GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2021

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

RE: License #: AS630391550
Investigation #: 2021A0611020
Brandon East

Dear Mr. Burnett:

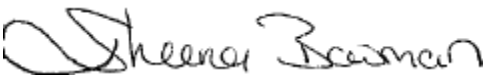
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630391550
Investigation #:	2021A0611020
Complaint Receipt Date:	05/18/2021
Investigation Initiation Date:	05/19/2021
Report Due Date:	07/17/2021
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Nicholas Burnett
Licensee Designee:	Nicholas Burnett
Name of Facility:	Brandon East
Facility Address:	301 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 964-1430
Original Issuance Date:	04/24/2018
License Status:	REGULAR
Effective Date:	10/24/2020
Expiration Date:	10/23/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/11/2021, Resident J was having a behavior and was injured during the behavior. A staff member pushed Resident J causing the injury.	Yes

III. METHODOLOGY

05/18/2021	Special Investigation Intake 2021A0611020
05/19/2021	Special Investigation Initiated - Telephone I made a telephone call to recipient rights worker, Lisa Jolly. Ms Jolly stated she will send me a copy of the pictures of Resident J's injuries and her notes.
05/20/2021	Contact - Document Received I received a copy of pictures of Resident J's injury to his eye.
05/25/2021	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident J, staff member, Anquawn Burt, Resident P, and Resident W.
05/27/2021	Contact - Telephone call made I sent a text message to the recipient rights specialist, Lisa Jolly. Ms. Jolly stated she will be substantiating her investigation.
05/27/2021	Contact - Telephone call made I made a telephone call to the licensee designee, Nicholas Burnett. Mr. Burnett stated he will provide a copy of Resident J's medical records, incident report, the complete name of staff member V, and confirm if Mr. Brown was fired.
05/28/2021	Contact - Document Received I received a copy of the incident report, discharge summary, termination record for staff member, Marquese Brown, and contact information for the other staff that were on shift.
05/28/2021	Contact - Telephone call made I made a telephone call to the home manager, Gary Kittle. The allegations were discussed.

05/28/2021	Exit Conference I completed an exit conference with the licensee designee, Nicholas Burnett via voice message.
06/01/2021	Contact-Telephone call made I made a telephone call to the licensee designee, Nicholas Burnett regarding a copy of Resident J's assessment plan. Mr. Burnett confirmed that an outside-inside hold is apart of a CPI intervention.
06/02/2021	Contact-Document Received I received a copy of Resident J's assessment plan.

ALLEGATION:

On 5/11/2021, Resident J was having a behavior and was injured during the behavior. A staff member pushed Resident J causing the injury.

INVESTIGATION:

On 05/18/21, I received an intake regarding the abovementioned allegations.

On 05/20/21, I received a copy of pictures of Resident J's injury to his right eye. Resident J's right eye was observed to be completely black and purple.

On 05/25/21, I completed an unannounced onsite. I interviewed Resident J, staff member, Anquawn Burt, Resident P, and Resident W.

On 05/25/21, I interviewed Resident J. Regarding the allegations, Resident J stated staff member Mark (Marquese) hurt his eye and cheek. Initially Resident J stated he did not know how Mark hurt his eye but, he later stated Mark punch him on the cheek one time. Resident J stated he does not know why Mark hit him. Resident J stated after Mark hit him, he went to the hospital. Resident J stated Mark quit working at the AFC group home today. Resident J stated his eye does not feel better. Resident J's right eye was observed to be red and appeared to be healing. Resident J's cheek was a light greenish color.

Resident J stated he told staff member, Quan about the incident. Resident J stated he has never been hit by a staff member before since he has lived at the AFC group home. Resident J stated he wants to move to a different home so that he can go to a different school.

On 05/25/21, I interviewed staff member Anquawn (Quan) Burt. Regarding the allegations, Mr. Burt stated the incident took place after his shift ended. Mr. Burt stated the following day he saw that Resident J had a black eye. Resident J told Mr. Burt that staff member Marquese Brown hit him. Mr. Burt gave Resident J a Tylenol for the pain

and an ice pack. Mr. Burt stated Resident P and Resident W also told him what happened. Mr. Burt was informed by the other residents that Resident J wanted to use the telephone and he tried to take the phone from another resident. Mr. Brown intervened and Resident J started to spit and kick at Mr. Brown. Mr. Brown then punched Resident J in the eye. This happened in the kitchen. Mr. Brown also dragged Resident J on the floor, tipped a couch on top of him, and used a water bottle to pour water on him. Mr. Burt stated Mr. Brown was fired.

On 05/25/21, I interviewed Resident P. Regarding the allegations, Resident P stated Resident J got upset and Mr. Brown and staff member Ms. V tried to calm him down. Mr. Brown hit Resident J because Resident J tried to spit on Mr. Brown and Ms. V. Mr. Brown punched Resident J in his right eye, threw a couch on him, and poured water on him. Ms. V hit Resident J on his hand and arm. Resident P stated Mr. Brown and Ms. V were fired. Resident P stated Mr. Brown had put him in a choke hold in the past.

On 05/25/21, I interviewed Resident W. Regarding the allegations, Resident W stated he does not know all of the details but Mr. Brown tipped a couch on top of Resident J and he dragged him on the floor to the laundry room. Mr. Brown smacked him with both hands-on Resident J's cheek which is how he got a black eye.

On 05/28/21, I received a copy of the incident report, discharge summary, termination record for Mr. Brown, and contact information for the other staff members who were on shift on the day of the incident.

The incident report is dated for 05/11/21. According to the incident report, Resident J was inside another resident's bedroom and they started arguing over the telephone. The staff redirected and separated the residents. Resident J went into the common area and called his parents on his iPad. Resident J was told by his parents that if he did not calm down, he would not be able to come home later. Resident J started to throw objects at his peers. The staff redirected and separated Resident J and tried to validate his feelings. Resident J would not calm down. Resident J became aggressive towards staff by trying to punch, kick, and bite staff.

The staff utilized an outside-inside hold on Resident J. Resident J lunged at staff and staff moved out of the way and Resident J hit his face on the edge of the wall. Resident J's face started to swell up and he was taken to the hospital. The other staff members that were on shift were Maalik Mitchell and Vinencia Bamfield. Mr. Mitchell and Ms. Bamfield were terminated as well.

According to the termination record dated for 05/18/21. Mr. Brown was terminated on 05/18/21 for failure to comply with company policy.

According to the discharge summary dated 05/12/21 at 12:12 am, Resident J was seen at McLaren Lapeer for a facial and scalp contusion.

On 05/28/21, I made a telephone call to the home manager, Gary Kittle. Regarding the allegations, Mr. Kittle stated he was not present during the incident. Mr. Kittle stated Mr. Brown wrote the incident report. Mr. Kittle asked Mr. Brown several times if he hit Resident J and his response was no. Mr. Kittle told Mr. Brown that whatever he writes in the incident report must be the truth. Mr. Kittle stated per Resident J's assessment plan, staff are permitted to utilize an outside-inside hold if Resident J is a danger to himself or others. Mr. Kittle stated that he participated in a debriefing meeting with Mr. Brown and shortly after the meeting, Mr. Kittle was instructed to terminate Mr. Brown for not following protocol. Mr. Kittle was not given details as to why Mr. Brown was terminated. Mr. Kittle stated Mr. Mitchell and Ms. Bamfield were also terminated but he is not sure why. Mr. Mitchell had attendance issues and; it is possible Ms. Bamfield was terminated due to what transpired during the incident.

On 05/28/21, I completed an exit conference with the licensee designee, Nicholas Burnett via voice message. Mr. Burnett was informed the allegations will be substantiated and a corrective action plan will be required.

On 06/02/21, I received a copy of Resident J's assessment plan. The assessment plan indicates that Resident J has a history of mildly acting out aggressively towards others by hitting, kicking, pushing, and biting. Resident J may also pick up items and throw them. Staff are expected to provide verbal redirection and encouragement of coping strategies. In the event these measures are unsuccessful, staff are trained in crisis prevention institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills.

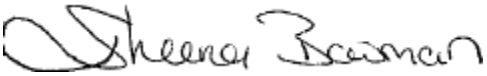
APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	According to the incident report dated 05/11/21, the staff utilized an outside-inside hold on Resident J when he became aggressive towards other residents and staff. According to Resident J's assessment plan, Resident J has a history of mildly acting out aggressively. The assessment plan

	indicates that in the event Resident J cannot be verbally redirected, staff are trained to utilize crisis prevention institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	According to Resident J, Mr. Brown punch him on the cheek. Resident P and Resident W also confirmed that Mr. Brown hit Resident J on the face. Following the incident on 05/11/21, Resident J was taken to the hospital and was seen for a facial and scalp contusion. On 05/20/21, I received pictures of Resident J's black eye. On 05/18/21, Mr. Brown was terminated for not following company policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

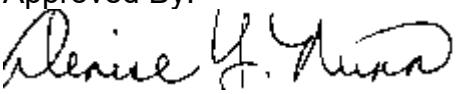
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman
Licensing Consultant

06/02/21
Date

Approved By:



06/07/2021

Denise Y. Nunn
Area Manager

Date