GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 7, 2023

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

RE: License #: AS590084032
Investigation #: 2023A0466049
McBride Todd's Place

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) 284-9727.

Sincerely,

Julie Elkins, 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

I. IDENTIFYING INFORMATION

License #:	AS590084032
Investigation #:	2023A0466049
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/09/2023
Report Due Date:	08/07/2023
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 Todd's Place
Facility Address:	107 Charlotte St. Edmore, MI 48829
Facility Telephone #:	(989) 427-2844
Original Issuance Date:	12/30/1998
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION

	Violation Established?
Direct care worker (DCW) Brandi Blizzard administered Resident A's medications to Resident B.	Yes

III. METHODOLOGY

06/08/2023	Special Investigation Intake 2023A0466049.
06/09/2023	Contact - Document Sent to Complainant.
06/09/2023	Referral - Recipient Rights.
06/09/2023	Special Investigation Initiated – Letter from ORR Milessa Leach.
06/09/2023	Contact - Document Received from ORR Milessa Leach.
06/29/2023	Inspection Completed On-site.
7/24/2023	APS Referral.
7/31/2023	Exit Conference with Kent Vanderloon.

ALLEGATION: Direct care worker (DCW) Brandi Blizzard administered Resident A's medications to Resident B.

INVESTIGATION:
On 06/08/2023 Complainant reported that during the morning shift on 6/3/2023 direct care worker (DCW) Brandi Blizzard administered Resident A's medications to Resident B. Complainant reported when DCW Blizzard passed the medications it was chaotic in the facility. Complainant reported the medications Resident B received that were not prescribed to her were: Divalproex 500mg, Fluoxetine 10mg, Omeprazole 40mg, Quetiapine 200mg and Vit D3 2,000 units. Complainant reported DCW Blizzard took Resident B directly to Sheridan Hospital Emergency Room (ER). Complainant reported the ER doctor indicated non-toxic ingestion. Complainant reported psychiatrist Dr. Adam's response was, "Higher amount of Divalproex, Seroquel 200 mg & Zyprexa, all could cause excessive sedation within hours of administration in worst case scenario." Complainant reported that if not treated could cause respiratory distress, swallowing problems, falls with consequent injuries, delirium and agitation, possible death from central nervous system (CNS) depression. Complainant reported that getting Resident B to ER was a good call and allowed professional assessment and any needed specific treatment. Complainant

reported that Resident B was discharged in a stable medical state and ER confirmed that Resident B was ready to resume her prescribed medications.

On 06/09/2023, Milessa Leach, from the office of recipient rights (ORR) Montcalm Care Network, reported that she interviewed DCW Blizzard who confirmed that it was chaotic during the morning medication pass on 06/03/2023 with several recipients yelling and wanting breakfast. ORR Leach reported DCW Blizzard stated that she “accidentally gave [Resident A’s] medications to [Resident B] and knew right away so she asked [Resident B] to spit them out and [Resident B] would not." ORR Leach reported Resident B is nonverbal and has pica. ORR Leach reported DCW Blizzard stated she took Resident B right to the ER, where they diagnosed her with non-toxic ingestion. ORR Leach reported Resident A is non-verbal and could not be interviewed. ORR Leach reported that her findings are Neglect III, which indicates that harm could have occurred, and a standard of care was not followed. ORR Leach reported she asked the facility to have a training and in-service on the "5 Rights" of medication administration, reminded them if the environment is too chaotic then close the medication drawer and get everything under control before passing medications. ORR Leach reported facility administration implemented passing medications in a quiet space which they identified as their laundry room. ORR Leach reported reviewing the job description for direct care worker which documented "responsible for the reading of and comprehension of medical prescriptions, follow and administer Physician Orders.” ORR Leach reported Resident B’s *Person-Centered Plan* (PCP) documented "All staff will be familiar with [Resident B’s] prescribed medications and treatments. Staff will administer medications and treatments as prescribed." Additionally, ORR Leach reported facility administration has a staff meeting on 06/13/2023 and a nurse will be presenting on the 5 Rights of Medication Administration.

On 06/09/2023, I reviewed a *Montcalm Care Network Incident Report* that was dated 06/03/2023 and signed by DCW Blizzard and DCW Katelyn Parsons. It stated that on 06/03/2023 at 7:15am, “staff popped [Resident A’s] medication and [Resident B] was talking to staff and another house mate was following and trying to get staffs attention, the staff administered the medication to [Resident B].”

On 06/29/2023, I conducted an unannounced investigation and I interviewed DCW Parsons who works both as a DCW and as house manager. DCW Parsons reported she was not working on the day of the incident but interviewed DCW Blizzard who confirmed that on 06/03/2023 she administered Resident A’s morning medications to Resident B. DCW Parsons stated during her interview with DCW Blizzard, she described the facility environment as being chaotic and loud while she was trying to administer resident medications. DCW Parsons reported one resident was described as refusing to leave the medication room while another was tugging and pulling on DCW Blizzard. DCW Parsons reported that DCW Blizzard spoon fed Resident A Resident B’s medications by mistake. DCW Parsons reported that Resident A is non-verbal and would not be able to verbalize what occurred on 06/03/2023. DCW Parsons reported DCW Blizzard was disciplined for this incident. DCW Parsons

reported DCW Blizzard was trained in medication administration on 3/11/2022. DCW Parsons reported this was the first medication error DCW Blizzard has ever had.

On 06/29/2023, I interviewed DCW Blizzard who reported that on 06/03/2023 during morning medication passes she administered Resident A's medications to Resident B. DCW Blizzard reported that morning was very chaotic and loud. DCW Blizzard reported she typically administers medication in the medication room but she did not on 06/03/2023. DCW Blizzard reported that on 06/03/2023 one resident would not get out of the medication room and another resident was tugging and pulling on her. DCW Blizzard reported she spoon fed Resident A Resident B's medications by mistake. DCW Blizzard reported that while she was administering Resident B the wrong medications, she realized that they were Resident A's medications and she asked Resident B to spit them out but she would not. DCW Blizzard reported she immediately took Resident B to the ER and contacted her guardian and case manager. DCW Blizzard reported the ER stated that Resident B was fine, it was safe to administer her prescribed medications, and reported that she may be sleepy and to watch her blood pressure. DCW Blizzard reported Resident A and Resident B were prescribed all of the same medications except for one. DCW Blizzard reported she wrote an IR and reported the incident to ORR. DCW Blizzard reported Resident B is non-verbal and would not be able to verbalize what occurred on 06/03/2023. DCW Blizzard reported that APS has not been out, just ORR. DCW Blizzard reported that she did receive discipline from ORR and the facility.

I reviewed Resident B's record which contained *After Care Instructions* from Sheridan Community Hospital dated 06/03/2023 at 7:49am which documented Resident B was diagnosed with "non-toxic (non-poisonous) ingestion" meaning a person ingested something not meant to be ingested. The *After Care Instructions* further documented Resident B was able to take all other medications as prescribed and to follow up with a primary care physician as needed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Complainant, ORR Leach, DCW Blizzard and DCW Parsons all reported that on 06/03/2023 during morning medication pass DCW Blizzard administered Resident A's medications to Resident B. Reasonable precautions were not taken to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/31/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

08/07/2023

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Dawn N. Timm Date
Area Manager