GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 24, 2022

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

RE: License #: AS250406894
Investigation #: 2022A0582017
Lippincott

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

I. IDENTIFYING INFORMATION

License #:	AS250406894
Investigation #:	2022A0582017
Complaint Receipt Date:	01/20/2022
Investigation Initiation Date:	01/21/2022
Report Due Date:	03/21/2022
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Morgan Yarkosky
Licensee Designee:	Nicholas Burnett
Name of Facility:	Lippincott
Facility Address:	4408 Lippincott Blvd. Burton, MI 48519
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/21/2021
License Status:	REGULAR
Effective Date:	10/21/2021
Expiration Date:	10/20/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Resident A's bedroom window is covered with sheet of plexiglass nailed in, preventing it from being opened.	Yes
The bathroom is not being cleaned.	No
On 01/13/2022, Medical Coordinator Jordan Smith did not send Resident A to the emergency room to see if she had a concussion after she banged her head.	No
The facility is short staffed.	No

III. METHODOLOGY

01/20/2022	Special Investigation Intake 2022A0582017
01/21/2022	Special Investigation Initiated - On Site
01/21/2022	Contact - Face to Face With DCW Anna Grabowski
01/21/2022	Contact - Face to Face With Resident A
02/08/2022	Contact - Telephone call made With DCW Breshanna Bailey
02/08/2022	Contact - Telephone call made With DCW Aaniah Wilson
02/08/2022	Contact - Telephone call made With Medical Coordinator Jordan Smith
02/22/2022	Inspection Completed On-site
02/22/2022	Contact - Face to Face With Resident C, Resident D, DCW Dyamond Polk, and DCW Nikita Smith
02/23/2022	Exit Conference With Nicholas Burnett, Licensee Designee

02/24/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A's bedroom window is covered with sheet of plexiglass nailed in, preventing it from being opened.

INVESTIGATION:

I received this complaint on 01/20/2022 and conducted an unannounced, onsite inspection on 01/21/2022. I interviewed Resident A, who stated that she has a sheet of plexiglass on the window in her bedroom. Resident A stated that she would have no way to escape if a fire happens in the hallway outside of her bedroom. Resident A stated that on 01/13/2022, she was angry and went to her room. Resident A stated that she began pounding on the plexiglass covering her window and tried taking the plexiglass off. Resident A stated that the plexiglass was taken off during a recent inspection but put back on after the inspection was completed.

I observed the window in Resident A's room and determined that there was plexiglass covering the window, which could not be opened. I observed other resident bedrooms and did not find them to have plexiglass on their windows.

On 01/22/2022, I contacted Christina Garza, Licensing Consultant for the facility. Ms. Garza stated that she conducted a renewal inspection at the facility, and resident bedrooms did not have windows that could be easily opened. I reviewed the *Licensing Study Report* completed by Ms. Garza, which documented that at the time of her inspection on 09/20/2021, "resident bedrooms did not have at least one easily operable window." I reviewed a *Corrective Action Plan* dated 11/04/2021, which documented that "Flatrock has removed objects that made the windows not easily accessible during inspection. Pictures of completion were submitted on 09/27/2021."

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	Based on my interview with Resident A and personal observation of the window in Resident A's room, there was a sheet of plexiglass covering the window in Resident A's room. The window could not be opened.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED.** **LSR date-11/04/2021, CAP date-11/04/2021**

ALLEGATION:

The bathroom is not being cleaned.

INVESTIGATION:

I received this complaint on 01/20/2022 and conducted an unannounced, onsite inspection at the facility on 01/21/2022. I interviewed Resident A. Resident A stated that staff leave paper towel on the bathroom floor and hair in the shower and sink. I observed two bathrooms in the facility which were clean and orderly. I interviewed DCW Anna Grabowski, who stated that she had no concerns about the cleanliness of resident bathrooms.

On 02/08/2022, I interviewed Breshanna Bailey, DCW Aaniah Wilson, and Medical Coordinator Jordan Smith, and they had no concerns regarding the cleanliness of bathrooms in the home.

On 02/22/2022, I conducted an unannounced, onsite inspection at the facility. I inspected both resident bathrooms, which were found to be clean and orderly. I interviewed DCW Dyamond Polk and DCW Nikita Smith, who stated that they had no concerns about the bathrooms being dirty. I interviewed Resident C and Resident D, who stated that they had no concerns about the cleanliness of the bathrooms in the home.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on interviews and personal observations during two unannounced inspections, there is no evidence to suggest that the bathrooms are not being cleaned. Bathrooms were found to be clean during unannounced inspections on 01/20/2022 and 02/22/2022, and those interviewed had no complaints of a dirty bathroom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 01/13/2022, Medical Coordinator Jordan Smith did not send Resident A to the emergency room to see if she had a concussion after she banged her head.

INVESTIGATION:

I received this complaint on 01/20/2022, and conducted an unannounced, onsite inspection at the facility on 01/21/2022. I interviewed Resident A, who stated that on 01/13/2022 around 6 PM, she became angry and went to her room. Resident A stated that she began pounding on the plexiglass covering her window, trying to take it off. Resident A stated that she then went to take a shower and laid down inside, trying to flood the bathroom by blocking the drain. Resident A stated that she then wanted to go outside, but DCW Breshanna Bailey told her that she was not being safe and asked her if she could assist cleaning up the water in the bathroom. Resident A stated that she agreed and began cleaning the bathroom with the assistance of another staff member. Resident A stated that she did not finish cleaning the bathroom and staff member took over. Resident A stated that she again became upset about the entire situation and began banging her head on the wall. Resident A stated that staff allowed her to continue banging her head, and she began bleeding. Resident A stated that DCW Breshanna Bailey thought she was putting her in a "CPI hold," but she was "laying on her." Resident A stated that she was finally able to calm down without any staff assistance. Resident A stated that she was not sent to the hospital afterwards because Medical Coordinator Jordan Smith said she was having behavioral problems. Resident A stated that she went to get checked at the hospital the next day. I observed Resident A to have a mark on her forehead which appeared to be an old scab wound. Resident A stated that she was feeling fine at that time and did not need medical attention.

On 01/21/2022, I reviewed the *AFC Licensing Division-Incident/Accident Report* for this complaint, which documented the following:

> **Name of Person Directly Involved**: [Resident A]
> **Persons Involved/Witnesses:** Breshanna Bailey, Aaniah Wilson
> **Date of Incident:** 01/13/2022, **Time:** 7:13 PM
> **Location of Incident:** Hallway
> **Explain What Happened:** [Resident A was upset due to her not being able to go outside, due to her being unsafe. Afterwards, [Resident A] then went downstairs to the bathroom and began to use the shower and attempted to flood the bathroom and peers' bedrooms. Staff successfully redirected [Resident A] and validate her feelings. [Resident A] was still upset and began to cry and bang her head on the wall as staff utilized blocking techniques and validated [Resident A's] feelings. [Resident A] was bleeding from her head and allowed staff to administer first aid. Staff also prompted PRN, [Resident A] accepted staff prompts.
>
> **Action Taken by Staff/Treatment Given:** Validate feelings, blocking skills, administer first aid, verbal redirected aid, prompt PRN, notify med coordinator.

I reviewed an additional *AFC Licensing Division-Incident/Accident Report* for this complaint, which documented the following:

Name of Person Directly Involved: [Resident A]
Persons Involved/Witnesses: Breshanna Bailey, Shantel Stone
Date of Incident: 01/14/2022, **Time:** 3:45 PM
Location of Incident: Living Room
Explain What Happened: At start of shift [Resident A] was complaining about her head hurting. Med coordinator stated to send her out to hospital. Staff transported her to Genesys Hospital for treatment. Staff will continue to monitor her to ensure health and safety while validating her feelings.
Action Taken by Staff/Treatment Given: Staff validated her feelings while closely monitoring her to ensure health and safety.
Addendum: [Resident A] was diagnosed with a contusion. Test ran were CT scan, Urine analysis. [Resident A] was then discharged and returned safely to the care home.

On 02/08/2022, I interviewed DCW Breshanna Bailey. Ms. Bailey stated on 01/13/2022, Resident A was upset and threatening to run away. Ms. Bailey stated Resident A was having behavioral problems and tried flooding the bathroom. Ms. Bailey stated Resident A banged her head on the wall, which is something she has done before. Ms. Bailey stated that she used blocking techniques to prevent Resident A from continuing to bang her head. Ms. Bailey stated that Resident A began to bleed a little from her head. Ms. Bailey stated that Resident A had an old wound on her head from banging it in the past. Ms. Bailey stated that Resident A received first aid to stop the bleeding, which was from a little scratch on her head. Ms. Bailey stated that she contacted the home manager and medical coordinator to inform them of the situation. Ms. Bailey stated that Resident A did not require hospital attention as the scratch on Resident A's forehead was not significant.

On 02/08/2022, I interviewed DCW Aaniah Wilson. Ms. Wilson stated that Resident A was upset about not being able to go outside because she was threatening to harm herself and run away. Ms. Wilson stated that she tried to talk with Resident A to calm her down and use her coping skills. Ms. Wilson stated she told Resident A that if she could be safe and engaged, then she would go outside with her. Ms. Wilson stated that Resident A continued to be upset and went to the bathroom, attempting to flood the shower. Ms. Wilson stated that she assisted Resident A with mopping up the water, but Resident A became upset about something to do with the mop bucket. Ms. Wilson stated that Resident A banged her head near the frame of the door. Ms. Wilson stated that she placed her hand on the front of Resident A's head to block her from continuing to bang her head. Ms. Wilson stated that Resident A fell to the floor and began crying as staff tried calming her down. Ms. Wilson stated that Resident A has banged her head in the past, and she was bleeding from her forehead but not leaking blood. Ms. Wilson stated that Resident A's injury was not serious enough for hospitalization, and she received first aid by cleaning up the blood to stop the bleeding.

On 02/08/2022, I interviewed Jordan Smith, Medical Coordinator. Ms. Smith stated that he was not on the floor during Resident A's behavioral issue on 01/13/2022. Ms. Smith stated that staff members were intervening when Resident A tried to bang her head by blocking to prevent her from hurting herself. Ms. Smith stated that Resident A was bleeding slightly, which was cleaned up and instructed staff to monitor her. Ms. Smith stated that Resident A had a pre-existing scab on her forehead that became irritated when she banged her head against the wall. Ms. Smith stated that the next day Resident A complained that her head was hurting, so she had her sent to the hospital to be checked out. Ms. Smith stated that Resident A returned home the same day after being seen.

On 02/22/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Resident A, who stated that she had not been to the hospital since the incident and her head is fine.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based a review of *Incident/Accident Reports* submitted and interviews with DCW Bailey, DCW Wilson, and Medical Coordinator Ms. Smith, there is no indication that staff did not provide the necessary medical attention to Resident A after she banged her head. Resident A received first aid for bleeding after the initial incident and was sent to the hospital the next day and discharged with a contusion.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

I received this complaint on 01/20/2022. I reviewed the licensing information in BITS, which documented that the facility is licensed for six residents. On 01/21/2022, I conducted an unannounced, onsite inspection at the facility. I observed that there were four staff members working at the time of my onsite inspection. I interviewed Resident A, who stated that there are two residents that require one on one staff, and there is a need for more staff. I interviewed DCW Anna Grabowski, who stated the facility has six residents. Ms. Grabowski stated that Resident B is the only resident that requires a one-on-one staff at this time, but Resident C previously

required a one-one-one staff a month ago. Ms. Grabowski stated that typically there are four staff on first shift, four staff on second shift, and three staff on third shift. I observed Resident B to be with a one-on-one staff at the time of my onsite inspection.

On 02//03/2022, I reviewed the staff schedule for January 2022, which documented at least three staff members scheduled per shift, with an additional staffing scheduled for a one-on-one resident.

On 02/08/2022, I interviewed DCW Breshanna Bailey. Ms. Bailey stated that she typically works with three to four other staff members during her shift, depending on who is scheduled. Ms. Bailey stated that she has no concerns regarding the facility being short staffed. Ms. Bailey stated that Resident B is the only resident who requires one-on-one staffing.

On 02/08/2022, I interviewed DCW Aaniah Wilson, who stated that she typically works with at least 4 to five residents during shift, including one-on-one staff. Ms. Wilson stated that Resident B is the only resident that requires a one-one-one staff at this time, but other staff are on shift for additional support.

On 02/08/2022, I interviewed Medical Coordinator Jordan Smith, who stated that she typically works a 9am to 6 pm shift. Ms. Smith stated that she has no concerns about the facility being short staffed and is usually working with four staff members and five on weekends.

On 02/22/2022, I conducted an unannounced, onsite inspection at the facility. I observed that there were three staff members working at the time. I interviewed Resident C and Resident D, who stated that there are typically three to four staff members working at a time. I interviewed DCW Dyamond Polk and DCW Nikita Smith, who stated that they have no concerns about the facility being short staffed, and they typically have three to four staff members on shift. Ms. Smith stated that they have additional staff due to watch Resident A who has eloping behavior and other staff who take residents on outings.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on personal observations and interviews with staff, there is no evidence to suggest that the facility is lacking sufficient staffing that is commiserate with resident needs. There is one resident that requires one-to-one staff, which she was receiving during onsite inspections. The staff schedule and interviews with staff/residents reveal that there is sufficient staffing for six residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 02/23/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett asked to brainstorm solutions for residents who break windows and elope from their windows in their rooms. Mr. Burnett stated that he previously received consultation that if a resident is not compatible at a facility, he should submit a discharge notice.

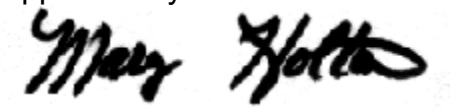
IV. RECOMMENDATION

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

02/24/2022

Derrick Britton Date
Licensing Consultant

Approved By:



02/24/2022

Mary E Holton Date
Area Manager