GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 10, 2021

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

RE: License #: AM250402509
Investigation #: 2021A0582037
Fenton South

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM250402509
Investigation #:	2021A0582037
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	09/24/2021
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:	Fenton South
Facility Address:	Suite 2, 17600 Silver Parkway Fenton, MI 48430
Facility Telephone #:	(810) 354-8581
Original Issuance Date:	03/09/2021
License Status:	TEMPORARY
Effective Date:	03/09/2021
Expiration Date:	09/08/2021
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
On multiple occasions, including 06/05/2021, Resident A has not been able to locate his assigned 1:1 staff.	Yes
On 07/24/2021, Direct Care Worker (DCW) Brian Britt shoved Resident A to the ground and pulled his pants off him.	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A0582037
07/28/2021	Special Investigation Initiated - On Site
07/14/2021	Contact – Telephone call made With Complainant
07/16/2021	Contact – Telephone call made With Najsha Fox, Home Manager
07/16/2021	Contact – Telephone call made With DCW Kaleb Glaza
07/28/2021	Contact - Face to Face With Resident A
07/30/2021	Contact - Document Sent Email communication with Kentera Patterson, Recipient Rights Officer
07/30/2021	Contact - Telephone call made With DCW Jacob Browning
07/30/2021	Contact - Telephone call made With DCW Demetrius Noakes
07/30/2021	Contact - Telephone call made With DCW Taleah Moye
07/30/2021	Contact - Telephone call made

	With DCW Nevaeh Greer
07/30/2021	Contact - Telephone call made With DCW Tiffany Reed
08/04/2021	Contact - Document Received With Kentera Patterson, Recipient Rights Officer
08/31/2021	Contact - Telephone call made With Guardian A1
09/09/2021	Inspection Completed-BCAL Sub. Compliance
09/09/2021	Exit Conference With Carrie Aldrich, Administrator
09/10/2021	Corrective Action Plan Requested and Due on 09/27/2021

ALLEGATION:

On multiple occasions, including 06/05/2021, Resident A has not been able to locate his assigned 1:1 staff.

INVESTIGATION:

On 07/14/2021 I interviewed Complainant, who stated that Guardian A1 was talking to Resident A at the time that he could not find his 1:1 staff member on 06/05/2021. Complainant stated that Resident A was trying to “track down” his assigned staff member. Complainant stated that Resident A requires a 1:1 staff member on first and second shift. Complainant stated that the issue was confirmed by Manager Najsha Fox, who stated that she met with staff members and informed them that if they were assigned to a resident for 1:1, they must be present at all times. Complainant stated that Ms. Fox informed him that these incidents were occurring prior to her becoming manager.

On 7/16/2021, I interviewed Najsha Fox, Manager. Ms. Fox stated that she was not working at the time but was informed that the facility was short staffed on 06/05/2021 and did not have a 1:1 for Resident A. Ms. Fox stated that she spoke with Guardian A1 about Resident A not having a 1:1 staff and corrected the issue. Ms. Fox stated that the issue has not occurred since 06/05/2021 and she ensures that Resident A always has a 1:1 staff. Ms. Fox stated that the facility typically has two 1:1 staff members and three other staff on shift, for a total of five direct care workers.

On 07/16/2021, I interviewed Direct Care Worker Kaleb Glaza, who stated that he has never left Resident A alone while being his 1:1 staff. Mr. Glaza stated that whenever he is on shift, he always sees a 1:1 staff with Resident A, and Resident A has never asked him where his 1:1 staff was located.

On 07/28/2021, I conducted an unannounced, onsite inspection at the facility. I observed that Resident A had a 1:1 staff member at the time. I interviewed Resident A, who stated that there are times that he cannot locate his 1:1 staff. Resident A stated that this typically happens on second shift. Resident A stated that when first shift leaves, there would be times that there would be no second shift staff for him. Resident A stated that sometimes the staff member would go to the bathroom and never return or leave without telling him. Resident A stated that he has told staff members not to leave him. Resident A stated that he could not recall the names of staff members who would leave him alone, just that he could not find the person.

I reviewed Resident A's *Assessment Plan* dated 12/31/2020, which documented that Resident A "is provided with enhanced staffing 1:1 (16 hours a day, first and second shift) who monitor from 10-15 feet distance." Additionally, I reviewed Resident A's *Individual Plan of Service* (IPOS) dated 12/09/2020, which documented that he has "1:1 staffing provided for 16 hours per day to assist [Resident A] in being safe in his home and within the community." I reviewed the Structured Daily Routine staff document for Resident A, dated 06/05/2021, which documented that Neveah Greer and Demetrius Noakes were the 1:1 staff for Resident A for first and second shift, respectively.

On 07/30/2021, I interviewed Direct Care Worker Jacob Browning in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Mr. Browning stated that there have been shifts that he observed where Resident A did not have a 1:1 staff assigned to him. Mr. Browning stated that on days when Resident A does have a 1:1 staff assigned, there are certain staff members who do not stay with Resident A the entire shift.

On 07/30/2021, I interviewed Direct Care Worker Demetrius Noakes in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Mr. Noakes stated that he has not observed an occasion in which Resident A was without a 1:1 staff and Resident A has never asked him where his 1:1 staff was located.

On 07/30/2021, I interviewed Direct Care Worker Taleah Moye in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Ms. Moye stated that there have been occasions in which Resident A has asked her where his 1:1 staff was. Ms. Moye stated that Resident A's 1:1 staff is typically not too far from Resident A and are to be in his line of sight. Ms. Moye 1:1 staff are typically close by or trailing Resident A when he moves around the facility.

On 07/30/2021, I interviewed Direct Care Worker Nevaeh Greer in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Ms. Greer stated

that she did not remember working with Resident A on 06/05/2021 as his 1:1 staff, but she has worked in that capacity. Ms. Greer stated that she has never left Resident A alone. Ms. Greer stated that Resident A has never asked her who/where his 1:1 staff is. Ms. Greer stated that she did not believe that they were short staffed, and the least number of staff she has worked with has been three direct care workers.

On 07/30/2021, I interviewed Direct Care Worker Tiffany Reed in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Ms. Reed stated that she was probably the lead staff person on 06/05/2021. Ms. Reed stated that Resident A always has his 1:1 staff. Ms. Reed stated that the least number of staff on shift she has worked with has been three staff. Ms. Reed stated that she has never seen Resident A without his 1:1 staff and Resident A has never had to ask her where his 1:1 staff was located.

On 08/04/2021, I received notes from Kentera Patterson, Recipient Rights Officer, who interviewed Home Manager Najsha Fox on 06/14/2021, Guardian A1 on 07/30/2021, and Resident A on 07/30/2021. Ms. Patterson documented the following:

> Najsha Fox: On the 5th it was a weekend, I was not working. I was told they were short staffed all day. Other staff [were] helping out on the floor, so [Resident A] did not get a 1 to 1 staffing. I was made aware on the 5th at 8:40 pm, I told staff to get him 1 on 1 to make sure that he has it. I spoke with [Guardian A1] on the 5th about the incident. [Guardian A1] also told Kevin [Saginaw County CMHA] he when he came on the 11th and we talked about it again during IPOS. Since I've been here 3 weeks, [it is] not an issue, only happened on the 5th. But [Guardian A1] stated this happened before with no 1 to 1. I'm not positive but I think they were not right next to him. 10 to 15 feet away, [I was] told from behavior specialist Casey that is ok.
>
> Guardian A1: On 06/05/2021, [Resident A] called and told me that he did not have his 1 to 1. He didn't call to report it, it just came out. This happened on occasion because they didn't have enough staff. The Home Manager Najsha Fox said that's not acceptable. I informed them that SCCMHA (Saginaw County Community Mental Health Authority) is paying for that service. I told [Resident A] to call me when he goes without 1 to 1. When he tells me, I call Home Manager right away she fixes it immediately. It happens every time she's not there.
>
> Resident A: Most of the time I don't have a 1 to 1 staff. They don't follow my plan. What happens is they are short staffed, so I don't have a staff or staff leaves and I don't know where they are. Sometimes I'm on my own and no one really checks in with me. I look everywhere like where's my staff. They wander off, I have to find them. 1 to 1 is usually in my room. On 3rd they don't schedule 1 to 1 because I'm asleep, cut down to 16 hours instead of 24 hours.

On 08/31/2021, I interviewed Guardian A1, who stated that Resident A typically calls her when he cannot find his 1:1 staff. Guardian A1 stated that she instructed Resident A to call her anytime he does not have a 1:1 because it is a safety issue for Resident A. Guardian A1 stated that Saginaw County Community Mental Health Association supplements funds to pay for Resident A to have a 1:1 staff, and the facility has not always had one for him. Guardian A1 stated that she has been told that the facility is short staffed, so they did not have a 1:1 staff for Resident A. Guardian A1 stated that on one occasion she "Face Timed" Resident A, who would walk around and show her that there was no 1:1 staff for him. Guardian A1 stated that she brings this issue to the attention of manager Najsha Fox every time, and she is very responsive and works to correct the issue. Guardian A1 stated that yesterday Ms. Fox acted as Resident A's 1:1 because he did not have one.

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:	Resident A's *Assessment Plan* and *Individual Plan of Service* (IPOS) both document the requirement of 1:1 staffing 16 hours a day for Resident A, who is monitored from 10-15 feet distance. Based on interviews with Complainant, Ms. Fox, Resident A, Guardian A1, and Mr. Browning, there have been occasions in which Resident A has not received this 1:1 staff. Home Manager Najsha Fox stated that she was made aware that Resident A did not have 1:1 staff on 06/05/2021 and corrected the issue. Kentera Patterson, Recipient Rights Officer, also documented that Ms. Fox informed her that Resident A did not have 1:1 staff on 06/05/2021. DCW Jacob Browning admitted that there have been shifts which he observed Resident A without a 1:1 staff. Guardian A1 stated that there was an occasion in which she had a video call with Resident A, who would show her that there was no 1:1 staff present for him.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 07/24/2021, Direct Care Worker Brian Britt shoved Resident A to the ground and pulled his pants off him.

INVESTIGATION:

I received this complaint on 07/26/2021 and conducted an unannounced, onsite inspection at the facility on 07/28/2021. I interviewed Resident A in person and did not notice any bruising. Resident A stated that on Saturday, 7/24/2021 DCW Demetrius Noakes was yelling at him, and he did not like it. Resident A stated that he called Guardian A1 because there was a tornado warning, and the facility was not taking shelter. Resident A stated that Mr. Noakes told him that staff has the situation under control, and there was no need to call his mother. Resident A stated that he became upset and threw some things at Mr. Noakes (a shoe and a phone). Resident A stated that staff member Brian Britt came from the other side of the building because he was not sure what was going on with all the yelling between him and Mr. Noakes. Resident A stated that Brian came into his room and he began hitting Brian. Resident A stated that Brian punched and shoved him. Resident A stated that Brian tried to knee him in the nuts. Resident stated that he fell after being shoved, and Demetrius pulled his pants off during the scuffle. Resident A stated that stated that staff member Jacob saw the whole thing, and staff member Taleah "acted like" she wanted to fight him but did not. Resident A stated that afterwards he called Guardian A1 and told her what happened. Resident A stated that he did not tell management what took place.

I reviewed Resident A's *Assessment Plan*, which documented the following:

> **Communicates Needs**: [Resident A] communicates his needs verbally. [Resident A] needs encouragement to communicate wants/needs in a calm manner. Staff will assist [Resident A] with utilizing coping skills and encourage him to express emotions appropriately and calmly. [Resident A] has a history of becoming aggressive towards others and/or destructive of property as a means of expressing dissatisfaction or anger. This is often impulsive in nature. More often this is verbal, rather than physically aggressive.
>
> **Understands Verbal Communication:** [Resident A] is able to understand verbal communication from others. [Resident A] may be slow to respond if agitated. [Resident A] may require much coaxing to calm before he is able to follow directions/prompts from others.
>
> **Alert to Surroundings:** [Resident A] is alert to his surroundings, but during periods of emotional dysregulation, he may fail to recognize or ignore dangers and risks. Judgment and insight can become impaired. Staff will provide additional instruction as needed to maintain safety during periods of exacerbation of mental health functioning.

Follows Instructions: Typically, able to follow multiple step directions, however, may become anxious or emotionally overwhelmed during non-preferred task requests. Benefits from staff taking a "we do" approach to help guide [Resident A] through directives and prompting initially and then he can continue to carry out on his own.

Controls Aggressive Behavior: [Resident A] has a history of acting out aggressively towards others predominately toward staff. [Resident A] may strike out, hit, punch, kick, and/or attempt to bite others. Since his stay at Flatrock Manor, [Resident A] has also engaged in property destruction during more severe episodes of agitation. Episodes of aggression (hitting, kicking, spitting at staff) has been observed since his stay at Flatrock Manor and has required the use of physical management for health/safety, as a last resort. The incidents of aggression since his stay at Flatrock Manor have not resulted in significant injury to care staff, however, it has resulted in bruises and/or marking on staff (for example, left a mark when attempting to bit staff and left bruising when hit staff). Staff will monitor for mood changes and provide verbal redirection and encouragement of coping strategies to assist with reducing aggressive behavior episodes. In the even these measures are unsuccessful, staff are trained in Crisis Prevention Institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills.

On 07/29/2021, I reviewed the Incident/Accident Report submitted for this complaint, which documented the following:

On Saturday afternoon, Fenton experience severe weather, which caused [Resident A] to become anxious. [Resident A] called [Guardian A1] to express his anxiousness. When off the phone, [Resident A] told staff they should begin to shelter. Staff let [Resident A] know they were waiting on management to direct them when it's necessary to begin tornado protocol. This made [Resident A] upset and he became verbally aggressive with staff. Staff attempted to validate [Resident A's] feelings and were unsuccessful. [Resident A] became physically aggressive and threw his phone at staff. Staff then held on to his phone due to him being escalated. [Resident A] grabbed a peer's shoe and threw it at staff and began to follow staff and spit at them. Another staff attempted to utilize blocking techniques and verbally redirect [Resident A] and [Resident A] hit staff in the face. Another staff prompted [Resident A] to talk in his bedroom and practice coping skills and [Resident A] complied, walking with staff to his bedroom. Staff asked for assistance in case [Resident A] became escalated again and when extra staff entered the room [Resident A] began to hit and push them. While [Resident A] was swinging his arms, he stumbled over his feet and landed on his butt. While on the floor, [Resident A] continued to kick at staff, resulting in his pants falling down. Then [Resident A] also attempted to bite staff and staff utilized blocking techniques. Extra staff left the room and allowed one staff to validate [Resident A's] feelings and were able to calm him down after prompting

him to get up. [Resident A] laid in his bedroom for the rest of the night and spoke to staff.
Staff actions: Validating feelings, blocking techniques, verbal redirection
Corrective measures: Staff will remind [Resident A] of his goals and work on coping skills.

On 07/30/2021, I interviewed DCW Jacob Browning, in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Mr. Browning stated that on 07/24/2021, the shift became hectic because of a tornado warning alert. Mr. Browning stated that Resident A received the alert on his personal cell phone and contacted Guardian A1. Mr. Browning stated that DCW Demetrius Noakes told Resident A that he did not need to call Guardian A1 to freak her out, since the tornado was not nearby. Mr. Browning stated that another notification came across indicating that a tornado was nearby. Mr. Browning stated that staff began rounding up residents into the hallway and Resident A was on the phone again with Guardian A1, informing her that staff was not sheltering. Mr. Browning stated that staff was assuring Resident A that they were sheltering, but DCW Demetrius Noakes became verbally aggressive with Resident A, stating "you do not need to call [Guardian A1], we are sheltering. Mr. Browning stated that Mr. Noakes was loud and aggressive with Resident A. Mr. Browning stated that Resident A yelled out in angry voice and chased after Mr. Noakes into the living room area.

Mr. Browning further stated that Mr. Noakes was able to get away from Resident A and DCW Taleah Moye intervened by standing in the way to prevent Resident A from getting to Mr. Noakes. Mr. Browning stated that Resident A hit Ms. Moye and she said "got damn [Resident A], what the fuck? I'm tired of getting hit, I'm tired of working here!" Mr. Browning stated that Resident A also threw his phone, and another staff member held on to it. Mr. Browning stated that Resident A went back to his room, where he was throwing things around. Mr. Browning stated that staff from the north side (Fenton North) were notified to let them know that they needed assistance. Mr. Browning stated that Resident A was in his own bedroom and was calming down. Mr. Browning stated that DCW Brian Britt arrived and went into Resident A's room, which made Resident A "super upset." Mr. Browning stated that Mr. Britt and Mr. Noakes were now in Resident A's room and were "egging on" the situation. Mr. Browning stated that Mr. Britt and Resident A confronted each other and began "rough housing," and were not using CPI (crisis prevention) techniques. Mr. Browning stated that Resident A ended up on the floor. Mr. Browning stated that Mr. Britt was standing over Resident A while he was on the floor and threw five punches at Resident A's face. Mr. Browning stated that he pleaded with Mr. Britt to stop, and Mr. Browning said to him "you don't tell me what to do." Mr. Browning stated that at this time Resident A's pants were halfway down. Mr. Browning stated that he was not sure how Resident A's pants got down. Mr. Browning stated that Mr. Noakes was trying to verbally redirect Resident A. Mr. Browning stated that he went back into Resident A's room after everyone left, and saw that Resident A's lip was busted, he had a scrape on his arm, and his face was red. Mr. Browning stated that what Mr. Britt did to Resident A was "assault if I've ever seen it." Mr. Browning stated

that Mr. Britt and Resident A were fighting each other, and Mr. Noakes was standing by.

On 07/30/2021, I interviewed DCW Demetrius Noakes, in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Mr. Noakes stated that on 07/24/2021 during the tornado alert, staff was monitoring the situation to confirm if they needed to shelter residents. Mr. Noakes stated that before the tornado was confirmed, Resident A called Guardian A1 and told her that staff did not allow him to shelter. Mr. Noakes stated that staff and residents eventually went to the designated shelter area, and once in the area Resident A told him “bitch leave.” Mr. Noakes stated that he told Resident A that he could leave. Mr. Noakes stated that it could have seemed like he raised his voice at Resident A, but he did not, and Resident A was already upset with him. Mr. Noakes stated that Resident A threw his phone at him and threw another resident’s shoe at him. Mr. Noakes stated that Resident A charged at him, so he ran. Mr. Noakes stated that DCW Taleah Moye jumped in front of Resident A, and Resident A responded by hitting Ms. Moye in the face. Mr. Noakes stated that Ms. Moye said, “What the fuck,” and other residents were becoming scared. Mr. Noakes stated that staff from the north side (Fenton North) were contacted and DCW Brian Britt came over. Mr. Noakes stated that Mr. Britt was able to get Resident A’s attention, then Resident A began to target Mr. Britt. Mr. Noakes stated that Resident A started punching at Mr. Britt as Resident A made his way back towards his room. Mr. Noakes stated that as Resident A was backing into his room he tripped over his chair and was on the floor. Mr. Noakes stated that Mr. Britt was standing over Resident A, and Resident A was punching at Mr. Britt’s legs. Mr. Noakes stated that Mr. Britt was taking hits from Resident A to tire him out. Mr. Noakes stated that Mr. Britt never hit Resident A. Mr. Noakes stated that Mr. Britt pushed Resident A’s face down as Resident A was attempting to bite Mr. Britt’s leg. Mr. Noakes stated that while Resident A was hitting Mr. Britt, Mr. Britt was telling Resident A to “just stop Bro, that doesn’t hurt.” Mr. Noakes stated that while Resident A was on the floor, he was trying to kick Mr. Britt in the groin. Mr. Noakes stated that while Resident A was kicking, his pants came off from the kicking motion. Mr. Noakes stated that Mr. Britt never yelled or threatened Resident A. Mr. Noakes stated that Mr. Britt should have moved away from Resident A.

On 07/30/2021, I interviewed DCW Taleah Moye, in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Ms. Moye stated that Resident A knew that there was a tornado alert from his phone and called his mother to tell her that staff are not taking shelter. Ms. Moye stated that staff was awaiting confirmation from management to shelter. Ms. Moye stated that Mr. Noakes told Resident A that they were going to shelter now, and he did not have to worry. Ms. Moye stated that Resident A responded by spitting and throwing his shoe at Mr. Noakes. Ms. Moye stated that Resident A started charging at Mr. Noakes to attack him. Ms. Moye stated that she tried to calm Resident A down and he slapped her with his right hand across her face. Ms. Moye stated she said, “what the fuck?” Ms. Moye stated that she called manager Najsha Fox, but she did not answer. Ms. Moye stated that Resident A threw his cell phone. Ms. Moye stated that Resident A’s

phone rang, and she answered it. Ms. Moye stated that Resident A's mother was calling and she told her that Resident A was having a behavior at the moment and she did not feel comfortable going into Resident A's room to give him the phone. Ms. Moye stated that she was not keeping Resident A's phone away from him as punishment. Ms. Moye stated that Resident A and Mr. Noakes were trying to talk over each other and there was a lot going on. Ms. Moye stated that after Resident A slapped her, she sat in the living room until everything ended with Resident A.

On 07/30/2021, I interviewed DCW Brian Britt, in conjunction with Kentera Patterson and Tony Navarre, Recipient Rights Officers. Mr. Britt stated that he was working on the other side (Fenton North) and he heard screaming. Mr. Britt stated that he observed Resident A yelling and angry at staff, who were huddled up. Mr. Britt stated that he was not sure how Resident A's behaviors started, but he was spitting and throwing things. Mr. Britt stated that he placed himself in the middle of Resident A and staff because "I'm a bigger staff" and I had Resident A focus his attention on him. Mr. Britt stated that he just tried to talk with Resident A and try to figure out why he was so mad. Mr. Britt stated that Resident A started "blocking" Resident A back towards his room and was Resident A was hitting him. Mr. Britt stated that he let Resident A "tee off" on him, and Resident A tripped over a chair in his room. Mr. Britt stated that Resident A was not hurting him with his punches, and he let Resident A punch him until he got tired. Mr. Britt stated that Resident A tried to bite him on his ankle, so he pushed Resident A's head away from his ankle. Mr. Britt stated that he stood over Resident A as Resident A was hitting his legs. Mr. Britt stated that he told Resident A that he was not hurting him asked Resident A "are you done yet, Bro? Mr. Britt stated that he did not know how Resident A's pants came down. Mr. Britt stated that he never yelled or hit back at Resident A. Mr. Britt stated that he was trained in CPI training in February 2021, but he was not trained to stand over Resident A and him to punch him while he was on the floor. Mr. Britt stated that he left Resident A's room when his 1:1 staff came in. Mr. Britt stated that Resident A calmed down after he left Resident A's room. Mr. Britt stated that no other staff asked him to step away from standing over Resident A, but he did tell DCW Jacob Browning "I got this." Mr. Britt stated that he should have went back to his side (Fenton North), but there was a behavioral issue and staff could not handle Resident A. Mr. Britt stated that DCW Browning was yelling, but he told him that this was not his first time dealing with Resident A.

On 08/04/2021, I received notes from Kentera Patterson, Recipient Rights Officer, who interviewed Guardian A1 on 07/30/2021. Ms. Patterson's notes documented the following:

> [Resident A] called me on 07/24/2021 and it was the night of the tornado warning. [Resident A] is afraid of bad weather. Every time there is bad weather, he calls my mom and myself. Shortly after he called me, the home manager texted saying [Resident A] was having a behavior. So, I called [Resident A's] cellphone to calm him down. A female staff answered, and she refused to let me talk to him. I did not know her name. The home manager Najsha Fox told me that

she debriefed, and it is under investigation. I stayed on the phone and did not hang up. She (staff) was loud and rude, saying [Resident A] threw his phone at her. After she got done talking, I told her I'm trying to assist with him. Then she informed another staff that [Guardian A1] wants to talk to him, and I'm not going in that room. Somehow [Resident A] got his phone and sounded calm. [Resident A] reported to me that staff were yelling at him for calling my mom and myself about the weather. But I think staff got upset because they thought [Resident A] was calling to tell on them. [Resident A] Facetimed me and he had a cut on his lip (bottom). [Resident A] said he got upset about staff yelling at him. [Resident A] said a staff from the other side of the house (Brian) shoved him to the ground, kneed him in groin. [Resident A] was kicking at him and Brian pulled his pants down. I guess [Resident A's] pants were loose. [Resident A] did admit that he spit and kicked at staff. Jacob did not call me, but he was in the room when I was on Facetime with [Resident A]. Jacob did say that [Resident A] was telling the truth. He did not share any other information.

On 08/04/2021, I received notes from Kentera Patterson, Recipient Rights Officer, who interviewed Home Manager Najsha Fox on 07/26/2021 and 07/30/2021. Ms. Patterson's notes documented the following:

07/26/2021: Staff said Brian was alone in the room with [Resident A], that's what others said. [Resident A's] behavior is so aggressive, so we try to limit staff in the room. It should've been Brian and [Resident A's] staff. Jacob was [Resident A's] 1 to 1.

07/30/2021: We did debrief the situation and [Resident A] was anxious about the weather. Staff told [Resident A] they were waiting for my directive for tornado protocol. [Resident A] got upset about waiting. He got verbally aggressive calling staff "bitches." He then got physically aggressive, threw shoe, phone, and charged at Demetrius. Taleah attempted to intervene by getting in between Demetrius and [Resident A] and [Resident A] hit her in the face. [Resident A] was still escalated. Taleah had Andrew's phone, [Guardian A1] called and Taleah answered. She refused to give phone, she did it because he was escalated and was going to wait until he was calm. We told her that wasn't ok. Brian heard the commotion and came over to help out from north side. Brian was doing blocking techniques until Jacob calmed [Resident A] down to go to [Resident A's] room. Jacob wanted staff in room just in case. [Resident A] escalated again then Brian entered room. [Resident A] got escalated again. [Resident A] hit Brian again, lost balance and ended up on floor, he started kicking at staff. Brian said [Resident A's] pants were loose and feel down. Jacob helped calm down [Resident A] after Brian left and [Resident A] also spoke with [Guardian A1].

On 08/04/2021, I received notes from Kentera Patterson, Recipient Rights Officer, who interviewed Resident A 07/30/2021. Ms. Patterson's notes documented the following:

> Demetrius was yelling at me because I told him we needed to take shelter for tornado warning. I called my mom because of the weather. Demetrius said you shouldn't have called your mom we have it under control. Your mom can't make us do anything. I got mad threw my phone at him. He was rude. Then more staff came. I hit Taleah in the neck because she was blocking me from Demetrius. She yelled why did you hit me. More staff came from other side. One staff Brian kept walk up on me. I ended up in room, I was walking backwards. I went to hit him he pushed me I fell. I started hitting him, kicking, and swinging, he then hit me three times with a closed fist. I then picked up vacuum cleaner to throw it at him, but I put it down. He tried to knee me in groin about 4 times or more. I blocked with my leg. Then I hit him and fell more times. When I was on the ground kicking long jeans were kind of down and Demetrius took them off all the way. I'm not sure why he took my pants off. He grabbed my legs to stop kicking them. Brian left and Jacob came in he witnessed the whole thing. He said he knew it wasn't right what they did. Jacob told mom about what happened. [Guardian A1] Facetimed that's how Jacob told her. I was tired of them yelling at me, so I got violent and the weather made me nervous.

On 08/31/2021, I interviewed Guardian A1. Guardian A1 stated that Resident A is a "nine-year old in a grown body." Guardian A1 stated that it is very normal for Resident A to become anxious about extreme weather Guardian A1 stated that once the tornado alert started, Resident A tried calling her, but she did not initially answer. Guardian A1 stated that Resident A then called his grandmother and told her that they were not sheltering at the facility. Guardian A1 stated that after Resident A got off the phone, he was still in his room and had not gone into the hallway. Guardian A1 stated that Resident A was told that they were waiting on directives from management to shelter. Guardian A1 stated that she felt as if staff was teasing Resident A about "tattling" on them for not sheltering. Guardian A1 stated that she later received a text message from the manager stating that Resident A was having an incident. Guardian A1 stated that she called Resident A's phone and a woman (later identified as DCW Taleah Moye) answered his phone. Guardian A1 stated that the woman who answered Resident A's phone was rude, flippant, and indignant. Guardian A1 stated that the woman told her that Resident A threw his phone at her. Guardian A1 stated that she told the woman that she wanted to talk to her son, but she refused to give him the phone. Guardian A1 stated that she remained on the phone and told the woman to find someone to give Resident A his phone so that she could talk to him since he was upset. Guardian A1 stated that she could hear staff shouting in the background, and minutes went by. Guardian A1 stated that Resident A finally got his phone. Guardian A1 stated that Resident A was calm when he got on the phone and told her what occurred with staff. Guardian A1 stated that Resident A told her that staff got upset with them and said he had no business "telling" on them, which was not the case. Guardian A1 stated that Resident A told her that Mr. Britt was on the other side (Fenton North) and she does not know if he was called over, but he was not working at Fenton South. Guardian A1 stated that Resident A told her that Mr. Britt shoved Resident A. Guardian A1 stated that Resident A admitted to spitting and hitting at staff. Guardian A1 stated that Resident

A told her that Mr. Britt grabbed his pants and pulled them down. Guardian A1 stated that she sent an email to manager Najsha Fox, who took everyone involved off the schedule until the investigation was completed. Guardian A1 stated that she video called Resident A after this occurred and observed him with a fat lip. Guardian A1 stated that there was another staff member (Jacob Browning) who was nearby when she was video calling Resident A, and Mr. Browning confirmed Resident A's version of the incident. Guardian A1 stated that she staff should be in control of their emotions and not have gotten upset at Resident A for calling her during the tornado warning. Guardian A1 stated that staff did not have the right to tell her that she could not talk to Resident A while he was in crisis, and she could have helped him to calm down. Guardian A1 stated that Mr. Britt was not working on that side of the building and he should not have been in Resident A's room manhandling him. Guardian A1 stated that once Resident A was in his room, Mr. Britt should have walked away. Guardian A1 stated that the whole situation could have been avoided if Resident A's feelings about the tornado warning were properly acknowledged.

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:	Based on interviews with Resident A, Direct Care Workers Browning, Noakes, Moye, Britt, and Guardian A1, it cannot be confirmed that DCW Britt shoved Resident A to the ground and pulled his pants off of him. However, staff interviews and the *Incident Report* submitted reveal that there was verbal/physical incident that occurred involving Resident A with staff intervention on 07/24/2021. Resident A became anxious due to a tornado alert he received on his cell phone. The Incident Report documented that staff actions in response to Resident A's verbal/physical aggression included "validating feelings, blocking techniques, and verbal redirection." Resident A's Assessment Plan documents that "staff will monitor for mood changes and provide verbal redirection and encouragement of coping strategies to assist with reducing aggressive behavior episodes. In the even these measures are unsuccessful, staff are trained in Crisis Prevention Institute (CPI) non-volent crisis intervention foundational course including disengagement and holding skills." Resident A's feelings did not appear to be validated by DCW Noakes, who Resident A and DCW Browning stated that DCW Noakes told Resident A that he did not need to call Guardian A1. Resident A and DCW Browning both stated that DCW Noakes was "loud" and "yelling"

	at Resident A, while DCW Noakes stated that "it could have seemed like he raised his voice at Resident A, but he did not and Resident A was already upset." As the incident continued, DCW Britt from Fenton North became involved and further escalated Resident A's physical aggression by coming into his room, standing over Resident A when he was on the floor, allowing Resident A to hit him, and telling Resident A that his punches did not hurt. While DCW Britt stated that he was trained in CPI, he admitted that standing over Resident A and allowing him to punch him was not what he learned in CPI. Instead of disengaging with Resident A as documented in his Assessment Plan, DCW Britt provoked more aggression from Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/09/2021, I conducted an Exit Conference with Carrie Aldrich, Administrator. Ms. Aldrich acknowledged the violations and will address them in a Corrective Action Plan.

IV. RECOMMENDATION

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

09/10/2021

Derrick Britton Date
Licensing Consultant

Approved By:

09/10/2021

Mary E Holton Date
Area Manager