GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 14, 2022

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

RE: License #: AM440388517
Investigation #: 2022A0582018
Elba North

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 #:	AM440388517
Investigation #:	2022A0582018
Complaint Receipt Date:	01/24/2022
Investigation Initiation Date:	01/26/2022
Report Due Date:	03/25/2022
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Nicholas Burnett
Licensee Designee:	Morgan Yarkosky
Name of Facility:	Elba North
Facility Address:	300 N. Elba Rd. Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	09/05/2017
License Status:	REGULAR
Effective Date:	03/05/2020
Expiration Date:	03/04/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
On 01/01/2022, Resident A eloped from the facility and was not supervised, which was not in compliance with his Assessment Plan.	Yes

III. METHODOLOGY

01/24/2022	Special Investigation Intake 2022A0582018
01/25/2022	APS Referral
01/26/2022	Special Investigation Initiated - On Site
01/26/2022	Contact - Face to Face With Asjia Blanton, Manager
01/27/2022	Contact - Telephone call made With Elisabeth Simon, Livingston County Recipient Rights
01/27/2022	Contact - Telephone call made With Deputy Sergeant Jason Parks, Lapeer County Sherriff's Office
01/27/2022	Contact - Telephone call made With Deputy Laura Nelson, Lapeer County Sherriff's Office
02/01/2022	Contact - Document Received Lapeer County Sherriff's Office Case Report
02/14/2022	Contact - Document Received Staff schedule and contacts
02/14/2022	Contact - Telephone call made With DCW Anasha Reese
02/21/2022	Contact - Telephone call made With DCW Kenyatta Campbell
02/22/2022	Contact - Telephone call made With DCW Jarvon Brown

02/22/2022	Contact - Telephone call made With DCW John Ryder
03/02/2022	Contact - Telephone call made With Guardian A1
03/07/2022	Contact - Telephone call made With DCW Carson Robinson
03/08/2022	Contact - Telephone call made With DCW Larry Robinson
03/11/2022	Exit Conference With Nicholas Burnett, Licensee Designee
03/11/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 01/01/2022, Resident A eloped from the facility and was not supervised, which was not in compliance with his Assessment Plan.

INVESTIGATION:

I received this complaint on 01/24/2022, and conducted an unannounced, onsite inspection at the facility on 01/26/2022. I reviewed Resident A's *Assessment Plan*, which documented the following:

> **Diagnoses**: Autism Spectrum Disorder/Asthma
> **Moves Independently in Community:** [Resident A] has a history of being consistently physically aggressive (including slapping, hitting, pushing or pulling others, crying and throwing himself on the ground) with family members, respite and school staff. His involvement in the community is very limited due to these behaviors. His only access to the community is to attend medical appointments. For these reasons, he will always be provided with 1:1 supervision while in the community and community access should only occur out of necessity (medical, for instance), to start, until his ability to function in the community is fully assessed for possible increased community access (with continued supervision).
> **Communicates Needs:** [Resident A] is non-verbal and communicates through behavior and gestures. It should be noted that [Resident A] does not report to others when he feels sick or has an injury. Staff with support and utilize clarifying questions and gestures as needed during such time to assist him in adequately and accurately expressing his needs.

Alert to Surroundings: In general, yes, [Resident A] is alert to his surroundings but he may be unsafe with surroundings if not supervised. He may inadvertently place self in danger when agitated/anxious; become aggressive towards others or attempt to destruct property. Staff will monitor closely for health/safety. He requires 24 hours supervision and support to maintain safety.
Walking/Mobility: [Resident A] is independent in walking. However, he is an elopement risk as he has done so many times from the family home. Staff will maintain a line of sight monitoring to ensure he does not elope.

I reviewed Resident A's goals from his IPOS meeting through Community Mental Health Services of Livingston County, which documented "health and safety concerns": "[Resident A] is an elopement risk and needs consistent supervision. Staff should ensure [Resident A] is within 'line of sight' during periods of transition and while around peers in the home and community."

I reviewed Resident A's "Structured Daily Routine" for the evening of 12/31/2021 to the morning of 01/01/2022, which documented that Resident A was "asleep in bed" at 4:00AM, but had eloped at 4:30AM through 5:00 AM, after which Resident A was hospitalized. The narrative from the "Structured Daily Routine" documented that during check in of third shift, Resident A was "asleep in bed upon arrival." At checkout of third shift, the narrative documented "Elopement this morning. Went to ER. Still off property at shift end. Prior to elopement slept well."

I reviewed Elopement Protocol for the facility, which documented the following :

If an alarm is triggered or staff are not able to identify the location of a resident during 15-minute welfare check, an elopement is then suspected. Direct Care staff will notify lead on shift immediately. Lead staff will direct two assigned staff via radio to complete a perimeter check around the home while staff remaining in the home will complete a head count. The lead staff is to contact the Home Manager immediately and post in the home messaging group. If all residents are identified in the home, the lead staff is to complete another head count to ensure all residents are present. If a resident is not identified, staff are to complete a deep check, checking all areas of the home. Home Manager will contact Upper Manager using the Chain of Command to gather support from all homes to search through the community. Home Manager will notify 911 once the C.O.O./C.E.O. have been notified. The search is not completed until the resident is identified.

If resident exits the home quickly, staff will immediately follow, radio for assistance, and use physical management if possible, to prevent elopement from the property. Another staff will stay within the home, providing supervision to the other residents. If the resident is calm and attempts to exit the door to the home, staff will follow the resident and radio for assistance while attempting verbal redirection and de-escalating strategies, using body positioning and offering a

prn (if applicable). The staff will use positive reinforcement strategies, especially those (if any) that are specifically outline in the resident's individual plan.

I reviewed the *Incident/Accident Report* associated with the complaint, which documented the following:

Date of Incident: 01/01/22
Time: 4:30 AM
Location of Incident: Outside care home
Explain What Happened: Staff were performing 15 min checks when the noticed [Resident A] was missing. Staff immediately contacted lead who contacted home manager. Staff began elopement procedure completing a house sweep and head count, while another staff began to complete a perimeter check. While completing perimeter check police arrived and talked with staff about [Resident A] elopement. Staff continued to search. Police [found] [Resident A] walking along the road and contacted staff. Staff arrived and began prompting [Resident A] to get in the van to return to the care home. [Resident A] refused and got on the ground. Staff continued to prompt [Resident A] to get in van, with preferred activities and snacks. [Resident A] still refused. Police made the decision to have [Resident A] taken to the hospital. [Resident A] was transported to McLaren Lapeer Regional Hospital by ambulance. Staff followed behind in company vehicle and sat with [Resident A] until discharged. [Resident A] rode with staff safely back to the care home. Staff will closely monitor [Resident A] to ensure his health and safety.

Staff action: Elopement protocol, 15 min check, contacted home manager, verbal redirection, prompting, transported [Resident A] back to care home. Sat with [Resident A at hospital.

Corrective measures: Staff will increase supervision to ensure [Resident A's] health and safety.

Addendum: [Resident A] was diagnosed with ambulatory care.

During the onsite inspection on 01/26/2022, I interviewed Asjia Blanton, Manager, who provided contact numbers for Direct Care Workers who were scheduled during the shift in which Resident A eloped. Ms. Blanton stated that she was on leave at the time, and Joey Hoffner, Manager of Elba South, was covering for her at the time. I asked Ms. Blanton to demonstrate that the alarm system was functioning appropriately. The alarm activated when Ms. Blanton opened the door and a window, and the alarm was audible throughout the area.

On 01/26/2022, I observed Resident A. Resident A appeared to be receiving adequate care and supervision during my onsite inspection.

On 01/27/2022, I interviewed Elisabeth Simon, Livingston County CMH Recipient Rights Officer. Ms. Simon stated that she received and reviewed a report from the Lapeer County Sheriff dated 01/20/2022. Ms. Simon stated that the report indicated that the Sheriff's office was dispatched at approximately 5:30am to the area around the facility due to a report of an individual walking down the middle of the road. A deputy followed up regarding the incident, and suspected the person was from Flatrock, as officers in the area have responded to previous elopement incidents. The deputy reportedly arrived at the facility to find the front door ajar and no staff present. Ms. Simon stated that the report indicated that deputy went to the adjoining facility, Elba South and spoke with staff there who went to assist with Resident A. The report indicated that Resident A was found 1.5 miles away from the facility, without supervision, and it was estimated that he had been away for up to an hour. Resident A was reportedly in his pajamas. The deputy reported that Resident A refused to get in the van with the staff members. The deputy was concerned and contacted an ambulance for Resident A.

On 01/27/2022, I contacted Deputy Sergeant Jason Parks, Lapeer County Sherriff's Office. Mr. Parks stated that Deputy Laura Nelson was the responding officer for the elopement of Resident A on 01/01/2022 and he provided her contact information. Deputy Sergeant Parks stated that his department has had numerous incidents of residents from the facility being in the road or laying in the road. Deputy Sergeant Parks stated that his office receives regular calls from concerned citizens regarding resident safety, and officers go to the facility at least once a week. Deputy Sergeant Parks stated that the road in which the facility sits has a speed limit of 50mph, and someone could be seriously hurt walking on the road. Deputy Sergeant Parks stated that on 01/12/2022 he had a meeting with Licensee Designee Nicholas Burnett to discuss the safety of residents at the facility. Deputy Sergeant Parks stated that the meeting was not productive, with Mr. Burnett stated that resident rights prevents staff from stopping residents from leaving the facility.

On 01/27/2022, I contacted Deputy Laura Nelson, Lapeer County Sherriff's Office. Deputy Nelson stated that they received a citizen's call in the early morning of 01/01/2022 regarding a male walking down the middle of the road wearing pajamas. Deputy Nelson stated that since the location of the individual was near Elba North, it was assumed that he was from the facility. Deputy Nelson stated that the Sherriff's Office has responded to numerous elopement calls for residents from the facility. Deputy Nelson stated that there were no staff with the male, later identified as Resident A. Deputy Nelson stated that she called the facility numerous times and did not get an answer. Deputy Nelson stated that she went to the facility to check if they were missing a resident. Deputy Nelson stated that she rang the doorbell at the facility, but there was no answer. Deputy Nelson stated that she noticed that the door to get inside the facility, which requires a passcode for entry, was ajar. Deputy Nelson stated that she peeked inside, called out to staff, but did not get an answer or see anyone. Deputy Nelson stated that she went to the adjoining facility Elba South and spoke with a staff member, asking if they were missing anyone. Deputy Nelson stated that the staff member responded they did not know, and that no one was

working on "that side." Deputy Nelson stated that the staff member from Elba South went over to Elba North and discovered that Resident A was not in his room. Deputy Nelson stated that the staff member contacted coworkers to check the area. Deputy Nelson stated that she received a call from a police sergeant that Resident A was located in his pajamas with no shoes or coat. Deputy Nelson estimated that Resident A was missing from about one or two hours based on where he was located. Deputy Nelson stated that an ambulance was called for Resident A to have him checked out.

On 02/01/2022, I reviewed Lapeer County Sheriff's Office Case Report for this incident, which documented the following from Deputy Laura Nelson:

> On 01/01/22 around 0515 dispatch advised they had received several calls regarding a male walking down Ebla Rd. in his pajamas. Dispatch advised the subject may have been from an assisted living home in the area at 300 N. Elba Rd. Dispatch attempted to call the facility but there was no answer. I checked the area but did not locate the male. I attempted to make contact with staff at the facility. I went through the main doors on the north end of the facility and rang the doorbell. There was no answer. I then noticed that the door that led into the facility (which requires a passcode) was ajar. I walked into the facility and could not locate anyone. I then went to the south end of the building and made contact with staff working the south end. I asked if they were missing anyone from the building and described the male. The staff stated they weren't sure because no one was working the north side of the building. Staff then returned and stated that [Resident A] was missing. [Resident A] is autistic/nonverbal. Staff advised he could have been missing for more than an hour. [Resident A] was located at Oregon Rd/Indian Rd. by 4408. [Resident A] was transported to the hospital by EMS. I have been on several calls where [Resident A] has left the facility and been in the roadway even though the facility is supposed to have a one on one staff member with him and the doors are supposed to be secured with a passcode.

On 02/14/2022, I received the staff schedule and staff phone numbers for Elba North and Elba South, which documented four direct care workers scheduled for Elba North, and five direct care workers scheduled for Elba South.

On 02/15/2022, I observed Resident A during a renewal inspection. Resident A appeared to be receiving adequate care and supervision.

On 02/21/2022, I interviewed Direct Care Worker Anasha Reese, who stated that she worked on the morning of 01/01/2022 when Resident A eloped. Ms. Reese stated that she was completing her 15-minute checks and routines at around 4:30 AM, when she noticed that Resident A was not in his room. Ms. Reese stated that at her previous room check, Resident A was asleep in his pajamas. Ms. Reese stated that she went to scatter to try and locate Resident A. Ms. Reese stated that she did not hear an alarm sound, and she believes that the alarm was loud enough if it did

sound. Ms. Reese stated that neither she nor DCW Jarvon Brown, who she was working with, heard an alarm sound. Ms. Reese stated that staff members from Elba South assisted in trying to locate Resident A. Ms. Reese stated that she did not know who located Resident A. Ms. Reese stated that she was relatively new working at the facility in her third week, and was later told that Resident A regularly tries to elope. Ms. Reese stated that the alarm system is currently louder for her to hear.

On 02/21/2022, I interviewed DCW Kenyatta Campbell, who works at Elba South, the adjoining facility. Ms. Campbell stated that she was working in the early morning of 01/01/2022 as a 1:1 staff. Ms. Campbell stated that she was sitting in the living room area with the resident she was responsible for, when she heard an alarm go off at Elba North. Ms. Campbell stated that no one from Elba South went to check on the alarm because they were working on their own side of the building. Ms. Campbell stated that she and another staff had 1:1 supervision, while other staff were in the office at the time. Ms. Campbell stated that sometime later a police officer knocked on their door and informed them that the door on the other side was wide open and they had a report of a missing resident. Ms. Campbell stated that she did not go out to search due to being a 1:1 staff, but two of her coworkers went to assist in searching for Resident A. Ms. Campbell stated that Resident A was found by the police as he was going towards the highway. Ms. Campbell stated that she believes that there were two direct care staff working at Elba North on the morning of 01/01/2022.

On 02/22/2022, I interviewed DCW Jarvon Brown, who stated that he was working at the facility (Elba North) on the morning of 01/01/2022. Mr. Brown stated that he was working as a 1:1 staff with another resident. Mr. Brown stated that he did not hear an alarm. Mr. Brown stated that Resident A and one other resident require 1:1 staff on first and second shift, but not on third shift. Mr. Brown stated that he did not know that Resident A had eloped until a direct care worker from Elba South came an informed him. Mr. Brown stated that he did not go out to search for Resident A because he had 1:1 supervision with a resident. Mr. Brown stated that he believes that Resident A was returned to the facility after about 20 minutes.

On 02/22/2022, I interviewed DCW John Ryder, who works at Elba South, the adjoining facility. Mr. Ryder stated that he was working at Elba South on the morning of 01/01/2022, when he heard an alarm go off. Mr. Ryder stated that he and his coworkers checked around their facility but found no indication of someone missing. Mr. Ryder stated that about an hour went by, and they heard a buzzer go off for someone “getting out” at Elba North. Mr. Ryder stated that he and his coworkers assumed that staff at Elba North would take care of the situation. Mr. Ryder stated that later they heard a knock at the door and one of their residents told them that the police were at the door. Mr. Ryder stated that staff immediately answered and was told that the police were getting calls from the community that someone was walking down the side of the road and wanted to know if they were missing a resident. Mr. Ryder stated that every resident at their facility was accounted for, so he and another staff went to Elba North. Mr. Ryder stated they discovered that Resident A

was not accounted for. Mr. Ryder stated that he and another staff located staff for Elba North who were alarmed that Resident A was missing. Mr. Ryder stated that staff from Elba South took the van to assist searching for Resident A, but he stayed at the facility with the other residents. Mr. Ryder stated that he has heard that Resident A elopes from time to time. Mr. Ryder stated that he believes that Resident A had on only a t-shirt and pajama pants.

On 03/02/2022, I interviewed Guardian A1, who stated that she was made aware of Resident A's elopement on 01/01/2022. Guardian A1 stated that she received notice from the facility and from Resident A's CMH caseworker Elisabeth Simon. Guardian A1 stated that Ms. Simon informed here that the Incident Report she received was conflicting with the police report about the elopement. Guardian A1 stated that Resident A is currently on 1:1 supervision for 16 hours, which does not include third shift. Guardian A1 stated that Resident A has an alarm on his window and there are door alarms, but it is possible that Resident A could get out of other windows. Guardian A1 stated that Resident A requires 24-hour supervision because he does not know any better. Guardian A1 stated that it was very cold on the day that he eloped, and she fears that he could be seriously hurt in such situations without supervision.

On 03/07/2022, I interviewed DCW Carson Robinson. Mr. Robinson stated that he was working at Elba North on 01/01/2022 on the morning when Resident A eloped. Mr. Robinson stated that he was working with two other direct care workers. Mr. Robinson stated that Resident A was awake early that morning and he heard the alarm sound while doing paperwork. Mr. Robinson stated that he immediately noticed that Resident A was not in the facility and called a "code 3." Mr. Robinson stated that he contacted Larry Robinson who was working at Elba South to inform that Resident A had eloped. Mr. Carson Robinson stated that Resident A was spotted in front of the facility on the grass. Mr. Robinson stated that the police arrived at the facility, but that Resident A was not a mile away from the facility. Mr. Robinson stated that Resident A was within view of staff at the time. Mr. Robinson stated that staff tried to verbally redirect Resident A back inside, but he was taken to the hospital for observation.

On 03/08/2022, I interviewed DCW Larry Robinson, who was working at Elba South. Mr. Robinson stated that he was working on the morning of 01/01/2022, when he received a phone call from Carson Robinson at Elba North who called a "Code 3" for Resident A's elopement. Mr. Robinson stated that he ran over to Elba North to assist and Resident A was found in the area around the facility, but not far away. Mr. Robinson stated that the police arrived, but he did not speak with the officer. Mr. Robinson stated that he went back to Elba South once Resident A was found.

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:	Based on interviews and documentation from the *Incident Report*, Lapeer County Sheriff's Case Report, and Structured Daily Routine, Resident A eloped from the facility in the early morning of 01/01/2022. Direct Care Workers Anasha Reese and Jarvon Brown reported that they did not hear the door alarm, leaving staff from the adjoining facility at Elba South to respond. There were conflicting reports from Direct Care Workers Carson Robinson and Larry Robinson, who reported that they responded to the alarm and found Resident A around the facility, which does not coincide with the *Incident Report* submitted by the facility or the Lapeer County Sherriff's Case Report. As a result of his diagnoses, Resident A's *Assessment Plan* documents that "he will always be provided with 1:1 supervision while in the community," "he requires 24 hours supervision and support to maintain safety," and "staff will maintain a line of sight monitoring to ensure he does not elope." Direct Care Workers did not have supervision or line of sight monitoring of Resident A during his elopement on 01/01/2022, which is not in compliance with his Assessment Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/11/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett asked for clarity regarding elopement violations and agreed with the findings.

IV. RECOMMENDATION

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

03/14/2022

Derrick Britton — Date
Licensing Consultant

Approved By:

03/14/2022

Mary E Holton — Date
Area Manager