



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 18, 2026

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

RE: License #: AS540305481
Investigation #: 2026A1029061
McBride Sherman Street 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 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, 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 #:	AS540305481
Investigation #:	2026A1029061
Complaint Receipt Date:	08/12/2026
Investigation Initiation Date:	08/12/2026
Report Due Date:	10/11/2026
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 Sherman Street Home
Facility Address:	825 Sherman, Big Rapids, MI 49307
Facility Telephone #:	(231) 796-3643
Original Issuance Date:	02/25/2010
License Status:	REGULAR
Effective Date:	10/02/2024
Expiration Date:	10/01/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's knee was red, swollen, and hot with significant pain and he repeatedly asked for medical care but he was not taken to Urgent Care.	Yes
When Resident A asked to receive treatment, Ms. Gilman informed Resident A the doctor would cut his knee open.	No

III. METHODOLOGY

08/12/2026	Special Investigation Intake 2026A1029061
08/12/2026	Special Investigation Initiated – Letter to ORR Sarah Watson
08/12/2026	APS Referral made to Centralized Intake – Complaint assigned to APS Andrew Castillo.
08/12/2026	Contact - Telephone call received from APS Andrew Castillo
08/21/2026	Inspection Completed On-site - Face to Face with Brian Dempsey, Resident A, Danyelle Gilman at McBride Sherman Street Home
08/26/2026	Contact - Document Sent to Crystal Weed and Miranda Merrill requesting documents
08/26/2026	Contact - Telephone call made to direct care staff members Miranda Merrill, Patsy Mischler (mailbox full, sent text), reviewed AFC IR, Rebecca Barwick (left message), Jennifer Knopsnyder, Kayla Spicer, Crystal Weed, licensee designee Kent VanderLoon, Aleaha Griffin (left message), ORR Sarah Watson, email from APS Castillo
08/27/2026	Contact - Telephone call received from ORR Sarah Watson
09/02/2026	Contact - Telephone call made to direct care staff members Patsy Mischler, Chad Tatro
09/04/2026	Contact - Telephone call made to direct care staff member Aleaha Griffin, Crystal Weed, Rebecca Barwick, Sarah Watson (left message)
09/16/2026	Contact – telephone call from APS Andrew Castillo and ORR Sarah Watson

09/18/2026	Exit conference with licensee designee Kent VanderLoon
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ALLEGATION:

- **Resident A's knee was red, swollen, and hot with significant pain and he repeatedly asked for medical care, but he was not taken to Urgent Care.**
- **When he asked to receive treatment, direct care staff Ms. Gilman informed Resident A the doctor would cut his knee open.**

INVESTIGATION:

On 08/14/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that Resident A's knee was red, swollen, and hot with significant pain and he repeatedly asked for medical care but was not taken to Urgent Care. According to the complaint allegations, when Resident A asked to receive treatment, direct care staff member Danielle Gilman informed Resident A that the doctor would cut his knee open causing him to become upset. According to the allegations, the pain started on 08/07/2026 and he was not taken to Urgent Care until 08/10/2026. Office of Recipient Rights (ORR) advisor, Sarah Watson was also assigned to investigate these concerns.

On 08/21/2026 I completed an unannounced onsite investigation at McBride Sherman Street Home and interviewed direct care staff member Brian Dempsey and Resident A. Mr. Dempsey reported that he did not know the cause of Resident A's knee pain or the reason for any delay in treatment.

Resident A stated his knee no longer hurts because he was seen by a doctor. Resident A reported that Miranda Merrill transported him for medical evaluation. He stated he had been worried after hearing that his knee might be "cut open," but the doctor did not indicate this was necessary so he was glad. Resident A stated he receives medical care when needed, did not feel there was a long wait to be seen, and repeated that his knee was better. He reported no fear or concerns about going to the doctor.

I reviewed the pictures that were sent from direct care staff members Ms. Barwick to Ms. Merrill and it's clear that his knee was red and swollen in the pictures from the time period of 08/08/2026-08/10/2026.

I also reviewed screenshots of text messages which Ms. Mischler sent to Ms. Merrill on 08/10/20256 at 8:00 AM which stated the following:

Saturday (08/08/2026) "[Resident A] was complaining that his knee was hurt very bad and it was very swollen and hot to the touch. When Danyelle arrived he asked repeatedly to go see a doctor and after multiple times Danyelle snapped at him and said, "I know exactly what

they're going to do, they're going to cut it open" which put him into a screaming behavior getting two other clients screaming as well."

I also reviewed a text message sent on 08/09/2026 at 6:46 AM from Ms. Merrill to Ms. Gilman which stated, *"Make sure an IR is done for his knee and if it looks bad, take him in. Midnights need to fill out a shift report if they haven't told you already."* Ms. Gilman responded to this message with *"okay, no problem"*.

I reviewed the *After Visit Summary* from Corewell Health Big Rapids showing that Resident A was treated on 08/10/2026 at 11:00 AM for Cellulitis of right leg and was prescribed Cephalexin (Keflex) for this infection.

On 08/21/2026 I interviewed direct care staff member Ms. Gilman. Ms. Gilman reported being informed that Resident A's knee was hurting and observed a small bump on his knee cap, noting it was cold from the ice applied for pain relief. She stated direct care staff members discussed whether he should be seen by a doctor, and she was told by Ms. Merrill to use her judgment regarding taking Resident A to urgent care. Ms. Gilman reported she did not believe medical attention was required, noting Resident A sometimes repeats statements he hears. Ms. Gilman stated she was not instructed to take him to urgent care and did not complete an *AFC Incident / Accident Report* for this incident. She acknowledged discussing with direct care staff members the bump appeared similar to an infected hair follicle and that a doctor might drain it or prescribe an antibiotic, but denied making these statements to Resident A.

On 08/26/2026 I interviewed direct care staff member, whose current role is home manager, Miranda Merrill. Ms. Merrill stated she advised Ms. Gilman to take Resident A in for medical evaluation if his knee appeared concerning. Ms. Merrill stated that Ms. Gilman sent her a text stating that Resident A's knee looked like an infected hair follicle but later she recognized this was not accurate. Ms. Merrill stated that if she would have received pictures on 08/08/2026, she would have directed them to take Resident A in for medical evaluation at that time. Ms. Merrill stated she received pictures of Resident A's knee the morning of 08/09/2026. Ms. Merrill stated that Resident A began complaining of knee pain on 08/08/2026 and although he sometimes repeats what others say, his complaints should not have been ignored. After seeing his knee herself on 08/10/2026, Ms. Merrill immediately took Resident A to urgent care, where he was diagnosed with cellulitis that had begun spreading down his leg, and he was started on antibiotics. Ms. Merrill stated she instructed Ms. Gilman to complete an *AFC Incident / Accident Report* but the report that she wrote did not accurately describe the severity of the condition observed on 08/08/2026. Ms. Merrill also reported that she heard concerns from several other direct care staff members that Ms. Gilman told Resident A that his knee would be "cut open," causing him distress as well as two other residents. Ms. Merrill stated Ms. Gilman received a three-day suspension, but she did not appear remorseful and attempted to shift blame rather than acknowledge her error. Ms. Merrill noted that prior to this incident she had no concerns with Ms. Gilman's performance.

On 08/26/2026 I reviewed the *AFC Incident / Accident Report* completed by Ms. Gilman on 08/09/2026 for this incident which was blank but included a paper attached with the following statement:

"Explain what happened: When staff arrived [Resident A] was in the dining room saying his knee was hurting. Staff looked at it and he had ingrown hair on his right knee that is red.

Actions taken: Staff clean the area and put a bandage on it.

Corrective measures: Staff reminded him not to pick."

On 08/26/2026 I interviewed direct care staff member Jennifer Knopsnyder. Ms. Knopsnyder stated she worked on 08/08/2026 and 08/09/2026. She reported that Resident A mentioned knee pain, and she examined his knee but did not observe redness or swelling. She stated she saw his knee again on 08/08/2026 during evening peri care, but Resident A would not allow her to compare both knees. She reported that Resident A asked for a bandage, but she did not hear him request to go to the doctor. Ms. Knopsnyder stated she was unsure whether medical evaluation was needed due to her limited familiarity with how Resident A expresses pain, so she notified Ms. Merrill. Ms. Knopsnyder stated she never heard Ms. Gilman make statements about refusing to take Resident A to the doctor or about his knee being cut open.

On 08/26/2026 I interviewed direct care staff member Kayla Spicer. Ms. Spicer stated Resident A sometimes reports knee pain and also crawls on his knees, which may contribute to discomfort. Ms. Spicer stated Resident A was adamant on the morning of 08/09/2026 that he wanted to see a doctor, but Ms. Gilman told him no and said it was because she did not want to complete the paperwork and because he had a scheduled visit with his mother. Ms. Spicer stated they could have canceled the visit and taken him to be seen, and she and Ms. Knopsnyder both offered to take him in, but Ms. Gilman continued to decline. She stated Resident A eventually changed his mind after being told he would miss the visit with his mother if he went to the doctor. Ms. Spicer reported that his knee appeared red and puffy on 08/09/2026 and that Ms. Gilman stated she had already spoken with Ms. Merrill. Ms. Spicer stated she never heard Ms. Gilman tell Resident A that his knee would be cut open. Resident A was ultimately seen at urgent care when Ms. Merrill took him in on 08/10/2026.

On 08/26/2026 I interviewed Associate Director of Services (ADOS) Crystal Weed. Ms. Weed stated she believed Resident A should have been taken for medical evaluation earlier, but Ms. Gilman did not want to take him and there was a delay. She stated Ms. Gilman recently stepped down from her management role for unrelated reasons and that she had no prior concerns with Ms. Gilman's performance. Ms. Weed stated she was informed by Ms. Merrill that Ms. Gilman told Resident A his knee would be cut open at the doctor, which caused distress and resulted in behavioral issues for Resident A and two other residents. Ms. Weed stated Resident A began complaining of knee pain on 08/08/2026 and was taken in for evaluation on 08/10/2026.

On 08/26/2026 I interviewed licensee designee Kent VanderLoon. Mr. VanderLoon stated he was aware of the situation and acknowledged that the cellulitis may have worsened over the weekend, and by the time Ms. Merrill observed his knee on 08/10/2026 she determined he needed to be taken to the doctor. Mr. VanderLoon reported he has never had concerns regarding Ms. Gilman's work performance.

On 08/26/2026 I received an email from APS Castillo stating that the case would be substantiated. APS Castillo reported that Ms. Gilman did not comply with house rules, failed to obtain medical attention for Resident A, and ignored directives from upper management, resulting in a delay in necessary medical care. APS Castillo noted that Resident A was ultimately diagnosed with cellulitis and prescribed medication once evaluated.

On 09/02/2026 I interviewed former direct care staff member Patsy Mischler. Ms. Mischler stated on 08/09/2026 Resident A stated he could not bathe due to knee pain. She observed that his knee appeared significantly enlarged, approximately double the size of his other knee. She reported that Resident A had not mentioned knee pain during the night and slept without issue. Ms. Mischler stated she recommended Resident A was taken to the emergency room and later learned that Ms. Merrill had instructed Ms. Gilman to take him in. She reported that when Resident A repeatedly said, "go to doctor," but Ms. Gilman told him they would "cut his knee open," which caused him to scream and resulted in behavioral episodes for him and two other residents. Ms. Mischler stated Ms. Gilman also claimed it was ingrown hair, though this was inaccurate. She stated Ms. Gilman did not express why she did not want to take Resident A in. Ms. Mischler stated that she and Ms. Griffin noted the swelling 08/09/2026 at approximately 5:00 AM, and she provided Resident A with an ice pack, which he kept on for over an hour. She reported that Ms. Gilman later advised switching to heat, stating it was ingrown hair. Ms. Mischler stated Resident A chose not to go to the doctor after being told he could either go to urgent care or visit his mother, and he repeatedly chose "Mommy's house." She stated there was a delay in treatment and noted that although Resident A sometimes falls on his knees, she had never seen an injury of this severity. Ms. Mischler stated she was present the prior morning on 08/08/2026, and his knee had not been enlarged at that time.

On 09/04/2026 I interviewed direct care staff member Aleaha Griffin. Ms. Griffin stated she worked the night shift on 08/08/2026 into 08/09/2026 and that Resident A was already asleep when she arrived. She reported that when she woke Resident A around 5:00 AM on 08/09/2026, he immediately stated his knee hurt. Ms. Griffin observed his knee, applied an ice pack, and notified Ms. Gilman when she arrived around 7:00 AM. Ms. Griffin stated she recommended that Resident A be taken to Urgent Care but Ms. Gilman told her he was fine and did not need to be seen. Ms. Griffin described the knee as appearing similar to a boil or hair follicle and stated that despite icing, there was no improvement. She reported that Ms. Gilman mentioned his knee would be cut open due to a hair follicle but Resident A did not initially show behaviors when hearing this. Ms. Griffin stated the possibility of a scheduled visitation was raised, though Resident A could have attended both the visit and an urgent care appointment.

On 09/04/2026 I spoke to Associate Director of Services (ADOS) Ms. Weed. Ms. Weed stated she remained concerned about the situation and that Ms. Gilman received a suspension for failing to follow supervisory directives and not taking Resident A to be evaluated, despite his knee being hot to the touch and unimproved with ice. Ms. Weed reported that Ms. Merrill stated the knee appeared worse in person than in the photos.

On 09/04/2026 I interviewed direct care staff member Rebecca Barwick. Ms. Barwick stated significant redness was noticeable on 08/08/2026 and that the injury was ignored for at least two days. She reported informing Ms. Merrill of her concerns, and Ms. Merrill informed her that she had already instructed Ms. Gilman to take Resident A to the hospital. Ms. Barwick stated she works with Resident A daily and applied ice but reminded direct care staff members it should only be used in short intervals. She stated the ice did not improve the injury and Resident A repeatedly asked to go to the hospital, which was unusual because he normally looks forward to visiting his mother on Sundays. Ms. Barwick reported that Resident A became extremely distressed after Ms. Gilman told him his knee would be “cut open,” resulting in him refusing urgent care.

On 09/16/2026 I interviewed ORR Ms. Watson. Ms. Watson stated that two direct care staff members and the home manager, Ms. Merrill, all indicated Resident A needed to go to urgent care, yet Ms. Gilman did not take him. She stated Ms. Gilman minimized the severity, claiming Resident A did not complain of pain on 08/09/2026, though this conflicted with statements from others. Ms. Watson stated she conducted a TEAMS call to view Resident A’s knee, which appeared red and swollen after he returned from urgent care.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident’s health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	The investigation established a violation due to Resident A not receiving timely medical care when his knee became painful, swollen, and visibly enlarged. Direct care staff member Ms. Gilman failed to take him to urgent care despite repeated concerns raised by multiple staff. Mr. Dempsey, Resident A, Ms. Gilman, Ms. Merrill, Ms. Knopsnyder, Ms. Spicer, Ms. Weed, Ms. Barwick, Ms. Mischler, Ms. Griffin, APS Andrew Castillo, and ORR Sarah Watson—consistently reported that Resident A demonstrated knee pain beginning on 08/08/2026, with swelling worsening throughout the weekend. Several direct care staff members stated Resident A should have been medically evaluated. APS Castillo and ORR Watson confirmed concerns that his condition required timely evaluation. Despite these reports and Resident A explicitly asking to go to the doctor, Ms. Gilman chose not to obtain medical care, resulting in a delay until 08/10/2026 when Resident A was taken to a local Urgent Care and diagnosed with cellulitis.
CONCLUSION:	VIOLATION ESTABLISHED

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:	Although Ms. Gilman told Resident A that his knee might be “cut open,” the investigation does not establish a violation related to dignity and respect. All direct care staff members interviewed indicated that Ms. Gilman made the comment because she believed his knee pain was related to an ingrown hair but she did not intend to be disrespectful or to frighten him.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



Jennifer Browning
Licensing Consultant

09/18/2026

Date

Approved By:



09/18/2026

Dawn N. Timm
Area Manager

Date