GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

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

RE: License #: AS160378155
Investigation #: 2023A0009014
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 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 (616) 356-0100.

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 #:	2023A0009014
Complaint Receipt Date:	01/17/2023
Investigation Initiation Date:	01/17/2023
Report Due Date:	02/16/2023
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
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:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was held down by staff.	Yes

III. METHODOLOGY

01/17/2023	Special Investigation Intake 2023A0009014
01/17/2023	Special Investigation Initiated – Telephone call made to Community Mental Health recipient rights officer Brandy Marvin
01/23/2023	Inspection Completed On-site Interview with direct care worker Amy Malice Face to face contact with Resident A
01/27/2023	Contact – Telephone call made to CMH recipient rights officer Brandy Marvin
01/27/2023	Contact – Document (email with attachment) received from CMH rights officer Brandy Marvin
02/07/2023	Contact – Telephone call made to CMH recipient rights officer Brandy Marvin
02/07/2023	Contact – Telephone call made to direct care worker Morgan Clark
02/07/2023	Contact – Telephone call made to licensee designee/administrator Dana Forman
02/08/2023	APS Referral
02/07/2023	Exit conference with licensee designee/administrator Dana Forman

ALLEGATION: Resident A was held down by staff.

INVESTIGATION: I spoke with Community Mental Health (CMH) recipient rights officer Brandy Marvin by phone on January 17, 2023. She said that it had been reported to her that Resident A was held down by a staff member last month. She was looking into the matter and was gathering information regarding the incident.

I conducted an unannounced site visit at the 1 Oak adult foster care home on January 23, 2023. Direct care staff member Amy Malice was present at the time of my visit and spoke with me at that time. I asked her about the report of Resident A being held down by a staff person in December of 2022. Ms. Malice seemed to know exactly which incident I was referring to. She said that she was present when it happened and observed some of the incident. She said that it was her and direct care worker Morgan Clark who were working that day. They were doing pedicures with the female residents at the time. Ms. Malice was doing a pedicure with Resident A and Resident A was having good behavior during the pedicure. The other residents were discussing who would be going next and hearing this aggravated Resident A. She and Ms. Clark told Resident A that if she did not stop yelling at the other residents, she would need to take a "quiet time" in her room. That seemed to further anger Resident A. Another resident entered the area to brush her teeth during the commotion and Resident A "body checked" her into a doorframe. Resident A ended up in her room but continued to be highly agitated. Ms. Clark went into her room to try to calm her down. It started with Ms. Clark trying to talk to Resident A. Ms. Malice said that she heard a physical altercation begin in the room so she walked in. She observed Ms. Clark on her knees next to Resident A's bed holding Resident A's wrists. Resident A was sitting on the bed at that point. Resident A's arms were across her body and both Morgan and Resident A had a hold of each other's wrists. Ms. Malice said that she went to call the licensee designee/administrator Dana Forman. After she got Ms. Forman on the phone, she went back to Resident A's room. Resident A was crying and hugged her, and kept saying that she was sorry for what she did. She was able to get her calmed down and had her lying on her bed. She said that Resident A was fine as soon as she had their undivided attention again. Resident A never said anything about being hurt at that time. Ms. Malice denied that she saw any injuries to Resident A. The next day, however, Resident A complained that her side hurt. Ms. Forman did not think she needed to go immediately to see a doctor but then agreed to take her when Resident A continued to complain. There was no sign of injury other than what Resident A was saying. After Resident A was taken in for evaluation, Ms. Forman reported that they had diagnosed her with a "pulled muscle". Ms. Malice said that Ms. Clark is not as experienced as the rest of them in dealing with Resident A and does not always try to redirect Resident A when Resident A becomes upset. Resident A can be quite challenging at times but can be redirected if one persists with her.

I spoke with CMH recipient rights officer Brandy Marvin by phone on January 27, 2023. She said she contacted instructor Linda Kleiber with CMH who teaches staff Crisis Prevention Institute (CPI) techniques. After hearing the details of how Ms. Clark intervened with Resident A, Ms. Kleiber did not believe that Ms. Clark used proper CPI techniques. Ms. Marvin stated that she would send me a statement from the CMH instructor, Linda Kleiber. Ms. Marvin stated that she also had the discharge report from when Ms. Forman took Resident A to Urgent Care following the incident at the home. She said that she would also provide me a copy of that report.

Ms. Marvin provided me with a copy of a discharge report from Munson Healthcare Indian River Clinic dated January 3, 2023. Resident A was diagnosed with a sprain of the right side of her back. Ms. Marvin also provided me with the following statement detailing her discussion with Ms. Linda Kleiber. The statement read as follow: *'This writer shared witness statements describing the incident (between Ms. Clark and Resident A) with NCCMH Safety Specialist and Nonviolent Crisis Intervention instructor, Linda Kleiber. It was her professional opinion, There is not an approved CPI/NVCI technique that allows staff to hold a recipient down or hold their wrists while the recipient is in a laying down position. Holding wrists can only be done in a standing or sitting position. This was not an approved technique and I see no justifiable reason for it and even more so because the client was not resisting.'*

I spoke again with CMH recipient rights officer Ms. Brandy Marvin by phone on February 7, 2023. She said that she did substantiate a resident rights violation due to direct care worker Morgan Clark using an improper physical management technique with Resident A. She said that Ms. Clark had admitted to her that Resident A had been lying on the bed at one point while they held each other's wrists. Ms. Clark also admitted that she had not used a proper intervention and was scheduled to receive retraining in CPI techniques. Ms. Marvin said that she also did not believe that either care worker tried to redirect Resident A to any significant degree before Ms. Clark intervened physically. She went on to say that Resident A's CMH Behavioral Treatment Plan directs staff at the facility to use various redirecting techniques when Resident A becomes agitated.

I spoke with direct care worker Ms. Morgan Clark by phone on February 7, 2023. I asked her to discuss the incident that occurred when she used physical intervention with Resident A in December of 2022. Ms. Clark said that she was aware of what incident I was speaking about. Ms. Malice had been giving Resident A a pedicure. Ms. Clark said that Resident A was "mean and threatening" to the other residents. She and Ms. Malice told Resident A that she should "go to her room to calm down". Resident A did go to her room but continued to yell and scream once she was in her room. Ms. Clark said that she went into Resident A's room to try to calm her down. When another resident walked by in the hallway, Resident A hit and pushed her. Ms. Clark said that she responded by putting her arm between the two residents. In the process, Resident A grabbed both of her wrists. She said that they then "backed into the room". She said that Resident A sat on her bed. They both had a hold of each other's wrists at that point. Their arms were both crossed. Resident A laid back on her bed so she was in a prone position. Ms. Clark said that she was kneeling by the bed continuing to hold her wrists as Resident A held her wrists. She said that she rested her hands on Resident A because that was all she could do at that point. She initially stated that they stayed in that position for two minutes and then said that it was probably more like one and a half minutes. Ms. Clark said that she was trying to talk to Resident A during that time saying things like "you need to calm down" and "you can't go around hurting other people like you did". Resident A started crying and eventually let go of her wrists. She and Ms. Malice gave her an as-needed medication at that point and Resident A went to sleep. I asked Ms. Clark

what had happened since that time. She said that she has been suspended from her job until such time that she can retake her CPI training. I asked her if she thought she had done anything wrong. She said that she "did not use a proper hold". She said that she shouldn't have stood in front of Resident A to let her grab her, she should have gotten behind her and used a proper hold from behind. She denied that there was any evidence that Resident A was harmed in any way from the incident. Resident A never said anything about being hurt that day or the morning of the next day. Resident A started to say that her side or rib hurt the next afternoon.

I then spoke with licensee designee/administrator Dana Forman. She said that she felt that Ms. Clark tried to defend herself and the other residents from Resident A. She did not handle it like she, herself, might have handled it but thought she did the best she could at the time. She acknowledged that Ms. Clark lacks experience which led her handle the situation in a less than ideal fashion. She said she thought that Ms. Clark should have used a different intervention technique. Ms. Clark is signed up to go through CPI training again. I asked her about her taking Resident A into Urgent Care. She said that Resident A said that she was sore after the weekend in which the incident occurred. Resident A was doing exercises with Ms. Clark over the weekend, including sit-ups and push-ups. She wanted me to know that she suspected that this might have contributed to her being "sore". There was no evidence that Resident A was hurt besides her verbalizing that her side or back hurt. The medical personnel did not take x-rays or anything but just diagnosed her as having a "pulled muscle" based on Resident A verbalizing of having some pain in her back. Ms. Forman said that it was possible that Resident A did pull a muscle when she pulled Ms. Clark back towards her during the incident.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(3) Crisis intervention shall be used to the minimum extent and the minimum duration necessary and shall be used only after less restrictive means of protection have failed.
ANALYSIS:	It was confirmed through this investigation that crisis/physical intervention was used in December of 2022 with Resident A before less restrictive means were used. Only minimal means of redirection were used with Resident A before she was told to go to her room to "calm down" and "take a quiet time". It was reported that direct care worker Morgan Clark lacks experience and does not have a lot of skill when trying to redirect Resident A. The CMH crisis intervention trainer did not feel that the technique that Ms. Clark used with Resident A was a proper hold. Both Ms. Clark and the licensee designee acknowledged that Ms. Clark may not have used a proper intervention technique at that time.

CONCLUSION:	VIOLATION ESTABLISHED

An exit conference was conducted with licensee designee/administrator Dana Forman by phone on February 7, 2023. I told her of the findings of the investigation and gave her the opportunity to ask questions. She said that Ms. Clark was currently suspended until such time that she completes CPI training again.

IV. RECOMMENDATION

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

2/8/2023

Adam Robarge Date
Licensing Consultant

Approved By:

2/8/2023

Jerry Hendrick Date
Area Manager