GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2019

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

RE: License #: AS160378155
Investigation #: 2019A0360025
1 Oak

Dear Ms. Forman:

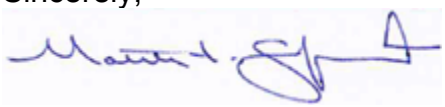
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste 3
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS160378155
Investigation #:	2019A0360025
Complaint Receipt Date:	04/26/2019
Investigation Initiation Date:	04/26/2019
Report Due Date:	05/26/2019
Licensee Name:	Forman AFC, Inc
Licensee Address:	6585 Berrywine Road Vanderbilt, MI 49795
Licensee Telephone #:	(989) 306-1974
Administrator:	Dana Forman
Licensee Designee:	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:	02/07/2018
Expiration Date:	02/06/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility on 4/17/19 to stay one night with his brother. He did not return until 4/22/19 and his guardian and parole officer were not notified he was missing.	Yes
Resident A lost all his medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/26/2019	Special Investigation Intake 2019A0360025
04/26/2019	Special Investigation Initiated - Letter Resident A's Guardian
04/26/2019	Contact - Telephone call made Vicky Rogers, Resident A's guardian
04/29/2019	Inspection Completed On-site Joyce Hanel, home supervisor, Resident A
04/29/2019	Contact - Face to Face licensee Dana Forman
05/16/2019	Contact - Telephone call made Vicky Rogers, Resident A's guardian
5/21/2019	Contact – Telephone Kristin Dudek, Cheboygan County Probation and Parole
05/23/2019	Exit Conference Licensee Designee Dana Forman

ALLEGATION: Resident A left the facility on 4/17/19 to stay one night with his brother. He did not return until 4/22/19 and his guardian and parole officer were not notified he was missing.

INVESTIGATION: On 4/26/2019 I was assigned a complaint from the LARA online complaint system.

On 4/26/2019 I contacted Resident A's guardian, Vicky Rogers. Ms. Rogers stated Resident A has been at the facility since his release from prison in July 2018. She stated he was also living at the AFC home prior to his most recent incarceration. She

stated he is currently on parole and a registered sex offender. She stated he has a history of stroke and short-term memory loss and has been diagnosed with dementia and mental impairment. She stated on Monday 4/22/2019 she was notified that he had left the facility on Wednesday 4/17/2019 to spend one night at his brother's home and had not returned to the facility. She stated he was supposed to return to the facility on 4/18/2019 because he had a scheduled dentist appointment on 4/19/2019 and he missed it. She stated he has admitted to drinking and smoking marijuana while at his brother's home which is across the street from an elementary school in Boyne City. She stated she has notified his parole officer and he is facing possible parole violations. She stated his parole officer stated he is not supposed to leave the facility for more than 5 days at a time. Ms. Rogers stated she did not give permission for Resident A to stay the night at his brother's house on 4/17/2019 but he has gone there in the past for overnight visits.

On 4/29/2019 I conducted an unannounced on-site inspection with licensing consultant Adam Robarge. The home supervisor Joyce Hanel stated Resident A asked to go visit his brother for the night on 4/17/2019. She stated she was busy with another resident and the next thing she knew Resident A's brother pulled into the driveway and she provided Resident A with his medications and he left. She stated Resident A has stayed at his brother's house about 4-5 times in the past. She stated Resident A had a dentist appointment on 4/19/2019 and she expected him back at the facility the next day on 4/18/2019. She stated on 4/18/2019 when Resident A hadn't returned, she attempted to contact him on his cell phone. She acknowledged that she did not contact Resident A's guardian or the police after he did not return on 4/18/2019. She stated she didn't hear from him again until Monday 4/22/2019 when he contacted the home, and the licensee Dana Forman went to Boyne City and picked him up. Ms. Hanel provided me with Resident A's written assessment plan, resident care agreement, health care appraisal and medication administration records.

While at the facility on 4/29/2019 I interviewed Resident A. He stated he has dementia and early onset Alzheimer's as well as a history of stroke. He stated he is not good with dates and times and his mind is stuck in the 90's. He stated he couldn't remember the exact date, but he left the facility and went to visit his brother for the night. He stated he didn't know why he didn't call or answer his phone after leaving the facility and not returning on 4/18/2019. He stated he probably didn't call because he knew he was with his family. Resident A stated he did not intend to cause any problems for the AFC home. He stated they provide good care for him and he doesn't want to see them get into trouble for him not following the rules.

On 4/29/2019 I met with the licensee designee Dana Forman. Ms. Forman stated it was her understanding that Resident A was not going to be returning to the facility until Sunday 4/21/2019. She stated when he didn't return on Sunday, although they had been trying to get into contact with him about his missed dentist appointment, she attempted to reach him on Monday 4/22/2019 and was able to get in touch with him and picked him up. She stated she thought his brother was going to be taking

him to his dentist appointment. She stated she didn't contact his guardian or parole officer until Monday because she anticipated he was staying with his brother until Sunday. She stated when he didn't return on Sunday, she contacted his guardian on Monday after getting in touch with Resident A and confirming he was at his brother's house. She stated she didn't contact the police because she was able to reach Resident A on Monday.

On 5/16/2019 I contacted Resident A's guardian Vicky Rogers. Ms. Rogers stated she has spoken with the licensee and any future overnight visitation with his brother will have to be approved prior to him leaving the facility. She stated Resident A did not test positive for marijuana but did admit smoking it. She stated he may be facing a parole violation because of admitting to smoking marijuana while at his brother's house.

On 5/21/2019 I contacted Kristin Dudek, Resident A's parole officer. She stated the expectation was that the foster care home will notify her anytime Resident A is away from the home overnight. She stated Resident A has spent time with his family in the past on at least 2 occasions and she was always notified by the foster care home. She stated she encourages Resident A to spend time with his family as they are an important support for him. She stated the AFC home brought Resident A to report to her on Wednesday 4/16/2019 and neither Resident A nor the AFC home notified her that he would be spending the night with his brother. She stated she thinks the AFC home assumed he informed her that he would be going to his brother's, but he did not. She stated Resident A suffers from memory issues and will often forget simple instructions that she has repeated to him. She stated the AFC home should have contacted her on Friday morning when Resident A didn't return as expected on Thursday evening. She stated the expectation is that Resident A will inform her when he will be absent from the facility prior to his absence and that the AFC home will confirm with her and his guardian. If Resident A does not return in the approved timeframe the AFC home is to contact her and the guardian immediately.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b) Contact the local police authority.**
ANALYSIS:	The complaint alleged that Resident A left the facility on 4/17/19 to stay one night with his brother. He did not return until 4/22/19 and his guardian and parole officer were not notified he was missing.

	The home supervisor Joyce Hanel stated Resident A left for one day on 4/17/2019 and when he didn't return on 4/18/2019 she attempted to contact his phone but he did not answer. She acknowledged that she did not contact the police or his guardian. Resident A confirmed that he left for one day and did not return until 4/22/2019. He stated he didn't call because he was with family. The licensee Ms. Forman stated she understood Resident A was planning on leaving for the entire weekend and returning on Sunday 4/21/2019. She denied ever contacting the police. She also denied contacting his guardian until Monday 4/22/2019. There is a preponderance of evidence that Resident A was absent without notice and the licensee or direct care staff did not make a reasonable attempt to contact the guardian or the local police authority.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A lost all his medication.

INVESTIGATION: On 4/26/2019 I contacted Resident A's guardian, Vicky Rogers. Ms. Rogers stated when Resident A left the home to visit his brother on 4/17/2019 the facility gave the entire month's supply of his medications to Resident A. She stated when they picked him up on Monday 4/22/2019 he had lost all his medications. She stated she had to special order replacement medications and pay out of pocket because the insurance was already billed for the medications once. She stated Resident A is not able to take his medications by himself and requires the facility to administer his medications. She stated that as a result of this incident, Resident A has gone several days without his medication.

On 4/29/2019 I conducted an unannounced inspection at the facility. The home supervisor Joyce Hanel stated she was busy with another resident when Resident A was getting ready to leave and the next thing she knew, Resident A's brother pulled into the driveway and she provided Resident A with all of his medications and he left. Ms. Hanel stated Resident A does not have a physician's approval to administer his own medications. She stated she assumed he would provide the medications to his brother and that he would administer the medications. She acknowledged that she did not talk with Resident A's brother to confirm that he would be assuming responsibility for Resident A and that he had all the appropriate information regarding his medication and instructions. Ms. Hanel provided Resident A's health care appraisal and medication administration sheets. The medication sheets

documented that Resident A did not receive his medication from 4/18/2019-4/25/2019. Ms. Hanel stated when Resident A returned to the home on 4/22/2019 he did not know where his medications were located. She also provided his written assessment plan. His written assessment plan documents that Resident A needs help taking medications and that staff will administer.

While at the home on 4/29/2019 I interviewed Resident A. Resident A was familiar with his medications but could not remember if he took his medications while out of the facility from 4/18/2019-4/22/2019. He stated he did not know where the medication for the rest of the month went after going to his brother's house.

On 4/29/2019 I interviewed the licensee Dana Forman. Ms. Forman stated when she picked up Resident A from his brother's house on 4/22/2019 she asked about his medications and Resident A and his brother didn't know where they were located.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	The complaint alleged that Resident A lost all his medication. Resident A was given all of his medication on 4/17/2019 by house supervisor Joyce Hanel when he was leaving the facility to spend the night at his brother's. Resident A did not return to the home until Monday 4/22/2019 after being absent without notice. He returned to the home without his medications and unsure of what he did or did not take. Resident A does not have a physician's approval to administer his own medications. His written assessment plan documents that Resident A needs help taking medications and that staff will administer. There is a preponderance of evidence that Resident A required medication while out of the home and the licensee did not assure that the person who assumed responsibility for him had all the appropriate information, medication, and instructions.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 4/29/2019 I requested Resident A's written assessment plan. The written assessment plan was not properly completed. It did not include the name of Resident A's designated representative, birthdate or sex. The written assessment plan was signed by the guardian but was not dated. The licensee did not sign the assessment plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The written assessment plan was not fully completed. There was missing resident identifying information and did not include the licensee signature or date.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 4/29/2019 I requested to see the resident care agreement for Resident A. Ms. Hanel provided Resident A's resident care agreement. The resident care agreement did not include the AFC license number on the top of the form. The resident or designated representative check boxes that apply were not checked. The licensee/licensee designee check boxes that apply regarding providing the resident with a copy of the AFC resident rights, discharge policy, the home's refund agreement and agreement to provide personal care, supervision, protection, in addition to room and board was not checked. The guardian signature was not dated.

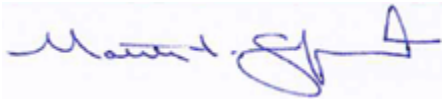
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**

ANALYSIS:	Resident A's resident care agreement was not filled out completely or include the guardian signature date.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/23/2019 I conducted an exit conference with the licensee designee Dana Forman. Ms. Forman stated she concurred with the findings of the investigation. She stated she has discussed the expectations regarding Resident A with both his guardian and parole officer and should have contacted both prior to his visit with his brother and immediately following his absence without notice. She stated they must confirm that Resident A has prior approval from his guardian and parole officer to visit family overnight away from the AFC home. She stated she will also contact the guardian and parole officer if he does not return within the approved timeframe.

IV. RECOMMENDATION

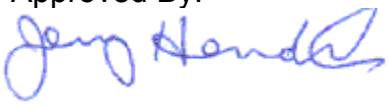
Upon receipt of an approved corrective action plan, I recommend no change in the status of the license.



05/23/2019

Matthew Soderquist Date
Licensing Consultant

Approved By:



05/23/2019

Jerry Hendrick Date
Area Manager