GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2026

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

RE: License #: AS370016147
Investigation #: 2026A0466011
McBride #8

Dear Mr. Vanderloon:

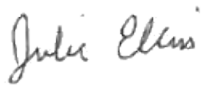
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Julie Elkins, 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 #:	AS370016147
Investigation #:	2026A0466011
Complaint Receipt Date:	01/06/2026
Investigation Initiation Date:	01/06/2026
Report Due Date:	03/07/2026
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent Vanderloon
Licensee Designee:	Kent Vanderloon
Name of Facility:	McBride #8
Facility Address:	8365 E Pickard Mount Pleasant, MI 48858
Facility Telephone #:	(989) 772-7803
Original Issuance Date:	11/10/1994
License Status:	REGULAR
Effective Date:	04/10/2025
Expiration Date:	04/09/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS:

	Violation Established?
Resident A has marks on his left upper arm.	No
Resident A ‘s adult incontinence briefs are not being changed.	No
Resident A’s feet are not being properly cared for.	No
Additional Findings	Yes

III. METHODOLOGY

01/06/2026	Special Investigation Intake 2026A0466011.
01/06/2026	Special Investigation Initiated – Telephone call to Complainant interviewed by licensing consultant Jennifer Browning.
01/06/2026	Referral - Recipient Rights Angela Wend assigned.
01/09/2026	Inspection Completed On-site.
02/05/2029	Contact- document received additional allegation.
02/09/2026	APS- referral.
02/09/2026	Contact- Document sent to Brandt Montague.
02/10/2026	Contact- Document received from Brandt Montague.
02/10/2026	Contact- telephone call made to DCW Mary Ann Wolters interviewed.
02/10/2026	Contact- telephone call made to DCW Ardi Worden interviewed.
02/13/2026	Exit Conference with licensee designee Kent Vanderloon, message left.

ALLEGATION: Resident A has marks on his left upper arm.

INVESTIGATION:
On 01/06/2025, Complainant reported that Resident A was found with fingernail marks on his left upper arm. Complainant reported that fingernail marks were from staff assisting him however no staff names were provided. Complainant reported that staff have long fake fingernails. Complainant provided a picture and reported that there is a bruise or thumb print on Resident A’s upper arm.

I looked at the picture provided by Complainant and I observed three circular pink/red marks on the backside of Resident A's arm.

On 01/07/2026, Angela Wend, office of recipient rights (ORR) reported that she was told that it was common for Resident A to have marks on his arms as he does this to himself due to how he holds his arms. ORR Wend also reported that Resident A's case manager reported that she has worked with Resident A for the last 1.5 years and she hadn't heard of this occurring.

On 01/09/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care Residents* (assessment plan) which documented that Resident A is non-verbal but shows direct care staff know what he wants. Additionally, the assessment plan documented that "[Resident A] will exhibit self-injurious behaviors by digging and scratching himself occasionally, staff just need to redirect him if he is doing this."

I interviewed house manager/direct care worker (DCW) Brandt Montague who reported that the facility does not complete resident body charts but that he did have a staff member identify bruising on Resident A and she filled out an *Incident Report* (IR). DCW Montague reported that there is an all-female DCWs team and that some of the DCWs do get their nails done. DCW Montague reported that when he looked at the marks/bruising on Resident A he thought that it looked like Resident A's own nails left the mark on his arm. DCW Montague reported that Resident A has a history of holding his arms with his hands. DCW Montague reported that Resident A has a diagnosis of Autism and that he uses sensory tools such as alphabet blocks and rubber balls with rubber spikes on it. DCW Montague reported that any of these sensory tools/toys could cause bruising/marks on Resident A's body. DCW Montague reported that he does not believe that any of the DCWs harmed Resident A. DCW Montague denied that he has ever grabbed Resident A nor that she has witnessed any other direct care staff grab him.

I interviewed DCW Tammy Ballinger who reported that she has worked with Resident A at different licensed facilities since 2012. DCW Ballinger reported that Resident A has lived at this facility for the past five to six years. DCW Ballinger reported that Resident A always has marks on his body as he rubs his feet on the wall or chairs, he will lay on his bed with the rails down and he will lay on the bed rails. DCW Ballinger reported that Resident A has longer fingernails and could scratch or mark himself with them. DCW Ballinger reported that both DCW Mary Ann Wolters and DCW Arie Worden have long fake fingernails who could have also left the marks on Resident A. DCW Ballinger reported that she does not believe that anyone would intentionally harm Resident A. DCW Ballinger denied that she has ever grabbed Resident A nor that she has witnessed any other direct care staff ever grab him.

On 02/10/2025, I reviewed an *AFC Licensing Division-Incident/Accident Report (IR)* with the date of the incident being 01/05/2026 at 8:30am and completed by DCW Michelle Canales on 02/10/2026. In the "explain what happened" section of the report it stated;

"[Resident A] soiled himself and staff went to take [sic] him a shower. Staff called another staff for help. When staff washed under his left arm there where [sic] nail marks and a bruise of thumb print."

In the "action taken by staff section of the report it stated;

"Staff immediately showed her shift partner. Staff finished with [Resident A] while shift partner took pictures of the wounds. When second shift came in, shift showed them and [Resident A] pulled away and ran into staff arms."

In the "corrective measures" section of the report it stated;

"Staff made sure wounds were tended to the wounds [sic]. Wrote and incident report and brought it to managers attention."

I noted that the name of the "shift partner" is not documented on the IR.

On 02/10/2026, I interviewed DCW Mary Ann Wolters and DCW Ardi Worden both by telephone separately. DCW Wolters reported that she was aware of the marks on Resident A's upper arm, and she believed that he gave himself those marks. DCW Wolters and DCW Worden both reported that Resident A has also scratched himself with his nails before. DCW Wolters and DCW Worden both reported that Resident A does not like to have his fingernails trimmed therefore his fingernails are usually a little long and jagged. DCW Worder reported that she had a two-inch scratch on her face which drew blood from Resident A's nails recently (exact date unknown) but she reported the scratch is still on her face now. DCW Worden reported that she did not see the marks on Resident A related to this investigation but she reported that she heard about them. DCW Wolters and DCW Worden both reported that Resident A sits frequently with his arms crossed and holding his upper arms for self-soothing. DCW Wolters and DCW Worden both reported that they have acrylic nails but that they do not interfere with personal care provided to residents. DCW Wolters and DCW Worden both reported they have been getting their nails done for years and they do not get in the way of any of the tasks they perform. DCW Wolters reported that none of the DCWs that work on the facility would ever do anything to harm Resident A. DCW Wolters reported that Resident A ambulates independently and if he has a behavioral issue they are trained to not grab anyone but to put their arms out in front to create space. DCW Wolters and DCW Worden both denied that they have ever grabbed Resident A nor that they have witnessed any other direct care staff ever grab him.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Resident A's record contained a written *Assessment Plan for AFC Residents* which documented that "[Resident A] will exhibit self-injurious behaviors by digging and scratching himself occasionally, staff just need to redirect him if he is doing this." DCW Montague, DCW Ballinger, DCW Wolters and DCW Worden all reported that Resident A always has marks on his body, he has nails that he does not like trimmed and he could scratch or mark himself. DCW Montague, DCW Wolters and DCW Worden all reported that Resident A frequently sits with his arms crossed holding his arms as a self-soothing measure. All staff interviewed denied ever grabbing Resident A or observing any other direct care staff member grab Resident A. Therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's adult incontinence briefs are not being changed.

INVESTIGATION:
On 01/06/2026, Complainant reported that Resident A was not being changed during the night by third shift staff as Resident A was "soaked" every morning. Complainant reported concerns that Resident A's briefs are saturated every morning and he leaks out of them because they are not the right size for him. Complainant stated that third shift staff reported that they change Resident A's bedding when he wakes up as it is wet.

On 01/09/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained a written *Assessment Plans for AFC Residents* completed on 01/01/2024 and signed by Resident A's designated representative and documented in the "toileting" section "[Resident A] will toilet himself, staff assist with post toileting needs and help with brief changes."

I reviewed Resident A's *Health Care Appraisal* that was dated 1/28/2025 and documented in the "diagnosis" section, "hyperlipidemia (HLD), Schizoaffective disorder, coronary artery disease (CAD), Autism, history (Hx) pulmonary embolism (PE), CRD, incontinence."

I interviewed DCW Montague who reported that Resident A is non-verbal but signs when he needs his adult incontinence brief changed and occasionally he will verbally say "change" when he is wet or soiled. DCW Montague reported that Resident A uses the toilet during the day and at night and DCWs assist with toileting needs and brief changes. DCW Montague reported that DCWs assist Resident A with post toileting needs, help with brief changes and prompt Resident A to use the restroom. DCW Montague reported that Resident A at times will refuse to use the toilet and therefore will be checked/changed every two hours. DCW Montague denied that Resident A is ever completely "soaked" and reported that he does not have any rash

or skin breakdown. DCW Montague reported that he does not have any information or reason to believe that Resident A is being left in a soiled brief for a long time. DCW Montague reported that Resident A's prompting to be changed and his refusals/successful changes are charted daily.

I reviewed Resident A's December 2025 *Frequency Recording* which documented that "[Resident A] will at times refuse getting changed, in the top light boxes chart how many times he refused changing. Initial in the darker boxes." The following dates/shifts were blank on the document and therefore not charted:12/10/2025 1st shift, 12/11/2025 1st shift, 12/11/2025 1st shift, 12/15/2025 1st shift, 12/29/2025 1st shift and 2nd shift, 12/30/2025 1st shift and 2nd shift and 12/31/2025 1st shift, 2nd shift and 3rd shift.

I interviewed DCW Ballinger who reported that she typically works 11am-9pm. DCW Ballinger denied that Resident A signs when he needs to use the restroom, she reported that some days Resident A will not sign at all. DCW Ballinger reported that Resident A always has his hand on his "crotch" so that does not mean anything. DCW Ballinger reported that not all DCWs prompt or encourage Resident A to use the restroom as much as they should. DCW Ballinger reported that a lot of DCWs just routinely check and change Resident A. DCW Ballinger reported that Resident A does not have any skin breakdown or rashes from being left wearing incontinence briefs too long. DCW Ballinger reported that staff assist with post toileting needs, help Resident A with brief changes and prompt/remind Resident A to use the toilet. DCW Ballinger reported that Resident A gets up on his own throughout the night about two to three times to use the restroom. DCW Ballinger reported that DCWs do not wake him up to toilet or check/change him throughout the night.

I observed Resident A who was in clean clothing and did not have any foul odor or smell. The facility did not have any odor or urine smell.

On 02/10/2026, I reviewed Resident A's January 2026 *Frequency Recording* which documented that "[Resident A] will at times refuse getting changed, in the top light boxes chart how many times he refused changing. Initial in the darker boxes." All the dates/shifts were completed on the document.

I interviewed DCW Wolters who reported that she works from 3pm-11pm and she has come into the facility and observed Resident A to be soaked to his knees. DCW Wolters reported that DCWs must do more than prompt Resident A to use the restroom or he will not use it. DCW Wolters reported that after prompting Resident A to use the bathroom direct care staff need to follow him to make sure he gets there. DCW Wolters reported that on the day she came to work and Resident A was soaked, DCW Montague reported that Resident A never asked to use the bathroom. DCW Wolters reported that Resident A consumes a lot of fluids thought out the day such as juice and water so he does urinate a lot. DCW Wolters reported direct care staff are trained to prompt Resident A at varying timelines but not everyone prompts and/or follows him to back sure that he gets to the bathroom enough. DCW Wolters

denied that Resident A has any rash or skin breakdown. DCW Wolters feels that Resident A's briefs are too tight as they do not go over his stomach and that Resident A needs a bigger size if available. DCW Wolters reported that Resident A has a large, bloated stomach which could be part of the issue with the briefs fitting properly.

I interviewed DCW Worden who reported that Resident A can toilet himself he just needs to be reminded or prompted. DCW Worden reported that Resident A can change his own brief and that she just opens up the brief, puts it in front of him and he puts the brief on. DCW Worden denied that Resident A has skin break down or rashes. DCW Worder reported direct care staff are trained that they cannot "force" Resident A to go to the bathroom, but they can keep encouraging and prompting him. DCW Worden reported that each DCW interacts with Resident A differently, some dress him, some prompt him to get dressed etc. DCW Worder reported that all DCWs assist Resident A with post toileting needs, prompting Resident A to use the restroom and help with brief changes. DCW Worder reported that she is always there to support Resident A but that she allows him to do the personal care tasks that he is able to do by himself.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(a) The amount of personal care, supervision, and protection required by the residents that is available at the facility.**
ANALYSIS:	Resident A's record contained a written *Assessment Plan for AFC Residents* signed by Resident A's designated representative that documented in the "toileting" section "[Resident A] will toilet himself, staff assist with post toileting needs and help with brief changes." DCW Montague, DCW Ballinger, DCW Wolters and DCW Worden all reported that Resident A does not have any skin breakdown or rashes from being left too long in soiled incontinence briefs. DCW Ballinger, DCW Montague, DCW Wolters and DCW Worden all reported that DCWs assist with post toileting needs, prompting Resident A to use the restroom and help with brief changes therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's feet are not being properly cared for.

INVESTIGATION:
On 02/05/2026, Complainant reported that on 01/31/2026, she worked 3rd shift and that Resident A woke up at 12:00AM and was "soiled." Complainant said she took Resident A to the bathroom and assisted him to get cleaned up. Complainant reported that Resident A's clothing was changed and Complainant noticed the staff member put clean socks on Resident A's dirty feet. Complainant said staff did not clean up his feet before putting socks on him. Complainant said she and another one of her co-workers DCW Ballinger had been working hard to keep Resident A's feet clean because his feet can get dry and cracked in the winter months. Complainant was concerned that Resident A's feet were not being taken care of properly.

I reviewed Resident A's record which contained a written *Assessment Plans for AFC Residents* did not document any feet issues or any special instructions pertaining to his foot care. I reviewed Resident A's Health Care Appraisal that was dated 1/28/2025 and it did not document any feet issues or any special instructions pertaining to his feet.

On 02/10/2025, I interviewed DCW Wolters who reported that Resident's feet are always dirty if DCWs do not put socks on his feet. DCW Wolters reported that she observed his feet to be "black" on 1/31/2026 at 9am. DCW Wolters reported that Resident A did not have socks on his feet at that time. DCW Wolters reported that it can be a struggle for Resident A to put socks on. DCW Wolters reported that Resident A can have socks on and then take them off or they will fall off when he lays on the couch with a blanket. DCW Wolters reported that Resident A also likes to be barefoot. DCW Wolters denied that Resident A has cracked feet. DCW Wolters reported that Resident A is given a shower daily and that he is complaint with showers. DCW Wolters reported that the floors at the facility are supposed to be moped every shift so the floors should be clean.

I interviewed DCW Worden who reported that Resident A's feet are always dirty. DCW Worden reported that Resident A takes his socks off and likes to walk around barefoot. DCW Worden reported that Resident A takes showers daily and the facilities floors are moped daily, so she is unsure how Resident A's feet get so dirty. DCW Worder denied that Resident A has cracked feet.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: **(a) Bathing or showering, or both.**

ANALYSIS:	DCW Wolters and DCW Worden both reported that Resident A is given a shower daily however his feet are always dirty as he likes to be in the facility barefoot.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	DCW Wolters and DCW Worden both denied that Resident A has cracked feet. Resident A's written *Assessment Plans for AFC Residents* did not document that he has any feet issues or any special instructions pertaining to his foot care. Resident A's Health Care Appraisal that was dated 1/28/2025 did not document that he has any feet issues or any special instructions pertaining to his foot care therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 01/09/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* documented a completed date of "01/01/2024" where it stated, "date assessment plan was completed." Resident A's assessment plan was signed by Resident A's designated representative, over eleven months later on 12/12/2024. The signature for the licensee designee is not legible but begins with a "J" in the first name and a "B" for the last name and the document was signed on 12/10/2024. The licensee designee that is documented in the facility file in the Bureau Information Tracking System (BITS) is Kent Vanderloon therefore this document was not signed by the licensee designee.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated

	representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's written *Assessment Plan for AFC Residents* documented a completed date of "01/01/2024" where it stated, "date assessment plan was completed." Resident A's designated representative signed the assessment plan eleven months later on 12/12/2024. Someone else signed in the licensee designee portion of the report on 12/10/2024. Therefore there is no documentation that the assessment plan was completed with the resident's designated representative, responsible agency if applicable, and the licensee annually. The signature for the licensee designee is not legible but begins with a "J" in the first name and a "B" for the last name and the licensee designee named is in the facility file is Kent Vanderloon therefore this document was not signed by the licensee designee therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan I recommend no changes in license status.

Julie Elkins

02/13/2026

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

02/18/2026

_____

Dawn N. Timm Date
Area Manager