GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2021

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

RE: License #: AS160378155
Investigation #: 2022A0009009
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
Suite 11
701 S. Elmwood
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 #:	2022A0009009
Complaint Receipt Date:	11/30/2021
Investigation Initiation Date:	11/30/2021
Report Due Date:	12/30/2021
Licensee Name:	Forman AFC, Inc
Licensee Address:	6585 Berrywine Road Vanderbilt, MI 49795
Licensee Telephone #:	(989) 255-6364
Administrator:	Dana Forman
Licensee Designee:	Dana Forman, Designee
Name of Facility:	1 Oak
Facility Address:	2160 M-33 Cheboygan, MI 49721
Facility Telephone #:	(989) 255-6364
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?
Resident A went missing from the home. Law enforcement was called to assist with locating him. Resident A was found a couple miles from home the next morning.	Yes

III. METHODOLOGY

11/30/2021	Special Investigation Intake 2022A0009009
11/30/2021	Special Investigation Initiated - On Site Interview with home manager Ms. Joyce Hanel
12/13/2021	Face to face with Resident A
12/15/2021	Contact – Telephone call made to direct care worker Ms. Karen Matts
12/15/2021	Contact – Telephone call made to licensee designee/administrator Ms. Dana Forman
12/16/2021	Exit conference with licensee designee/administrator Ms. Dana Forman

ALLEGATION: Resident A went missing from the home. Law enforcement was called to assist with locating him. Resident A was found a couple miles from home the next morning.

INVESTIGATION: I conducted an unannounced site visit at the 1 Oak adult foster care (AFC) home on November 30, 2021. I wore personal protection equipment to protect myself and others. Home manager Joyce Hanel was present at the time of my inspection and spoke with me about what occurred with Resident A. She reported that Resident A went missing on November 24, 2021. Ms. Hanel said that she worked until 4:05 p.m. that day. When she left, direct care worker Ms. Karen Matts was working in the front yard. She was pulling up the solar lights and putting them away until next Spring. Ms. Hanel stated that she told Ms. Matts where each of the residents was in the home which they always do at shift change. She told Ms. Matts that Resident A was sitting in a chair in the living room near the kitchen. This is where Resident A usually sits when he is not in his bedroom. At 6:10 p.m., Ms. Matts called her and asked her if Resident A had been in his bedroom when she left. Ms. Matts said she couldn't find him. Ms. Hanel said that she told Ms. Matts to search the home again. She told her to call the licensee designee Dana Forman

and the police if she could not find Resident A. Ms. Hanel went on to say that Resident A has become increasingly confused and has wandered outside before. Because of his increased level of disorientation, they put alerts on the door so that staff could check on him whenever a door opened. I asked her whether there is a requirement for them to check on Resident A every so often. Ms. Hanel replied that she was unaware of any requirement they had to check on any regular basis. Ms. Hanel did say that she, herself, checks on the residents on a regular basis but it is just what she does. As far as she is aware, Resident A's care plan does not require regular checks. They felt that the door alerts were an adequate safeguard for Resident A. The expectation was that staff would always check who came in or out of the house when they heard a door alert. Ms. Hanel stated that Ms. Matts did call law enforcement when it was clear that Resident A was not on the premises. A search was conducted and Resident A was found the next morning. He was found through the woods in the back of a field. Ms. Hanel stated that she knows there are some abandoned homes and barns in that direction. She does not know if he was able to find shelter or not during the night.

On December 13, 2021, I observed Resident A in his new AFC home. He seemed in good health at the time of my visit. The new home had also put alerts on their doors knowing of the possibility that he might wander.

I spoke with direct care worker Karen Matts by phone on December 15, 2021. I asked her what had happened regarding Resident A on November 24, 2021. She said that she was outside when home manager Joyce Hanel left to go home. This was at around 4:00 p.m. Ms. Hanel told her where each resident was including Resident A who she said was sitting in a chair in the living area near the kitchen. Ms. Matts stated that she was outside putting away the solar lights for the season. While she was removing the lights, she was in front yard of the home. She said that she would have seen anyone leave through the two front doors of the home during that time. Ms. Matts did say that she put the lights away in the shed which is "around the corner of the house". Ms. Matts admitted that she would not have been able to see anyone leave by the front doors while she was in the shed. She said that it was only a matter of minutes that she was in the shed. She surmised that Resident A must have left the home during that time. Ms. Matts said that she came in but did not see Resident A in the chair where he had been sitting. She assumed that he was in his bedroom. Ms. Matts began making dinner at that time. When dinner was finished, she went to round up the residents including Resident A. Resident A was not in his bedroom. She searched the rest of the home and did not find him. Ms. Matts called her administrators and then called law enforcement when it was clear Resident A was not on the premises. Resident A was found the next morning after spending the night outside. Ms. Matts stated that Resident A had started becoming confused in recent months. He had come outside on a couple of occasions acting confused. He talked about animals and a fire which had no basis in fact. Ms. Matts was not aware of any requirement for staff to check on residents on a regular basis. They do tell each other at shift change where each resident is. Ms. Matts said that she did know that the alerts on the doors were put up when

Resident A started to act confused. She said that she did always check who had left when she heard a door alert. She stated that she would not have heard the door alert when she was back in the shed.

I spoke with licensee designee/administrator Ms. Dana Forman by phone on December 15, 2021. She stated that Resident A had been in their care since they were licensed. He started having issues with confusion starting in around March of 2021. Resident A was having an extended manic episode and his psychiatrist adjusted his medication significantly. He started experiencing a lack of clarity and disorientation after that. Ms. Forman stated that she had alerts put on the doors after that. I asked her why she had installed the door alerts. She said that it was because Resident A had been acting confused in the home and had left the home on a couple of occasions, acting confused. Staff are supposed to check when they hear the door alert. I asked her about the report that Resident A was found two miles from the home. Ms. Forman stated that she did not know exactly where he was found but knew that the road he was down is a mile away from the home. She did not know how far down that road he was found.

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:	The licensee did not provide supervision, protection and personal care when Resident A was allowed to wander from the home on November 24, 2021. Door alerts had previously been installed at the home due to Resident A's confusion and incidents of him wandering. Resident A was missing for up to two hours before it was determined that he was no longer at the home. Resident A was found the next morning by a search and rescue team who found him in the woods.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee/administrator Ms. Dana Forman by phone on December 16, 2021. I told her of the findings of my investigation and gave her the opportunity to ask questions.

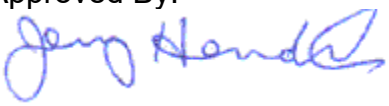
IV. RECOMMENDATION

I recommend no change in the license status.

12/20/2021

Adam Robarge — Date
Licensing Consultant

Approved By:



12/20/2021

Jerry Hendrick — Date
Area Manager