GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2024

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

RE: License #: AS560309066
Investigation #: 2024A0790022
Brooks Road AFC Home

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 #:** | AS560309066 |
| | |
| **Investigation #:** | 2024A0790022 |
| | |
| **Complaint Receipt Date:** | 04/29/2024 |
| | |
| **Investigation Initiation Date:** | 04/30/2024 |
| | |
| **Report Due Date:** | 06/28/2024 |
| | |
| **Licensee Name:** | McBride Quality Care Services, Inc. |
| | |
| **Licensee Address:** | 3070 Jen's Way<br>Mt. Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 772-1261 |
| | |
| **Administrator:** | Kent Vanderloon |
| | |
| **Licensee Designee:** | Kent Vanderloon |
| | |
| **Name of Facility:** | Brooks Road AFC Home |
| | |
| **Facility Address:** | 3434 Brooks Rd.<br>Freeland, MI 48623 |
| | |
| **Facility Telephone #:** | (989) 832-8285 |
| | |
| **Original Issuance Date:** | 10/29/2010 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/28/2023 |
| | |
| **Expiration Date:** | 04/27/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 04/24/2024 Direct care staff member (DCSM) Nicole Hawes used inappropriate language toward Resident A and was arguing with him. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/29/2024 | Special Investigation Intake 2024A0790022 |
| 04/29/2024 | APS Referral not necessary because the allegation does not meet Adult Protective Services (APS) assignment criteria. |
| 04/30/2024 | Special Investigation Initiated - On Site |
| 04/30/2024 | Inspection Completed On-site- Interviewed Resident A, direct care staff members (DCSMs) Mike Coldwell who functions as the home manager, and Taylor George who functions as the assistant home manager. |
| 05/03/2024 | Contact - Telephone call made. Interviewed Complainant. |
| 05/03/2024 | Contact - Telephone call made. Interviewed recipient rights advisor Angela Wend. |
| 05/03/2024 | Inspection Completed-BCAL Sub. Compliance |
| 05/06/2024 | Exit Conference with licensee designee Kent Vanderloon. |
| 05/06/2024 | Corrective Action Plan Requested and Due on 05/17/2024. |

**ALLEGATION: On 04/24/2024 Direct care staff member (DCSM) Nicole Hawes used inappropriate language toward Resident A and was arguing with him.**

**INVESTIGATION:**

I reviewed a Bureau of Community and Health Systems Online Complaint dated 04/26/2024. The complaint indicated on 04/24/2024 direct care staff member (DCSM) Nicole Hawes told Resident A to “fuck off” while they were arguing. The complaint indicated Office of Recipient Rights has been informed of this allegation.

I conducted an unannounced onsite investigation on 04/30/2024. I interviewed Resident A. Resident A said he cannot remember the exact date, but recently direct care staff member (DCSM) Nicole Hawes was "cussing quite a lot." He stated Ms. Hawes' cussing made him upset and he threw a chair. Resident A said he did not throw the chair at Ms. Hawes and was not trying to hit her. He stated the chair did not hit anyone. Resident A said Ms. Hawes called him a "mother fucker" and told him to "fuck off". Resident A stated Ms. Hawes later denied calling him this name or using any type of derogatory language toward him.

Resident A stated Ms. Hawes has not been back to the facility since speaking with the assistant director of services (ADOS) Bernie Myers. Resident A said he told Mr. Myers what had happened, and Mr. Myers informed him he would take care of it.

I reviewed an *AFC Licensing Division - Incident / Accident Report* dated 04/24/2024. DCSM Taylor George who functions as the assistant home manager wrote the following statement regarding the verbal altercation she witnessed between Resident A and Ms. Hawes: "At 5:00 p.m., [Resident A] was standing in front of the refrigerator in the kitchen while DCSM Nicole Hawes was cutting up onions for dinner. [Resident A] had made a comment about not liking when other residents cuss or yell obscenities. [Resident A] said, "I am sick of that shit!" Ms. Hawes replied, "Didn't your mother ever teach you if you do not have anything nice to say, do not say anything at all?" Ms. George turned toward Ms. Hawes and exclaimed loudly, "Nicole!" As soon as Ms. Hawes finished saying that, Resident A began screaming, "I do not have a mom; she died; fuck you bitch; shut the fuck up; shut the fuck up and let her rest peacefully!" Ms. Hawes yelled back, "How about you shut the fuck up for once!" Ms. George then stepped in between [Resident A] and Ms. Hawes. Ms. George turned to Ms. Hawes and exclaimed loudly, "Absolutely not! Ms. George told Ms. Hawes, "We do not do that!" Ms. George said, "That is too far!" Ms. Hawes stopped talking and continued into the kitchen making dinner. [Resident A] stood there in silence for a couple of minutes then began speaking with other residents again. [Resident A] then asked Ms. George when they were going to the store. Ms. George informed [Resident A] as soon as everyone gets done with dinner they would be going to the store. [Resident A] said, "Okay." Approximately 10 minutes later Resident A finished dinner and went to the store with DCSMs and other residents."

I reviewed a *Coach and Counsel form* dated 04/25/2024. The *Coach and Counsel form* was for DCSM Nicole Hawes and stated under 'Misconduct / Job Description': Ms. Hawes was heard getting into a verbal argument with Resident A. The form indicated this is considered verbal abuse and falls under unethical conduct, dignity, and respect.

The form said under, 'Show how the behavior has Legitimate Business Concerns': McBride Quality Care Services, Inc. as a company is contracted by the state of Michigan to protect resident rights and refrain from unethical conduct including refraining from verbal abuse. DCSMs are to always show residents dignity and respect. When a DCSM gets into a verbal argument with a resident which includes swearing at

the resident, this places McBride Quality Care Services, Inc. out of compliance with licensing rules and at risk of losing our license to run Adult Foster Care (AFC) facilities. The form stated DCSMS are to always protect residents' rights. DCSMs are to refrain from situations that may be seen as unethical. DCSMs are to always show residents dignity and respect and avoid any form of arguing and/or swearing when speaking with residents. Lastly, the form said Ms. Hawes admitted to verbally abusing Resident A, and verbally abusing another unknown resident on a previous occasion. Due to the severity of the incident Ms. Hawes was terminated immediately on 04/25/2024.

I reviewed a *Separation Report* confirming Ms. Hawes was terminated effect 04/25/2024 because of the verbal altercation between her and Resident A occurring on 04/24/2025, and Ms. Hawes' admitting to verbally abusing another unknown resident on a previous occasion.

I interviewed DCSM Taylor George. Ms. Goerge confirmed her statement provided along with the *AFC Licensing Division - Incident / Accident Report* dated 04/24/2024 was true and comprehensive. Ms. George stated she stands by her statement and has nothing further to add.

I interviewed DCSM Mike Coldwell who functions as the home manager. Mr. Coldwell said he had conducted a staff meeting on 04/23/2024 and specifically discussed with DCSMs, including Ms. Hawes, their responsibility to treat residents with dignity and respect. Mr. Coldwell stated Ms. Hawes was fully aware of her conduct when speaking to Resident A on 04/24/2024 the way she did was considered verbal abuse, unethical, and not in line with company standards of conduct.

I interviewed recipient rights advisor Angela Wend via phone on 05/03/2024. Ms. Wend said she investigated and because Ms. Hawes admitted to telling Resident A to "fuck off" while they were arguing on 04/24/2024, she substantiated for verbal abuse.

I conducted an exit conference with licensee designee Kent Vanderloon on 05/06/2024. Mr. Vanderloon was informed a rule violation was established because of this special investigation and was asked to provide a Corrective Action Plan (CAP) within the required timeframe.

| **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:**<br>**(f) Subject a resident to any of the following:**<br>**(ii) Verbal abuse.** |

| | |
|---|---|
| **ANALYSIS:** | Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSMs Ms. Hawes, Ms. George, Mr. Coldwell, and recipient rights advisor Ms. Wend there was sufficient evidence found indicating on 04/24/2024 Ms. Hawes used vulgar language multiple times and argued with Resident A amounting to verbal abuse. |
| **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.

05/03/2024

Rodney Gill — Date
Licensing Consultant

Approved By:

05/07/2024

Dawn N. Timm — Date
Area Manager