STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 1, 2022

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

RE: License #: AS250407224
Investigation #: 2023A0569004
Brookwood

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. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250407224
Investigation #:	2023A0569004
Complaint Receipt Date:	10/05/2022
Investigation Initiation Date:	10/05/2022
Report Due Date:	12/04/2022
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:	Brookwood
Facility Address:	5408 Brookwood Drive Burton, MI 48509
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/22/2021
License Status:	REGULAR
Effective Date:	10/22/2021
Expiration Date:	10/21/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Law enforcement arrived at this facility on 3/26/22 at 5:19am and found no staff supervising the residents.	Yes

III. METHODOLOGY

10/05/2022	Special Investigation Intake 2023A0569004
10/05/2022	Special Investigation Initiated - Letter Email to Amanda Doyle, Burton City Attorney.
11/30/2022	Contact- Telephone call made. Attempted contact with Jalen Williams, staff person.
12/01/2022	Inspection Completed On-site
12/01/2022	Inspection Completed-BCAL Sub. Compliance
12/01/2022	Contact- Telephone call made. Second attempted contact with Jalen Williams.
12/01/2022	Exit Conference Exit conference with Nick Burnett, licensee designee, and Morgan Yarkosky, administrator.
12/01/2022	APS Referral Referral Made to APS.

ALLEGATION:

Law enforcement arrived at this facility on 3/26/22 at 5:19am and found no staff supervising the residents.

INVESTIGATION:

This complaint was received via telephone complaint from the complainant. The complainant reported that the Burton Police Department have been called to this facility several times by Residents at this facility. The complainant reported that the police were called to the facility on 3/26/22, and when they arrived, the police observed that there were no staff present at the facility to supervise the residents.

A police report (#2283900839) was submitted to the department on 10/05/22. The police report was completed by Ofc. Erin Hodge of the Burton City Police Department on 3/26/22. Ofc. Hodge states in the report that they were dispatched to this facility at 5:19am due to a report of a missing resident. Ofc. Hodge stated that another resident had made the call to 911. Ofc. Hodge stated that police arrived and began searching a park next to the facility for the missing resident. Ofc. Hodge stated that Resident A, Resident B, Resident C, and Resident D were then found inside of the facility, and that Resident A had made the phone call to 911. Ofc. Hodge stated that Resident C and Resident D were sleeping and gave no statement. Ofc. Hodge stated that Resident A reported that Jalen Williams, staff person, had left the facility at about 2:30am and he did not know where the staff went. Ofc. Hodge stated that Resident A reported that Resident E had woken up and was looking for a staff person and became upset when he could not find a staff person, so he left the facility. Ofc. Hodge stated that they then found a list of staff phone numbers in a cupboard and began calling the numbers. Ofc. Hodge stated that a staff person was eventually contacted and then reported to the facility to supervise the residents. Ofc. Hodge stated that Resident E was then located, unharmed, and returned to the facility. Ofc. Hodge stated that resident files were observed on the dining table and the five books laying out on the table with sheets documenting the current day's events. Ofc. Hodge stated that they noticed that every half hour the residents had to be checked on and the employee needed to note what they were doing and initial next to it. In all five books the time slots had been filled out all the way through 6:30 am and initialed by "JW" even though no one had been present.

Ofc. Hodge stated that, Mr. Williams then returned to the facility and that, "Jalen said that he left the house because his daughter fell out of bed and could not fall back asleep, and his girlfriend was having a hard time with her. He said that he only left 45 minutes prior. Officers told him that he was not telling the truth about how long he had been gone. He then said that he left about 5:00 am and Officers again told him that did not seem correct. Jalen again changed his story and said it may have been earlier than that. Officer Hodge told him that the residents claimed he left around 2:30 am and he said that he did not leave that early. According to Jalen, all the residents were in bed except [Resident A] who was sitting in the living room watching tv. Officer Hodge asked

him if [Resident A] knew he left and he said yes. He said that he wasn't going to be gone long but he fell asleep. Officer Hodge asked him how he woke up just in time to get back before the end of his shift and he said that he set an alarm. Officer Hodge asked him why he set an alarm if he did not intend to go to sleep and he admitted that he did go to sleep on purpose. Officer Hodge asked Jalen if he had an emergency with his daughter then why did he prefill out the clients' charts until the end of his shift before he left and he had no response". Ofc. Hodge stated that no further action was taken.

Multiple attempts have been made to contact Mr. Williams via telephone for a statement. There has been no response when the phone calls were placed.

An unannounced inspection of this facility was conducted on 12/01/22. All the residents were observed to be appropriately dressed and groomed with no visible injuries. Resident A was alert and oriented to person, place, and time. Resident A stated that he did recall this incident. Resident A stated that he got up to use the bathroom and found Resident E was also up and was upset that there were no staff in the facility. Resident A stated that Resident E then left the facility so Resident A called 911. Resident A stated that the police then arrived at the facility and found the residents alone with no staff supervision. Resident A stated that the police did eventually find Resident E and another staff person then came to the facility. Resident A stated that this happened about "3 or 4" times prior to this incident and the same staff person, Mr. Williams, was the staff person who left the residents unsupervised. Resident A stated that none of the residents were injured. Resident A stated that the residents have never been left unsupervised since this incident, and that Mr. Williams has never worked at this facility since this incident occurred. Resident A stated that he believes that the other residents were sleeping when this incident occurred, and that Resident E no longer resides at this facility.

Ayanna May, facility manager, stated on 12/1/22 that Mr. Williams was the staff person working when this incident occurred. Ms. May stated that Mr. Williams was immediately terminated from employment and will not be rehired by Flatrock Inc.

An exit conference was conducted with Nicholas Burnett, licensee designee, on 12/1/22. The findings in this report were reviewed. Mr. Burnett stated that Mr. Williams was terminated from employment following this incident and will not be rehired.

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:	The complainant reported that police were called to this facility on 3/26/22, and when they arrived, they found no staff supervising the residents. Ofc. Hodge documented that the police did find the residents unsupervised, and that Resident E had left the facility. Resident A stated that he woke up to use the bathroom and found Resident E upset because there were no staff in the facility. Resident A also confirmed that there were no staff present in the facility. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident A stated that Mr. Williams had left the residents unsupervised previous to this incident. Ofc. Hodge's report documents that Mr. Williams claimed that he went home to help his girlfriend with their daughter and was only gone for 45 minutes. Ofc. Hodge documented, however, that Mr. Williams had pre-filled documentation found on the table with his initials for the entire shift, then returned to the facility just prior to the shift change indicating that Mr. Williams intended to leave the residents unsupervised. Based on the statements given and documentation reviewed, it is determined that Mr. Williams was intentional in his neglect of the residents and was not suitable to meet the residents' needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

12/01/2022

Kent W Gieselman Date
Licensing Consultant

Approved By:

12/01/2022

Mary E. Holton Date
Area Manager