GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

David Call
Freedom Adult Foster Care Corp.
PO Box 1588
Clarkston, MI 48347

RE: License #: AS630012315
Investigation #: 2023A0611010
Gunn Road Home

Dear Mr. Call:

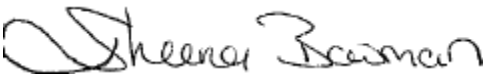
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012315
Investigation #:	2023A0611010
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/24/2023
Report Due Date:	03/21/2023
Licensee Name:	Freedom Adult Foster Care Corp.
Licensee Address:	3990 Bird Road Clarkston, MI 48348
Licensee Telephone #:	(248) 862-5792
Administrator:	David Call
Licensee Designee:	David Call
Name of Facility:	Gunn Road Home
Facility Address:	895 Gunn Road Rochester, MI 48306
Facility Telephone #:	(248) 923-2833
Original Issuance Date:	01/09/1981
License Status:	REGULAR
Effective Date:	06/13/2021
Expiration Date:	06/12/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member Thomas Tucker transported the residents to a store. While Mr. Tucker was in the store, he left the residents in the van unsupervised. One of the residents walked out of the van and wandered off. The resident was found by police.	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0611010
01/24/2023	Special Investigation Initiated - Telephone I spoke with the home manager, Catherine Woodward. Ms. Woodward provided a phone number for staff member, Thomas Tucker. Ms. Woodward stated she is not sure if Adult Protective Services is involved regarding the allegations reported on the incident report.
01/27/2023	Contact - Telephone call made I made a telephone call to staff member Thomas Tucker. The allegations were discussed.
01/31/2023	Inspection Completed On-site I completed an unannounced onsite. I spoke to the home manager, Catherine Woodward. I observed Resident R in his bedroom as he is non-verbal. I attempted to interview Resident D over the phone.
01/31/2023	Contact – Telephone call made I made a telephone call to the AFC group home. I spoke with staff member, Nicole Raeside. Ms. Raeside provided information regarding the residents assessment plans.
01/31/2023	Exit Conference I completed an exit conference with the licensee designee, David Call via email as he was not available over the phone.

ALLEGATION:

Staff member Thomas Tucker transported the residents to a store. While Mr. Tucker was in the store, he left the residents in the van unsupervised. One of the residents walked out of the van and wandered off. The resident was found by police.

INVESTIGATION:

On 01/20/23, I received an intake regarding the abovementioned allegations. The allegations were reported via incident report dated 01/10/23. According to the incident report, staff member Thomas Tucker transported the residents to Wal-Mart to get ice cream. When Mr. Tucker returned to the vehicle, he noticed that Resident R was missing from the vehicle. Mr. Tucker looked for Resident R around the parking lot and could not find him. Mr. Tucker called 911 and was informed that the police had Resident R in their custody. Mr. Tucker provided a description of Resident R and presented his ID to the police. The police released Resident R to Mr. Tucker, and he transported the residents back to the AFC group home. Mr. Tucker will be suspended pending investigation by licensing.

On 01/24/23, I contacted the home manager, Catherine Woodward. Ms. Woodward stated Mr. Tucker did not provide an explanation as to why he transported the residents to the store without another staff member or why he left the residents unsupervised in the vehicle while he was inside the store. Mr. Tucker works midnights, and he transported the residents to the store upon the beginning of his shift in the evening.

On 01/27/23, I made a telephone call to staff member Thomas Tucker. Mr. Tucker has worked for the AFC group home for over 20 years. Mr. Tucker stated he loves the residents, and he treats them like his own kids. Mr. Tucker works the midnight shift and arrives to work at 6:00pm. Regarding the allegations, Mr. Tucker stated he usually brings Resident D a milk shake as they have a close relationship and Resident D doesn't have as much as everyone else. However, on the day in question, Mr. Tucker did not bring Resident D a milk shake because he wanted to buy all the residents ice cream. Mr. Tucker transported all the residents to Wal-Mart around 6:45pm. Mr. Tucker stated he left all four residents in the vehicle unsupervised while he went inside the store. Mr. Tucker was in the store for approximately 15 minutes.

Mr. Tucker stated when he returned to the vehicle, he noticed that Resident R was missing. Mr. Tucker stated he started to panic and went inside the store looking for Resident R. Mr. Tucker then called 911 and provided a description of Resident R. Mr. Tucker was informed that the police found Resident R and he was nearby Wal-Mart in a parking lot. Mr. Tucker apologized to the police and Resident R was released back to him. Mr. Tucker stated Resident R was not injured. Mr. Tucker transported the residents back to the AFC group home. Mr. Tucker informed the home manager and completed an incident report. Mr. Tucker stated he is aware that he should have not left the residents unsupervised in the vehicle. Mr. Tucker stated in the past he has done the

same thing when he has taken the residents to the gas station or McDonald's. Mr. Tucker stated he will never make this mistake again.

On 01/31/23, I completed an unannounced onsite. I spoke with the home manager, Catherine Woodward. I observed Resident R in his bedroom as he is non-verbal. I attempted to interview Resident D over the phone.

On 01/31/23, I spoke with the home manager Catherine Woodward. Ms. Woodward stated Resident R is non-verbal and will not be able to be interviewed. I observed Resident R in his bedroom and walking throughout the AFC group home. Ms. Woodward contacted Resident D at workshop. I spoke with Resident D over the phone. Resident D stated he likes living at the AFC group home and he likes the staff members. Resident D stated he does not have any problems at the AFC group home. Resident D abruptly ended the conversation.

Ms. Woodward stated she does not know if Mr. Tucker will return to the AFC group home however; she prefers that he doesn't due to him putting the residents in immediate danger.

On 01/31/23, I made a telephone call to the AFC group home. I spoke with staff member, Nicole Raeside. Ms. Raeside looked at Resident R and Resident D's assessment plan. Ms. Raeside stated Resident R and Resident D's assessment plan state that both residents must be within arm's length of a staff member while in the community. A copy of this statement on the assessment plans was provided by Ms. Raeside via text message. Ms. Raeside stated all of the residents assessment plan have the same statement.

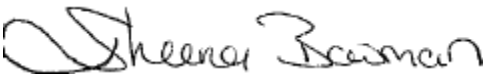
On 01/31/23, I completed an exit conference with the licensee designee, David Call via email as he was not available over the phone. Mr. Call was informed that the allegations will be substantiated, and a corrective action plan will be required.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my findings and the information gathered, there is sufficient evidence to support the allegations. It was confirmed in Resident R and Resident D's assessment plan that both residents should be within arm's length of a staff member while in the community. Staff member, Nicole Raeside stated all of the residents have this statement written on their assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Staff member, Thomas Tucker did not ensure the residents safety or protection as he left four residents in a vehicle unsupervised while he went inside a store. As a result, Resident R left the vehicle and was found wandering around by police.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

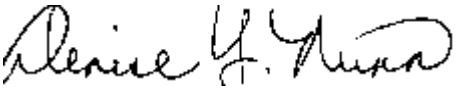
Contingent upon receipt of an acceptable corrective action plan, I recommend no changes in the license status.



01/31/23

Sheena Bowman — Date
Licensing Consultant

Approved By:



02/02/2023

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Denise Y. Nunn — Date
Area Manager