GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2023

Rebecca Forbes
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS800336566
Investigation #: 2023A1031035
True Blue AFC

Dear Rebecca 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,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800336566
Investigation #:	2023A1031035
Complaint Receipt Date:	04/17/2023
Investigation Initiation Date:	04/17/2023
Report Due Date:	05/17/2023
Licensee Name:	Rebecca Forbes
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Charles Kelly
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:	09/24/2021
Expiration Date:	09/23/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff are not providing proper supervision for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/17/2023	Special Investigation Intake 2023A1031035
04/17/2023	Special Investigation Initiated - Telephone Interview with Complainant.
04/18/2023	Contact - Telephone Interview held with Samantha Kelly.
04/18/2023	Contact - Police Report requested and received.
04/18/2023	Contact - Documents Requested.
04/20/2023	Inspection Completed On-site
04/20/2023	Contact - Face to Face Interviews completed with Anthony Bontrager, Janet Hefright, Karen Lynn, and Resident A.
04/21/2023	Contact - Document Received.
04/26/2023	Contact - Documents Requested and Reviewed.
04/26/2023	Contact – Telephone Interview with Relative #1
04/28/2023	Contact – Documents Requested.
05/08/2023	Contact – Documents Requested.
05/08/2023	Contact – Telephone Interview with Anthony Bontrager and Cheri Cliffman.
05/08/2023	Contact – Documents Reviewed.
05/10/2023	Contact - Face to Face contact with Cheri Cliffman.
05/10/2023	Contact – Documents Received.

05/15/2023	Contact – Telephone Interview with Complainant.
05/17/2023	Contact – Documents Received.
05/18/2023	Contact – Documents Reviewed.
05/19/2023	Exit Conference held with licensee Rebecca Forbes.

ALLEGATION:

Staff are not providing proper supervision for Resident A.

INVESTIGATION:

On 4/17/23, I interviewed Complainant #1 via telephone. Complainant #1 reported she arrived at her home and noticed her dog was outside. She then noticed that the door to the home was open, and the home was in disarray. Complainant #1 reported the refrigerator, freezer, and cupboards were all open. Complainant #1 reported there was a mess in the home that consisted of coffee, oil, and urine on the floors and walls. Complainant #1 reported a resident from True Blue had previously broke into their home and had similar behaviors. Complainant #1 reported she contacted the police, and the police informed her that an individual had eloped from True Blue AFC.

On 4/17/23, I received two incident reports involving Resident A on 4/14/23. The incident report completed by Direct Care Worker (DCW) Janet Hefright indicates that a Van Buren County Sherriff's Deputy came to the home and asked if a client had eloped. The officer asked if he could talk to Resident A, and they were informed that Resident A is nonverbal. The second incident report completed by DCW Karen Lynn indicates while staff was placing a pizza in the oven and doing dishes, they turned to look for Resident A. They looked in the backyard and throughout the house and then walked to the road and saw Resident A walking down the road. Ms. Lynn immediately contacted the owner, and they sent an additional staff member to assist with getting Resident A back to the home. The report also indicates the other staff member scheduled in the home was at an appointment with another resident.

On 4/18/23, I received a telephone call from the company manager Samantha Kelly. Ms. Kelly reported Resident A recently eloped from the home and entered a neighbor's residence. Ms. Kelly reported Resident A's behavior plan requires for staff to have him in "line of sight". Ms. Kelly reported there were two staff scheduled to work and one staff was at an appointment with another resident when Resident A eloped. Ms. Kelly reported she was informed by staff immediately that Resident A eloped. Ms. Kelly reported additional staff were sent to the home to assist with

redirecting Resident A back to the home as the primary staff needed to provide supervision for the other residents in the home.

On 4/19/23, I reviewed the police report involving Resident A. The police report indicates the police responded to a burglary complaint on 4/14/23. The report indicates Resident A illegally entered the home through an unlocked door and he left the home without staff being aware. The police informed DCW Janet Hefright of the incident and advised her to inform the owner of the residence. Ms. Hefright informed the police that Resident A left the home earlier in morning and was found walking down the road. The police closed the case due to Resident A being nonverbal and not competent for legal charges.

On 4/20/23, I interviewed the home manager Anthony Bontrager in the home. Mr. Bontrager reported he was not working when Resident A eloped from the home and broke into the neighbor's home. Mr. Bontrager reported Resident A has a history of eloping and elopes from the home frequently. Mr. Bontrager reported the home has two staff scheduled to ensure proper supervision for Resident A. Mr. Bontrager reported Resident A needs to be in line of sight as he tends to sneak out of the house. Mr. Bontrager reported although there are two staff in the home, he feels that Resident A requires 1:1 staffing due to more frequent elopement attempts. Mr. Bontrager reported Resident A will run from the home when staff are assisting other residents or completing tasks in the home.

On 4/20/23, I observed Resident A in the home. Resident A was not able to be interviewed due to being nonverbal.

On 4/20/23, I interviewed Ms. Hefright in the home. Ms. Hefright reported she was working when a sheriff's deputy came to the home. Ms. Hefright reported the deputy asked her if she was aware that one of the residents had eloped form the home. Ms. Hefright reported she was not working when Resident A had eloped but was aware that he left the home earlier that day. Ms. Hefright reported that having two staff in the home is not enough to meet Resident A's needs. Ms. Hefright reported it is difficult to always have Resident A in line of sight when they are caring for the other residents in the home as well as performing basic tasks. Ms. Hefright reported Resident A will run out the door and to the road very quickly and it is difficult to redirect him.

On 4/20/23, I interviewed Ms. Lynn in the home. Ms. Lynn reported Resident A elopes from the home frequently. Ms. Lynn reported she was the only staff working in the home when Resident A eloped. Ms. Lynn reported Resident A requires line of sight supervision according to his behavior plan. Ms. Lynn reported the other staff member scheduled to work in the home was assisting another resident to an appointment. Ms. Lynn reported she went into the pantry to grab food and when she came back out, she noticed Resident A was gone from the home. Ms. Lynn reported she ran outside to locate Resident A and he was walking down the road. Ms. Lynn reported she was not able to follow Resident A due to other residents being in the

home. Ms. Lynn reported she tried to redirect Resident A back to the home and he continued to run down the road. Ms. Lynn reported she contacted management to request staff assistance to have Resident A return to the home. Ms. Lynn reported Resident A's supervision needs are becoming too difficult to manage even with two staff as he is learning to sneak out of the home when staff are completing tasks or assisting other residents. Ms. Lynn reported she feels Resident A requires 1:1 staffing to ensure line of sight supervision at all times.

On 4/21/23, I received a 30-day notice for Resident A from the home. The notice states the home is not able to meet the level of supervision that is needed in order to ensure the health and safety of Resident A. Resident A has eloped on several occasions which involved going to neighboring homes. Staff have struggled to find ways to redirect attention away from this behavior according to his behavior plan but have had little success.

On 4/26/23, I reviewed the staff schedule for 4/14/23 and there were two staff scheduled to work in the home.

On 4/26/23, I reviewed Resident A's *Behavior Program Plan* and *AFC Assessment Plan for AFC Residents.* The behavior plan states that Resident A has elopement behaviors and staff should provide line of sight supervision in the community to ensure his and other's safety. Resident A's elopement behavior is defined as leaving the AFC home property without assistance of staff. Resident A has shown to be a threat to himself and others in the community. Resident A has eloped from the home multiple times and trespassed onto neighbor's property and damaging their property. A 30-foot radius is suggested, and staff should follow him closely if he attempts to cross the street to ensure target behaviors do not occur when he is unreachable. Resident A's Assessment Plan states that he requires staff assistance in the community for health and safety and requires verbal prompts and 30-foot distance for supervision.

On 4/26/23, I interviewed Resident A's guardian Relative #1 via telephone. Ms. Genia reported she feels that Resident A requires 1:1 supervision due to him frequently leaving the home. Relative #1 reported she has not been informed of all his elopement attempts but acknowledged this is an ongoing issue.

On 4/26/23, I reviewed Incident Reports and Behavior Treatment Plan involving Resident A's attempted and successful elopements. Between May 2022 to May 2023, Resident A has either eloped or attempted to elope 71 times.

On 5/8/23, I reviewed the licensing file and there was a previous investigation in 2022 involving Resident A eloping from the home. The home received a licensing violation for staff not providing appropriate supervision. The home terminated employment of the employee that neglected to provide appropriate supervision at that time.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Based on interviews with staff and the review of supporting documentation, it has been determined that the home does not have the appropriate resources or staffing to retain Resident A in the home and ensure his safety and protection. Despite having two staff scheduled, staff are not able to ensure Resident A's safety at all times. One staff was available in the home at the time Resident A eloped and was not able to provide line of sight supervision once he left the AFC property. This resulted in Resident A breaking into a neighboring home and causing damage to the property. Resident A's elopement behaviors have increased in frequency, and he has planned his elopement when staff are occupied with other tasks. Staff have expressed that it is too difficult to maintain line of sight supervision when meeting the needs of other residents in the home or completing basic tasks. The home has submitted a 30-day notice as they have recognized they are not able to meet Resident A's needs for supervision.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A1031028 and CAP dated 8/15/22**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/8/23, I interviewed Mr. Bontrager on the phone regarding an additional complaint for residents walking to the store unsupervised. Mr. Bontrager reported Resident B, Resident C, and Resident D have free access to the community according to their assessment plans and can go to the store unsupervised.

On 5/8/23, I interviewed the home manager Cheri Cliffman via telephone. Ms. Cliffman reported Resident B, Resident C, Resident D, and Resident E have free community access and can walk to the store independently.

On 5/10/23, I received and reviewed the *AFC Assessment Plan for Residents and Individual Plans of Service (IPOS)* for Resident B, Resident C, and Resident D. The assessment plans indicate that these individuals move independently within the community. Resident B's IPOS requires for staff to provide support to him when needed while participating in community activities. Resident B also has "anxiety that impacts his ability to be successful across all environments" which requires staff to provide prompts and redirection. Resident C's IPOS indicates he has a history of drinking too many fluids causing his sodium levels to drop to dangerous levels. It has been recommended by his physician that he consume no more than 1800ml fluids per day. Staff are responsible for maintaining appropriate dietary intake, providing supports in the community to ensure health and safety, and providing problem solving skills and encouraging the use of coping skills. Resident D's IPOS indicates staff will encourage community integration activities, provide support in the community to ensure health and safety, and provide problem solving skills and encourage the use of coping skills. Resident E's IPOS indicates he can advocate for himself and can navigate the community. Staff are to provide support in the community to ensure health and safety as well as providing problem solving skills and encouraging the use of coping skills.

On 5/15/23, Ms. Cliffman reported the residents walk to a gas station that is approximately 2 miles from the home.

On 5/15/23, I interviewed the Complainant #1 via telephone. Complainant #1 reported she observed two residents from the home walking on the side of the road. Complainant #1 reported there was a dump truck in front of her and the truck swerved to avoid hitting the residents. Complainant #1 reported the residents are walking 2.5 miles one way on a rural road where there are no sidewalks, and the speed limit is 55 miles per hour. Complainant #1 reported she has observed the residents walking to the store frequently and sitting on the side of the road and is concerned they will be hit by a vehicle.

On 5/18/23, I reviewed recent incident reports submitted by the home. An Incident Report dated 5/9/23 states Resident C called 911 because his sodium level

dropped. Resident C was transported to the emergency room for observation and to get his sodium levels back to normal. On 5/11/23, I received an incident report dated 5/11/23 stating Resident C was discharged from the hospital and received treatment for low sodium. On 5/18/23, I received two incident reports dated 5/16/23 stating Resident C and E went out on community access from 4pm to 6pm. Once they returned home, they were avoiding staff. Staff noticed they both smelled like alcohol and Resident C admitted to buying and consuming beer on the walk home.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
For Reference: MCL 400.707	**Definitions; R to T.**
	(5) "Protection", subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision.
ANALYSIS:	Based on interviews and the review of documentation, there are concerns that the home is not ensuring the health, safety, and well-being of the residents in the home. The residents have been observed on multiple occasions walking 2.5 miles in one direction to the store on a rural road with no sidewalks and a 55-mph speed limit. Resident have been observed to be sitting on the side of the road and have allegedly almost been hit by a vehicle. Multiple resident's IPOS read staff will provide support in the community to ensure health and safety. Staff allowing the residents to walk to the store and accessing the community unsupervised, does not allow for staff to provide supports when needed. Two residents in the home recently purchased and consumed alcohol on their walk back to

	the home. This is a safety concern as the residents are walking 2.5 miles while under the influence of alcohol. Resident E requires staff intervention to monitor fluid intake due to him drinking too many fluids and causing his sodium levels to drop to dangerously low levels. Staff are not able to monitor Resident E's fluid intake while unsupervised. Resident E was recently hospitalized due to low sodium levels. Seven days after discharge from the hospital, Resident E returned to the home and reported purchasing and consuming alcohol. Staff were not present to monitor the amount of alcohol Resident E consumed.
CONCLUSION:	**VIOLATION ESTABLISHED**

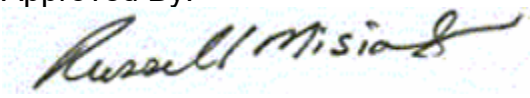
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/15/23

Kristy Duda Date
Licensing Consultant

Approved By:



5/19/23

Russell B. Misiak Date
Area Manager