STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 1, 2022

Rebecca Forbes
130 45th Street
Bloomingdale, MI 49026

RE: License #: AS800336566
Investigation #: 2022A1031028
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,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
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 #:	2022A1031028
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/07/2022
Report Due Date:	08/02/2022
Licensee Name:	Rebecca Forbes
Licensee Address:	130 45th Street Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4500
Administrator:	Charles Kelly
Licensee Designee:	Rebecca Forbes
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 did not provide appropriate supervision to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A1031028
06/07/2022	Special Investigation Initiated - On Site
06/07/2022	Contact - Face to Face Interviews completed with home manager Anthony Bontrager and Resident A.
06/13/2022	Contact - Email exchange with APS worker Mike Hartman.
06/15/2022	Contact – Requested police report.
06/22/2022	Contact - Voicemail left with DCW Brandy Rayborn.
06/29/2022	Contact - Voicemail left with DCW Brandy Rayborn.
07/14/2022	Contact – Document Received.
07/15/2022	Contact - Telephone interview completed with DCW Brandy Rayborn.
07/18/2022	Contact - Email exchange with APS worker Mike Hartman.
08/01/2022	Exit Conference

ALLEGATION:

Staff did not provide appropriate supervision to Resident A.

INVESTIGATION:

On 6/7/22, I interviewed home manager Anthony Bontrager in the home. Mr. Bontrager reported he was not working when the incident occurred. Mr. Bontrager

reported direct care worker (DCW) Brandy Rayborn was working the day Resident A eloped from the home. Mr. Bontrager reported Ms. Rayborn informed him she was preparing a meal when Resident A left the home. Mr. Bontrager reported Ms. Rayborn informed him that she was not aware that he had left the home.

On 6/7/22, I attempted to interview Resident A. Resident A was not able to be interviewed due to being non-verbal. Resident A was observed to be safe and content in the home.

On 6/13/22, I emailed adult protective services (APS) worker Mike Hartman requesting information he obtained from his investigation. Mr. Hartman reported he found a preponderance of evidence that Resident A was neglected by staff as he had left the home unsupervised. Mr. Hartman reported he spoke with the Michigan State Police Officer who returned Resident A home. Mr. Hartman reported the police closed the case due to Resident A being returned home safely.

On 7/14/22, I completed a telephone interview with DCW Brandy Rayborn. Ms. Rayborn reported she was working alone when the incident occurred. Ms. Rayborn reported she was preparing a meal when Resident A left the home. Ms. Rayborn reported she was not aware that Resident A had left the home. Ms. Rayborn reported she later noticed Resident A was gone and went outside to look for him. Ms. Rayborn reported a police officer then pulled into the driveway and they had Resident A in the police car. Ms. Rayborn reported Resident A was located at the neighbor's home who had contacted the police. Ms. Rayborn reported she did not know how long Resident A had been gone. Ms. Rayborn reported Resident A does not typically leave the premises alone, but he does have a history of elopement.

On 7/14/22, I reviewed Resident A's *Assessment for AFC Residents* and *Behavior Program Plan* developed by West Michigan Community Mental Health. The assessment indicates there is not an identified need for additional supervision. The behavior plan indicates that Resident A has a history of elopement which has occurred on average one time per month within the last year. The plan indicates that Resident A receive "line of sight supervision while in the community".

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan**
	(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:	Interviews with staff determined Resident A was not provided with the proper amount of supervision and protection. As identified in Resident A's behavior plan, he requires line of sight supervision. Staff did not provide line of sight supervision which resulted in Resident A eloping from the home without proper supervision within the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

KDuda

7/18/22

Kristy Duda — Date
Licensing Consultant

Approved By:

Russell Misiak

7/19/22

Russell B. Misiak — Date
Area Manager