GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2025

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

RE: License #: AS590012177
Investigation #: 2025A0577058
McBride Corlisa Jade Home

Dear Mr. Vanderloon:

Attached is the Special Investigation Report for the above-mentioned 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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AS590012177
Investigation #:	2025A0577058
Complaint Receipt Date:	08/25/2025
Investigation Initiation Date:	08/26/2025
Report Due Date:	10/24/2025
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Sarah Nestle
Licensee Designee:	Kent Vanderloon
Name of Facility:	McBride Corlisa Jade Home
Facility Address:	610 S Fifth Street Edmore, MI 48829
Facility Telephone #:	(989) 427-3244
Original Issuance Date:	09/27/1991
License Status:	REGULAR
Effective Date:	04/08/2024
Expiration Date:	04/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On August 19, 2025, Resident A eloped from the facility without staff knowledge.	Yes

III. METHODOLOGY

08/25/2025	Special Investigation Intake 2025A0577058
08/26/2025	Special Investigation Initiated - Telephone Angela Loiselle, MCN-ORR.
08/26/2025	Referral - Recipient Rights
08/26/2025	APS Referral- Witness 1 filed APS.
08/26/2025	Referral - Law Enforcement- Law Enforcement involved due to B& E.
09/08/2025	Contact - Telephone call made- Telephone Interviews.
09/08/2025	Inspection Completed On-site- Interview and resident file review.
09/08/2025	Inspection Completed-BCAL Sub. Compliance
09/08/2025	Contact - Telephone call made- Interviews with DCS.
09/08/2025	Exit Conference with Kent VanderLoon, LD and Sarah Nestle, Admn.
09/09/2025	Contact - Telephone call made- Interviews with Cassandra McCain, HM.
09/09/2025	Contact-Document Received- Via email, Angela Loiselle, ORR-MCN.

ALLEGATION: On August 19, 2025, Resident A eloped from the facility without staff knowledge.

INVESTIGATION:

On Monday, August 25, 2025, a complaint was received reporting that on August 19, 2025, Resident A broke into a neighbor's home at approximately 1:35am and was holding a knife, standing over the children in the home.

On August 26, 2025, Anglela Loiselle, Office of Recipient Rights with Montcalm Care Network (ORR-MCN) contacted me regarding a complaint she received on August 23, 2025. Ms. Louiselle reported Witness 1 contacted Montcalm Care Network and filed a complaint that Resident A broke into their home on August 19, 2025. Ms. Loiselle reported Witness 1 stated around 1:38am she woke from her dogs barking and her husband saw a shadow in their bedroom doorway. Ms. Loiselle reported Witness 1 stated her husband pushed Resident A out of their home and called the police. Ms. Loiselle reported Witness 1 also stated she observed Resident A standing over her children with a knife in his hands.

On August 26, 2025, via email, Angela Loiselle, ORR-MCN provided me with a copy of Resident A's *Person Centered Plan* (PCP) and Behavioral Treatment Plan (BTP). Resident A's PCP was implemented on March 20, 2025, documenting Resident A understands the exit doors, his bedroom door, and bedroom windows have alarms as part of his behavior plan. Resident A's BTP was completed on April 29, 2025, to address target behavior of eloping which is defined as any incident of leaving his AFC or any other area without permission. The BTP documents "[Resident A] has displayed occasional incidents of eloping, although with an increase in the frequency of such behavior in recent months with an isolated incident of entering the home of a nearby neighbor. [Resident A's] BTP documents, secondary to safety concerns regarding this behavior, restrictive procedures (alarms on bedroom window, bedroom door, and the AFC exit doors) have been put in place." Per Resident A's BTP, alarms have been put into place to alert direct care staff that Resident A has exited the bedroom window, his bedroom or the facility entry doors. Resident A's BTP documents if Resident A elopes from the facility, then a staff member will need to follow him to assure his safety. Per the BTP, this includes any time that he elopes out any exit door, even if he is only going into he back yard of the home. Resident A's BTP also documents direct care staff should use a calm approach until you can encourage him to return home. Resident A's BTP documents behavioral data from May 2024-April 2025 that Resident A eloped from the facility four times in March 2025 and three times in April 2025.

On September 8, 2025, I interviewed Witness 1 who reported on August 19, 2025, around 1:45am, she woke up to her dogs baring, stating, "this is not unusual for our dogs to bark in the middle of the night." Witness 1 reported upon waking up in their bedroom, Witness 1 and her husband noticed a shadow by the front door of the living room, and her husband yelled, "who are you, what are you doing in here?" Witness 1 reported that her husband grabbed Resident A and started pushing Resident A toward

the front door, when Witness 1 opened the front door and shoved Resident A out of their front door. Witness 1 reported Resident A was saying, “no, sorry, stop” as he was being pushed out the door. The complaint reported that after Resident A was pushed out the door, he started walking north down their sidewalk and they closed the door and called the police. Witness 1 reported the Michigan State Police, Trooper Thomsen responded. Witness 1 reported initially they did not know who was in their house, so she posted a warning on Facebook about someone entering their home and put a description of the person and received a response from an ex-employee of the facility telling Witness 1 who it might be. Witness 1 reported speaking with home manager Cassandra McCain and identifying the resident who was in their house. Witness 1 was asked about Resident A having a knife and standing over their children and stated, “oh I forgot about this, yes, when I saw the person standing over my children in their bedrooms with a knife in their hand.” Witness 1 reported she does not remember when this occurred in the timeframe of events. Witness 1 reported she did not leave her bedroom until her husband left the bedroom and started pushing Resident A towards the entry door to leave their home. Witness 1 stated, “I believe he had the knife in his hand during the time my husband and I were pushing him out the door.”

On September 08, 2025, I interviewed direct care staff (DCS) Javier Claxton who reported he has worked third shift at the facility for over a year and Resident A had not tried to elope during his third shift until August 19, 2025. Mr. Claxton reported Resident A’s bedroom had an alarm on his bedroom door and on the bedroom window to alert the direct care staff of Resident A trying to elope. Mr. Claxton reported the bedroom window alarm did not engage and alerted direct care staff when Resident A eloped out his bedroom window. Mr. Claxton reported Resident A has a feeding tube and ileostomy bag, both of which are changed between 12:30pm and 1:00am nightly. Mr. Claxton reported on August 19, 2025, around 12:30am that Mr. Claxton entered Resident A’s bedroom to flush the feeding tube, Resident A had his head covered with blankets and appeared to be sleeping really hard. Mr. Claxton reported Resident A will usually groan or make a noise acknowledging the feeding tube being flushed or the ileostomy being changed, but on this particular evening he did not. Mr. Claxton reported Resident B, Resident A's roommate came out of the bedroom around 12:45am to go to the bathroom. Mr. Claxton reported this is unusual for Resident B, because Resident B normally sleeps through the night. Mr. Claxton reported that he believes this is about the time Resident A climbed out of the bedroom window which woke Resident B up. Mr. Claxton reported around 1:00am a neighbor came to the facility and knocked on the door to notify the direct care staff that the neighbor saw one of the residents outside of his house. Mr. Claxton reported he went to Resident A’s bedroom and found Resident A not in his bed, the bedroom window open and the screen missing. Mr. Claxton reported he completed a search of the backyard, and a slat of the vinyl fence was missing. Mr. Claxton reported Resident A either left the yard through the broken slat or open/closed the gate to the yard and left through the gate. Mr. Claxton reported he left the facility and started walking down the street and found Resident A walking towards town. Mr. Claxton reported Resident A kept asking Mr. Claxton if Resident A could go to the psychiatric hospital, Resident A returned to the facility with no issues and

returned to his bedroom to go back to sleep. Mr. Claxton reported he believes Resident A was probably out of the facility unsupervised for approximately 30-45 minutes.

On September 08, 2025, I completed an unannounced onsite investigation and interviewed DCS Cassandra McCain, whose role is Home Manager. Ms. McCain reported Resident A no longer resides in the facility and Resident A's last elopement from the facility prior to this incident was in January 2024. Ms. McCain reported Resident A was admitted into the facility on May 09, 2025, and the window and door alarms were added prior to moving in. Ms. McCain reported the backyard is fenced and Resident A had alarms on his bedroom window, bedroom door, and the back door was alarmed. Ms. McCain reported Resident A eloped from his bedroom window on August 19, 2025, and the window alarm did not disengage appropriately to alert direct care staff of Resident A opening his window and climbing out. Ms. McCain reported earlier in the day that Resident A had an appointment with his psychiatrist and Resident A asked the psychiatrist if Resident A could be hospitalized because he wanted to stay somewhere else. Ms. McCain reported the psychiatrist told Resident A that he was not going to be hospitalized and Resident A became upset. Ms. McCain reported she advised the direct care staff to keep eyes on Resident A as he might try and elope due to being upset about not being hospitalized. Ms. McCain reported during the first and second shift there were no concerns regarding Resident A trying to elope. Ms. McCain provided me with a copy of Resident A's *Assessment Plan for AFC Residents* which documented the following:

- "Social/Behavioral Assessment, A-Moves Independently in Community No- [Resident A] has no safety boundaries. Staff will be in attendance while in the community.
- Social/Behavioral Assessment, I. Controls Aggressive Behavior, No- Staff will follow BTP. [Resident A] may try to bite, hit and run away, he will go to neighbor's house and knock on windows and will also climb fences."

On September 09, 2025, I contacted DCS Cassandra McCain who reported she is not aware of Resident A eloping and being found in a neighbor's home prior to this incident. Ms. McCain reported she was off work during this time. Ms. McCain reported she does not see any *AFC Licensing Division-Incident/Accident Report* (IR) regarding Resident A eloping to a neighbor's home unattended by direct care staff. Via Email from Cassandra McCain, a copy of *Specialized Residential Progress Notes-Incident Report* (SRPN-IR) regarding an incident that happened on April 05, 2025, at 12:30pm. The SRPN-IR documented that Resident A had been upset earlier in the morning and when it was time for lunch, all the residents were at the table except for Resident A. It further documented that someone knocked on the entry door to notify direct care staff that Resident A was on the run. The SRPN- IR documented the neighbor reported Resident A barged into her house saying he needed help then asked to use the bathroom at which time the neighbor asked Resident A to leave. The SRPN-IR documented the neighbor stated noticing Resident A was disables so allowed Resident A to use her bathroom. The SRPN- IR documented Resident A came out of the bathroom then went into the neighbor's kitchen and asked to use the phone. The neighbor reported she told Resident A her phone was in the truck and to follow her outside. The neighbor stated

once outside she shut and locked the door while Resident A ran down the street. The SRPN- IR documented once the neighbor reported the incident to the facility, staff got into the van and went to find Resident A. Per the SRPN- IR, Resident A was located, returned to the facility and the police arrived. Per the IR Resident A reported to police that he removed the window alarm, pushed out the screen, climbed out his bedroom window, and went through vinyl fence in the backyard.

On September 09, 2025, I contacted Angela Loiselle, ORR-MCN to inquire about an SRPN- IR completed in March or April of 2025 documenting Resident A eloping to a neighbor's house. Ms. Loiselle reported their office has access to direct care staff's daily documentation through *Specialized Residential Progress Notes* and on April 23, 2025, at 8:20am, DCS Evelyn Przybylski completed an SRPN- IR documenting a neighbor came to the facility door to inform staff that Resident had broken the fence and was running down the road. DCS Przybylski got into the van, found Resident A and was able to get Resident A to get into the van and return to the facility.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during the investigation, Resident A not only eloped from the facility on August 19,2025, but also on April 05, 2025, and April 23, 2025, with all three elopements involving Resident A going into a neighbor's home. Resident A's *Assessment Plan for AFC Residents* documented Resident A does not have access to the community without the supervision of staff. At the time of Resident A's admission to the facility, alarms were placed on Resident A's bedroom windows, bedroom door, and facility entries/exits to alert direct care staff when Resident A has exited the facility. On all three elopements, per the IR's and interviews, direct care staff were not aware Resident A had eloped from the facility until neighbors reported observing Resident A outside of the facility without staff supervision. Resident A was not provided supervision and protections as defined in the Act and as specified in Resident A's written assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the acceptance of an acceptable corrective action plan, I recommend the current status of the license does not change.

Bridget Vermeesch

09/11/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

09/11/2025

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Dawn N. Timm Date
Area Manager