GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 23, 2021

Dana Forman
Forman AFC, Inc
6585 Berrywine Road
Vanderbilt, MI 49795

RE: License #: AS160378155
Investigation #: 2021A0009025
1 Oak

Dear Ms. Forman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS160378155
Investigation #:	2021A0009025
Complaint Receipt Date:	06/02/2021
Investigation Initiation Date:	06/03/2021
Report Due Date:	07/02/2021
Licensee Name:	Forman AFC, Inc
Licensee Address:	6585 Berrywine Road Vanderbilt, MI 49795
Licensee Telephone #:	(989) 255-6364
Licensee Designee/Admin.:	Dana Forman
Name of Facility:	1 Oak
Facility Address:	2160 M-33 Cheboygan, MI 49721
Facility Telephone #:	(906) 630-0407
Original Issuance Date:	08/07/2015
License Status:	REGULAR
Effective Date:	02/07/2020
Expiration Date:	02/06/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On May 28, 2021, direct care worker Karen Matts transported Resident A in a vehicle without having her use a seatbelt.	Yes

III. METHODOLOGY

06/02/2021	Special Investigation Intake 2021A0009025
06/03/2021	Special Investigation Initiated – Telephone call made to Ms. Amanda Dixon, Community Mental Health recipient rights officer
06/07/2021	Inspection Completed On-site Interviews with home manager Ms. Joyce Hanel and direct care worker Ms. Karen Matts Face to face contact with Resident A
06/22/2021	Telephone call made to licensee designee/administrator Ms. Dana Forman
06/22/2021	Exit conference with licensee designee/administrator Ms. Dana Forman

ALLEGATION: On May 28, 2021, direct care worker Karen Matts transported Resident A in a vehicle without having her use a seatbelt.

INVESTIGATION: I spoke with recipient rights officer Ms. Amanda Dixon by phone on June 3, 2021. She stated that she received information recently regarding a resident living at the 1 Oak adult foster care (AFC) home. On May 28, 2021, direct care worker Ms. Karen Matts did not think Resident A would "fit" into the third row of her Buick Enclave. Ms. Matts did not put the seat up for Resident A, making her sit in what would be the trunk/cargo area of her personal vehicle due to the seat being folded down. Ms. Matts transported the residents since she was the only staff on duty and wanted to purchase cigarettes for herself. It was reported that the other residents transported at that time were seated in a seat with an appropriate seatbelt. Ms. Dixon stated that she already spoke with Ms. Matts regarding the matter. Ms. Matts admitted to her that Resident A did not have a seat to sit on or a seatbelt to wear while riding in the vehicle. Ms. Matts knew that it was not right to transport Resident A in that fashion and agreed not to do it again.

I made an announced site visit at the 1 Oak AFC home on June 7, 2021. I wore personal protection equipment to protect myself and others. I spoke with home

manager Ms. Joyce Hanel at that time. I asked her about the report I received. Ms. Hanel stated that she was not present at the facility when it happened but did hear of it after it occurred. Ms. Hanel stated that she works until 4:00 p.m. and that Ms. Matts works in the afternoon/evenings. Ms. Matts was working by herself later in the day on May 28, 2021, and took the residents with her when she drove to a gas station/convenience store. She used her own vehicle and chose to transport Resident A without having her use a seatbelt. Ms. Hanel denied that this is standard practice for Ms. Matts or for any of the staff at the facility. It was the only time she was aware of this happening before.

I also spoke with direct care worker Ms. Karen Matts while on-site at the facility. Ms. Matts spoke with me and showed me her personal vehicle. She told me that she had transported four residents with her on May 28, 2021. Ms. Matts was the only staff on duty and so took them with her to obtain cigarettes for herself. She transported them to Dave's Place in Cheboygan, Michigan. Ms. Matts showed me that there is a third seat in her vehicle but admitted that she did not want to put the third seat up for a "short trip" into town. She had Resident A sit in the way back of the vehicle during the trip. There was no way for Resident A to use a seat belt while back there without the seat being in the up position. Ms. Matts denied that she had transported residents without them using seatbelts before and promised not to do it again.

I used Mapquest.com to determine that the distance between the 1 Oak AFC home and Dave's Place in Cheboygan, Michigan, is 7.9 miles.

I spoke with administrator/licensee designee Ms. Dana Forman by phone on June 22, 2021. She acknowledged that she was aware that Ms. Matts had transported Resident A without a seatbelt. She said that Ms. Matts received a "write-up", that she went over the agency's policy with Ms. Matts and that she would be providing Ms. Matts with additional training.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was confirmed through this investigation that Resident A did not have her personal needs, including protection and safety, attended to when she was transported in the way back of a vehicle without the use of a seat belt on May 28, 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with administrator/licensee designee Ms. Dana Forman by phone on June 22, 2021. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

06/23/2021

Adam Robarge — Date
Licensing Consultant

Approved By:

06/23/2021

Jerry Hendrick — Date
Area Manager