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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2022

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

RE: License #: AM440388514
Investigation #: 2022A0580030
Elba 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,

A handwritten signature in cursive script that reads "Sabrina McGowan". The letters are fluid and connected, with a prominent 'S' at the beginning and a 'G' at the end.

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388514
Investigation #:	2022A0580030
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	04/04/2022
Report Due Date:	05/30/2022
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:	Elba South
Facility Address:	280 North Elba Road Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	02/08/2018
License Status:	REGULAR
Effective Date:	08/08/2020
Expiration Date:	08/07/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Multiple residents were in the van with two staff when the staff driving kept flooring the gas and slamming on the brakes, repeatedly so the residents were being thrown around in their seats. The driver almost lost control going towards a semi-truck and had to swerve tossing all residents around and some were hurt/bruised.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake 2022A0580030
04/04/2022	Special Investigation Initiated - Telephone A call was made to Ms. Ross of APS.
04/04/2022	APS Referral This referral was denied by APS for investigation.
04/14/2022	Inspection Completed On-site An onsite inspection was conducted at Elba South. Contact was made with Resident A.
04/14/2022	Contact - Face to Face An interview was attempted with Resident B.
05/17/2022	Contact - Telephone call made A call was made to Ms. Andrea Banamo, case manager for Resident A.
05/17/2022	Contact - Telephone call made A call was made to Ms. Joey Marsh of Recipient Rights, Livingston Co.
05/19/2022	Contact - Document Received An email was received from Ms. Morgan Yarkosky, license administrator.

05/20/2022	Contact - Telephone call made A call was made to Mr. Dominique Strong, staff.
05/20/2022	Contact - Telephone call made A call was made to Ms. Grasa McClure, staff.
05/23/2022	Contact - Document Received An email was received from the license administrator, Ms. Morgan Yarkosky.
05/23/2022	Exit Conference An exit conference was held with the license administrator, Ms. Morgan Yarkosky.

ALLEGATION:

Multiple residents were in the van with two staff when the staff driving kept flooring the gas and slamming on the brakes, repeatedly so the residents were being thrown around in their seats. The driver almost lost control going towards a semi-truck and had to swerve tossing all residents around and some were hurt/bruised.

INVESTIGATION:

On 03/31/2022 I received a complaint via BCAL complaints.

On 04/04/2022, I spoke with Ms. Rose Koss of APS in Lapeer County. She indicated that APS would not be investigating the allegations.

On 04/14/2022, I conducted an onsite inspection at Elba South. An interview was conducted with Resident A. Resident A indicated that the driver of the van kept flooring the gas and slamming on the brakes. He and the other residents were thrown around as a result. He also almost lost control and barely missed hitting a semi-truck. Resident A indicated that staff was being attacked by Resident B while driving. He indicated that he did hurt his neck, however, it does not hurt at this time. Resident A's neck was observed. No bruising was observed at the time of the visit.

On 04/14/2022, I attempted an interview with Resident B. Resident B indicated that she is not interested in participating in an interview at this time and requested that I leave the room.

On 05/17/2022, I spoke with Ms. Andrea Banamo assigned Livingston County case manager for Resident A. She indicated that she has been made aware of the allegations made by Resident A. She also shared that the case is being investigated by recipient rights in her county.

On 05/17/2022, I spoke with Ms. Joey Marsh, assigned Recipient Rights Investigator in Livingston County. She indicated that based on her interviews with residents and staff, it appears as if the driver was being physically attacked by one of the residents. As a result of the attack the driver had to maneuver the vehicle while driving, which may have appeared as reckless driving. She indicated that will not be substantiating the case.

05/19/2022, I received an email from Ms. Morgan Yarkosky, license administrator. She indicated that Resident A was in the vehicle at the time when Resident B began attacking the driver from behind, which made the driving appear reckless. Resident B's behavior was noted in her behavior chart. No incident report was written. A copy of the behavior chart was received. It indicated that on 03/17/2022, due to staff driving on the highway, Resident B began hitting and slapping the driver of the van. Staff, Dominique Strong was identified as the driver. Staff Grasa McClure was also present in the vehicle.

On 05/20/2022, I spoke with direct staff, Mr. Dominique Strong. He indicated that on the day in question, as he was driving the residents back to the home, Resident B began attacking him. He indicated that he had went around two sharp turns when Resident B told him to stop driving crazy. He informed Resident B that it was he was not driving crazy, it was the way the road was made. After driving a bit further, Resident B began smacking and punching him upside his head. She also began hitting him with the walkie-talkie radio. He recalled that there were five residents present in the van. Staff, Ms. Grasa McClure was also present in the vehicle. Mr. Strong indicated that while attempting to block Resident B, he was tapping the brakes to maintain control of the vehicle while being attacked. He eventually was able to pull over to the side of the road to assist with getting Resident B under control. Mr. Strong denied that he kept flooring the gas and slamming on the brakes, repeatedly so the residents were being thrown around in their seats. He also denied that he almost lost control going towards a semi-truck as alleged.

On 05/20/2022, I spoke with direct staff, Ms. Grasa McClure. She indicated that Resident B had become upset because staff, Mr. Strong had gotten on the expressway. She added that the van can only go 65 mph and Resident B was getting upset due to the amount of time it was taking to get back to the home. Resident B began attacking the driver. The driver pulled over in an effort to redirect Resident B and to keep everyone in the vehicle safe. She denied that that he kept flooring the gas and slamming on the brakes, repeatedly so the residents were being thrown around in their seats. She also denied that he almost lost control going towards a semi-truck as alleged.

On 05/23/2022, I received an emailed copy of a valid driver's license for staff, Mr. Dominique Strong.

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:	<p>It was alleged that the driver almost lost control going towards a semi-truck and had to swerve tossing all residents around and some were hurt/bruised.</p> <p>Resident A indicated that the driver of the van kept flooring the gas, slamming on the brakes and also almost lost control, and barely missed hitting a semi-truck. Resident A indicated that staff was being attacked by Resident B while driving.</p> <p>Resident B refused to participate in an interview.</p> <p>Livingston County case manager for Resident A, Ms. Andrea Banamo, has been made aware of the allegations.</p> <p>Livingston County Recipient Rights Investigator, Ms. Joey Marsh, indicated that will not be substantiating the case.</p> <p>License Administrator, Ms. Morgan Yarkosky, indicated that Resident A was in the vehicle at the time when Resident B began attacking the driver from behind, which made the driving appear reckless. Resident B's behavior was noted in the residents' behavior chart. No incident report was written.</p> <p>Direct Staff, Mr. Dominique Strong, denies the allegations. A copy of a valid driver's license for staff, Mr. Dominique Strong was observed.</p> <p>Direct staff, Ms. Grasa McClure, denied the allegations.</p> <p>Based on the information gathered in the course of the investigation indicating that staff was being attacked while driving, there is insufficient evidence to support the rule violation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/19/2022, 05/19/2022, I received an email from Ms. Morgan Yarkosky, license administrator. She indicated that Resident A was in the vehicle at the time when Resident B began attacking the driver from behind, which made the driving appear reckless. Resident B's behavior was noted in her behavior chart. No incident report was written.

On 05/23/2022, I conducted an exit conference with the license administrator, Ms. Morgan Yarkosky. Ms. Yarkosky was informed that such an incident should have been written as an incident report based on the serious display of hostility by the resident towards the staff. A licensing violation was established. A corrective action plan is due within 15 days.

APPLICABLE RULE	
R 400.14311	Investigation and reporting of incidents, accidents, illnesses and death.
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (iii) Attempts at self-inflicted harm or harm to others.
ANALYSIS:	Resident B began hitting and slapping the driver of the van while driving. Resident B's behavior was noted in her behavior chart. No incident report was written. Due to the harm displayed towards staff, there is sufficient evidence to support the rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

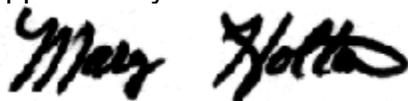


May 24, 2022

Sabrina McGowan
Licensing Consultant

Date

Approved By:



May 25, 2022

Mary E Holton
Area Manager

Date