GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2022

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

RE: License #: AS370088019
Investigation #: 2022A1029009
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.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370088019
Investigation #:	2022A1029009
Complaint Receipt Date:	11/09/2021
Investigation Initiation Date:	11/09/2021
Report Due Date:	01/08/2022
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 #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:	04/01/2020
Expiration Date:	03/31/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Alexis Wheeler speaks in a disrespectful tone to Resident A by telling her to go into her bedroom and the living room is closed so she cannot sit in there.	Yes

III. METHODOLOGY

11/09/2021	Special Investigation Intake 2022A1029009
11/09/2021	Contact - Document Sent - Email to complainant
11/09/2021	Special Investigation Initiated - Telephone to direct care staff member, Megan Shiavo
11/19/2021	Contact - Face to Face with direct care staff member, Alyssa Margiotta, Resident A, Resident B
12/07/2021	Contact - Telephone call made to direct care staff member, Alexis Wheeler, Community Mental Health, Julie Oliver, Crystal Flowers, left messages for all.
12/07/2021	Contact - Telephone call received from Julie Oliver, Community Mental Health -Returned call.
12/07/2021	Contact - Telephone call made to direct care staff member, Mariah Chagoya
12/07/2021	Contact - Telephone call received from direct care staff member, Emily Little
12/07/2021	Contact - Telephone call made to direct care staff member, Alexis Wheeler
12/07/2021	Exit Conference with licensee designee, Kent VanderLoon
12/08/2021	Contact - Telephone call received from home manager Crystal Flowers

ALLEGATION:

Direct care staff member Alexis Wheeler speaks in a disrespectful tone to Resident A by telling her to go into her bedroom and the living room is closed so she cannot sit in there.

INVESTIGATION:

On November 9, 2021, a complaint was received alleging that direct care staff member, Alexis Wheeler, speaks in a disrespectful tone to Resident A by telling Resident A to go to her bedroom or that the living room is closed so she cannot sit in there.

On November 9, 2021, I interviewed direct care staff member, Megan Shiavo. She has worked there since August 2021. Ms. Shiavo stated she worked with Ms. Wheeler in the past and had concerns because Ms. Wheeler told Resident A to sit in her bedroom. Ms. Shiavo also stated Ms. Wheeler had other direct care staff members give Resident A her snack because she did not want to do it or she had Resident A wait for the snack for no apparent reason. Ms. Shiavo stated if Ms. Wheeler was upset, she would throw Resident A's snack in the trash. Ms. Shiavo stated when she did not want to talk to her, she would move Resident A into her room while Resident A was sitting in her wheelchair. Ms. Shiavo further stated Ms. Wheeler would tell Resident A that she could not sit at the table with the other residents and express to the other staff that she did not like Resident A. Ms. Shiavo stated Resident A has a diagnosis of dementia so she will sometimes get upset and tell the direct care staff member that she hates them which seemed to trigger Ms. Wheeler. Ms. Shiavo stated Ms. Wheeler only acted like this toward Resident A but overall Ms. Shiavo found that Ms. Wheeler had an overbearing personality. Ms. Shiavo stated Ms. Wheeler would get mad at her when they worked together for being nice too Resident A or tell her that she should be punished. Ms. Shiavo stated Resident A did not want to come out of her room when Ms. Wheeler was working. Ms. Shiavo stated other direct care staff members have also observed these behaviors resulting in a few direct care staff members being intimidated by her.

On November 19, 2021, I interviewed direct care staff member, Alyssa Margiotta. She has been employed at McBride #1 for three years. She was familiar with Ms. Wheeler but had not worked with her in a long time. She stated Ms. Wheeler quit working at the home the weekend prior to this interview. She has observed her with the residents and she seemed like she was "a little short" with the residents and had "little patience" especially with Resident A. Ms. Margiotta stated when they begin employment, they are trained how to handle the resident behaviors and how to talk to the residents. Ms. Margiotta observed Ms. Wheeler stating to Resident A the living room was closed and that she should stay in her room during June and July 2021. Ms. Margiotta stated after hearing this she did not want to work with Ms. Wheeler because she was worried about becoming involved in an investigation because of her behaviors and attitude toward the residents. Ms. Margiotta denied hearing Ms. Wheeler use profanity toward any of the residents.

On November 19, 2021, I attempted to interview Resident A at McBride #1 however, she stated that she was going to take a shower and she did not want to speak with me. She was asked a couple times by Ms. Margiotta but she continued to refuse to complete an interview.

On November 19, 2021, I interviewed Resident B at McBride #1 who stated she remembered Ms. Wheeler and said she no longer works there. Resident B stated she did not care for her because she was mean to Resident A. Resident B said Ms. Wheeler was upset with Resident A so she took her snow globe off of her dresser just to be mean and Resident A was upset with her after that because she would not give it back to her. Resident B heard Ms. Wheeler tell Resident A the living room was closed and she did not talk to her nicely. She denied that she was disrespectful to her rather Ms. Wheeler only said these comments to Resident A. Resident B stated Resident A would try to stay in her bedroom when Ms. Wheeler was working her shift.

On December 7, 2021, I called Resident A's case manager through Community Mental Health, Julie Oliver. Ms. Oliver stated Resident A will not talk to her about the incident. She has dementia and was not willing to discuss this with her either. Ms. Oliver stated she tried to interview her but she also refused to speak with her about these concerns.

On December 7, 2021, I interviewed direct care staff member, Mariah Chagoya who stated she observed Ms. Wheeler telling Resident A to go to her room around medication time. Ms. Chagoya stated Resident A had behaviors such as yelling or showing agitation and Ms. Wheeler talked back to and was rude toward Resident A in response. Ms. Chagoya stated if Resident A would say that she did not want to take her medications, she and Ms. Wheeler would bicker back and forth with each other. Ms. Chagoya state she observed Ms. Wheeler swearing at Resident A in the past. Ms. Chagoya also heard Ms. Wheeler tell Resident A she needed to go into her room to cool down because they were bickering again. Ms. Chagoya described the relationship between Resident A and Ms. Wheeler as a strange and tense relationship but since she was a new employee, she did not feel comfortable questioning this. Ms. Chagoya stated she has not observed her to physically move or put her hands on any of the residents. She has not observed any of the other direct care staff members acting this way toward any of the residents. Ms. Wheeler did not withhold her food but she would tell Resident A if she did not come now for mealtime, her food would be given to someone else. Resident A would eventually come down and eat and she would always receive her food. Ms. Chagoya never heard her say the living room was closed but because Resident A was in a wheelchair, she would have to assist her in going down the one step but Ms. Wheeler would not help her when she wanted to go into the living room.

On December 7, 2021, I interviewed former direct care staff member, Alexis Wheeler. She described her relationship with Resident A as "a little tough" because of Resident A's condition. When asked to describe why, she stated she treated her fine when she was working. Ms. Wheeler stated Ms. Shiavo is the one who told Resident A to go into the bedroom. Ms. Wheeler denied swearing at any residents. Ms. Wheeler stated the

only time she could not go into the living room was when they were cleaning it. There was never a time that she wanted a snack and a direct care staff member or herself would not give Resident A a snack.

Ms. Wheeler stated if she got angry with someone she would not express it toward them however, she said Resident A's episodes were tough to handle because Resident A would just scream at her and argue. She felt that there may have been times that her irritation showed through the interactions at times. There were no other residents with whom she had a difficult time communicating.

On December 7, 2021, I interviewed direct care staff member, Emily Little. She has worked in health care for over ten years and knows when someone is not appropriate with a resident. Ms. Little stated Ms. Wheeler put residents to bed as soon as they were done eating so it would be easier for her. Ms. Little stated, "it would be 5:00 p.m. in the middle of summer and she would be closing all the blinds so the residents would think it was dark." Ms. Little stated she heard Ms. Wheeler say several times in the past that Resident A needed to go to her room. Ms. Little also noted a change in behavior and mood of the residents when Ms. Wheeler was working. The days she worked she made sure nothing happened in front of her. Ms. Little stated she observed Ms. Wheeler be very rude to Resident A. Ms. Little stated even Resident A called her aside and asked why Ms. Wheeler was so mean to her. Ms. Little stated if Resident A was not eating or at medication times, she wanted to be in her room if Ms. Wheeler was working. She was concerned with the tone that Ms. Wheeler used with Resident A. Ms. Little stated she asked Ms. Wheeler, "what if this was your grandmother?" while she was working with her one day and she just responded with "well it's not" and did not seem to be concerned. Ms. Little felt it was tense while she was working with her. At one point, Ms. Little was told she was going to be shift partners permanently with Ms. Wheeler. She stated that if that happened, she was going to resign from her position so she did not have to work with her full time. Direct care staff members and residents seem to get along better since Ms. Wheeler resigned. Ms. Little stated Ms. Wheeler antagonized and yelled at Resident A and then punished Resident A by yelling when she was mad. Ms. Little felt like she did not have the heart to be employed in this position so it would not have been resolved by further training. She has never observed Ms. Chagoya or any other direct care staff members treating the residents with disrespect.

On December 8, 2021, I interviewed direct care staff member Crystal Flowers whose current role is home manager. She stated she never observed Ms. Wheeler put any of the residents in their bedroom. She described Ms. Wheeler as "cold" toward the residents. She never heard her make any direct comments but it was more in her tone. Ms. Flowers stated she was not surprised when the other direct care staff members brought this to her attention. She has never observed any of the other direct care staff members to treat residents with disrespect. Ms. Flowers stated Ms. Wheeler completed all trainings required when she started her position and has shadowed other direct care staff member so there was no reason she did not know how to communicate effectively with all the residents in the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Former direct care staff member, Alexis Wheeler, did not treat Resident A with respect to her personal dignity while working with her at McBride #1. On several occasions, she was disrespectful to Resident A making statements that the living room was closed, to stay in her room, and her overall demeanor toward her was different than how she treated the other residents. Based on the interviews with Resident B, direct care staff members, Ms. Chagoya, Ms. Shiavo, and Ms. Little and the home manager, Ms. Flowers, I found that Ms. Wheeler did not treat Resident A with consideration and respect. Ms. Wheeler also admitted that she experienced frustration and described the relationship as “a little tough” with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

___ 12/15/2021_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

01/03/2022

_____

Dawn N. Timm — Date
Area Manager