose has substantiated a case of abuse and lack of dignity and respect against Resident A regarding this complaint.</p>

	<p>APS worker Ms. Seaman has substantiated an abuse case against Ms. George and reported that law enforcement has pressed charges against Ms. George.</p> <p>There is sufficient evidence in this case to substantiate that Resident A was not treated with dignity and his protection and safety were not attended to at all times.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.



05/08/2025

Rhonda Richards
Licensing Consultant

Date

Approved By:



05/08/2025

Jerry Hendrick
Area Manager

Date