GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 3, 2023

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

RE: License #: AS370406683
Investigation #: 2023A0790049
McBride Air Newton 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS370406683
Investigation #:	2023A0790049
Complaint Receipt Date:	05/24/2023
Investigation Initiation Date:	05/25/2023
Report Due Date:	07/23/2023
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Sarah Nestle
Licensee Designee:	Kent Vanderloon
Name of Facility:	McBride Air Newton AFC
Facility Address:	4643 Airport Rd Mt Pleasant, MI 48858
Facility Telephone #:	(989) 772-9140
Original Issuance Date:	06/25/2021
License **Status:**	REGULAR
Effective Date:	12/25/2021
Expiration Date:	12/24/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Mark Dean followed Resident A outside and swore at Resident A.	Yes

III. METHODOLOGY

05/24/2023	Special Investigation Intake 2023A0790049.
05/25/2023	Special Investigation Initiated – Telephone call made. Interviewed the complainant via phone on 05/25/2023 and verified the allegations were accurate and comprehensive.
05/25/2023	Contact – Telephone call received from assistant director of services Bernie Myers. Interviewed Mr. Myers.
05/26/2023	APS Referral not necessary as the allegations do not meet assignment criteria.
06/07/2023	Inspection Completed On-site- Interviewed direct care staff members (DCSMs) Nicole Merrill, Thomas Davenport, and Resident A.
06/14/2023	Contact - Telephone call made to interview DCSM Chris Clark. Voicemail message left requesting a return call.
06/14/2023	Contact - Telephone call made to interview recipient rights advisor Katie Hohner.
06/14/2023	Contact - Document Received- Ms. Hohner provided supporting documentation.
06/16/2023	Contact - Telephone call received from DCSM Chris Clark. Interviewed Mr. Clark.
06/16/2023	Inspection Completed-BCAL Sub. Non-Compliance
06/16/2023	Exit Conference with licensee designee Kent Vanderloon.
06/16/2023	Corrective Action Plan Requested and Due on 07/06/2023.

ALLEGATION:

Direct care staff member (DCSM) Mark Dean followed Resident A outside and swore at Resident A.

INVESTIGATION:

I reviewed a BCAL Online Complaint dated 05/24/2023 indicating that on 5/23/23, Resident A told a story direct care staff member (DCSM) Mark Dean believed to be untrue. Mr. Dean argued with Resident A about the truth of the story. The complaint indicated Resident A eventually ignored Mr. Dean's comments and went outside to smoke a cigarette. Mr. Dean followed Resident A outside and said to Resident A, "No you didn't just fucking ignore me. Nobody fucking treats me like that. That is so fucking disrespectful."

I reviewed an *AFC Licensing Division – Incident / Accident Report (IR)* dated 05/08/2023. The IR indicated on 05/08/2023 at 4:40 a.m., Resident A was in the living room talking to DCSM Mr. Dean about how Resident A was in the war and in the navy. Mr. Dean told Resident A he was never in the navy or any wars. Resident A then argued with Mr. Dean explaining he was in the navy and in a war. Mr. Dean and Resident A argued about Resident A being in the navy and in a war for approximately 10 minutes and Resident A finally away and went to his bedroom.

The *IR* indicated Resident A later walked outside to smoke a cigarette on the front porch and while walking past Mr. Dean, Mr. Dean mumbled something to Resident A. Resident A ignored Mr. Dean and continued to walk outside onto the front porch. Resident A was on the front porch smoking. Mr. Dean stood up from the couch and stated to Resident A, “Oh no, no one fucking ignores me.” Mr. Dean then followed Resident A outside onto the front porch. Mr. Dean proceeded to tell Resident A he was being “fucking disrespectful and no one fucking ignores me when I am talking to them and you’re going to listen to what I have to say.” The *IR* indicated Resident A remained quiet and ignored Mr. Dean. Mr. Dean went back inside and sat down on the couch. Resident A went to his bedroom and asked DCSM Mr. Clark if he could speak to DCSM Walter Wedding who functions as the house manager. Resident A asked if the verbal altercation could be reported to Community Mental Health of Mid-Michigan Office of Recipient Rights (CMH-CM ORR). Mr. Clark later assured Resident A the verbal altercation would be reported to CMH-CM ORR and would be taken care of. Resident A thanked Mr. Clark and went to bed.

I interviewed the complainant via phone on 05/25/2023 and verified the allegations were accurate and comprehensive.

I interviewed licensee designee Bernie Myers who called on 05/25/2023 to discuss this special investigation. Mr. Myers said CMH-CM ORR is investigating the allegations and Mr. Myers and recipient rights advisor Katie Hohner will be conducting interviews this

afternoon. Mr. Myers said Ms. Hohner has already interviewed Resident A. Mr. Myers said Resident A has always told the truth and is a trustworthy individual. He stated Ms. Hohner stated Resident A confirmed the allegations to be true.

Mr. Myers stated if he finds sufficient evidence the allegations are true, he plans to suspend Mr. Dean for three days and provide Recipient Rights and Sensitivity training. Mr. Myers said he will draft and implement a Corrective Action Plan (PCP) and email it to the Bureau of Community and Health Systems (BCHS) – Michigan Department of Licensing and Regulatory Affairs (LARA) for review and approval as soon as administratively possible.

Mr. Myers called a second time on 05/25/2023. Mr. Myers stated Mr. Dean lied about the incident. He said Mr. Dean denied following Resident A outside and swearing at him. Mr. Myers stated Mr. Dean said Resident A went to his room after the incident, remained in there, and never went outside. Mr. Myers said Mr. Dean said the only confrontation between him and Resident A occurred in the house, and he never used foul language. He stated Mr. Dean said he does not swear. Mr. Myers stated Resident A confirmed the allegations were true when interviewed. Resident A said he felt unsafe around Mr. Dean which is why he stopped listening to Mr. Dean and went outside.

Mr. Myers said Ms. Hohner will be substantiating abuse three against Mr. Dean. He stated this along with the fact Mr. Dean has a history of arguing with the residents at the facility led to the decision to terminate his employment. Mr. Myers stated he is not going to allow DCSMs to abuse the residents physically or verbally.

I interviewed recipient rights advisor Katie Hohner via phone on 06/14/2023. Ms. Hohner said she is going to substantiate for verbal abuse.

I reviewed a Coach and Counsel report dated 05/29/2023 involving DCSM Mark Dean. The report indicated on 05/23/2023, Mr. Dean was arguing with Resident A telling Resident A he was lying about being in the war, when Resident A walked away from Mr. Dean. Mr. Dean told Resident A not to “fucking walk away when someone is talking to him”. Mr. Dean followed Resident A outside onto the porch and continued to try and argue with Resident A telling him, “This is not how it fucking works”. Resident A stated he was scared and thought Mr. Dean was going to physically attack him.

The report stated under Explanation of Desired Performance, DCSMs are not to argue with or swear at residents. When a resident walks away to get out of the situation, DCSMs are not to follow and continue to engage or argue with the resident.

The report stated under Manager Comments because of the seriousness of this violation, Mr. Dean employment with McBride Quality care is terminated effective 05/30/2023.

I conducted an unannounced onsite investigation on 06/07/2023. I interviewed DCSMs Nicole Merrill and Thomas Davenport. Ms. Merrill and Mr. Davenport both indicated they were not working when the alleged verbal altercation occurred.

I interviewed Resident A. Resident A stated the allegations are true. Resident A disclosed DCSM Mark Dean followed him outside onto the front porch and said to him, “No you didn’t just fucking ignore me. Nobody fucking treats me like that. That is so fucking disrespectful.” Resident A stated Mr. Dean told Resident A he had been disrespecting him for several days. Resident A stated Mr. Dean said that is why he verbally attacked Resident A. Resident A said he was afraid of Mr. Dean while being verbally abused. Resident A stated he was scared Mr. Dean was going to physically attack him.

I interviewed DCSM Christopher Clark via phone on 06/16/2023. Mr. Clark said he was working on 05/08/2023 and witnessed the verbal altercation between DCSM Mark Dean and Resident A. Mr. Clark said Resident A likes telling stories. He stated on 05/23/2023 Resident A began saying he was in the navy and fought in wars in places like Afghanistan. Mr. Clark stated Mr. Dean became upset and began arguing with Resident A and telling him what Resident A was saying about being in the navy and fighting in wars was not true. Mr. Clark stated Resident A appeared fed up and walked away. He said Resident A went to his bedroom, got a cigarette, and walked outside to smoke. Mr. Clark said Mr. Dean followed Resident A outside. Mr. Clark stated the window and door were both open, so he heard everything Mr. Dean said to Resident A.

Mr. Clark stated Mr. Dean told Resident A, “No you didn’t just fucking ignore me. Nobody fucking treats me like that. That is so fucking disrespectful.” Mr. Clark also stated Mr. Dean said, “You don’t sit there, and fucking disrespect me.” He said Mr. Dean then came back inside the facility, sat down, and was mumbling stuff under his breathe. Mr. Clark said he told Mr. Dean he should not have reacted the way he did and should have not said those things to Resident A because Resident A will report it. He said Mr. Dean said, “Fuck him.” Mr. Clark said Resident A approached him later and stated he wanted to speak with direct care staff member (DCSM) Walter Wedding who functions as the house manager and report how Mr. Dean was acting and what he said to him. Mr. Clark stated he assured Resident A the verbal altercation would be reported to CMH-CM ORR and would be taken care of. Mr. Clark said Resident A thanked him and went to bed.

I conducted an exit conference with licensee designee Kent Vanderloon informing him a rule violation had been established because of this special investigation and a Corrective Action Plan (CAP) would need to be completed within 15 business days of receiving a copy of the Special Investigation Report (SIR).

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:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with the complainant, assistant director of services Mr. Myers, DCSMs Ms. Merrill, Mr. Davenport, Resident A, recipient rights advisor Ms. Hohner, and DCSM Mr. Clark, although discrepancy regarding the date of the incident, there is evidence indicating DCSM Mark Dean verbally abused Resident A causing emotional distress. Resident A disclosed he was scared and worried Mr. Dean was going to physically attack him while being verbally abused.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

06/16/2023

Rodney Gill Date
Licensing Consultant

Approved By:

07/03/2023

Dawn N. Timm Date
Area Manager