GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 2, 2022

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

RE: License #: AS370068192
Investigation #: 2022A0783048
McBride Rosebush 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 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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370068192
Investigation #:	2022A0783048
Complaint Receipt Date:	06/13/2022
Investigation Initiation Date:	06/14/2022
Report Due Date:	08/12/2022
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 Rosebush AFC
Facility Address:	4419 N Mission Rosebush, MI 48878
Facility Telephone #:	(989) 433-5667
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Charlotte Birgy grabbed Resident A by the wrist, then let go, causing Resident A to fall.	No
Additional Findings	Yes

III. METHODOLOGY

06/13/2022	Special Investigation Intake - 2022A0783048
06/14/2022	Special Investigation Initiated -Telephone call with Complainant
06/15/2022	Contact - Telephone call made to direct care staff member Devon Sterling
06/15/2022	Contact - Telephone call made to direct care staff member Pam Hook
06/30/2022	Contact - Document Received - Written *AFC Licensing Division Incident/Accident Report* for Resident A
06/30/2022	Inspection Completed On-site
06/30/2022	Contact - Face to Face interviews with direct care staff members Amanda Bonar, Caitlynn Reihl, Miranda Mathis, and Taylor Christman
07/28/2022	APS Referral
08/01/2022	Contact - Document Received - Employee record for direct care staff member Charlotte Birgy
08/02/2022	Exit Conference – Written email message for Kent VanderLoon

ALLEGATION:

Direct care staff member Charlotte Birgy grabbed Resident A by the wrist, then let go causing Resident A to fall.

INVESTIGATION:

On June 13, 2022, I received a complaint via centralized intake that stated direct care staff member Devon Sterling reported that on June 8, 2022, he heard Resident A tell direct care staff member Charlotte Birgy that he did not want to take medications or eat breakfast. The complaint stated Mr. Sterling reported that Ms. Birgy did not accept Resident A's decision to refuse medication and/or breakfast and grabbed Resident A by the wrist and tried to pull him to the kitchen. The written complaint stated that at some point Ms. Birgy let go of Resident A's wrist causing him to fall over backwards.

On June 14, 2022, I spoke to Complainant who said she interviewed Ms. Birgy who told her she worked from 6:00 am to 2:00 pm on June 8, 2022 and Resident A was in bed upon her arrival. Complainant said Ms. Birgy told her that she was encouraging Resident A to get up and get ready for work and she acknowledged "pulling" Resident A by the hand but described it as gentle coaxing. Complainant said Ms. Birgy said Resident A did get out of bed and go to the bathroom and direct care staff member Devon Sterling assisted Resident A with changing his clothing and then Resident A came out into the common area where he started yelling and stating he was going back to his room. According to Complainant, at that point Ms. Birgy approached Resident A and took his hand as a way to calm Resident A but he began "swinging" so Ms. Birgy let go and Resident A fell. Complainant said while Ms. Birgy acknowledged that she held Resident A's hand to calm him and coax him to eat and drink which he had not been doing, she denied grabbing Resident A by the wrist forcefully nor causing him to fall. Complainant said Resident A was not injured when he fell and that Resident A "is not steady on his feet at all," so it is common for him to fall. Complainant said Resident A nor any of the other residents admitted to the home are able to participate in an interview nor provide any information about the allegation.

On June 30, 2022, I received a written *AFC Licensing Division Incident/Accident Report* for Resident A dated June 8, 2022. The written report contained statements written by direct care staff members Devon Sterling and Pam Hook who were working with Charlotte Birgy on June 8, 2022. The written statement from Mr. Sterling in part stated, "[Resident A] proceeded to walk down the hallway where [Ms. Birgy] followed then eventually grabbing [Resident A's] wrist and trying to pull him back to the living room/kitchen. Once [Resident A] pulled her past his [bedroom] door [Ms. Birgy] proceeded to let go of [Resident A's] wrist. [Resident A] then flew backwards falling onto his hip." The written statement from Ms. Hook in part stated, "I saw [Mr. Sterling] standing to the left of [Resident A] and [Ms. Birgy] was in front of

[Resident A]. I could see [Ms. Birgy] holding on to [Resident A.] I could not tell where she was holding him or how. I saw [Resident A] falling on his left side." The written incident report stated Resident A was assessed for injury and found to have a rectangle shaped "rug burn" on his left elbow and was offered first aid which he refused. The written incident report stated the incident was reported to home manager Amanda Bonar who arranged for Resident A to receive medical treatment to rule out injury.

On June 15, 2022, I spoke to direct care staff member Devon Sterling who said he worked with Ms. Birgy on June 8, 2022 and that he observed Ms. Birgy grab Resident A by the wrist and then let go, causing Resident A to fall down. Mr. Sterling said Resident A was "in a bad mood" and refused to receive assistance with morning grooming and hygiene tasks. Mr. Sterling said Resident A was in the living room and Ms. Birgy was in the kitchen preparing breakfast while verbally encouraging Resident A to sit at the table for breakfast. Mr. Sterling said Resident A refused and started down the hallway toward his bedroom and Ms. Birgy followed Resident A. Mr. Sterling said as he followed behind Ms. Birgy and Resident A, he saw Ms. Birgy grab Resident A by the right wrist with both hands and then pulled on him. Mr. Sterling said Resident A was pulling away from Ms. Birgy and Ms. Birgy "put weight into it" and pulled harder. Mr. Sterling said Ms. Birgy let go of Resident A and he fell backward onto his left hip. Mr. Sterling said Resident A fell due to Ms. Birgy pulling forcefully on his wrist and then suddenly letting go. Mr. Sterling said he tried to verbally diffuse the situation prior to Resident A falling but was unable to redirect Resident A. Mr. Sterling said Resident A had a "rug burn" on his left elbow because of the fall but had no further injuries. Mr. Sterling said that was the first time he ever saw Ms. Birgy touch a resident in a rough or inappropriate manor. Mr. Sterling said direct care staff member Pam Hook was also working at the time but was in the medication room and did not directly witness the encounter between Ms. Birgy and Resident A that resulted in Resident A falling. Mr. Sterling said he told Ms. Birgy that her actions were inappropriate and she "shrugged it off."

On July 28, 2022, I spoke to direct care staff member Charlotte Birgy who stated she recalled working with Resident A on June 8, 2022 and was aware of the reason I telephoned her. Ms. Birgy stated she has a history with Resident A dating back prior to his placement at the facility and stated she and Resident A have a good relationship. Ms. Birgy said Resident A refers to her as "mother," and that often she is able to "talk [Resident A] into" doing things he initially refuses such as eating, toileting, showering or taking medication. Ms. Birgy stated on June 8, 2022, she was in the kitchen preparing breakfast when direct care staff member Devon Sterling told her that Resident A had been refusing to shower or eat so she decided to go speak to Resident A to see if she could encourage him to come to the table for breakfast. Ms. Birgy said she offered Resident A her hand and he took her hand and walked toward the bathroom where Mr. Sterling assisted Resident A with toileting and getting dressed. Ms. Birgy said she went back to the kitchen and then a few minutes later Resident A walked out into the living room with Mr. Sterling and shouted "no," started "pushing and pulling away" from Mr. Sterling and then walked down the

hallway toward his bedroom. Ms. Birgy said she walked up to Resident A in the hallway and that Mr. Sterling followed. Ms. Birgy stated she stood on Resident A's right side and Mr. Sterling stood on Resident A's left side and she held Resident A's hand while she verbally encouraged Resident A to come to the table and eat breakfast. Ms. Birgy stated she held Resident A's hand with one hand and used her other hand to "pat" Resident A on the hand to console and encourage him. Ms. Birgy stated she was only holding Resident A's hand and was not pulling Resident A. Ms. Birgy stated she did not have Resident A by the wrist and that she was not trying to physically redirect Resident A when she held his hand. Ms. Birgy said she and Resident A took three steps before Resident A said "no" and "pulled away" which is when Ms. Birgy stated she let go of Resident A's hand. Ms. Birgy said Resident A then fell on his left side and Mr. Sterling assisted Resident A and assessed him for injury and determined Resident A was not injured. Ms. Birgy described Resident A as having lack of balance and stated it is not abnormal for Resident A to fall and that she does not believe he fell because she let go of his hand.

On June 15, 2022, I spoke to direct care staff member Pam Hook who said she worked with Ms. Birgy and Mr. Sterling on June 8, 2022 but did not witness Ms. Birgy grab Resident A by the wrist. Ms. Hook said she was in the medication room when she heard Resident A yelling so she went into the dining room to see "if everything was under control," which is when she saw Mr. Sterling and Ms. Birgy standing near Resident A. Ms. Hook said Ms. Birgy "had a hold of" Resident A but she could not see where or how Ms. Birgy was holding Resident A. Ms. Birgy said she could tell that Resident A's arm was extended and it "looked like [Resident A] was trying to get away from [Mr. Sterling] and [Ms. Birgy]." Ms. Hook said she saw Resident A fall and that Resident A has a history of falling. Ms. Hook said from her perspective it appeared that Resident A "was trying to get away from" both Mr. Sterling and Ms. Birgy before he fell, but that she was not certain if that caused Resident A to fall.

On June 30, 2022, I interviewed direct care staff member and home manager Amanda Bonar who said she was not present in the home on June 8, 2022, when Resident A fell. Resident A and Ms. Birgy had a very positive relationship, and that Resident A refers to Ms. Birgy as "mother," and relates to her as a mother figure. Ms. Bonar said it is not uncommon for staff members to hold Resident A's hand while he is standing or walking to help ensure he does not fall. Ms. Bonar said she never saw Ms. Birgy grab Resident A by the wrist nor physically redirect Resident A in any way. Ms. Bonar said Ms. Birgy does not manage resident behaviors in general but rather cooks and cleans and that she was only trying to verbally encourage Resident A to eat breakfast etc. as Ms. Birgy and Resident A have a longstanding positive relationship. Ms. Bonar said Ms. Birgy is not physically capable of doing any hands – on resident care or behavior management. Ms. Bonar said Ms. Birgy has never done anything to violate Resident A's rights in any way that she ever observed. Ms. Bonar said she communicated with Resident A and he "understood that he fell," but could not articulate any details. Ms. Bonar said she assessed Resident A for injury, and he was not hurt. Ms. Bonar described Resident A as "very

unsteady on his feet," and said that staff members attempt to stay within arm's reach of Resident A because of his numerous falls.

On June 30, 2022, I interviewed direct care staff member and assistant home manager Caitlynn Reihl who said she was not working on June 8, 2022, when Resident A fell but that she read the written statements and incident report related to the fall. Ms. Reihl said according to what she read Resident A had been feeling ill and refused to eat, take medication, or receive assistance with showering and grooming on June 8, 2022, so Ms. Birgy tried to redirect Resident A and encourage him to eat, etc. Ms. Reihl said according to what she read Ms. Birgy was holding Resident A but she was not sure where. Ms. Reihl said she understood that Resident A was trying to pull away and fell onto the ground. Ms. Reihl described Ms. Birgy as "an older woman" with limited physical abilities whose primary responsibilities in the facility are cooking and cleaning. Ms. Reihl said Resident A and Ms. Birgy have a good relationship and that Resident A related to Ms. Birgy as a mother so she is often able to verbally redirect Resident A when he refuses care. Ms. Reihl said it is not uncommon for staff members to hold Resident A's hand. Ms. Reihl said she worked with Ms. Birgy daily and never had any concerns regarding her interactions with Resident A nor any other resident. Ms. Reihl said Resident A is "unsteady" when ambulating and that he requires the use of a gait belt and standby assistance because he often falls.

On June 30, 2022, I interviewed direct care staff member Miranda Mathis who said she was not working on June 8, 2022 and knew nothing about the alleged incident between Resident A and Ms. Birgy. Ms. Mathis said she regularly worked with Ms. Birgy and when asked to describe Ms. Birgy she stated Ms. Birgy was "like a grandma." Ms. Mathis said Ms. Birgy was responsible for cooking and doing laundry and that Ms. Birgy was not physically "strong enough" to do resident care related activities. Ms. Birgy said Resident A and Ms. Birgy had a positive relationship and that Resident A referred to Ms. Birgy as "mother," and "was always excited to see" Ms. Birgy. Ms. Mathis said Ms. Birgy behaved "motherly" toward Resident A and never did anything to cause him emotional or physical discomfort that she witnessed. Ms. Mathis said it is common for staff members to hold out a hand for Resident A to hold because he is "very unsteady" on his feet. Ms. Mathis said Resident A falls "quite a bit" due in part to low blood pressure.

On June 30, 2022, I interviewed direct care staff member Taylor Christman who said she regularly worked with Ms. Birgy but was not there on June 8, 2022 and had no information regarding incident wherein Ms. Birgy allegedly grabbed Resident A by the wrist and caused him to fall. Ms. Christman described Ms. Birgy as "a sweet little old lady." Ms. Christman said Ms. Birgy was responsible for cooking and laundry and did not do any tasks that required physical strength. Ms. Christman said Resident A referred to Ms. Birgy as "mother," and that the two had a positive relationship. Ms. Christman said Resident A never appeared afraid of Ms. Birgy or as if he wanted to avoid her. Ms. Christman said she never saw Ms. Birgy grab and pull Resident A nor any other resident. Ms. Christman said it was common for staff members to offer

Resident A their hand to encourage him and support him since he is a fall risk. Ms. Christman said Resident A required the use of a gait belt and standby assistance to ambulate because he is “unsteady” on his feet, and it is not uncommon for Resident A to fall.

On August 1, 2022, I received and reviewed direct care staff member Charlotte Birgy’s employee record and noted that she was trained and deemed competent in all the required topics including positive approach/non-aversive techniques. I noted that Ms. Birgy had no written disciplinary infractions in her record related to resident care. I noted that personal and professional references were contacted and reported no concerns regarding Ms. Birgy nor her ability to care for vulnerable adults.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on statements from Mr. Sterling, Ms. Birgy, Ms. Hook, Ms. Bonar, Ms. Reihl, Ms. Mathis, and Ms. Christman along with written documentation at the facility and in Ms. Birgy’s employee record there is lack of evidence to support the claim that Ms. Birgy grabbed Resident A by the wrist and then let go, causing Resident A to fall. The investigation revealed that there were no witnesses to corroborate Mr. Sterling’s claim, Resident A and Ms. Birgy had a positive relationship, and none of Ms. Birgy’s co-workers expressed any concerns regarding Ms. Birgy nor her interactions with Resident A and other residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On August 1, 2022, I received a copy of direct care staff member Charlotte Birgy’s employee record which did not include written documentation that Ms. Birgy participated in a criminal history background clearance through the Michigan Workforce Background Check system. Lisa Torres who is the director of human resources for the facility wrote in an email message that she could not locate said documentation and that Ms. Birgy was scheduled to be fingerprinted via the Michigan Workforce Background Check system on August 2, 2022. Ms. Torres stated Ms. Birgy’s hire date was June 25, 2013.

APPLICABLE RULE	
R 400.14734(b)	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has Rendered Wednesday, July 20, 2022 Page 25 Michigan Compiled Laws Complete Through PA 134 of 2022 □ Courtesy of www.legislature.mi.gov received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment

ANALYSIS:	Based on a written statement from Ms. Torres and the written documentation in direct care staff member Charlotte Birgy's employee record I determined that Ms. Birgy was hired on 06/25/2013 and a criminal history background clearance through the Michigan Workforce Background Check system was not completed at the time of this report and was scheduled for 08/02/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/02/2022

_____

Leslie Herrguth Date
Licensing Consultant

Approved By:

08/02/2022

_____

Dawn N. Timm Date
Area Manager