GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2022

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

RE: License #: AS540305481
Investigation #: 2022A0577008
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 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,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS540305481
Investigation #:	2022A0577008
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/22/2021
Report Due Date:	01/21/2022
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator/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:	10/02/2020
Expiration Date:	10/01/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was having a behavior when direct care staff member Shelbie Kadwell hit Resident A.	Yes
Resident B was left in urine soiled clothes and not provided peri care in a timely manner.	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A0577008
11/22/2021	Special Investigation Initiated - Telephone Jackie Brown, Area Manager, call on 11/19/21 to report incidents and notify of IR being completed.
11/22/2021	Contact - Document Received IR Received on 11/19/21, reviewed on 11/22/2021.
11/22/2021	Referral - Recipient Rights
11/22/2021	APS Referral
11/23/2021	Inspection Completed On-site Interview staff and resident.
11/23/2021	Contact - Telephone call made Interview Shelbie Kadwell, DCS.
12/01/2021	Inspection Completed On-site- Reviewed staff progress notes, duties of staff, and resident assessment plan.
12/01/2021	Contact - Document Sent Katie Hohner, CMHCM-ORR, scheduled interview with staff.
12/06/2021	Contact - Document Received Ashley Lyzenga, CPS-MIC Specialist.
12/06/2021	Contact - Telephone call made- Interviews with staff.
12/07/2021	Inspection Completed-BCAL Sub. Compliance

12/07/2021	Exit Conference with license designee Kent VanderLoon

ALLEGATION: Resident A was having a behavior when direct care staff member Shelbie Kadwell hit Resident A

INVESTIGATION:

On November 22, 2021, a complaint was received alleging Resident A was having a behavior and in response direct care staff member Shelbie Kadwell grabbed Resident A's wheelchair, pushed him to his bedroom and when Resident A swung his arm back hitting direct care staff member Shelbie Kadwell, Shelbie Kadwell hit Resident A back in the face. The complaint reported Resident A did not have any visible marks and the resident's safety was assured.

On November 22, 2021, I spoke with Jackie Brown, Area Director for the licensee, who notified me of the incident and advised an *Incident/Accident Report (IR*) will be completed and turned in.

On November 22, 2021, I received an IR completed by Mya Walker. The IR reported on November 18, 2021, "staff had asked [Resident A] to go to his quiet place because [Resident A] was yelling and trying to grab at housemates. Staff pushed [Resident A] to his room in wheelchair and [Resident A] swung and hit staff, then staff hit [Resident A] back. Staff checked on [Resident A] found no injuries or marks. Talked to Staff who hit [Resident A] and made it clear this was not acceptable and that it is not to be done." The "staff" referred to in this IR was Shelbie Kadwell.

On November 22, 2021a Child Protective Service (CPS) Complaint was completed due to Resident A being a minor who was recently placed at the facility under a Youth Waiver Variance.

On November 23, 2021, I completed an onsite investigation with Katie Hohner, Office of Recipient right with Community Mental Health Central Michigan (ORR-CMHCM). Together, we interviewed Mya Walker Assistant Manager/Direct Care Staff (DCS) who reported on November 18, 2021 Ms. Walker was in the kitchen passing medications while Resident A was in the living room with other resident when Resident A started yelling and grabbing other residents. Ms. Walker reported DCS Shelbie Kadwell was in the living room and asked Resident A if he wanted to go to his bedroom to which Resident A said, "no, no, no." Ms. Walker reported Ms. Kadwell went to Resident A's wheelchair, turned Resident A around and wheeled him back to his bedroom. Ms. Walker reported while Ms. Kadwell was pushing Resident A in his wheelchair, Resident A started slapping Ms. Kadwell. Ms. Walker reported Ms. Kadwell slapped Resident A back in the face and took Resident A to his bedroom. Ms. Walker reported Resident A stayed in his bedroom for about five minutes, wheeled himself back into the living room

and apologized for slapping Ms. Kadwell. Ms. Walker reported she called out Ms. Kadwell's name and said, "that is not acceptable, we are not supposed to do that."

On November 23, 2021, we interviewed DCS Morgan Gulick who reported on November 18, 2021 Resident A was in the living room having a behavior when DCS Shelbie Kadwell turned Resident A in his wheelchair and started pushing Resident A toward his bedroom when Resident A started swinging his arm backwards trying to hit Ms. Kadwell in the face. Ms. Gulick reported Ms. Kadwell hit Resident A back in the face/neck area. Ms. Gulick reported Ms. Walker said to Ms. Kadwell, "you cannot do that, that is unreasonable." Ms. Gulick reported Ms. Kadwell said, "[Resident A] is hitting me in the face and I could go blind."

On November 23, 2021, we attempted to interview Resident A but due to his cognitive disabilities Resident A was not able to provide us with any information pertaining to the incident being investigated. Resident A appeared to be happy, laughing, smiling, and showed us his toys and bedroom.

On November 23, 2021, Tonya Todd, Home Manger (HM) provided Ms. Hohner (ORR-CMHCM) and me with a copy of a letter written by DCS Abigail Maguire reporting on November 18, 2021 Ms. Maguire came to work a few minutes before her shift at 11:00pm and found DCS Shelbie Kadwell sitting on the couch on her phone while DCS Mya Walker was on the house phone. Ms. Maguire wrote Ms. Kadwell followed Ms. Maguire into the garage and proceeded to tell Ms. Maguire how Resident A hit Ms. Kadwell earlier in the day and when Resident A hit Ms. Kadwell, she hit Resident A across the face. Ms. Maguire wrote Ms. Kadwell admitted DCS Mya Walker also witnessed the incident and did not say anything.

On November 23, 2021, Katie Hohner, CMHCM-ORR and I interviewed direct care staff Shelbie Kadwell by telephone. Ms. Kadwell stated that she had worked at the facility for about two months. Ms. Kadwell said, "Mya asked [Resident A] to get out of the dining room and [Resident A] refused to move." Ms. Kadwell reported DCS Mya Walker was cleaning the kitchen and dining room area when Ms. Walker asked Mr. Kadwell to move Resident A from the dining room area because Resident A was in the way. Ms. Kadwell reported she grabbed Resident A's wheelchair and moved Resident A towards the living room when Resident A started hitting Ms. Kadwell in the face. Ms. Kadwell reported she put her arm up to block Resident A from hitting her and ended up hitting Resident A in the face/neck area. Ms. Kadwell stated, "I was trying to block his hand." Ms. Kadwell reported she pushed Resident A from the dining room to the living room and denied pushing Resident A to his bedroom. Ms. Kadwell reported Ms. Walker called Ms. Kadwell's name but did not say anything to Ms. Kadwell about blocking Resident A's hit.

On December 06, 2021, I received an email from Ashley Lyzenga, Children's Protective Service-Maltreatment in Care Unit and Kristin Sherrill, Foster Care Specialist notifying me the complaint was not assigned for investigation.

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:	Based on the information gathered during the investigation there was sufficient evidence found that direct care staff Shelbie Kadwell hit Resident A in the face during a behavioral incident. Direct care staff Mya Walker and Morgan Gulick witnessed the incident and Abigail Maguire documented an encounter with Shelbie Kadwell admitting she hit Resident A purposefully. Although DCS Shelbie Kadwell denied the allegation and stated she was trying to block Resident A from hitting her, there was enough evidence to find DCS Shelbie Kadwell mistreated Resident A by hitting Resident A after he hit her.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B was left in urine soiled clothes and not provided peri care in a timely manner by direct care staff members.

INVESTIGATION:

On November 30, 2021, a second complaint was received alleging that on November 27, 2021 at 9:00am direct care staff members Shilo Hawkins and Vickie Burden arrived to work and found Resident B sitting in her wheelchair in soiled briefs with urine dripping on the floor. The complaint alleged Resident B's briefs have not been changed since 9:00pm on November 26, 2021.

On December 01, 2021, I completed an unannounced onsite investigation and interviewed home manager Tonya Todd who provided me with copies of Resident B's *Assessment Plan for AFC Residents*, staff progress notes from November 26 and 27, 2021 and staff duty sheet per shift.

- Per Resident B's *Assessment Plan for AFC Residents,* Resident B is in need of staff assistance with toileting-Staff will provide incontinence brief changes every 2-3 hours, bathing-staff will prompt her to complete what she is able and provide bathing for areas that she is not able to do herself, and dressing-staff will prompt

her to complete what she is able to and provide dressing where she is not able to dress.

- Duty Sheet For Staff: (5:00am-7:00am) Task 1: Get residents up for the day; Task 2: Do personal care and bathes, brush teeth and gums after breakfast.
- Progress Note from November 26, 2021, 11:00pm-9:00am, written by DCS Malik Pore documented "[Resident B] was asleep upon arrival. During this time, she was monitored throughout the night. When she woke up, she was fed and given her meds. Staff that was assigned peri care refused to do peri care at the end of the shift [Resident B] received peri care."
- Progress Note from November 27, 2021, 9:00am-9:00pm written by DCS Vickie Burden documented "[Resident B] was sitting in her chair by office. Staff was informed that [Resident B] did not have any peri care done. Staff took her to bathroom and did full peri care. She had a bm and then had her feeding."

On December 01, 2021, I attempted to interview Resident B but Resident B was not able to be interviewed due her cognitive impairments and being non-verbal but I observed Resident B who appeared to be in good spirits, clean with no odor and appropriately dressed.

On December 06, 2021, Katie Hohner, CMHCM-ORR officer, and I interviewed DCS Vickie Burden who reported on November 27, 2021 she received a phone call from DCS Malik Pore around 8:30am reporting DCS Mykayla Morales was not assisting Mr. Pore with caring for the residents. Ms. Burden reported she arrived at the facility around 9:00am and saw DCS Malik Pore standing by island in the kitchen doing something and DCS Mykayla Morales sitting in the recliner. Ms. Burden reported she noticed Resident B was sitting in her wheelchair by the office door still in her pajamas. Ms. Burden reported she asked who was on peri care and Ms. Morales said, "I am but I am on restriction and I cannot lift so this is why I have not provided [Resident B] with peri care." Ms. Burden reported she noticed Resident B was sitting in urine-soaked pajamas and there was urine on the floor. Ms. Burden reported she asked Ms. Morales to provide care to Resident B but Ms. Morales said she was not going to, clocked out and left the facility. Ms. Burden reported herself and DCS Shilo Hawkins immediately provided peri-care along with other personal care to Resident B. Ms. Burden reported she questioned Mr. Pore why Resident A was sitting in urine-soaked clothes and not bathed/dressed for the day to which Mr. Pore reported he was trying to provide care to all of the residents, make meals and clean up by himself while Ms. Morales was not willing to assist. Ms. Burden reported Mr. Pore expressed his frustration with Ms. Morales and how he cannot do his job and her job also. Ms. Burden reported Mr. Pore discussed how he approached Ms. Morales and explained she needed to do her part of the job and if she needs help just to ask and apologized to Ms. Burden for being behind. Ms. Burden reported she was not aware of Ms. Morales being under the care of a doctor or having any restrictions related to doing her daily work tasks.

On December 06, 2021, we interviewed DCS Shilo Hawkins who reported on November 27, 2021 Ms. Hawkins arrived at 9:00am for her shift and saw Resident B sitting across from bathroom in her wheelchair and notified DCS Vickie Burden of Resident B needing

peri care. Ms. Hawkins reported Ms. Burden went to DCS Mykayla Morales and requested she finish giving Resident B a shower and dress her for the day. Ms. Hawkins reported Ms. Morales got up from the recliner, clocked out and left for the day. Ms. Hawkins reported DCS Malik Pore was cleaning the kitchen up from breakfast when she arrived at work and Mr. Pore reported to Ms. Hawkins, he has not had time to get to peri care of residents because he had other duties to finish and Ms. Morales was supposed to provide peri care. Ms. Hawkins reported Mr. Pore did not acknowledge to her that he knew Resident B was wet while sitting in her wheelchair.

On December 06, 2021, we interviewed DCS Malik Pore who reported he worked with DCS Mykayla Morales on November 26, 2021 from 9:00pm-9:00am and on the morning of November 27, 202. Mr. Pore reported he was in the kitchen making breakfast for the residents while Ms. Morales was assigned to provide peri care to the residents. Mr. Pore reported after breakfast was made for the residents, he got Resident B out of bed and found Resident B had soaked through her brief. Mr. Pore reported he started Resident B's tube feeding and set her by the bathroom for Ms. Morales to provide peri care to Resident B. Mr. Pore reported he returned to the kitchen area to finish cleaning up and asked Ms. Morales to provide peri care to Resident B multiple times but Ms. Morales refused to provide peri care to Resident B. Mr. Pore reported around 8:30am he told Ms. Morales he was going to have to call management if she did not provide care to Resident B and Ms. Morales said, "go ahead." Mr. Pore reported he contacted Vickie Burden, on call manager and explained what was happening and Ms. Burden told Mr. Pore she was on her way to the facility. Mr. Pore reported Ms. Morales provided peri care to all of the other residents but was not sure why she would not provide care to Resident B. Mr. Pore reported he was not aware of Ms. Morales being under a doctor's order or had restrictions because he worked with her the night before with no concerns.

On December 06, 2021, Tonya Todd, Home manager reported DCS Mykayla Morales was off work due to medical reasons and was supposed to return to work on November 22, 2021 but called in sick. Ms. Todd reported she asked Ms. Morales, DCS if she had any work restrictions and Ms. Morales provided Ms. Todd a copy of the discharge paperwork which documented no work restrictions. Ms. Todd reported Ms. Morales, DCS worked on November 24 and 25, 2021 and completed all of her work duties with no problems.

On December 06, 2021, we attempted to interviewed Mykayla Morales, DCS by phone with no answer.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the information gathered during the interview was found that per Resident B's *Assessment Plan for AFC Residents,* Resident B is in need of staff assistance with toileting, however Resident B was not provided with peri-care assistance on November 27, 2021, after Resident B was found sitting in her wheelchair in urine-soaked clothes. DCS Mykayla Morales was assigned peri-care but refused to provide assistance to Resident B and left the facility when directed to perform this task for Resident B. Although Resident B's peri-care needs were addressed, it was not until a period of time had passed and not until after DCS Mykayla Morales blatantly refused to meet those needs per her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

Exit conference was completed on December 07, 2021 with licensee designee Kent VanderLoon who agreed the care provided to Resident A and Resident B was not quality care but the care was provided in the end. Mr. VanderLoon reported both direct care staff are no longer employed at the facility.

IV. RECOMMENDATION

It is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 12/08/2021

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 01/18/2022

_____

Dawn N. Timm Date
Area Manager