GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 23, 2025

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

RE: License #: AS290404417
Investigation #: 2025A0622064
Woodhaven AFC

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.
- 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,

Amanda Blasius, 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 #:	AS290404417
Investigation #:	2025A0622064
Complaint Receipt Date:	09/24/2025
Investigation Initiation Date:	09/24/2025
Report Due Date:	11/23/2025
Licensee Name:	McBride Quality Care Services, Inc.
LicenseeAddress:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent Vanderloon
Licensee Designee:	Kent Vanderloon
Name of Facility:	Woodhaven AFC
Facility Address:	1015 S. St. John Ithaca, MI 48847
Facility Telephone #:	(989) 388-4029
Original Issuance Date:	11/20/2020
License Status:	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A received Resident B's medication.	Yes

III. METHODOLOGY

09/24/2025	Special Investigation Intake 2025A0622064
09/24/2025	Special Investigation Initiated - Telephone
10/10/2025	Inspection Completed-BCAL Sub. Compliance
10/20/2025	Contact - Telephone call made
10/23/2025	Exit Conference with licensee designee, Kent Vanderloon

ALLEGATION: Resident A received Resident B's medication.

INVESTIGATION:
On 09/24/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. The complaint reported that direct care worker, Sally Denman administered Resident B's medication to Resident A. According to the complaint, the medications passed to Resident A were 5mg methylphenidate and 4 mg guanfacine.

On 09/24/2025, I emailed recipient rights advisor, Jessica Butler. Ms. Butler confirmed that during her interview with direct care worker, Sally Denman she confirmed that she did not follow the medication administration procedures.

On 10/10/2025, I completed an unannounced onsite investigation to Woodhaven AFC. During the investigation, I interviewed two direct care workers and viewed documentation. I interviewed direct care worker (DCW), Cindi Robinson in person. DCW Robinson identified as the home manager and reported that she was working when the medication error occurred. She explained that direct care worker, Sally Denman was passing medications on 9/17/25 in the basement and called Resident B down to take his medication. According to DCW Robinson Resident B did not come down to the basement after being called several times, therefore DCW Sally Denman set his medications aside after putting his name on his cup and then went on to prepare Resident A's medications. DCW Robinson stated that Resident A can't come to the basement for his medications, therefore staff bring them directly to Resident A. DCW Robinson explained that DCW Sally Denman brought both

Resident A and Resident B's medications upstairs in labeled separate cups. DCW Robinson explained that DCW Sally Denman ended up giving Resident A, Resident B's medication and then realized her mistake right after administration. DCW Robinson explained that DCW Sally Denman came directly to her and explained her mistake. DCW Robinson stated that they then called the doctor for guidance, informed the guardian, monitored his blood pressure and completed an incident report. DCW Robinson stated that they are sending DCW Sally Denman back through medication administration training.

I interviewed direct care worker, Meranda Hunt in person. DCW Hunt stated that she was working with DCW Sally Denman when the medication error occurred. She explained that DCW Denman brought both Resident A and B's medications and then she administered Resident A's medication but looked shocked afterwards. DCW Hunt explained that DCW Denman came to her and told her she gave Resident A, Resident B's medication. DCW Hunt explained that she told DCW Denman to go to DCW Robinson. DCW Hunt reported that the doctor told them that Resident A would either get hyper or calm and they were to hold his 2pm Guanfacine 2mg. DCW Hunt stated that staff monitored Resident A the rest of the day and he appeared happy and had no medical concerns.

On 10/10/2025, I viewed Resident A's medication administration record and confirmed that his Guanfacine 2mg was held at 2pm. I also confirmed that Resident B did receive all his correct medications on 9/17/25. I also reviewed an *AFC licensing division incident/accident report* which documented the medication error and steps taken afterwards, which were consistent with what direct care workers reported during interviews.

On 10/20/2025, I interviewed DCWSally Denman via phone. DCW Denman stated that she was prepping Resident B's medication and called him down to the basement several times. Resident B never came down for his medications, therefore she put his medications in a cup and labeled it with his name. DCW Denman stated that she then went onto prep Resident A's medications. She explained that Resident A needs his medication mixed with applesauce and given to him upstairs. DCW Denman reported that she took both Resident A and B's medications upstairs. She added applesauce to Resident B's cup and then took them to Resident A. DCW Denman stated that right after Resident A took his medications she noticed that the cup said Resident B's name and she realized her mistake. DCW Denman stated that she then went to DCW Robinson and told her about her mistake. DCW Denman reported that they called the doctor and he told them to hold his 2pm medication of Guanfacine 2mg and monitor his blood pressure. DCW Denman stated that she knows she made a mistake and did not complete her "who" of the medication rights and should have only brought one medication up at a time.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based upon interviews with direct care workers and documentation reviewed a violation is established as reasonable precautions were not taken to prevent Resident A from being administered Resident B's prescribed medications. Direct care worker Sally Denman confirmed that she did not take the correct reasonable precautions when administering the wrong medications to Resident A on 9/17/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

10/23/2025

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Amanda Blasius Date
Licensing Consultant

Approved By:

10/23/2025

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Dawn N. Timm Date
Area Manager