GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 15, 2026

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

RE: License #: AS430088209
Investigation #: 2026A0230018
Beech Street

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 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 (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS430088209
Investigation #:	2026A0230018
Complaint Receipt Date:	04/24/2026
Investigation Initiation Date:	04/24/2026
Report Due Date:	06/23/2026
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way, Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent Vanderloon
Licensee Designee:	Kent Vanderloon
Name of Facility:	Beech Street
Facility Address:	610 Fifth Street, Baldwin, MI 49304
Facility Telephone #:	(231) 745-8737
Original Issuance Date:	07/01/2000
License Status:	REGULAR
Effective Date:	09/03/2025
Expiration Date:	09/02/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has not received his prescribed medication methadone.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/24/2026	Special Investigation Intake 2026A0230018
04/24/2026	Special Investigation Initiated - On Site Interviews with Christina Burch, observed Resident A.
04/27/2026	Contact - Telephone call made Program Manager Crystal Weed
04/27/2026	APS Referral
05/22/2026	Contact - Telephone call received Crystal Weed
06/12/2026	Contact - Telephone call made Crystal Weed
06/15/2026	Exit Conference with Licensee Designee Kent Vanderloon

ALLEGATION: Resident A has not received his prescribed medication methadone.

INVESTIGATION: On 04/27/2026, I conducted an unannounced on-site investigation at the facility. I interviewed facility manager Christina Burke regarding the above allegation. Ms. Burke stated that Resident A had not been provided with his methadone medication for the past two weeks. She stated that she had been attempting to make phone calls to find Resident A a new doctor as the one who prescribed the medication has retired. This former physician was located at a pain clinic office in Greenville. When Resident A went to his primary care physician a routine bloodwork test was conducted. On this test it was noted that Resident A did not have any evidence of his prescribed methadone in his system. Due to this particular drug being not commonly prescribed the physician referred back to the pain clinic. Ms. Burke stated she was following protocol that the physician recommended which was to administer Tylenol until she can get the methadone prescription filled. She stated Resident A had gone two weeks without his methadone.

While at the facility I was able to observe Resident A but unable to interview him due to his inability to speak. I noted he was clean and dozing off and on while sitting in the living room.

On 04/27/2026 I spoke with Crystal Weed who is the program manager for the facility. She stated she had not been notified that Resident A had gone without his methadone. She stated she would follow-up with the pharmacy and contact me with more information.

On 05/22/2026, I spoke with Ms. Weed in reference to the complaint. She stated that Ms. Burke was immediately placed on suspension following my contact with Ms. Weed on 04/27/2026. Since then, Ms. Weed along with Licensee Designee Kent Vanderloon contacted the pharmacy to inquire about Resident A not receiving the full amount of his methadone prescription. The pharmacy stated they had provided the full amount and not a partial amount of methadone. Ms. Weed also learned that Ms. Burke had placed over the counter Tylenol in Resident A’s prescription bottle which was labeled as methadone. Ms. Weed stated Ms. Burke’s employment has been officially terminated.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Ms. Burke stated she only received half of Resident A’s methadone. She stated Resident A did not receive his methadone for two weeks. Resident A had a prescription for methadone from a licensed physician and the medication was not provided to Resident A for two weeks.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

During my interview with Ms. Burke, she stated that she had been administering Resident A over the counter Tylenol instead of his methadone. Ms. Weed later explained that Ms. Burke had placed the over-the-counter Tylenol in Resident A’s methadone prescription bottle.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Ms. Burke placed Resident A's Tylenol in his prescription methadone bottle. Resident A's over the counter Tylenol was not kept in the original manufacturer's container.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/15/2026, I conducted an exit conference with Licensee Designee Mr. Vanderloon and reviewed the findings of the investigation. He had no additional questions. He will provide a plan of correction.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend this license remain unchanged.

06/15/2026

Rhonda Richards — Date
Licensing Consultant

Approved By:

06/15/2026

Jerry Hendrick — Date
Area Manager