GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2025

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

RE: License #: AS590012177
Investigation #: 2025A1029029
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

I. IDENTIFYING INFORMATION

License #:	AS590012177
Investigation #:	2025A1029029
Complaint Receipt Date:	03/27/2025
Investigation Initiation Date:	03/27/2025
Report Due Date:	05/26/2025
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 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:	04/08/2024
Expiration Date:	04/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On March 20, 2025, direct care staff member Mercedes Maloney-Delong placed Resident A in an unnecessary restraint.	Yes

III. METHODOLOGY

03/27/2025	Special Investigation Intake 2025A1029029
03/27/2025	Special Investigation Initiated – Telephone Interviews with ORR Ms. Loiselle with Ms. Maloney-Delong, and Ms. Ockert
03/27/2025	APS Referral made to Centralized Intake
03/28/2025	Inspection Completed On-site- Face to Face with Jessica Antcliff, Ann Foster, Resident A, Cathie Griffis, Brandi Cowling at McBride Corlisa Jade Home
04/11/2025	Contact - Telephone call made with licensee designee Kent Vanderloon, Ms. Maloney-Delong, Ms. Nowotny
04/15/2025	Contact - Telephone call made to ORR Angela Loiselle and McBride Director of Operations Sarah Nestle
05/09/2025	Exit conference with Kent Vanderloon and Sarah Nestle

ALLEGATION: On March 20, 2025 direct care staff member Mercedes Maloney-Delong placed Resident A in an unnecessary restraint.

INVESTIGATION:

On March 27, 2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns Resident A was restrained improperly by direct care staff member Mercedes Maloney-Delong at McBride Corlisa Jade Home on March 20, 2025. Office of Recipient Rights (ORR) Officer Angela Loiselle from Montcalm Care Network was also assigned to investigate these concerns. According to the allegations, Resident A was trying to get into Ms. Maloney-Delong's pocket and she was restrained, which is not in compliance with Crisis Prevention Institute (CPI) training. According to the allegations, these behaviors are also Resident A's baseline behaviors and were not putting Ms. Maloney-Delong at risk.

On March 27, 2025 I interviewed Cecelia McIntyre and Ms. Loiselle from ORR. McBride ADOS Cathie Griffis was also present in the room. Ms. Griffis stated according to Resident A's *Person Centered Plan* if Resident A is getting into pockets, direct care staff members are to redirect Resident A to other activities while using a calm but firm tone. Ms. Loiselle stated in this instance Resident A only tried to grab things out of Ms. Maloney-DeLong pockets which are typical behaviors for Resident A and she is concerned Ms. Maloney-DeLong was trying to control the situation. Ms. McIntyre stated Ms. Maloney-DeLong completed the CPI training at Montcalm Care Network and would have known this was not an appropriate time to use this restraint.

On March 27, 2025, ORR Ms. Loiselle, Ms. McIntyre, and I interviewed direct care staff member Samantha Ockert. Ms. Ockert stated Resident A came out of her bedroom wanting to have her pain pill but it was not time so she became irritated and upset. Ms. Ockert stated after Ms. Maloney-DeLong told Resident A "no", Resident A started grabbing at Ms. Maloney-DeLong pockets and swatting her drink out of her hand. Ms. Ockert stated Resident A was trying to get attention and was more antagonistic instead of being mean to her because Resident A likes to annoy people when she does not get her way. Ms. Ockert stated she knew how to get the interaction and that's exactly what she was doing. Ms. Ockert stated she was familiar with Resident A's Behavioral Treatment Plan and felt Ms. Maloney-DeLong "was making a bigger deal about the situation" because when she would speak to her it was a normal tone but when she would talk to Resident A she was more "riled up." Ms. Ockert stated at no point did she feel that a restraint or hold was necessary. Ms. Ockert stated she was sitting on the couch trying to talk to Resident A and Ms. Maloney-DeLong had her hand on Resident A's hand. Ms. Ockert stated Resident A kept saying "ow my thumb." Ms. Ockert stated Ms. Maloney-DeLong held Resident A down on the couch by linking her arm through hers and pressing down on her hand. Ms. Ockert stated Resident A was not trying to hit or threaten Ms. Maloney-DeLong at all but she had her in a "low level sitting hold" for four minutes. Ms. Ockert stated Resident A's hands were in her lap and she did not have her in a hold during that time but she was sitting next to her. Ms. Ockert stated Resident A asked staff to let her go and Ms. Maloney-DeLong asked her if she was going to leave her alone and she said she would, but Resident A continued to bother Ms. Maloney-DeLong. Ms. Ockert stated Resident A will typically aggravate people and it was working with Ms. Maloney-DeLong because was getting "wound up" and it was feeding into Resident A's behaviors. Ms. Ockert stated law enforcement was called around 6 AM but at no point Ms. Ockert stated did she feel like the incident was enough to call law enforcement. Ms. Ockert stated she asked Ms. Maloney-Delong not to call them however Michigan State Police came to the home. Ms. Ockert stated a hold was used on Resident A despite there being no imminent risk of harm. Ms. Ockert stated at first Ms. Maloney-DeLong tried to engage with her less and minimize how much she talked to Resident A. Ms. Ockert stated the more Resident A started following her and pestering her, then Ms. Maloney-DeLong started raising her voice to the point of "almost yelling" at her. Ms. Ockert stated the hold she was referring to can be a one person or a two-person hold. Ms. Ockert stated she attempted to verbally de-escalate Resident A but she felt like she was "wasting her breath." Ms. Ockert stated when she left the shift,

she did call her supervisor to inform her of this incident. Ms. Ockert stated it has been years since Resident A has been in a CPI hold due to her behaviors.

On March 27, 2025, ORR advisors Ms. Loiselle, Ms. McIntyre, and I interviewed direct care staff member Ms. Maloney-DeLong who stated she did read Resident A's *Treatment Plan* but she may have to read it again because she works at other homes. Ms. Maloney-DeLong stated Resident A was upset she could not receive her pain medication and started to have behavioral issues including targeting Ms. Maloney-Delong. Ms. Maloney-DeLong stated starting around 4:45 AM-5:45 AM Resident A was smacking at her, stepping on her feet, not wanting her to get up and move around, almost poked her in the eye, and scratched her face. Ms. Maloney-DeLong stated she looked at the other staff (Ms. Ockert) and said, "we can do CPI, can't we?" and she said Ms. Ockert said she was pretty sure because Resident A was being aggressive. Ms. Maloney-DeLong stated she had her hand in Resident A's hand and they were holding hands on the couch "pretty much." Ms. Maloney-DeLong stated Resident A told her that she had her thumb held down and she was hurting her, however, she does not believe she hurt her. Ms. Maloney-DeLong stated tried to ignore Resident A but there was one time she felt like she was also getting elevated. Ms. Maloney-DeLong stated she quickly got up, moved away from Resident A and asked her to, "please give me space" and tried to stop these behaviors by telling her to calm her down, ignoring her, but Resident A kept getting physical with her. Ms. Maloney-Delong stated she did take her coat off so she had her keys in her hoodie pocket which Resident A was trying to get from her. Ms. Maloney-Delong stated she called law enforcement about 20-30 minutes after she put Resident A into the hold.

After this interview, Ms. Loiselle stated there was no imminent risk in this situation and a restraint should not have been used. Ms. Loiselle stated she has investigated Ms. Maloney-DeLong in the past and there have been previous substantiations by ORR for similar concerns.

On March 28, 2025 I completed an unannounced on-site investigation at McBride Corlisa Jade Home and interviewed direct care staff members Jessica Antcliff and Ann Foster. Ms. Antcliff and Ms. Foster were not present for this incident and Ms. Foster stated she works with Ms. Maloney-Delong occasionally. Both direct care staff members stated when Resident A has behaviors, they try to redirect her into other activities but they have never had to restrain her. Ms. Antcliff stated all new direct care staff members working in the home need to review the residents' *Behavior Treatment Plans* and *Person Centered Plans* so they know how to provide care to the residents. Neither direct care staff member stated they have ever observed Ms. Maloney-Delong be disrespectful or yell at the residents. Ms. Antcliff stated if you do not engage with Resident A's behaviors she will stop and redirect to something. Ms. Antcliff stated she has known Resident A since 2016 and she has never seen her in a restraint. Ms. Antcliff stated because she was restrained, she believes Ms. Maloney-Delong was overreacting to this situation.

During the on-site investigation, I reviewed the following documents:

1. Resident A's *Behavior Treatment Plan* which states Resident A does have target behaviors which include antagonizing peers, verbal outbursts, and physical aggression.
    a. Under Proactive Strategies: "*Use of a calm approach. Set consistent behavioral expectations it is extremely important to maintain a calm approach with [Resident A]. Speak to her in a calm manner. Do not display extreme emotional reactions rather remain firm and set clear expectations. Refrain from getting into a "power struggle" type of interaction with her."*
    b. To address physical aggression / property destruction / self-harm gestures:
        i. *"Remain calm and consistent. Speak to her in a low calm voice. The less words you use, the better.*
        ii. *If she escalates toward staff (swings out at you or charges you) then you can sidestep or maneuver out of her way. Continue to remain calm with her and attempt to verbally redirect her to an acceptable activity maintain a neutral expression with her during this time showing no emotion.*
        iii. *As necessary you should also serve as a buffer by standing between her and peers so she cannot become aggressive toward them. Periodically continue to attempt to verbally redirect her to other activities until she calms down.*
        iv. *If she destroys property remain calm and matter of fact while assuring the safety of her and others.*
        v. *When she has been verbally redirected to an acceptable activity remain nearby until she has been calm for 15 to 30 minutes with no further yelling aggression or disruptive behaviors."*
    c. Attestation form confirming Ms. Maloney-Delong signed off on *Resident A's PCP Addendum* on March 20, 2025 which is the same day as this incident.
    d. Attestation form confirming Ms. Ockert signed off on *Resident A's PCP Addendum* on March 21, 2025 which is the same day as this incident.
    e. Resident A's *Assessment Plan for AFC Residents* under I. Controls Aggressive Behavior, "[Resident A] can control her behavior. When she is not feeling safe you will see more outbursts. Staff will follow BTP."

On March 28, 2025 I interviewed direct care staff member whose current role is home manager Brandi Cowling. Ms. Cowling stated she was not there for the incident but she has worked with Ms. Maloney-Delong at another McBride AFC and lately she has quote "toned down her attitude" however she has never seen her be rough or aggressive with the residents. Ms. Cowling stated she does not believe the restraint was warranted because Resident A was doing similar stuff to her and other staff members recently and they were able to redirect her. Ms. Cowling stated Resident A did not have any marks on her from this incident and she had not said anything about this to her. Ms. Cowling stated Resident A not had increased behaviors because of the incident.

On March 28 2025 I interviewed Resident A in her bedroom and she stated that Ms. Maloney-Delong restrained her and was hurting her thumb because Resident A had been slapping Ms. Maloney-Delong's hands away and bothering her throughout the night. Resident A stated Ms. Maloney-Delong never yelled at her during this incident but she did tell her to calm down however Resident A stated she did not do so. Resident A stated she did try to hit Ms. Maloney-Delong at one point because she was trying to break free from her restraint. Resident A stated she was mad and upset because she refused to take a pain pill but then was not able to get one later. Resident A stated she was trying to get the medication keys out of Ms. Maloney-DeLong's hoodie and that is why she was put into a restraint. Resident A stated her right thumb was hurting her but she did not have any marks on her. Resident A stated her thumb was hurting her because Ms. Maloney-Delong was holding her thumb down during the restraint and also had her arm around her elbow. Resident A stated Ms. Ockert also had a hold of her but she was not grabbing her hand and did not hurt her.

On April 11, 2025 I interviewed licensee designee Kent Vanderloon. Mr. Vanderloon stated he did hear that Ms. Maloney-Delong used an improper restraint for this incident. Mr. Vanderloon stated Ms. Maloney-Delong has been terminated and is no longer an employee for McBride Quality Services.

On April 11, 2025, I contacted Ms. Maloney-Delong for further clarification and she stated she thought imminent risk meant she could use a restraint if she was physically harmed by a resident and Resident A was trying to hit her. Ms. Maloney-Delong stated she tried to go outside to get away from her however Resident A slammed the door on her and tried to lock her out. Ms. Maloney-Delong stated Resident A did not have any injuries from the restraint because they were on the couch and they were "holding each other hands". Ms. Maloney-Delong stated she did not push down on her hand or try to cause harm while she was holding it.

On April 11, 2025, I interviewed direct care staff member Sarah Nowotny. Ms. Nowotny stated she has never observed her to restrain someone that she did not need to but she would "nitpick residents plans like they were her children." Ms. Nowotny stated Ms. Maloney-Delong did not treat the residents as grown adults and this would cause behavior with the residents.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(2) Crisis intervention may be used only for the following reasons: **(a) To provide for self-defense or the defense of others.** **(c) To quell a disturbance that threatens physical injury to any person.**

ANALYSIS:	Based on the interviews completed, there is evidence to show Ms. Maloney-Delong improperly used crisis intervention with Resident A. During this situation, Resident A was presenting baseline behaviors and Ms. Maloney-Delong responded with crisis intervention and restrained Resident A. According to Resident A's *Behavior Treatment Plan*, verbal redirection and a calm demeanor should have been used but Ms. Maloney-DeLong became upset which aggravated Resident A. Ms. Maloney-Delong participated in the Crisis Prevention Institute (CPI) training taught by Montcalm Care Network and according to the instructor Cecelia McIntyre the use of restraint was not in compliance with the rules associated with CPI because no imminent risk was apparent.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning _____05/09/2025_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 05/13/2025

_____

Dawn N. Timm Date
Area Manager