GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2020

Rebecca Forbes
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS800336566
Investigation #: 2020A0581031
True Blue AFC

Dear Ms. Forbes:

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 (616) 356-0183.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800336566
Investigation #:	2020A0581031
Complaint Receipt Date:	03/20/2020
Investigation Initiation Date:	03/20/2020
Report Due Date:	05/19/2020
Licensee Name:	Rebecca Forbes
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Benjamin Kelly
Licensee Designee:	N/A
Name of Facility:	True Blue AFC
Facility Address:	42124 38th Avenue Paw Paw, MI 49079
Facility Telephone #:	(269) 415-0014
Original Issuance Date:	02/19/2013
License Status:	REGULAR
Effective Date:	09/24/2019
Expiration Date:	09/23/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff at the facility did not follow physician's instructions for Resident A's Coumadin medication.	Yes

III. METHODOLOGY

03/20/2020	Special Investigation Intake 2020A0581031
03/20/2020	Special Investigation Initiated - Letter Email correspondence with Complainant.
03/26/2020	Contact - Telephone call made Interviews with direct care staff via telephone.
03/27/2020	Contact - Document Received Received requested AFC documents via fax.
05/01/2020	Contact - Document Sent Sent email to facility requesting additional documentation.
05/03/2020	Contact - Document Received Received additional documentation from the facility.
05/06/2020	Contact - Document Sent Sent an email to the licensee's human resource dept. requesting additional documentation.
05/08/2020	Inspection Completed-BCAL Sub. Compliance
05/08/2020	Contact - Telephone call made Interview with home manager, Jane Carmey.
05/11/2020	Exit conference with licensee, Rebecca Forbes. Unable to reach using the phone numbers on file.
05/11/2020	Contact – Telephone call made Exit conference with administrator, Ben Kelly.

ALLEGATION:

Direct care staff at the facility did not follow physician's instructions for Resident A's Coumadin medication.

INVESTIGATION:

On 03/20/2020, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged a medical assistant contacted the facility on 03/20/2020 regarding Resident A's Coumadin medication in order to obtain his blood levels in case his Coumadin needed to be adjusted; however, direct care staff members seemed unfamiliar with the resident and the requirements of his Coumadin medication.

On 03/20/2020, I emailed Complainant. Complainant stated Resident A is prescribed Coumadin because he has a history of a pulmonary embolism. Complainant stated the dosage of Coumadin depends on the Prothrombin Time and International Normalized Ratio (PT/INR) of Resident A's blood, which is obtained through a blood draw. Complainant stated in the email that these numbers determine the viscosity or the clotting tendency of Resident A's blood. Complainant stated in the email on 3/19/2020, Resident A's PT/INR levels were high; therefore, direct care staff were instructed to hold his Coumadin. Complainant stated direct care staff were also instructed by medical professionals to recheck Resident A's PT/INR levels on 03/20/2020 and call them back to receive further instructions on his Coumadin medication; however, staff never called on 03/20/2020 to report his PT/INR levels.

On 03/20/2020, I emailed Erica McLaughlin, an outpatient social worker from the hospital in which Resident A is a patient. Ms. McLaughlin confirmed the facility had been instructed on 03/19/2020 to contact the hospital on 03/20/2020 and inform them of Resident A's PT/INR levels; however, no one from the facility ever followed up with the hospital.

On 03/26/2020, I conducted interviews with direct care staff via telephone. I interviewed direct care staff and home manager, Jane Carmey, via telephone. Ms. Carmey stated Resident A's blood is checked once a week to monitor his PT/INR levels, which determines the amount of Coumadin medication he's administered. She stated direct care staff members are to contact the number on the blood draw machine to report his PT/INR reading from his blood draw and wait to hear back from Resident A's physician for further instruction. Ms. Carmey stated when the instruction from the physician's office is given to direct care staff members, they should document the instruction on a note board where the medication is kept so all direct care staff members are aware of the most current Coumadin medication orders for Resident A.

I also interviewed direct care staff members Monica Koblinski via telephone. Ms. Koblinski did not have any specific information regarding Resident A's Coumadin

medication and not contacting his doctor's office on 03/20/2020; however, she was able to discuss how blood draws need to be conducted with Resident A because his PT/INR levels need to be within a certain range in order for him to continue taking his Coumadin medication. She stated she was aware how his doctor's office needs to be contacted and notified of the levels and direct care staff members are to expect a phone with further instructions. She stated she was also aware she needed to relay that information and instruction to other direct care staff, particularly the facility's home manager, Ms. Carmey, when it was received.

I did not interview Resident A via telephone as he was not at the facility when I was interviewing Ms. Carmey and Ms. Koblinski.

On 03/27/2020, I received documentation from the facility, via fax, containing the PT/INR level for Resident A, which was taken on 03/18/2020. According to this read out of Resident A's PT/INR levels, his blood was tested on 03/18/2020 with a reading of 4.1, whereas the prescribed range is between 2 and 3. The readout indicated Resident A's PT/INR reading was "out of prescribed range."

On 05/08/2020, I interviewed Ms. Carmey again via telephone. Ms. Carmey stated the issue had been direct care staff, Gayle Rathbun, worked at the facility on the 03/19/2020 and spoke to Resident A's physician's office about direct care staff rechecking Resident A's PT/INR levels on 03/20/2020 and contacting them back; however, Ms. Rathbun failed to write down the instructions or document her conversation so direct care staff who worked on 03/20/2020 didn't know they were supposed to follow-up with the physician's office.

Ms. Carmey stated Ms. Rathbun doesn't work at the facility that often; however, Ms. Carmey stated she walked her through the whole process of documenting physician's instructions. Ms. Carmey stated there are several areas in the facility, like resident notes, where staff should be documenting physician instructions so that all staff are aware of what they should be doing.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation, direct care staff member Gayle Rathbun, took instructions and recommendations from Resident A's physician's office on 03/19/2020 regarding his Coumadin medication; however, she never took any notes or documented this conversation in Resident A's physician contact record, medication administration record or any document. Subsequently, staff failed to follow the physician's instructions and recommendation to recheck Resident A's PT/INR levels on 03/20/2020 and contact his physician's office to advise them of these readings, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/11/2020, I attempted to conduct an exit conference with the licensee, Rebecca Forbes, via telephone; however, I was unable to reach her using the phone numbers I had on file for her. On the same day, I was able to reach the facility's Administrator, Ben Kelly, and conducted the exit conference with him. Mr. Kelly acknowledged and understood my findings. He had no questions relating to the report.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

05/11/2020

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

05/11/2020

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Dawn N. Timm Date
Area Manager