GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 20, 2020

Nicholas Burnett
Flatrock Manor, Inc.
2360 Stonebridge Drive
Flint, MI 48532

RE: License #: AL250397136
Investigation #: 2020A0501014
Flatrock Manor of Fenton

Dear Mr. Burnett:

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 (810) 787-7031.

Sincerely,

Crecendra Brown

Crecendra Brown, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-0965

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250397136
Investigation #:	2020A0501014
Complaint Receipt Date:	12/26/2019
Investigation Initiation Date:	12/26/2019
Report Due Date:	02/24/2020
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Flatrock Manor of Fenton
Facility Address:	17600 Silver Parkway Fenton, MI 48430
Facility Telephone #:	(810) 354-8581
Original Issuance Date:	05/07/2019
License Status:	REGULAR
Effective Date:	11/07/2019
Expiration Date:	11/06/2021
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On December 21, 2019, Resident A walked away from the facility at night and staff were outside looking for her with flashlights.	Yes

III. METHODOLOGY

12/26/2019	Special Investigation Intake 2020A0501014
12/26/2019	Special Investigation Initiated - Letter
12/30/2019	Contact - Document Sent Requested Police Report from the Fenton Police Department.
12/30/2019	Contact - Telephone call received Complainant 1.
01/02/2020	Contact - Document Received Police Report from the Fenton Police Department.
02/07/2020	Inspection Completed On-site Staff Kelsey Dimick, Floor Manager Nick Brazeal, and Resident A.
02/12/2020	APS Referral APS Referral made to Centralized Intake.
02/12/2020	Contact - Telephone call made Staff Tyree Watson.
02/12/2020	Contact - Telephone call made Staff Dezmon Griffen.
02/12/2020	Contact - Telephone call made Staff Erica Jackson.
02/12/2020	Exit Conference Licensee Designee Nick Burnett.

ALLEGATION:

On December 21, 2019, Resident A walked away from the facility at night and staff were outside looking for her with flashlights.

INVESTIGATION:

An incident report dated 12/21/2019 at 8am reports that Resident A was having a rough night after she had a fight with another peer. Resident A took a shower and then showed staff a sore that had re-opened on her leg. Staff treated it and Resident A stayed in her bedroom. During a welfare check, Staff noticed that Resident A was not in her room. Staff searched the facility, the perimeter of the property and drove around looking for Resident A, but could not find her. Police notified management that they found Resident A and staff went to go pick her up. Resident A refused to get into the company van and assaulted the police. The police called an ambulance and Resident A was taken to McLaren Hospital for psychiatric evaluation for the remainder of the shift. Resident A returned back to the facility later that night. Staff found a faulty elopement bar on the back door to the facility. Maintenance was contacted to come fix the door.

The Fenton Police Department Report dated 12/21/2019 indicates that they received a call at 8:30 pm. Resident A was seen wearing pajamas, agitated and talking to herself walking on the north side of between Tim Hortons and Andiamo's. More calls started coming in from different people about Resident A. The police found Resident A near a hotel and she was not cooperative. Police receive a call 15 minutes later that Flatrock was looking for someone that matched Resident A's description. Resident A would not tell police where she was from and started walking northbound on North Leroy Street in Fenton. Officer Jones kept a visual on Resident A and when staff arrived on the scene Resident A refused to go with them. When the ambulance came, Resident A refused to get into the ambulance. Officer Jones and Officer Whitman placed handcuffs on Resident A and escorted her to the ambulance. Resident A was sedated by the EMS staff due to her attempting to escape the restraints. Resident A calmed down and the handcuffs were removed. Resident A was transported to McLaren Hospital and Flatrock Manor staff followed.

I reviewed Resident A's assessment plan. Resident A is to be supervised in the community by staff. Resident A has a history of physical aggression towards others and self-injurious behavior. Resident A also has a history of eloping and walking away from supervision of staff.

On December 30, 2019, I conducted a phone interview with Complainant 1. Complainant 1 stated that Flatrock Manor of Fenton staff were outside behind the building with flashlights looking for a missing resident. Complainant 1 stated that the police found the missing resident. Complainant 1 stated that she doesn't understand how the resident was able to get out of the facility without the staff knowing it. Complainant 1 stated that the staff were panicking, and she was sure the resident was not supposed to be out with no staff with her.

On February 7, 2020, I conducted an investigation at Flatrock Manor of Fenton. Staff Kelsey Dimick, Floor Manager Nick Brazeal, and Resident A were interviewed.

Staff Kelsey Dimick stated that she started working at the facility January 1, 2020. Staff Dimick stated that she is new to working at the facility as the Administrative Assistant. Staff Dimick stated that Resident A is her own guardian. Staff Dimick stated that she has no information on the allegation.

Floor Manager Nick Brazeal stated that the back door to the facility was not working properly and the alarm was not working. Floor Manager Brazeal stated that Resident A went out of the back door that was broken. Floor Manager Brazeal stated that once staff realized she was gone, they started looking for her immediately. Floor Manager Brazeal stated that Resident A was found in downtown Fenton. Floor Manager Brazeal stated that Resident A ended up having to go to the hospital because she refused to get into the facility van. Floor Manager Brazeal stated that the broken door has been fixed and he showed me that it was working properly with the alarm sounding when you open it. Floor Manager Brazeal stated that they are not sure how long Resident A was missing when they discovered she had eloped from the facility.

I examined the back door. The back door has a single doorknob and when working properly the alarm sounds as soon as you open it. The back door also has a number keypad connected to it that when the keypad code is entered the door can be opened without the alarm sounding. Floor Manager Brazeal and Resident A stated that the door alarm was not working when Resident A eloped and that is why Resident A was able to leave out the door undetected by staff.

Resident A stated that the day she eloped she had a behavior and felt like no one wanted her there. Resident A stated that she walked right out of the back door around 7:30 pm and headed for the road. Resident A stated that she walked to downtown Fenton. Resident A stated that the police saw her and followed her to a gas station while she walked. Resident A stated that the police eventually cornered her at someone's property. Resident A stated that Licensee Designee Nicholas Burnett and someone else came to where she was located. Resident A stated that she was handcuffed and taken to the hospital. Resident A stated that she returned to the facility that same night. Resident A stated that the door has now been fixed and staff do 15-minute checks on her. Resident A stated that she tried to fight the police and that is why they handcuffed her. Resident A stated that they back door had been broken for a while and other residents had walked out of it too. Resident A stated that she meant to head for the highway so she could jump in front of traffic, but she went the wrong way.

On February 12, 2020, I conducted a phone interview with Staff Tyree Watson. Staff Tyree Watson stated that staff were doing room checks when they discovered Resident A was gone. Staff Watson stated that some residents did not close the door after they were done smoking and Resident A went out of the door. Staff Watson stated that that the police called and said they found her. Staff Watson stated that they went to go get

Resident A, but she refused to get into the van. Staff Watson stated that the police called an ambulance and Resident A went to the hospital.

On February 12, 2020, I attempted to contact Staff Dezmon Griffen. Staff Griffen's phone mailbox was full and would not let you leave a voice message. The phone rang several times, but kept going to voicemail. To date, I have received a return phone call from Staff Griffen.

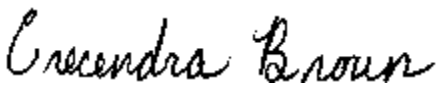
On February 12, 2020, I attempted to contact Staff Erica Jackson. The phone kept going to voicemail and I left a detailed message for her to call me back. To date, I have not received a return call from Staff Jackson.

On February 12, 2020, I conducted a phone exit conference with Licensee Designee Nicholas Burnett. I informed Mr. Burnett that I would be requesting a corrective action plan. Mr. Burnett did not say if he would be completing the corrective action plan.

APPLICABLE RULE	
R 400.15305	**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:	Floor Manager Brazeal and Resident A stated that the back door alarm was not working when Resident A eloped and that is why Resident A was able to leave out the door undetected by staff. Complainant 1, Resident A, Floor Manager Nick Brazeal and Staff Tyree Watson stated that on December 21, 2019 Resident A walked away from the facility unsupervised by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

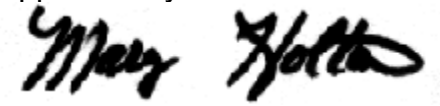
Upon the receipt of an acceptable and approved corrective action plan, no change to the license status is recommended.



February 19, 2020

Crecendra Brown — Date
Licensing Consultant

Approved By:



February 20, 2020

Mary E Holton — Date
Area Manager