GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 11, 2026

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

RE: License #: AS370411456
Investigation #: 2026A1029053
McBride Blanchard AFC

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 licensee designee 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

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS370411456
Investigation #:	2026A1029053
Complaint Receipt Date:	06/26/2026
Investigation Initiation Date:	06/26/2026
Report Due Date:	08/25/2026
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 Blanchard AFC
Facility Address:	4692 E. Blanchard Rd., Shepherd, MI 48883
Facility Telephone #:	(989) 772-1261
Original Issuance Date:	05/25/2022
License Status:	REGULAR
Effective Date:	11/25/2024
Expiration Date:	11/24/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 06/25/2026 direct care staff member Josie Massuch smoked marijuana with Resident A during her shift at McBride Blanchard AFC.	Yes

III. METHODOLOGY

06/26/2026	Special Investigation Intake 2026A1029053
06/26/2026	Special Investigation Initiated - Email to ORR Sarah Watson
06/26/2026	Contact - Telephone call received from ADOS Carrie Todd
06/29/2026	Contact - Telephone call made to ORR Sarah Watson, Josie Massuch, Heather Yats
07/09/2026	Inspection Completed On-site – face to face with direct care staff member / home manager Monica McGuire, Carrie Todd, Resident B, Resident C at McBride Blanchard AFC
08/06/2026	Contact -Email sent to Carrie Todd and Monica McGuire
08/07/2026	APS Referral made to Centralized Intake
08/07/2026	Contact - Email to ORR Sarah Watson
08/07/2026	Telephone call to Resident A (left message)
08/11/2026	Telephone call to Resident A, email to ORR Ms. Watson, and licensee designee Kent VanderLoon
08/11/2026	Exit conference with Kent VanderLoon

ALLEGATION: On 06/25/2026 direct care staff member Josie Massuch smoked marijuana with Resident A during her shift at McBride Blanchard AFC.

INVESTIGATION:

On 06/26/2026 a complaint was entered after concerns were received that on 06/25/2026 direct care staff member Josie Massuch was smoking marijuana outside of the McBride Blanchard AFC during her shift with Resident A. Another direct care staff

member Heather Yats arrived to work to find Resident A and Ms. Massuch outside the facility using marijuana. According to the allegations, Resident A kept the marijuana in his resident bedroom. Associate Director of Services (ADOS) Carrie Todd terminated Ms. Massuch immediately after this incident. Ms. Todd stated that Ms. Massuch informed her “I don’t know how to separate boundaries” and that Resident A was having a bad day as her reason for this incident occurring. Ms. Todd also stated that Resident A will not be returning to McBride Blanchard AFC. ORR Ms. Watson is also investigating these concerns.

On 06/29/2026, ORR Sarah Watson and I interviewed direct care staff member Josie Massuch. Ms. Massuch reported that she resigned on 06/27/2026 after this incident. Ms. Massuch stated when she observed Resident A becoming upset and “having an episode,” discussing electromagnetic frequency, repeatedly standing and sitting rapidly, she became personally triggered. Ms. Massuch stated Resident A noticed her agitation and offered her marijuana which she accepted. Ms. Massuch stated she did not want to escalate the situation due to her own emotional response and felt she was “not in a work mindset,” but instead trying to remove herself from what she described as an overwhelming internal reaction. She also reported that the metal table and chairs were “loud and too much” so she used marijuana to cope with this.

Ms. Massuch stated that, because this was how she typically copes at home, she accepted the marijuana, and direct care staff member Ms. Yats arrived to work at that moment. Ms. Massuch stated she recognizes she lacks professional boundaries necessary to keep others safe, and acknowledged the behavior was inappropriate. Ms. Massuch stated when she was smoking marijuana, she was the only direct care staff member working and she was outside with Resident A under the influence.

Ms. Massuch stated shortly afterward Resident B came outside and was acting “like he drank a fifth” and was clearly intoxicated. Ms. Massuch stated the device used to smoke marijuana was a green Puffco vaporizer, which Resident A typically used. She stated the substance belonged to Resident A and that she had seen him use it previously. She reported uncertainty regarding how to handle the situation because she had been told to call the police if he smoked inside the home but she could ignore it if he smoked near the patio. Ms. Massuch stated she knew that she was not supposed to smoke marijuana with the residents but did so in the moment.

On 06/29/2026, ORR Ms. Watson and I interviewed direct care staff member Heather Yats. Ms. Yats stated she had returned to work at Blanchard House for the first time in nearly a year and, upon arrival, could not locate the direct care staff member working. Ms. Yats stated she looked through the second living room door and observed Ms. Massuch holding what she described as a bong with a rounded base. Ms. Yats stated this is when she observed Ms. Massuch exhaling a large cloud of smoke. Ms. Yats stated she tried not to create a scene, went inside, and texted her manager. Ms. Yats stated after observing this, Resident B entered the home, was unable to stand upright and was leaning against the wall. While reviewing his *Person Centered Plans* for this home, she heard Resident B vomiting into a trash can and began cleaning it. She asked

Ms. Massuch what she had been smoking, and Ms. Massuch stated it was “dabs” and claimed she had been told Resident A could use them on the property at night. Resident B could not answer questions or identify where he was. Ms. Yats stated Resident B began nodding his head, she placed a pillow behind him and called 911.

Ms. Yats stated Resident A was walking around laughing during this time and Resident A admitted the THC oil was his and that he had used it for years. Ms. Yats stated following EMS departure, she was instructed to confiscate Resident A’s marijuana paraphernalia, and although she feared causing conflict, she complied. Resident A surrendered a circular oil component and part of a vape pen. Ms. Yats stated during this time Ms. Massuch was increasingly nervous during this time, wasn’t helpful, and she felt that Ms. Massuch’s emotional state at the time escalated the situation. She stated management arrived approximately an hour later, instructed Ms. Massuch to clock out and leave, and directed her to report to the office the next morning.

07/09/2026, I completed an unannounced on-site investigation and interviewed direct care staff member whose role is home manager Monica McGuire. Ms. McGuire stated Resident A no longer resides at McBride Blanchard AFC because he was issued a discharge notice following this incident. She stated she never personally observed Resident A use marijuana on the property, as he had been instructed to leave the premises if he chose to smoke. Ms. McGuire stated Ms. Massuch told EMS the marijuana was not laced because she had used it too and did not know why Resident B became so ill. Ms. McGuire stated Ms. Massuch was in her third week of employment but she had completed all required AFC trainings.

Ms. McGuire stated McBride maintains a zero-tolerance drug policy and this was noted in the Employee Policies Handbook to ensure a drug- and alcohol-free workplace and protect resident health and safety. I also observed a posted policy at the facility entrance lists illegal drugs and drug paraphernalia, as well as weapons, as prohibited items.

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

- *24 hour Discharge* notice for Resident A indicating that McBride Quality Care Services was no longer able to ensure his health and safety or others due to his marijuana use and possible other substances at McBride Blanchard AFC.
- A*FC Incident / Accident Report* stating that staff reported to work and found Resident A and staff member (Ms. Massuch) smoking some form of oil from a bong, they contacted home manager and ADOS, and reminded Resident A that drugs are prohibited on the property but he was refusing to release the bong to his guardian.
- A signed statement written by Ms. Yats describing the incident:

“I arrived at the house at 11:12 p.m. I came through the side door and yelled “hello.” I went upstairs and also yelled for staff. I walked down into the living room and saw a woman (staff) and two men outside. When I opened the door, the staff member was hitting a bong. She handed it to the resident, and we then walked inside. clocked into

APP and immediately texted the manager, Monica, stating that I was uncomfortable and asked if I could leave. I received no reply. I tried calling Monica several times to report what was happening. At that time, both male residents walked in from outside, and [Resident B] came in stumbling and could not make out what he was saying. He walked to the kitchen, stumbling down the hall. The other resident said he ate staff's pizza and then threw up. I called 911 because I could not get [Resident B] to tell me his birthday or where we were. I took his blood pressure while waiting for the ambulance."

On 07/09/2026, I interviewed Resident C, who stated she was unaware of any direct care staff smoking marijuana with residents but knew Resident B had used marijuana provided by Resident A, which led to Resident B becoming sick. Resident C stated they never observed direct care staff members smoking marijuana. Resident C stated that while she did not see Ms. Massuch use marijuana, Ms. Massuch frequently allowed residents to use her nicotine vape while she was working. Resident C stated she personally used Ms. Massuch's vape multiple times.

07/09/2026, I interviewed Resident B, who first stated he was unaware of an incident involving Resident A smoking with direct care staff members, but later reported he had been hospitalized after receiving "a double hit of marijuana from a vaporizer that wasn't cleaned properly," causing vomiting and illness. Resident B stated the vaporizer belonged to Resident A. He stated he completed tests at the hospital and felt better after resting. Resident B stated he had been smoking with Resident A when the incident occurred. Resident B stated Ms. Massuch was working but did not check on him until after he became sick. He stated he did not see Ms. Massuch use the vaporizer.

On 08/07/2026, I received an email from ORR Ms. Watson stating she intended to substantiate these concerns.

On 08/11/2026, I interviewed Resident A. Resident A stated he smoked marijuana with Resident B and that Ms. Massuch smoked with them, though he did not clearly remember the details. Resident A stated this was the only time Ms. Massuch used marijuana. He stated Resident B went to the hospital afterward and that he himself went to the hospital days later for unrelated reasons. Resident A stated Resident B became tired and unresponsive, prompting concerns and EMS involvement. He stated Resident B became sick because he was not accustomed to marijuana use. Resident A stated Ms. Massuch did not ask for marijuana; but he passed it to her and she used it while on shift. He stated he observed residents sharing Ms. Massuch's vape and had personally used it before but could not state what was in it or how often he used it.

08/11/2026, I conducted an interview and exit conference with licensee designee Kent VanderLoon. Mr. VanderLoon stated he learned of the incident the same night it occurred and they immediately terminated Ms. Massuch. Mr. VanderLoon stated there is a zero-tolerance substance abuse policy in the workplace and confirmed Ms. Massuch will not return to employment at McBride Quality Services. Mr. VanderLoon stated he will submit a corrective action plan addressing the incident.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Direct care staff member Ms. Massuch violated McBride Blanchard AFC policy by using marijuana with Resident A while on duty, resulting in her being under the influence during an active shift. Her impaired condition limited her ability to appropriately respond to Resident B's medical emergency and increased the overall stress of the situation, as noted by staff member Ms. Yats. Additionally, because Ms. Massuch was outside with Resident A and not monitoring the facility, she would not have been aware of an emergency occurring inside the home, further compromising resident safety and demonstrating a failure to maintain required supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning _____08/11/2026_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

Dawn Timm 08/11/2026

_____

Dawn N. Timm
Area Manager

Date