GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 20, 2024

Kent Vanderloon
McBride Quality Care Services, Inc.
3070 Jen's Way
Mt. Pleasant, MI 48858

RE: License #: AS190396493
Investigation #: 2024A0790009
McBride Turner Rd. AFC

Dear Kent 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 #:	AS190396493
Investigation #:	2024A0790009
Complaint Receipt Date:	02/01/2024
Investigation Initiation Date:	02/01/2024
Report Due Date:	04/01/2024
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 Turner Rd. AFC
Facility Address:	14354 Turner Road DeWitt, MI 48820
Facility Telephone #:	(517) 487-0105
Original Issuance Date:	02/11/2019
License **Status:**	REGULAR
Effective Date:	08/11/2023
Expiration Date:	08/10/2025
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member (DCSM) Cassidy Hoag was heard verbally abusing and threatening residents and specifically Resident A.	Yes
Ms. Hoag was witnessed kicking and smacking Resident A.	Yes

III. METHODOLOGY

02/01/2024	Special Investigation Intake 2024A0790009
02/01/2024	Special Investigation Initiated – Telephone call made. Interviewed Complainant.
02/05/2024	Contact - Telephone call made. Interviewed direct care staff member (DCSM) Kristin Wetzel.
02/06/2024	Inspection Completed On-site- I observed Resident A and the five other residents living at the facility and interviewed DCSMs Jessica Berry and Kristin Wetzel.
02/07/2024	Inspection Completed-BCAL Sub. Compliance
02/07/2024	Corrective Action Plan Requested and Due on 02/22/2024.
02/08/2024	Exit Conference with licensee designee Kent Vanderloon.

ALLEGATION: Direct care staff member (DCSM) Cassidy Hoag was heard verbally abusing and threatening residents.

INVESTIGATION:

I called the complainant on 02/01/2024. Complainant said she was told DCSM Kristin Wetzel witnessed the allegations. Complainant stated Ms. Wetzel allegedly recorded Ms. Hoag verbally attacking Resident A and other residents at the facility. Complainant said Ms. Hoag allegedly threatened to smack Resident A and told Resident A to “stay

the fuck away from her". Complainant also reported Ms. Hoag was threatening Resident A and said, "Fuck that, I do not like any of you", referring to all residents living at the facility.

I interviewed direct care staff member (DCSM) Kristin Wetzel via phone on 02/05/2024. Ms. Wetzel was read the allegations. Ms. Wetzel said she witnessed the verbal and physical altercation between DCSM Cassidy Hoag and Resident A firsthand, and the allegations are true. Ms. Wetzel stated the altercation happened on 01/28/2024 at approximately 6:30 p.m. She said she and Ms. Hoag were working first shift together on 01/28/2024 and their shift ended at 7:00 p.m. Ms. Wetzel said around 4:00 p.m., Ms. Hoag had left her pop sitting on the floor in the living room while she went to administer medications. Ms. Wetzel said when Ms. Hoag returned to the living room to retrieve her pop, she discovered Resident A had taken the pop and drank it. She stated Ms. Hoag was visibly upset because of Resident A drinking her pop. Ms. Wetzel stated DCSMs and the other residents at the facility know Resident A has a history of taking other individuals' pops and drinking them. She said because of this, DCSMs and residents know not to leave their pop unattended where Resident A can get a hold of it.

Ms. Wetzel said at approximately 6:30 p.m., she, Ms. Hoag, and several residents were sitting in the living room watching television. Ms. Wetzel stated Resident A came into the living room and Ms. Hoag told Resident A not to come and sit by her on the couch. Ms. Wetzel said Ms. Hoag warned Resident A if she came over and attempted to sit by her, she would kick Resident A. Ms. Wetzel said Ms. Hoag told Resident A to sit by Ms. Wetzel because Ms. Wetzel likes her. Ms. Wetzel stated she responded to Ms. Hoag stating, "You like Resident A too." Ms. Wetzel said Ms. Hoag responded by stating, "Fuck that, I do not like any of you guys no more", referring to all the residents. Ms. Wetzel said Resident A then walked toward the television and Ms. Hoag said, "Look at that dumb ass", referring to Resident A.

Ms. Wetzel said she worked with Ms. Hoag many times and never saw Ms. Hoag act like this before. She stated Ms. Hoag never verbally or physically abused any of the residents prior to the above-mentioned altercation. Ms. Wetzel stated she has an audio recording of the approximately two-minute verbal and physical altercation. Ms. Wetzel emailed me the audio recording.

Ms. Wetzel stated Recipient Rights and Dewitt Township Police were also aware of the altercation. Ms. Wetzel said she has been interviewed by recipient rights advisor Greg Fox. Ms. Wetzel stated an officer from the Dewitt Township Police Department also interviewed her but she could not recall his name. Ms. Wetzel said Ms. Hoag has been terminated because of the verbal and physical altercation with Resident A.

I listened to the audio recording and confirmed the allegations in this special investigation pertaining to DCSM Cassidy Hoag verbally abusing Resident A and other residents to be accurate and comprehensive. I heard Ms. Hoag multiple times threaten to kick Resident A.

I conducted an unannounced onsite investigation on 02/06/2024. I interviewed DCSM Jessica Berry who functions as the assistant house manager. Ms. Berry stated none of their six residents can participate in an interview because of significant cognitive delays and mental illness.

I observed Resident A and the other five residents and confirmed they are unable to be interviewed due to significant cognitive delays and mental illness.

Ms. Berry confirmed DCSM Cassidy Hoag's employment was terminated because of the altercation between Ms. Hoag and Resident A.

I interviewed DCSM Kristin Wetzel a second time. Ms. Wetzel confirmed there were no other DCSMs working or visitors when the altercation occurred between Ms. Hoag and Resident A.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 01/28/2024. The report stated DCSM Kristin Wetzel witnessed DCSM Cassidy Hoag verbally and physically abuse Resident A. The report stated Ms. Hoag told Resident A if she went to the couch where Ms. Hoag was sitting, she would kick Resident A and then told Resident A to "come on". The report said Resident A walked over to Ms. Hoag and Ms. Hoag began kicking and hitting Resident A. The report stated Ms. Hoag told Resident A she "did not like her" and that Resident a was "dumb."

The report indicated the home manager was informed of the verbal and physical altercation and a report was sent to Recipient Rights and the Dewitt Township Police Department. The report indicated the home manager contacted the assistant director of services and informed her of the verbal and physical altercation. The director of the company was also notified. The report indicated the home manager immediately took Ms. Hoag off the schedule until further notice and Resident A's guardian was notified. The report indicated Ms. Wetzel spoke with recipient rights and the Dewitt Township Police Department.

I reviewed a Separation Report dated 02/02/2024 for DCSM Cassidy Hoag indicating the separation reason to be misconduct. The report stated Ms. Hoag was "mistreating consumers, cursing, and yelling at them". The report stated Recipient Rights and Licensing are investigating.

I reviewed a Coaching and Counseling Report for Cassidy Hoag dated 02/01/2024. Ms. Hoag received coaching and counseling because of the verbal and physical altercation involving Resident A prior to her termination of employment.

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.** **(iv) Threats.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, DCSMs Ms. Wetzel, and Ms. Berry there was sufficient evidence found indicating DCSM Ms. Hoag verbally abused, made derogatory remarks about, and in front of Resident A subjecting Resident A to mental and emotional cruelty. There was sufficient evidence provided to prove DCSM Ms. Hoag verbally abused Resident A and other residents at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Ms. Hoag was witnessed kicking and smacking Resident A.

INVESTIGATION:

Complainant indicated she was told Ms. Hoag was witnessed kicking at and smacking Resident A.

Ms. Wetzel said Resident A walked up to Ms. Hoag and Ms. Hoag began kicking Resident A in the stomach attempting to push her back. Ms. Wetzel stated this happened three times. She said Resident A walked up to Ms. Hoag a fourth time and Ms. Hoag began smacking Resident A in the arm and on her stomach. Ms. Wetzel stated Resident A thought Ms. Hoag was playing around initially. Ms. Wetzel stated Ms. Hoag told Resident A, “You think I am playing but I’m not.” She said the last time Ms. Hoag began kicking Resident A in the stomach, Resident A fell back a little bit and Ms. Hoag laughed at her.

Ms. Wetzel stated Resident A did not have any marks, bruises, or suffer any injuries because of Ms. Hoag kicking and smacking her.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 01/28/2024. The report stated DCSM Kristin Wetzel witnessed DCSM Cassidy Hoag verbally and physically abuse Resident A. The report stated Ms. Hoag told Resident A if she went to the couch where Ms. Hoag was sitting, she would kick Resident A and then told Resident A to "come on". The report said Resident A walked over to Ms. Hoag and Ms. Hoag began kicking and hitting Resident A.

I conducted an exit conference with licensee designee Kent Vanderloon via phone on 02/08/2024. Mr. Vanderloon was asked to complete a Corrective Action Plan (CAP) because of the rule violations established.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation, and interviews with the Complainant, DCSMs Ms. Wetzel, and Ms. Berry there was sufficient evidence found indicating DCSM Ms. Hoag was witnessed kicking and smacking Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

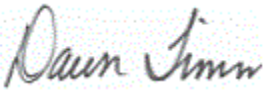
Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

02/08/2024

_____

Rodney Gill — Date
Licensing Consultant

Approved By:



02/20/2024

_____

Dawn N. Timm — Date
Area Manager