

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

December 18, 2024

MARLON I. BROWN, DPA DIRECTOR

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

> RE: License #: AS560395819 Investigation #: 2025A1038012 McBride Meridian Rd. AFC

Dear Mr. Vanderloon:

GRETCHEN WHITMER

GOVERNOR

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (616) 356-0100.

Sincerely,

Johnnie Daniels, Licensing Consultant Bureau of Community and Health Systems 350 Ottawa Ave NW Grand Rapids MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS560395819
	A3300393019
Investigation #:	2025A1038012
	2023A1030012
Complaint Receipt Date:	12/12/2024
	12/12/2024
Investigation Initiation Date:	12/12/2024
Investigation Initiation Date:	
Report Due Date:	02/10/2025
	02/10/2023
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way
Licensee Address.	Mt. Pleasant, MI 48858
	Mil. Pleasant, Mil 40000
Licensee Telephone #:	(989) 772-1261
Licensee relephone #.	(909)772-1201
	Kent Vanderloon
Licensee Designee:	
Name of Facility:	McBride Meridian Rd. AFC
Name of Facility.	
Facility Address:	2530 S. Meridian Rd.
racinty Address.	Midland, MI 48640
Facility Telephone #:	(989) 835-7688
Original Issuance Date:	12/07/2018
License Status:	REGULAR
Effective Date:	06/07/2023
Expiration Date:	06/06/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff were rude to residents and not respecting their privacy.	Yes

III. METHODOLOGY

12/12/2024	Special Investigation Intake 2025A1038012
12/12/2024	Special Investigation Initiated - Telephone to the complainant.
12/16/2024	Inspection Completed On-site
12/16/2024	Contact - Face to Face interviews were conducted with Resident A, Resident B, Resident C, Resident D and Resident E.
12/16/2024	Contact - Face to Face interviews were conducted with administrator Bernie Myers and home manager Alexandra Garibaldi.
12/16/2024	Contact - Face to Face interviews were conducted with DCS Kari Hompstead, DCS Cheryl Thompson, DCS Amber Kelly and DCS Nicole Painter.
12/17/2024	APS Referral not required as there is no suspected abuse or neglect.
12/17/2024	Contact - Telephone call made to Guardian A1.
12/18/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff were rude to residents and not respecting their privacy.

INVESTIGATION:

On 12/10/24, I received a complaint from the Bureau of Community and Health System regarding the facility. The complaint alleged the staff were rude to residents and not respecting their privacy.

On 12/12/24, I interviewed the complainant who verified the information.

On 12/12/24, I met with home manager Alexandra Garibaldi and recipients' rights officer (ORR) Angela Wend via Teams. Ms. Garibaldi was able to play an audio recording of an incident which took place in the facility on 12/8/24. There were voices heard on the recording arguing. Ms. Garibaldi stated the ones in the recording arguing were direct care staff (DCS) Amber Kelly, DCS Nicole Painter with Resident A. Ms. Garibaldi stated staff were unaware they were recorded.

On 12/16/24, I conducted an investigation at the facility. ORR Wend, home manager Garibaldi and regional manager Bernie Myers were present for all the interviews. I interviewed DCS Kari Hompstead who verified, she audio recorded Resident A and staff without their permission. DCS Hompstead stated the arguing started over Resident A not being able to share cigarettes with another Resident. DCS Hompstead verified DCS Kelly and Resident A were yelling at each other. DCS Hompstead stated she yelled at DCS Kelly and DCS Painter to stop antagonizing Resident A. DCS Hompstead stated Resident A tried to hit DCS Kelly to which she replied, "hit me and see where that gets you". DCS Hompstead stated the incident ended with Resident A being taken to the hospital to be evaluated.

On 12/16/24, I interviewed DCS Cheryl Thompson whose statement was consistent with those made by DCS Hompstead.

On 12/16/24, I interviewed DCS Amber Kelly who provided a statement consistent of those made by DCS Hompstead and DCS Thompson.

On 12/16/24, I interviewed DCS Nicole Painter who provided a statement consistent of those made by DCS Hompstead, DCS Thompson and DCS Kelly. DCS Painter added she tried to calm Resident A down during the incident.

On 12/16/24, I was unable to interview Resident A as she was still in the hospital being evaluated for her mental health.

On 12/16/24, I interviewed Resident B who stated she heard staff and Resident A yelling at each other. Resident B stated she loves the staff and does not get along with DCS Hompstead. Resident B was unaware of the reason why.

On 12/16/24, I interviewed Resident C who stated she did not see the entire incident. Resident C stated she heard DCS Kelly and DCS Painter yelling at each other and Resident A. Resident C stated no staff were rude to residents. Resident C stated Resident A was yelling at everyone. Resident C stated staff normally do not

yell at the residents. Resident C stated she has no concerns for the staff as they treat residents great.

On 12/16/24, I interviewed Resident D who stated she does not remember the incident. Resident D stated she only remembered everyone yelling for an unknown reason.

On 12/16/24, I interviewed Resident E who stated she was sleeping during the incident. Resident E stated she was awakened by screaming but didn't know what it was about.

On 12/16/24, I reviewed the incident report which verified the incident. I reviewed the facility training which involved proper ways to deal with Residents Trauma and their primary care plan. I also reviewed the facility policy on staff having no personal cellular phones while at work.

On 12/16/24, I conducted an exit conference with administrator Bernie Myers. I spoke with Mr. Myers regarding the resident's privacy while at the facility. Mr. Myers advised he would speak with the company regarding adding no recording to their policies. Mr. Myers advised ORR would provide additional training on the incident and dealing with Residents behaviors.

On 12/17/24, I interviewed Guardian A1 via telephone. Guardian A1 stated they were made aware of the incident. Guardian A1 verified Resident A spoke with her during the incident. Guardian A1 stated she did not know who Resident A was arguing with. Guardian A1 stated she thought Resident A was being disrespected by the staff during the incident. Guardian A1 verified Resident A was sent to the hospital for evaluation.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:
	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.

ANALYSIS:	Based on my interviews with staff, residents and the review of documents. There is enough corroborating evidence of the staff rudeness towards Resident A and not respecting her privacy.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan. I recommend the status of the license to remain unchanged.

e Dariel

Johnnie Daniels Licensing Consultant

12/18/24

Date

Approved By:

Russell Misial

12/18/24

Russell B. Misiak Area Manager Date