



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

June 2, 2025

RE: License #: AS560309066
Investigation #: 2025A1038035
Brooks Road AFC Home

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.
- 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 #: | AS560309066 |
| Investigation #: | 2025A1038035 |
| Complaint Receipt Date: | 05/13/2025 |
| Investigation Initiation Date: | 05/14/2025 |
| Report Due Date: | 07/12/2025 |
| Licensee Name: | McBride Quality Care Services, Inc. |
| Licensee Address: | 3070 Jen's Way Mt. Pleasant, MI 48858 |
| Licensee Telephone #: | (989) 772-1261 |
| Licensee Designee: | Kent Vanderloon |
| Name of Facility: | Brooks Road AFC Home |
| Facility Address: | 3434 Brooks Rd. Freeland, MI 48623 |
| Facility Telephone #: | (989) 832-8285 |
| Original Issuance Date: | 10/29/2010 |
| License Status: | REGULAR |
| Effective Date: | 04/28/2025 |
| Expiration Date: | 04/27/2027 |
| Capacity: | 6 |
| Program Type: | DEVELOPMENTALLY DISABLED MENTALLY ILL |

II. ALLEGATION(S)

| | Violation Established? |
|---|------------------------|
| Staff member did not administer Resident A's medication according to the label. | Yes |

III. METHODOLOGY

| | |
|------------|---|
| 05/13/2025 | Special Investigation Intake 2025A1038035 |
| 05/14/2025 | Special Investigation Initiated - Telephone call made to complainant. |
| 05/28/2025 | Contact - Face to Face interviews were conducted with home manager Mike Coldwell DCS Michelle Thurston and DCS Larry Costley. |
| 05/28/2025 | Contact - Face to Face interview was conducted with Resident A. |
| 05/28/2025 | Inspection Completed On-site |
| 05/30/2025 | Contact - Telephone call made to DCS Marrison Huntley. |
| 06/02/2025 | Exit Conference with LD Kent Vanderloon. |
| 06/02/2025 | Inspection Completed-BCAL Sub. Compliance |
| 06/02/2025 | APS Referral Not required as there is no suspected abuse or neglect. |

ALLEGATION:

Staff member did not administer Resident A's medication according to the label.

INVESTIGATION:

On 5/28/25, I conducted an unannounced investigation at the facility. I interviewed home manager Mike Coldwell who stated Resident A is still currently not at the facility. Mr. Coldwell stated the incident happened on 5/6/25. Mr. Coldwell stated the only part of the incident he witness was arriving at the facility and Resident A taken to the hospital regarding being found halfway under the bed having a seizure. Mr. Coldwell stated he went to the hospital with Resident A. Mr. Coldwell advised Resident A was only given one pill of his Keppra equaling 750mg. Mr. Coldwell advised Resident A is required to get two pills equaling 1,500mg of Keppra. Mr. Coldwell advised the medication error was done by direct care staff (DCS) Marrissa Huntley. Mr. Coldwell stated DCS Michelle Thurston noticed the medication error. Mr. Coldwell stated Resident A was found by DCS Thurston and DCS Larry Costley on 5/6/25.

Mr. Coldwell provided me with incident reports (IR), completed training done by DCS Huntley, along with coaching and counseling that was given to DCS Huntley. DCS Huntley was given medication administration retraining on 5/7/25 witness by Mr. Coldwell, 5/8/25 witness by Mr. Coldwell and 5/16/25 witness by administrator Bernie Myers. I reviewed Resident A's medication administration records (MAR) which verified Resident A's medication of Keppra required two pills to be given of 750mg each. The MAR was documented of DCS Huntley giving Resident A one pill instead of two.

On 5/28/25, I conducted an interview with DCS Michelle Thurston who provided a statement consistent with those made by Mr. Coldwell. DCS Thurston stated her written statement she provided the facility was written by her and a detailed account of what happened. DCS Thurston added Resident A was not responsive when she went to go give him the medication. DCS Thurston added the Keppra was supposed to be given in the evening on 5/5/25, to which he was only given one instead of two pills by DCS Huntley. DCS Thurston IR statement confirmed her verbal statement.

On 5/28/25, I conducted an interview with DCS Larry Costley who provided a statement consistent with those made by Mr. Coldwell and DCS Thurston.

On 5/30/25, I conducted an interview with DCS Marrissa Huntley via telephone. DCS Huntley provided a statement consistent with those made by DCS Coldwell, DCS Thurston and DCS Costley. DCS Huntley added everything in the incident report is in her own words and wrote by her.

On 6/2/25, I conducted an Exit conference with licensee designee Kent Vanderloon. Mr. Vanderloon advised he understood the incident and the citation.

| APPLICABLE RULE | |
|------------------------|--|
| R 400.14312 | Resident medications. |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| ANALYSIS: | Based on my interviews with staff and the review of documents. There was enough corroborating evidence of staff not following proper medication label instructions and only gave the resident one Kepra tablet instead of two. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

Contingent on an acceptable corrective action plan. I recommend the status of the license to remain unchanged.

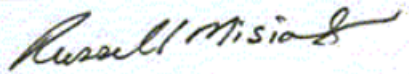


6/3/25

Johnnie Daniels
Licensing Consultant

Date

Approved By:



6/3/25

Russell B. Misiak
Area Manager

Date