GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 8, 2022

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

RE: License #: AM440388517
Investigation #: 2022A0582036
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.
- 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9700.

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 #:	2022A0582036
Complaint Receipt Date:	05/11/2022
Investigation Initiation Date:	05/11/2022
Report Due Date:	07/10/2022
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 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:	03/05/2022
Expiration Date:	03/04/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
On 05/10/2022, Resident A eloped from the facility, and staff were unaware of his whereabouts.	Yes
Staff smoke marijuana while working.	Yes

III. METHODOLOGY

05/11/2022	Special Investigation Intake 2022A0582036
05/11/2022	Special Investigation Initiated - Letter Email communication with Jason Parks, Detective Sergeant, Lapeer County Sheriff's Department
05/12/2022	Contact - Document Received Reviewed Incident Report
05/12/2022	Contact - Document Received Reviewed 30-Day Notice for Resident A
05/17/2022	Contact - Document Received Case Report from Lapeer County Sheriff's Office
05/17/2022	Contact - Document Received Reviewed Professional Conduct Policy for facility
05/18/2022	Inspection Completed On-site Face to face with Resident A, Interview with Asjia Blanton, Manager, Received Resident A's *Assessment Plan* and *Behavioral Treatment Plan*
05/26/2022	Contact - Telephone call made Interview with DCW Breanna Craig
05/26/2022	Contact - Telephone call made Interview with Porcha McCullough, Elba South staff
05/26/2022	Contact - Telephone call made Attempted contact with DCW Jarvon Brown

06/01/2022	Contact - Telephone call made Attempted contact with DCW Jarvon Brown
06/23/2022	Contact - Document Received Reviewed Elopement Protocol for facility
06/27/2022	Contact - Telephone call made With DCW Quiara Boswell-Osborne
06/27/2022	Contact - Telephone call made With Relative A
06/30/2022	Exit Conference With Nicholas Burnett, Licensee Designee
06/30/2022	Inspection Completed- BCAL-Sub. Compliance
07/01/2022	Contact – Telephone call made Interview with Mr. Burnett.
07/05/2022	APS Referral Referral made to APS.

ALLEGATION:

On 05/10/2022, Resident A eloped from the facility, and staff were unaware of his whereabouts.

INVESTIGATION:

I received this complaint on 05/11/2022, and reviewed an email sent from Jason Parks, Detective Sergeant, Office of Lapeer County Sheriff. Detective Sergeant Parks documented that on 05/10/2022, Resident A “escaped” from the facility and was located within the roadway. Detective Sergeant Parks provided the Case Report for this incident, which documented the following welfare check from Deputy Austin Jerome:

> **INFORMATION:**
> On May 10th, 2022, at approximately 0415 HRS, I, Deputy Austin Jerome, responded to the area of Elba Rd and Oregon Rd for the welfare check of a male subject in the middle of the road called in by a passerby. Myself and Deputy Keller found a male whom we are familiar with as being a resident of Flatrock Manor located at 300 N Elba.

INVESTIGATION:
While myself and Deputy Keller were responding, Lapeer Central Dispatch attempted to call Flatrock Manor to ask if all of their residents were accounted for. Lapeer Central Dispatch advised me they could not get a hold of any employee via telephone at Flatrock Manor. Myself and Deputy Keller arrived to the area of N Elba Rd and Oregon Rd. Myself and Deputy Keller located a male in the middle of Oregon Rd east of N Elba Rd. I recognized the male as a resident of Flatrock Manor (300 N Elba Rd). The male, who I later identified through staff as [Resident A], immediately sat down in the middle of the road.

I responded to Flatrock Manor as Deputy Keller stayed on scene with [Resident A]. I arrived at Flatrock Manor and spoke to several staff members who were surprised that [Resident A] had left the building. I asked them to get the company van and to go pick [Resident A] up and bring him back to the residence.

Five staff members responded to Deputy Keller's location. The five staff members could not get [Resident A] into the van to be transported back to the residence. After approximately 15 minutes of failed attempts to get [Resident A] into the van, Sgt. Davis requested EMS respond to the scene.

While waiting for EMS, I spoke with Breanna Monae Craig, a staff member. She stated she was working on the North Side of the building tonight, which is the side [Resident A] is on. She stated they had no manager working and the North Side team leader by the name of Raven called in and did not report to work. Breanna stated the North Side of the building, the side [Resident A] resides on, was short by one staff member.

I spoke with Quiara Haleema Bauswell-Osborn. Quiara stated she was not scheduled to work today but stated she was covering the lead position on the north side. I asked her who approved her to cover for the lead position and she stated Raven and the administration approved it in a group chat. I asked her if she is certified to act as a lead staff member and she stated no.

EMS arrived and transported [Resident A] to McLaren in Lapeer. I responded to Flat Rock Manor for follow up. I spoke with Porscha McCullough who stated she was the lead staff member for the south side of the residence. She stated she called Asjia Blanton who is the manager and informed her of [Resident A's] escape. Porscha stated Asjia said "okay" and "thanks" but was not going to respond to the residence.

RESIDENT: [Resident A] … [Resident A] does not have 1 on 1 supervision on 3rd shift.
LOCATION: Oregon Rd east of Elba Rd.
WEATHER: Dark, unlighted. Clear skies, approximately 55 degrees.
CLOTHING: No shoes, no socks. Pajama pants and a T-shirt.

ROOM: I found [Resident A's] bedroom window to be closed and locked. The alarm on his door was working as I tested it and heard the audible alarm sound off in the kitchen.
CARETAKER: I spoke with Jarbon [sic] Craig Brown outside at his vehicle in the parking lot of Flat Rock Manor. I asked him if he had [Resident A's] board, indicating he was in charge of [Resident A] on this given night. He stated he did have [Resident A's] board. I asked Jarbon [sic] if he knew how [Resident A] got out of the building and he stated no. I asked Jarbon [sic]where he was when he learned [Resident A] was missing. He stated he was in the sensory room, a room with a T.V. and a ball pit for the residents. I asked Jarbon [sic] how many residents were in the sensory room, and he stated none. He stated he fell asleep in the sensory room after he checked on [Resident A] at approximately 0200 HRS.

On 05/12/2022, I reviewed an Incident Report associated with this allegation, which documented the following:

Persons Involved: Breanna Craig, Quaira Bauswell-Osborn
Name of Employee Assigned to Resident: Jarvon Brown
Date of Incident: 5/10/2022 **Time**: 4:30 AM **Location of Incident**: Road
Explain What Happened: The police arrived to the care home notifying staff that [Resident A] had been found. Staff immediately went to [Resident A's] location and noticed [Resident A] was sitting on the ground acquainted by the police. [Resident A] was prompted to get in the van (refused0 resulting in [Resident A] to be transported by ambulance to McLaren Lapeer followed by staff. Once arrived to McLaren Lapeer, [Resident A] then was observed for any injuries (scratch on right side). [Resident A] was then discharged to be safely transported back to the care home. [Resident A] was closely monitored by 1:1 staff to ensure his health and safety for the remainder of the shift.
Staff Action: Contacted Home Manager, went to [Resident A] location, observed [Resident A] for injuries, followed ambulance to McLaren Lapeer, safely transported back to care home, and one to one closely monitored [Resident A] for remainder of the shift.
Corrective Measures: One to one staff will continue to closely monitor for the remainder of the shift.

On 05/12/2022, I reviewed a "Thirty Day Discharge Notice" for Resident A from the facility, dated 05/11/2022. The reason listed stated that "it has been our clinical recommendation in order to keep [Resident A] safe that 1:1 services are required 24/7. At this point, without this authorization, we are unable to keep him safe. If Livingston County Community Mental Health is willing to provide funding for 1:1 services 24/7 then we will rescind this notice.

On 05/18/2022, I conducted an unannounced, onsite inspection at the facility.

I observed Resident A in his room with a 1:1 staff. Resident A was asleep at the time and appeared to be receiving proper supervision and care. I was aware that Resident A is nonverbal from a previous investigation.

I interviewed Asjia Blanton, Manager. Ms. Blanton stated that she was made aware of Resident A's elopement on 05/10/2022. Ms. Blanton stated that staff did not hear the alarm sound during the elopement. Ms. Blanton stated that staff began doing their routine checks, when the police arrived and informed them that they had Resident A. Ms. Blanton stated that Resident A's supervision will be increased from 16 hours a day to 24 hours a day.

I reviewed Resident A's Assessment Plan dated 04/02/2021, 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."

On 05/26/2022, I interviewed Breanna Craig, who stated that she was working on the early morning of Resident A's elopement. Ms. Craig stated that she was working with Direct Care Workers (DCW) Quaira Bauswell-Osborn, Jarvon Brown, and

Tieriana Harris. Ms. Craig stated that she was with Ms. Bauswell-Osborn in the kitchen, Jarvon Brown was monitoring the hallway and “assigned” to Resident A, and Tieriana Harris was assigned as a 1:1 with another resident. Ms. Craig stated that Resident A was not a 1:1 resident during third shift, but staff are assigned to his general area on third shift to ensure supervision. Ms. Craig stated that at some point during the shift, Resident A was awake and in the hallway by the kitchen. Ms. Craig stated that Resident A is very “sneaky.” Ms. Craig stated that she asked DCW Jarvon Brown if he needed any assistance with Resident A, and he denied needing help. Ms. Craig stated that she was in the kitchen cleaning up and heard an alarm go off, but staff checked on Resident A and he was in his room. Ms. Craig stated that she and DCW Bauswell-Osborn went to do laundry and continue cleaning. Ms. Craig stated that later in the shift, a staff member from Elba South came to Elba North and informed them Resident A was missing. Ms. Craig stated that staff checked, and Resident A was not in his room. Ms. Craig stated that she did not hear an alarm. Ms. Craig stated that she jumped in the van with staff from Elba South to go to Resident A’s location “all the way down the street.” Ms. Craig stated that DCW Jarvon Brown was nowhere to be found. Ms. Craig stated that she was told by a staff member from Elba South that Mr. Brown was asleep in the television room at the time of Resident A’s elopement. Ms. Craig stated that she was interviewed by police and staff were trying to get Resident A into the van. Ms. Craig stated that she recalls the officer telling her that “this is ridiculous,” referring to the number of times they have dealt with Resident A eloping. Ms. Craig stated that she met with management afterwards and was fired.

On 05/26/2022, I interviewed Porcha McCullough, staff from Elba South who was working during Resident A’s elopement. Ms. McCullough stated that she and other staff were working around 4 AM they heard the doorbell go off three times, before going to answer and seeing that it was the police and a citizen. Ms. McCullough stated that the police asked if they were missing anyone, because a guy was almost hit in the middle of the road. Ms. McCollough stated that she asked staff “who was assigned to Resident A’s board,” meaning who was assigned to the chore area near Resident A. Ms. McCollough stated that she was told that DCW Jarvon Brown was assigned to Resident A’s board. Ms. McCollough stated that when she went over to Elba North, she initially could not find anyone in sight. Ms. McCollough stated that the alarm in the kitchen was going off, which was from Resident A’s bedroom. Ms. McCollough stated that police were at Resident A’s location away from the facility and had the road blocked off. Ms. McCullough stated that DCW Breanna Craig came over and went with Elba South staff to retrieve Resident A. Ms. McCollough stated that Ms. Craig tried calling other staff on shift with her but could not reach them. Ms. McCollough stated that DCW Quiara Boswell-Osborne later came and assisted with Resident A. Ms. McCollough stated that she spoke with DCW Jarvon Brown, who stated that it was impossible for Resident A to get out; however, Ms. McCollough stated that DCW Brown was very nonchalant about the situation. Ms. McCollough stated that EMS was contacted, as Resident A was sitting in the middle of the road with his legs crossed. Ms. McCollough stated that EMS took Resident A to the hospital while DCW Jarvon Brown trailed EMS. Ms. McCollough stated that police

interviewed other staff at the scene. Ms. McCollough stated that she contacted Elba North manager Asjia Blanton to inform her of the situation.

On 05/26/2022 and 06/01/2022, I attempted to contact and interview DCW Jarvon Brown, but did not receive a return call.

On 06/23/2022, 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.

On 06/27/2022, I interviewed DCW Quaira Boswell-Osborne. Ms. Bauswell-Osborn stated that she was with DCW Breanna Craig for the majority of the shift. Ms. Bauswell-Osborn stated that she was fired because of the incident and has moved on and did not want to revisit the situation. Ms. Bauswell-Osborn stated that things occurred the way DCW Breanna Craig reported it.

On 06/27/2022, I interviewed Relative A. Relative A stated that she was informed of the 05/10/2022 elopement, which was one of many. Relative A stated that she is afraid that something bad will happen with Resident A's elopements. Relative A stated that she is hoping to find another placement for Resident A, but in the meantime, he currently has 24-hour supervision with a 1:1 staff after the last elopement occurred.

On 06/30/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett was not in agreement with original actions being taken

against the license and felt that the facility was progressively moving towards a solution for their elopements. Mr. Burnett admitted that there have been difficult staff members, who are fired once management becomes aware.

On 07/08/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett stated that Resident A's Assessment Plan was still applicable up until it was update on 05/12/2022, which was after the elopement on 05/10/2022. Mr. Burnett explained that during each shift, the Lead Worker divides residents and responsibilities among Direct Care Workers, who are responsible for implementing resident Plans of Service, Structured Daily Routine logs, progress notes, and checks as applicable to each resident. Mr. Burnett explained that these responsibilities are kept on a plastic clip board for Direct Care Workers to track. Mr. Burnett stated that "Line of Sight" is a loosely used term for residents that they do not have the authorization to provide 1:1 supervision. Mr. Burnett explained that for residents that have "line of sight" in their plan, staff must be in the general area of the resident, but not in private areas (bathrooms, bedrooms). Mr. Burnett stated that after reviewing the information, Resident A was out of the home for nine minutes during his elopement on 05/10/2022. Mr. Burnett stated that the Resident eloped through a window. Mr. Burnett asked for information regarding windows that partially open, to prevent future elopements. Mr. Burnett stated that he was not allowed to have fencing around the facility, as this would be in violation of Home and Community-Based Services (HCBS) regulations. Mr. Burnett stated that he has been working to implement a tracking system for staff to be more aware of their whereabouts while on shift. I explained to Mr. Burnett that a violation would still be applicable

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 has been a known elopement risk since being admitted to the facility in April 2021, which is clearly outlined in his *Behavioral Treatment Plan* and *Assessment Plan*. Resident A had supervision for 16 hours a day on first and second shifts and was given a 30-day discharge notice on 05/11/2022, after his most recent elopement on 05/10/2022. Resident A's

	Assessment Plan documents that he is “nonverbal,” “will always be provided with 1:1 supervision while in the community,” “requires 24 hours supervision and support to maintain safety,” and “staff will maintain a line-of-sight monitoring to ensure he does not elope.” Resident A eloped in the early morning hours on 05/10/2022 without staff knowing his whereabouts until alerted by Lapeer County Sheriff’s officers, who found him at 4:15 AM wearing pajama pants, a t-shirt, no shoes, and no socks. The facility did not provide proper supervision of Resident A, as staff were unaware of his whereabouts. Additionally, reasonable action had not been taken to ensure his safety and well-being, to include responding to the alarm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff smoke marijuana while working.

INVESTIGATION:

I received this complaint on 05/11/2022, and reviewed an email sent from Jason Parks, Detective Sergeant, Office of Lapeer County Sheriff. Detective Sergeant Parks documented that on 05/10/2022, Resident A “escaped” from the facility and was located within the roadway. Detective Sergeant Parks noted that while a staff member was interviewed about the incident, an officer detected marijuana use on staff, who denied using while working and claimed to smoke prior to starting shift. Detective Sergeant Parks provided the Case Report for the elopement incident, which documented the following interview with DCW Jarvon Brown from Deputy Austin Jerome:

> I spoke with Jarbon [sic] Craig Brown outside at his vehicle in the parking lot of Flat Rock Manor…I noticed Jarbon's [sic] car was emitting a heavy odor of marijuana. I asked Jarbon [sic] if he smoked any marijuana during his shift and he stated no. He stated he smoked marijuana at home prior to his shift which started at 2300 HRS.

On 05/16/2022, I received a report from Detective Sergeant Parks, who stated that on 05/13/2022 at 11:03 PM, Lapeer County Sheriff's Deputy Thomas Durant investigated a non-injury traffic crash within a quarter of a mile from Flatrock in Lapeer. Deputy Durant established contact with Eboney Deloney an employee of Flatrock in Lapeer. Detective Sergeant Parks reported that Eboney Deloney had

struck the back of another vehicle at a stop sign, and “an odor of marijuana was detected associated to Deloney.” Detective Sergeant Parks reported that upon questioning, “Deloney admitted to marijuana use on breaks during her shift at Flatrock Manor.” Detective Sergeant Parks stated that using marijuana on-site has a potential impact on caring for clients under her care.

On 05/17/2022, I received and reviewed the Lapeer County Sheriff's Office Case Report related to Ms. Deloney’s accident, which documented the following:

> **Occurrence Date/Time**: 05/13/2022, 11:03 PM
> **Location:** Davison Rd & N Elba Rd, Lapeer
> Narrative:
> **INFORMATION:**
> On 5/13/2022 I (Deputy Durant) was dispatched to the area of Davison and Elba Road in reference a two-vehicle crash.
> **ON SCENE:**
> Once on scene I observed a grey Chevrolet Colorado parked on the northwest side of Davison Road and a tan Saturn parked on the southwest side of Elba Road. The Driver of the Chevrolet, later identified as George Jones, was standing near the Saturn. The Driver of the Saturn, later identified as Eboney Deloney, was standing by the driver's open door. The passenger of the Saturn, later identified as Aniyah Everett, was standing at the front of the vehicle.
> **INTERVIEW CONDUCTED (Citizen):**
> I spoke with [Citizen] who stated he was going through the intersection at Davison and Elba when he felt something hit the rear of his vehicle. Mr. Jones stated he did not need medical assistance.
> **INTERVIEW CONDUCTED (Aniyah Everett):**
> I spoke with Ms. Everett who stated at the time of the crash she was looking at her phone and she did not see what had happened.
> **INTERVIEW CONDUCTED (Eboney Deloney):**
> I spoke with Ms. Deloney who stated she had just left work at Flat Rock Manor. She went on to tell me that she had pulled up to the stop sign at Elba and Davison heading south bound. After stopping at the stop sign, she proceeded into the intersection. At that time, her vehicle struck the right rear tire of [Citizen’s] vehicle. Ms. Deloney stated that she did not even see [Citizen’s] vehicle. I asked Ms. Deloney if she had used any marijuana because there was a noticeable odor coming from her vehicle. She stated that she had smoked marijuana on her break and then she had went back to work. At that time, I observed no signs of impairment.
> **OUTCOME:** Ms. Deloney and [Citizen] were given a copy of the crash slip and had it explained. A UD-10 was completed.

On 05/17/2022, I received and reviewed the “Professional Conduct Policy” for the facility, parts of which include the following:

> **Professional Conduct Policy Objective**

To identify the unacceptable and unauthorized conduct of Flatrock Inc. employees including standards of conduct, prohibited conduct examples, and violations of policy.

Standards of Conduct

- All Flatrock Inc. employees represent the company including in matters of personal conduct and are required to conduct themselves as such while serving the company in their normal professional capacity and when outside of normal work hours while wearing Flatrock attire.

Prohibited Conduct Examples

- Using illegal or prohibited substances while on duty and especially in the presence of residents.
- Engaging in any conduct specifically prohibited by local or temporary order.
- Any other nonprofessional behaviors exhibited in a Flatrock Inc. care home.

Violation

- Flatrock Inc. staff who do not adhere to this policy and reasonable variations of such are subject to disciplinary action, up to and including transferring to a different Flatrock Inc. location or termination.

On 05/17/2022, I interviewed DCW Eboney Deloney. Ms. Deloney confirmed that she was in the car accident, but no one was hurt and there was no damage to the other vehicle. Ms. Deloney stated that her front bumper came off. Ms. Deloney stated that she worked second shift that day from 3 PM – 11 PM and was leaving work at the time of the accident. Ms. Deloney stated that she typically takes work breaks from 5-5:30 PM and 9-9:45 PM. Ms. Deloney stated that she smoked marijuana during her last work break on that day. Ms. Deloney stated that she smokes outside of the facility.

On 05/26/2022 and 06/01/2022, I attempted to contact and interview DCW Jarvon Brown, but did not receive a return call.

On 05/26/2022, I interviewed DCW Breanna Craig. Ms. Craig stated that she was aware of coworkers who smoke marijuana during shifts. Ms. Craig stated that she informed management of this, but nothing was done about it.

On 07/01/2022, I contacted Nicholas Burnett, Licensee Designee. Mr. Burnett stated that it was against policy for staff to smoke marijuana while on shift.

On 06/30/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett admitted that there have been difficult staff members, who are fired once management becomes aware.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications:

	(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on documentation and interviews with Detective Sergeant Jason Parks, DCW Eboney Deloney, DCW Breanna Craig, there is sufficient evidence to confirm that at least one staff member (Eboney Deloney) was smoking marijuana during her shift on 05/13/2022. Nicholas Barnett, Licensee Designee, stated that it was against company policy for staff to smoke marijuana while on shift. Ms. Deloney did not follow company policy, demonstrating that she is unsuitable to meet resident needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/30/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett stated that he would submit a corrective action plan.

IV. RECOMMENDATION

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

Derrick L. Britton 07/08/2022

Derrick Britton Date
Licensing Consultant

Approved By:

Mary Holton 07/08/2022

Mary E Holton Date
Area Manager