RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 21, 2018

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

RE: License #: AS370088019
Investigation #: **2019A0867006**
McBride #1

Dear Mr. VanderLoon:

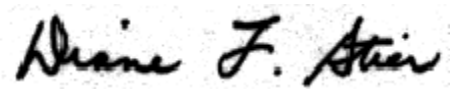
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Diane L Stier, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0560

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370088019
Investigation #:	2019A0867006
Complaint Receipt Date:	11/07/2018
Investigation Initiation Date:	11/07/2018
Report Due Date:	01/06/2019
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	209 E. Chippewa Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent VanderLoon
Licensee Designee:	Kent VanderLoon
Name of Facility:	McBride #1
Facility Address:	235 S. Bamber Road Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-7058
Original Issuance Date:	10/01/1999
License Status:	REGULAR
Effective Date:	04/01/2018
Expiration Date:	03/31/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff person pushed Resident A, in his wheelchair, outside when the resident complained of being cold. The resident was in his pajamas. The staff threatened to do this again later when the resident again reported being cold.	Yes
A staff person did not treat Resident A properly when the resident was cut while shaving.	No

III. METHODOLOGY

11/07/2018	Special Investigation Intake 2019A0867006
11/07/2018	APS Referral APS already had case open. Notified by local office.
11/07/2018	Special Investigation Initiated - Letter APS Worker
11/07/2018	Contact - Face to Face Interviews of staff at CMH
12/13/2018	Exit Conference Licensee Designee Kent VanderLoon

ALLEGATION: A staff person pushed Resident A, in his wheelchair, outside when the resident complained of being cold. The resident was in his pajamas. The staff threatened to do this again later when the resident again reported being cold.

INVESTIGATION:

Recipient Rights Advisor (RRA) Jane Gilmore, from CMH for Central Michigan, reported receiving an allegation that Assistant Manager Cheryl Mangus pushed Resident A outside in his wheelchair when the resident complained of being cold, and that Ms. Mangus threatened to do this again later when the resident again complained of being cold.

On 11/7/18, Direct Care Worker (DCW) Alyssa Margiotta reported that she worked with Assistant Manager Cheryl Mangus on 11/3/18 from 3-11 PM. Ms. Margiotta reported that around 5:30 PM she was getting ready to serve dinner. Ms. Margiotta said that Resident A kept saying he was cold. According to Ms. Margiotta, Ms. Mangus asked Resident A, "What do you need? What do you want?" Ms. Margiotta said, "There was a tone to it. He wasn't responding to her. He just kept repeating, 'Cold!'" Ms. Margiotta reported that Ms. Mangus then said to Resident A, "If you're going to keep saying you're cold, then I'm going to show you cold." Ms. Margiotta said that Resident A again said he was cold, and Ms. Mangus pushed Resident A outside onto the back porch. Ms. Margiotta said that Resident A was wearing and undershirt and a long-sleeved pajama shirt. Ms. Margiotta said she could not remember about his pants but said the resident had on his compression socks but no shoes. Ms. Margiotta said, "She [Ms. Mangus] did not close the door and she stood out there with him for about 1-2 minutes, and then she brought him back in." When asked what reaction Resident A had to this, Ms. Margiotta said, "He [Resident A] yelled! He yelled when he went outside, and I'm pretty sure he yelled before. It's well known that he doesn't like cold. We even cover the vent in his bedroom if air is blowing out of the vent." Ms. Margiotta said she has never seen Ms. Mangus do anything like this before. Ms. Margiotta said she and Ms. Mangus did not talk for the rest of the shift, which was unusual. Ms. Margiotta said that Ms. Mangus did not say anything to her about the incident. Ms. Margiotta said that Resident A went to watch TV after dinner, and about an hour later he said he was cold again. Ms. Margiotta reported that Ms. Mangus then said to Resident A, "You want me to show you cold again?" Ms. Margiotta said that it was not cold in the house. Ms. Margiotta said that Resident A is not able to take himself outside because he cannot push his wheelchair over the doorsill to get onto the back porch.

On 11/7/18, Assistant Manager Cheryl Mangus said that on 11/3/18, she worked the afternoon shift with DCW Alyssa Margiotta. When asked if Resident A complained about being cold during the shift, Ms. Mangus said, "He says that all the time." Ms. Mangus acknowledged that Resident A did say he was cold that day. When asked how she responded to Resident A, Ms. Mangus said, "I told him it's not as cold as it is outside. It was cold outside. I opened the door and stepped outside with him and said, 'It's not *this* cold inside. It's nice inside.'" Ms. Mangus said that she took Resident A in his wheelchair out onto the back porch to show him the temperature. Ms. Mangus said they were outside for less than a minute. When asked how Resident A responded, Ms. Mangus said, "He didn't act up or say anything after that. I just took him out the first time to show him that it's cold outside. I did ask him if he wanted anything else, like his slippers or a blanket, and he never answered." Ms. Mangus said that Resident A could not go outside by himself. Ms. Mangus said she stood beside Resident A the whole time he was outside. Ms. Mangus reported that she told Resident A, "Winter's going to be coming soon and it's going to be getting colder soon, and this isn't too bad." Ms. Mangus said that Resident A did not make any response to being taken outside. Ms. Mangus denied saying anything to Resident A later in the shift about showing him "cold" again.

I received and reviewed a copy of an *Incident/Accident Report* completed by DCW Alyssa Margiotta. According to the report, Resident A kept repeating "cold" around dinner time. Ms. Margiotta wrote that Ms. Mangus told Resident A, "Keep saying it's cold and I'm going to *show* you cold!" Ms. Margiotta wrote that when Resident A said "cold" again, Ms. Manus opened the sliding glass door in the living room and pushed Resident A outside. Ms. Margiotta wrote that Resident A yelled. Ms. Margiotta noted, "(Ms. Mangus) and (Resident A) were outside 1-2 minutes and then came back in. Shortly after, (Resident A) said he was cold and (Ms. Mangus) threatened to show him cold again."

On 11/8/18, Resident A indicated that Assistant Manager Cheryl Mangus did take him outside on the back porch. When asked additional questions, Resident A shook his head from side to side, indicating he did not wish to answer any more questions, and the interview was stopped.

On 11/8/18, Resident B said she remembered Ms. Mangus pushing Resident A out onto the back deck on Saturday [11/3]. Resident B said, "(Resident A) was mad!" Resident B said that Resident A "gets cold a lot." Resident B said, "She [Ms. Mangus] doesn't get mad or yell or anything at me; she's done excellent with me." When asked about Ms. Mangus's relationship with Resident A or other residents, Resident B said she thought it was all good.

On 11/8/18, Resident C was asked if anything unusual happened on Saturday 11/3/18. Resident C said, "I saw it but don't know the whole story. He [Resident A] was mad or something. She [Ms. Mangus] is nice to me." When asked what the "it" was that she had seen, Resident C said, "Putting (Resident A) out on the deck." Resident C had nothing else to contribute to this investigation.

Home Manger Chrystal Flower reported that she was shocked when Ms. Margiotta reported this incident to her, because Ms. Mangus has never done anything like this before. Ms. Flower said that Ms. Mangus and Ms. Margiotta do not typically work together. Ms. Flower said she knows that Ms. Mangus has been taking care of her mother and working a second job, in addition to working extra hours at the AFC home due to being understaffed.

During an exit conference on 12/13/18, Licensee Designee Kent VanderLoon stated that Ms. Mangus's behavior of pushing Resident A outside was unacceptable. Mr. VanderLoon said he would submit a written corrective action plan detailing what measures the licensee has already taken to address this violation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee,

	visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Although Ms. Mangus denied doing so, according to the statements of DCW Margiotta and residents present at the time, Assistant Manager Cheryl Mangus did mistreat Resident A by deliberately putting him outside in the cold after the resident had already reported feeling cold.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(iv) Threats.**
ANALYSIS:	No one other than the reporting staff person reported that Ms. Mangus threatened to put Resident A outside in the cold again after she did so the first time. Ms. Mangus denied threatening the resident. There is insufficient evidence to conclude that Ms. Mangus threatened Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: A staff person did not treat Resident A properly when the resident was cut while shaving.

INVESTIGATION:

Recipient Rights Advisor (RRA) Jane Gilmore, from CMH for Central Michigan, reported receiving an allegation that Assistant Manager Cheryl Mangus cut Resident A while shaving him and did not provide treatment.

Direct Care Worker (DCW) Alyssa Margiotta reported that she worked on 11/3/18 from 9AM – 11PM. Ms. Margiotta said that she worked with Assistant Manager Cheryl Mangus from 3-11PM that day. Ms. Margiotta said that around 3:30 PM, Ms. Mangus was assisting Resident A with his shower and shaving. Ms. Margiotta said that Ms. Mangus "was complaining that midnighters [the midnight shift staff] weren't shaving him

[Resident A]. He looked really fuzzy like he hadn't been shaved, and that is a midnight duty." Ms. Margiotta said she kept hearing Ms. Mangus saying, "Quit moving, quit moving, you're gonna get cut. I'm gonna cut you." Ms. Margiotta said, "I walked into the bathroom and (Resident A) was bleeding from his chin. She just said that he kept moving and got cut. She took him to his room to get him dressed. She tried controlling the bleeding, but he squinches his face a lot. She basically just gave up." Ms. Margiotta said that she thought Resident A was bleeding "like bad." Ms. Margiotta reported that Ms. Mangus told her, "Just leave it. Let him bleed." Ms. Margiotta said that she used a wet wipe on his chin, applying pressure, but the bleeding would begin again when she removed the wipe. Ms. Margiotta said she tried a band aid, but it was soaked with blood immediately. Ms. Margiotta said that Resident A "wiped away the band aid and got blood on his hands." Ms. Margiotta said that Ms. Mangus then said, 'Look what he did." Ms. Margiotta said, "It was more than her words. She just seemed angry and agitated with him [Resident A]." Ms. Margiotta said that Ms. Mangus finally applied some ointment or cream and that stopped the bleeding. Ms. Margiotta reported that there was no visible mark or injury on Resident A's chin the next day.

Assistant Manager Cheryl Mangus said that on 11/3/18, she worked the afternoon shift. Ms. Mangus said that the shift went "pretty good other than (Resident A) needed to be shaved. He looked like a scruffy man and I know he doesn't like to look that way." Ms. Mangus said she started her shift at 3 PM. Ms. Mangus said, "Midnights were supposed to shave him, and the book said that they had, but it was obvious they hadn't." Ms. Mangus said that Resident A usually shaves with an electric razor but that if his beard is too long, the electric razor pulls. Ms. Mangus said, "I had to use a straight razor, and I used conditioner. It went really good until he put his hand up and I kind of nicked him on his chin." Ms. Mangus said that Resident A put his hand up suddenly, perhaps as part of a muscle spasm, and it bumped her hand causing the cut on his chin. Ms. Mangus said it was not a serious cut, but it started bleeding. Ms. Mangus said, "He's on aspirin now as a blood thinner. I applied everything I could. I even put toilet paper on, and then he scrunched his face and it came off." Ms. Mangus said that DCW Alyssa Margiotta tried to help out, but "there was just no end to it." Ms. Mangus said, "I finally ignored him, and it stopped. I wanted to keep applying pressure, but he kept pushing my hands away and touching his chin. I thought that if we just let it go, he'd leave it alone. I told the other staff [Ms. Margiotta] that we should just leave it alone so he would stop playing with it." Ms. Mangus said that Ms. Margiotta "looked like she was pissed. She was concerned about the bleeding." Ms. Mangus said she was also concerned, but after working with Resident A for four years she knew that working on the cut was just going to antagonize Resident A more. Ms. Mangus said, "I kept checking on him. I showered him after shaving him, and it was still bleeding after the shower." Ms. Mangus said the bleeding finally stopped.

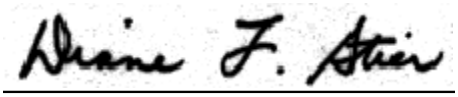
I received and reviewed a copy of an *Incident/Accident Report* completed by DCW Alyssa Margiotta. According to the report, Ms. Mangus was shaving Resident A when he got a gut on his chin. Ms. Margiotta wrote that Ms. Mangus attempted to control the bleeding and then stopped, at which point Ms. Margiotta attempted to stop the bleeding. Ms. Margiotta wrote that she suggested a band aid and Ms. Mangus "basically said

don't bother he won't keep it on anyway." According to the report, Ms. Mangus "stepped in and cleaned him, very agitated." Ms. Margiotta wrote that Ms. Mangus then applied cream to the cut and this stopped the bleeding.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	After Resident A's chin was cut while shaving, Assistant Manager Cheryl Mangus attempted to stop the bleeding, as did DCW Alyssa Margiotta. The bleeding was eventually stopped, and there was no last injury to the resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the current status of the license of this AFC adult small group home.



Diane L Stier
Licensing Consultant

December 13, 2018
Date

Approved By:

12/21/2018

Dawn N. Timm
Area Manager

Date