GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

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

RE: License #: AS540255143
Investigation #: 2025A1033035
McBride #3

Dear Mr. Vanderloon:

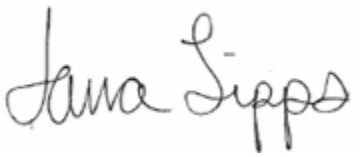
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,



Jana Lipps, 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 #:	AS540255143
Investigation #:	2025A1033035
Complaint Receipt Date:	05/12/2025
Investigation Initiation Date:	05/14/2025
Report Due Date:	07/11/2025
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 #3
Facility Address:	3414 W. 17 Mile Road Barryton, MI 49305
Facility Telephone #:	(989) 382-7399
Original Issuance Date:	05/30/2003
License **Status:**	REGULAR
Effective Date:	11/06/2023
Expiration Date:	11/05/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident medications are not being administered correctly.	Yes
Direct care staff are not trained to administer medications.	No

III. METHODOLOGY

05/12/2025	Special Investigation Intake 2025A1033035
05/12/2025	Contact - Telephone call made- Attempt to interview complainant. Voicemail message left, awaiting response.
05/14/2025	Special Investigation Initiated - On Site Interviews conducted with direct care staff/home manager, Kenda Gilbert, direct care staff, Eudora Cotter & Pam Vansyckle. Review of resident medication administration records, medication orders, and direct care staff medication administration training initiated.
05/14/2025	Contact - Document Sent Email correspondence sent to licensee designee, Kent Vanderloon, requesting medication administration training for direct care staff members. Awaiting response.
06/02/2025	Contact - Telephone call made- Interview conducted with Complainant via telephone.
06/12/2025	Contact – Document Received- Email correspondence received from direct care staff/home manager, Kenda Gilbert.
06/16/2025	Contact – Telephone call made- Attempt to interview direct care staff, Chris Larsen. Voicemail message left, awaiting response.
06/16/2025	Contact – Telephone call made- Interview conducted with Ms. Gilbert and Ms. Larsen via telephone call to the facility.
06/16/2025	Exit Conference conducted via telephone with licensee designee, Kent Vanderloon.

ALLEGATION: Resident medications are not being administered correctly.

INVESTIGATION:

On 5/12/25 I received an online complaint regarding the McBride #3, adult foster care facility (the facility). The complaint alleged that resident medications are being "popped" directly from the bubble pack container into a cup of applesauce, prior to all meds being accounted for before administration. On 5/12/25 I made a telephone call attempt to interview Complainant. A voicemail message was left and a returned call was not received.

On 5/14/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Kenda Gilbert, regarding the allegations. Ms. Gilbert reported that there are currently six residents residing at the facility. She reported that of the six residents there are five residents who direct care staff administer medications to in applesauce. Ms. Gilbert reported that Resident A and Resident B receive their medications crushed and in applesauce. Ms. Gilbert reported that they maintain a standing order for all residents to have medications administered in applesauce or yogurt. Ms. Gilbert reported that she is new to the facility as the home manager and has found that there were no physician orders in place for Resident A and Resident B to have their medications administered in a crushed form. She reported that direct care staff had been administering these medications in this form for a prolonged period prior to her hiring. Ms. Gilbert reported that she has requested an order from Resident A's medical provider to crush her medications. She reported that Resident A had a medical appointment on 5/9/25 and the provider was asked to supply an order for crushed medications for Resident A on this date.

During the on-site investigation on 5/14/25 I interviewed direct care staff, Eudora Cotter. Ms. Cotter reported that she has worked at the facility for about seven years. She reported she does administer medications at the facility. She reported Resident A and Resident C receive their medications in a crushed form. She reported that both Resident A and Resident C have been receiving their medications, crushed, for at least a year or longer. Ms. Cotter reported that Residents A, B, C, D, & E, have their medications administered in applesauce. Ms. Cotter reported that when she administers medications she takes the pills from the bubble packs, places them into a cup, counts the pills against the *Medication Administration Record* (MAR) for accuracy, verifies all medications are present and then places the medications in the applesauce. Ms. Cotter reported that she has no concerns about medications not being administered correctly at this time and feels all trained direct care staff follow this procedure.

During the on-site investigation on 5/14/25 I interviewed direct care staff, Pam Vansyckle. Ms. Vansyckle stated that she has worked at the facility for about sixteen years. Ms. Vansyckle reported that she administers medications at the facility. Ms. Vansyckle reported that Resident A and Resident C receive their medications, crushed. She reported that Residents A, B, C, D, & E, have their medications administered in applesauce. Ms. Vansyckle reported that when she administers medications, she puts

each pill in an empty cup. She scans the bubble packaging to ensure it is the correct pill and the correct time for administration. She reported that after she has counted the medications and ensured all mediations are available for administration she then mixes the medications in the applesauce. She reported that for Resident A and Resident C she will first crush their medications and then mix in the applesauce. Ms. Vansyckle reported that the only medications for Resident A and Resident C that cannot be crushed are the gel tablets as these do not crush and are administered in a whole form. Ms. Vansyckle reported that she had no concerns about the way medications are currently being administered and feels the direct care staff are following the proper procedures.

During the on-site investigation on 5/14/25 I reviewed the following documents:

- *Harmony Cares Medical Group, After Visit Summary for Visit Date: May 09, 2025*, for Resident A. Under the section, *Additional Patient Instructions*, it reads, "Dysphagia – ST recommending NDD1, or National Dysphagia Diet Level 1, (is a purred diet designed for individuals with difficulty swallowing (dysphagia). It requires all foods to be blended into a smooth, pudding-like consistency. This means no lumpy textures, coarse textures, raw fruits or vegetables, or nuts allowed) and thin liquids with divided meals."
- *Ancillary Female Orders*, for Resident A, dated 5/9/25, and signed by Resident A's medical provider. Item number 19 reads, "Medications can be administered with applesauce, pudding, yogurt, or an appropriate food substance with the same consistency to help aid in and ensure proper swallowing of all medications." This document states, "The duration of this ancillary order is indefinite and continues until revoked in writing by the MD/PA."
- *Ancillary Orders*, for Resident B, dated 5/14/19, and signed by Resident B's medical provider. This document does not contain an order to place Resident B's medications in applesauce for administration.
- *Ancillary Orders,* for Resident C, dated 7/15/21, and signed by Resident C's medical provider. This document does not contain an order to place Resident B's medications in applesauce for administration.
- *Ancillary Orders,* for Resident E, dated 9/22/20, and signed by Resident E's medical provider. This document does not contain an order to place Resident E's medications in applesauce for administration.
- *Medication Administration Records* for the month of May 2025 were reviewed for all six residents. These documents did not identify any written instructions or orders indicating that any of the current residents were ordered to have medications administered in applesauce/yogurt/pudding, or that any of the current residents had written instructions for crushed medications.
- *Physicians Orders,* current as of 5/14/25, were reviewed for all six residents. These documents did not include any written orders or instructions for residents to receive crushed medications or medications administered in applesauce/yogurt/pudding.

On 5/19/25 I received email correspondence from Ms. Gilbert providing additional documentation. I reviewed the following:

- *Health Care Appraisal* for Resident E dated 5/19/25. Under section, *16. Other Health Related Information or Concerns*, it reads, “Take medication with a tablespoon of applesauce as it is easier for patient.” This document is signed by Resident E’s medical provider.

On 6/2/25 I interviewed Complainant, via telephone, regarding the allegation. Complainant reported that they were aware of a recent incident where Resident D’s medication was not administered correctly. Complainant reported that the medication error was on 5/22/25 at 8am and was observed two days later by direct care staff, Chris Larsen. Complainant was uncertain which medication is in question, but that Ms. Larsen noted a medication was to be administered and was found still in the bubble packaging two days later. She reported that it appeared the medication was attempted to be removed from the bubble packaging as the seal was broken on the packaging, but the medication did not release from the packaging and was still in the container.

On 6/11/25 I sent email correspondence to Ms. Gilbert requesting she send a copy of the MAR for Resident D. On 6/12/25 Ms. Gilbert supplied the MAR requested and reported that there was a date in May when Resident D’s medication did not come out of the packaging correctly and only one pill was administered instead of the two pills that were ordered for administration on this date.

On 6/16/25 I made a telephone call to the facility to discuss the alleged medication error for Resident D. I spoke with Ms. Gilbert and Ms. Larsen on this date regarding the allegations. Ms. Gilbert reported that the medication error was brought to her attention via a text message from Ms. Larsen on 5/24/25. She reported that Ms. Larsen sent her a picture of a resident’s medication bubble package which had one pill left in a two-pill slot in the package and Ms. Larsen determined that both pills should have been administered but were not administered. She reported that the text message did not have any identifying resident information. She reported that this was seen as an error and it could not be properly identified which date the pills were meant to be administered but it was Resident C’s medication that was in question. Ms. Gilbert reported that Resident C is ordered to have Carbamazepine 200mg (two tablets) administered every day in the morning. Ms. Gilbert reported that it was apparent that there was a date during the month of May 2025 when both pills scheduled to be administered did not come out of the package and Resident C only received a half dose of this medication. Ms. Gilbert reported that an incident report was not completed and the physician and/or pharmacy was not notified of the error. Ms. Gilbert reported that she has instituted a practice by which the direct care staff will now initial and date the medication packages when they have administered medications from a bubble pack, so that it is clear what dose was administered by which direct care staff member. She further reported that they are also instituting a policy by which the direct care staff who administer medications will have another direct care staff follow up and check the medications to make sure all medications were administered correctly. She reported that this process should ensure that an error of this nature is caught quickly and remedied immediately.

Ms. Larsen reported that she could not recall which resident the medication error was concerning but did confirm that she found the medication still in the open bubble packaging and reported this information to Ms. Gilbert. She reported that she sent a text message regarding this information to Ms. Gilbert to inform her of the issue at hand.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the interviews conducted and documentation reviewed, it can be concluded that the direct care staff have been administering Residents A, B, C, D, & E's medications in applesauce/yogurt without a physician's order. A physician's order was presented for Resident A and Resident E to have their medications administered in applesauce/yogurt/pudding, after the on-site investigation occurred. Additionally, Residents A & C have been receiving their medications in a crushed form without a physician's order. Finally, Resident C was not administered a complete dose of her Carbamazepine medication on an unknown date in May 2025, based upon the findings of the interviews conducted. Therefore, a violation has been established as multiple residents have not been receiving their medications pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff are not trained to administer medications.

INVESTIGATION:

On 5/12/25 I received an online complaint regarding the facility. The complaint alleged that direct care staff members are not receiving adequate medication administration training prior to being scheduled to administer medications to residents.

On 5/14/25 I conducted an unannounced on-site investigation at the facility. I interviewed Ms. Gilbert regarding the allegation. Ms. Gilbert reported that she is new to the facility and the position of home manager. She reported she assumed this position in April 2025. Ms. Gilbert reported that there are currently 12 direct care staff members working at the facility and ten of them are trained to administer medications. She reported that direct care staff, Shyann Robinson and Calista Michaud, are not yet trained in medication administration. Ms. Gilbert reported that the current medication administration training process involves the direct care staff shadowing and training with a trained direct care staff member for a period of 3 to 7 days and then when they are feeling comfortable and ready to be certified, Ms. Gilbert, or direct care staff/assistant

home manager, Crystal Weed, will observe them administering medications and sign off on their competency. Ms. Gilbert reported that there was a recent change at the facility and the direct care staff are now utilizing the Quick MAR program for medication administration. She reported that this was instituted in April 2025 and some of the direct care staff are still adjusting to this change. Ms. Gilbert reported that she has not asked any of the untrained direct care staff to administer medications to residents. She reported that there was a recent scheduling error by which a trained medication administration provider was not scheduled during a shift where two untrained medication administration direct care staff were scheduled. She reported that the scheduled was modified and a trained direct care staff was substituted on the schedule to accommodate this situation. Ms. Gilbert reported that she was not sure of the exact date but recalls this occurred sometime around 5/8/25.

During the on-site investigation on 5/14/25 I interviewed Ms. Cotter regarding the allegation. Ms. Cotter reported that she has worked at the facility for about 7 years. She reported that she was trained in medication administration and does administer medications. Ms. Cotter reported that the current process for training new direct care staff to administer medications is that the direct care staff member will shadow a trained direct care staff member for multiple days, learn the Quick MAR system, and then have Ms. Gilbert observe them completing medication administration at least three times. Once Ms. Gilbert has determined competence, the direct care staff will be cleared to begin administering medications independently. Ms. Cotter reported that she has no concerns about the current training process and feels that medications are being administered correctly.

During the on-site investigation on 5/14/25 I interviewed Ms. Vansyckle regarding the allegation. Ms. Vansyckle reported that she has worked at the facility for about 16 years. She reported that she was trained in medication administration when she was first hired. She reported that if a direct care staff member makes an error in administering medications they are then required to go through a medication refresher class for retraining. Ms. Vansyckle reported that the process for new direct care staff members is that they shadow a seasoned direct care staff member who has already been training in medication administration. She reported that when they become comfortable with the process they will then be observed by Ms. Gilbert who will monitor them administering medications for at least three times. Once Ms. Gilbert has determined competence the direct care staff member will then begin administering medications independently. Ms. Vansyckle reported that she feels this training process is effective and does not have concerns about direct care staff not being properly trained to administer medications.

During the on-site investigation I requested to review the direct care staff training records for medication administration for the following direct care staff:

- Pam VanSyckle
- Shannon Sims (completed 8/9/23)
- Kendra Gilbert (completed 4/3/25)
- Eudora Cotter
- Brittany Foster

- Autum Krupinski
- Chris Larsen
- Miranda McCaul
- Tristin Bauman (completed 5/4/25)
- Crystal Weed

On 5/15/25 I received email correspondence from Ms. Gilbert with documentation of mediation administration training for the following direct care staff:

- Eudora Cotter (completed 10/13/10)
- Brittany Foster (completed 4/7/22)
- Autum Krupinski (completed 6/9/14)
- Crystal Weed (completed 8/6/08)

On 6/5/25 I emailed Ms. Gilbert inquiring about documentation of medication administration training for direct care staff, Miranda McCaul, Chris Larsen, and Pam VanSyckle. On 6/6/25, Ms. Gilbert provided the following documentation via email:

- Miranda McCaul, Medication Administration training date 4/26/24. This included a Basic Medication Administration Test which Ms. McCaul received a score of 100%.
- Chris Larsen, Medication Administration training date 4/27/23. This included a Basic Medication Administration Test which was completed by Ms. Larsen but not scored.
- Pamela VanSyckle, Medication Administration training date 6/11/08. This included a completed *Basic Medications Study Guide – Part I for Written Test*, dated 6/9/08.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based upon interviews conducted with Ms. Gilbert, Ms. Cotter, and Ms. VanSyckle, as well as review of direct care staff employee trainings, it can be determined that there is not adequate evidence to determine that direct care staff members are administering medications without receiving proper medication administration training prior to assuming this task. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

6/16/25

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Jana Lipps Date
Licensing Consultant

Approved By:

06/17/2025

_____

Dawn N. Timm Date
Area Manager