GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 28, 2022

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

RE: License #: AM440388517
Investigation #: 2023A0582010
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) 643-7960.

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 #:	2023A0582010
Complaint Receipt Date:	10/31/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	12/30/2022
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 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. ALLEGATION

	Violation Established?
While Resident A was showering, she was attacked by Resident B, leaving her with a broken nose, lacerations, bruising on her face, bite marks on her chest, shoulder, and knee.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/31/2022	Special Investigation Intake 2023A0582010
10/31/2022	APS Referral Denied APS Referral
10/31/2022	Special Investigation Initiated - On Site
11/01/2022	Contact - Document Received Review of Incident/Accident Report
11/22/2022	Contact - Telephone call made With Direct Care Worker (DCW) Shamyyah Brooks
12/12/2022	Contact - Document Received Resident B's Behavior Treatment Plan and Assessment Plan
12/15/2022	Contact - Face to Face With Resident A, Reviewed Discharge Instructions
12/15/2022	Contact - Telephone call made With Andrea Bonomo, Case Manager
12/15/2022	Contact - Telephone call made With Guardian A
12/19/2022	Contact - Telephone call made With DCW Scott Fredrick
12/19/2022	Contact - Telephone call made With DCW Lyric Burnett
12/21/2022	Contact - Telephone call made

	With David McCree, Lead Worker
12/26/2022	Exit Conference With Nicholas Burnett, Licensee Designee

ALLEGATION:

While Resident A was showering, she was attacked by Resident B, leaving her with a broken nose, lacerations, bruising on her face, bite marks on her chest, shoulder, and knee.

INVESTIGATION:

I received this denied Adult Protective Services complaint on 10/31/2022 and conducted an unannounced, onsite inspection on the same day. I observed Resident A, who had reportedly returned from the hospital on Saturday, 10/29/2022 according to Erika Hilliker, Home Manager. I observed Resident A's face to be extremely bruised with marks over her right eye, cheeks, and what appeared to be stitch marks on her nose. I could not interview Resident A due to her inability to communicate effectively. I interviewed Ms. Hilliker, who stated that the incident occurred on Saturday, 10/29/2022 on first shift. Ms. Hilliker stated that Resident B was agitated and wanted to shower. Ms. Hilliker stated that Resident B went into the first bathroom, and someone was using it. Ms. Hilliker stated that Resident B went into the second bathroom and used the urinal and staff was with him. Ms. Hilliker stated that Resident B ran and got to Resident A, who was in the shower. Ms. Hilliker stated that Resident B bit Resident A about 7 times on the face, chest, knee, and top of her foot. Ms. Hilliker stated that Direct Care Worker (DCW) Shamyyah Brooks, who was assigned to Resident B as a 1:1 staff, called a "Code 3" for assistance. Ms. Hilliker stated that Direct Care Worker Scott Frederick came to assist DCW Brooks, and by the time he arrived, Resident B was off Resident A. Ms. Hilliker stated that first aid was administered to Resident A and EMS was contacted. Ms. Hilliker stated that it was initially thought that Resident A's nose was broken, but it was not broken. Ms. Hilliker stated that Resident A required stitches on her nose from the bite and was prescribed pain medication. Ms. Hilliker stated that Resident B only requires 1:1 staff on first shift. Ms. Hilliker stated that she asked Resident B why he attacked and bit Resident A, but he only kept repeating "I'm sorry," and did not say anything else about the incident. Ms. Hilliker stated that Resident B was not injured during the incident. Ms. Hilliker stated that Guardian A and the case manager were notified of the incident, but Guardian A is difficult to get in contact with.

I attempted to ask Resident B questions about the incident, but he refused to speak about it.

On 11/02/2022, I reviewed the *Incident/Accident Report* related to the complaint, which documented the following:

> **Date of Incident:** 10/29/2022, **Time**: 1:15 PM, **Location:** Client Bathroom
> **Other Persons:** Shamyyah Brooks, Scott Frederick, Lyric Burnett, David McCree
> **Explain What Happened/Describe Injury**: [Resident B] was using the bathroom when he quickly became agitated and ran away from his 1:1 staff to the shower area where another peer was showering. [Resident B] bit peer all over peer's face and body, and also started hitting peer. [Resident B's] 1:1 staff quickly used blocking techniques, verbal redirection, and called a Code 3 for assistance. [Resident B] then stepped back after verbal redirection and was prompted to move to another area away from peer. Staff walked with [Resident B] down to his room and validated his feelings. Staff called the med coordinator and home manager. [Resident B] had no injuries. Staff will continue to monitor [Resident B] for the rest of the shift.
>
> **Action Taken by Staff/Treatment Given:** Blocking techniques, verbal redirection, called Code 3, validated feelings, contacted home manager and med coordinator, monitored for health and safety, prompted to move to another area.
>
> **Corrective Measure Taken to Remedy and/or Prevent Recurrence:** Staff will monitor [Resident B] for health and safety as a 1:1 for the rest of the shift.

I reviewed the *Incident/Accident Report* specific to Resident A, which documented the following:

> [Resident A] was sitting down in the shower when a peer became agitated and bit and hit [Resident A] on the nose, on the face 7 times, bit [Resident A] once on the chest, on her left top foot, and [Resident A's left knee]. Staff quickly used blocking techniques and verbal redirection and called a code 3 for assistance. Peer was verbally directed to another area away from [Resident A]. Staff validated [Resident A's] feelings and contacted the med coordinator and home manager. The med coordinator then called for the ambulance to take [Resident A] to the McLaren Lapeer Hospital. While waiting for the ambulance to arrive, staff was directed to apply basic first aid to the wounds on [Resident A]. Staff will monitor [Resident A] for heal and safety at the hospital…and when she returns home.

On 11/22/2022, I interviewed DCW Shamyyah Brooks. Ms. Brooks stated that she was the 1:1 staff assigned to Resident B. Ms. Brooks stated that she was in the television room with Resident B, when he suddenly got up and ran to the bathroom. Ms. Brooks stated that the bathroom is approximately 15 feet away from the television room. Ms. Brooks stated that Resident A is very fast and got to the bathroom quickly. Ms. Brooks stated that before she could get to Resident B, he went into the shower room and attacked Resident A, who was showering. Ms. Brooks stated that Resident A was in the bathroom by herself when Resident A went

in. Ms. Brooks stated that Resident A had bitten Resident A and her face was bleeding. Ms. Brooks stated that she immediately went to separate Resident B from Resident A when DCW Scott Frederick arrived to assist. Ms. Brooks stated that they were able to get Resident B off Resident A and out of the shower room and back to his bedroom to calm down. Ms. Brooks stated that Resident A was treated for her injuries and was transported to the hospital by EMS.

On 12/12/2022, I reviewed Resident B's *Behavior Treatment Plan*, which documented the following:

> [Resident B] has major deficits in attention, concentration, organization, impulse control, and frustration tolerance. Little snags in his day can upset him. Minor irritations will cause hand/arm biting and sometimes more intense reactions of head banging, assaulting others, and disrupting property. [Resident B] usually goes from 0-100 very quickly with little warning. Preventative Strategies: 1:1 Supervision. [Resident A] has 1:1 supervision for 8 hours a day on non-school days. This individual is assigned to supervise [Resident A] and will maintain a distance of approximately 4-6 feet at all times. Besides accompanying [Resident B] throughout his day, the 1:1 will accompany [Resident B] in the bedroom and bathroom at all times. Responsibility of 1:1 staff: Staff should stay a working partner with [Resident B], help him structure his day, coach appropriate peer interactions, mentor coping skills, encourage functional activities, and intervene with challenging behaviors. Justification: This supervision is necessary to keep him safe from frequent challenging behaviors.
>
> Reaction Strategies: Intense Agitation: During more intense agitation, [Resident B] will escalate very fast into self-injurious behaviors, physical aggression (hitting, biting, pinching, kicking others) and disrupting property. He quickly loses control and begins to act out. At these times: tell him in a calm voice, "[Resident B] let's calm down," getting his attention on you so you can help calm him. Next, if possible, engage him in a physical activity: bouncing on an exercise ball, going for a walk, down to the gym, etc. If [Resident B] is not responsive to the above and continues to act out, we need to immediately try and get him to a couch or his bed to provide a soft surface for him to calm. Block and step away from attempts to hurt staff and try to keep him standing to avoid head banging on the floor. Once on the couch or bed, reassure [Resident B] that he is okay with you. If too agitated to respond, simply stay with him, say very little and keep blocking any aggression and redirecting him to stay on the couch or bed until he calms down.

I reviewed Resident B's *Assessment Plan*, which documented that his deficits "contribute to self-abusive and aggressive behaviors towards others. [Resident B] has a history of becoming physically aggressive towards staff and peers. He is currently a 1:1, 8 hours a day to help protect himself and others, due to his aggression and self-abuse. His behaviors may include hitting, kicking, spitting, or biting others, yelling, and pulling of hair. Staff working with [Resident B] will monitor

for mood changes and provide verbal redirection, when needed. [Resident B's] behavior is chronic and characterized as minimal to moderate in severity in intensity. A positive behavioral support plan is in place to address his behavioral challenges. In the even these measures are unsuccessful, staff are trained in CPI non-violent crisis intervention foundational course including disengagement and holding skills. [Resident B] has a history of biting peers or antagonizing peers when agitated and/or anxious." With toileting, the Assessment Plan documents that Resident B is "Independent."

On 12/15/2022, I conducted an unannounced, onsite inspection at the facility. I observed Resident A in her bedroom, and she appeared to be receiving proper care and supervision, with her facial wounds healed. I reviewed Resident A's Discharge Instructions from McLaren Lapeer Emergency Department on 10/29/2022, which documented the reason for her visit was "agitation or violent behavior/assault, with a final diagnosis of "facial lacerations and human bite of face" that required sutures.

On 12/15/2022, I interviewed Andrea Bonomo, CMH Case Manager. Ms. Bonomo stated that she was made aware of the incident and injuries to Resident A. Ms. Bonomo stated that she has a lot of issues with the incident, particularly with Resident B having 1:1 supervision and getting into the shower room with Resident A.

On 12/15/2022, I interviewed Guardian A, who stated that she was not made aware of the incident. Guardian A stated that the last time she had communication with the facility was on 11/03/2022 regarding the flu vaccine. Guardian A stated that she would be contacting the facility to ask questions about the incident.

On 12/19/2022, I interviewed DCW Scott Frederick. Mr. Frederick stated that on the day of the incident, he was cleaning out the sensory room when he heard Resident A screaming. Mr. Frederick stated that he ran to the bathroom, and by the time he arrived DCW Brooks and DCW Burnett were removing Resident B off Resident A while they were in the shower room. Mr. Frederick stated that he could see blood on Resident A's face, and he contacted Lead Worker David McCree for assistance. Mr. Frederick stated that there is no shower curtain or door on the shower area, it is in an open area at the end of the bathroom.

On 12/19/2022, I interviewed DCW Lyric Burnett, who stated that on the day of the incident, Resident A was in the shower for hours. Ms. Burnett stated that she would occasionally check on Resident A to see if she was ready to get out of the shower, but she wanted to stay in. Ms. Burnett stated that Resident A would sit in the shower and let the water run on her, and she did not require assistance with showering. Ms. Burnett stated that she was in the middle of doing laundry after checking on Resident A, when she was contacted on the walkie talkie that Resident B was attacking Resident A in the shower. Ms. Burnett stated that she does not know how Resident B got in the bathroom to attack Resident A, since he has a 1:1 staff. Ms. Burnett stated that when she arrived at the shower room, Resident B was in the shower with Resident A and attacking her. Ms. Burnett stated that Resident A was

bleeding and Resident B had bit her nose and possibly banged her head. Ms. Burnett stated that the incident happened so fast and Resident B “messed her up pretty bad.”

On 12/21/2022, I contacted David McCree, who was identified as the lead worker during the incident. Mr. McCree stated that Resident A was showering when Resident B came to use the urinal. Mr. McCree stated that Resident B quickly attacked Resident A while she was in the shower. Mr. McCree stated that staff quickly responded to separate Resident B from Resident A and contacted EMS.

On 12/22/2022, I reviewed *Incident Reports* related to Resident B over the prior three months, which documented self-injuries (biting/hitting) on 09/12/2022, 09/19/2022, and 10/24/2022. There were no documented incidents of biting others over this time.

On 12/27/2022, I reviewed Resident A’s *Assessment Plan* for bathing, which states that she “enjoys showering/bathing as the water is calming for her. She prefers to sit with the shower running on her for brief periods while showering. She will be monitored for safety during bathing. Staff will assist to ensure appropriate and comfortable water temperature for safety. She will be verbally prompted to perform washing, however, staff will assist when needed to ensure thorough cleanliness.”

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, a review of documents, and observations, Resident A was attacked by Resident B while Resident A was showering. The attack resulted in bite marks over Resident A’s body to include her nose, which required stitches. Resident B, who requires 1:1 staff for 8 hours a day, was being watched by DCW Shamyyah Brooks. Resident B’s Behavior Treatment Plan documents that Resident B “usually goes from 0-100 quickly with little warning,” and the 1:1 staff will “maintain a distance of approximately 4-6 feet at all times. With the injuries sustained by Resident A, there is sufficient evidence to suggest that staff was not in close enough proximity to Resident B to prevent him from going into the shower room to attack Resident A. Ms. Brooks stated that the bathroom where Resident A ran to was approximately 15 feet away from the television room where she

	was supervising him, giving her time to get to Resident A and possibly prevent him from going into the bathroom to attack Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/31/2022, I conducted an unannounced, onsite inspection at the facility. I observed the bathroom where the incident occurred. The bathroom has urinals for males, two stalls with doors, and a shower area with no doors/shower curtain.

On 11/22/2022, I interviewed DCW Shamyyah Brooks. Ms. Brooks stated that the shower room is open inside of the bathroom. Ms. Brooks stated that the bathroom can be used by other residents while a resident is showering.

On 12/19/2022, I interviewed DCW Lyric Burnett. Ms. Burnett stated that the shower area is open, so it was easy for Resident B or anyone else to get in there if someone is showering.

On 12/21/2022, I interviewed David McCree, who was identified as the lead worker during the incident. Mr. McCree stated that the bathroom has an open area for the shower, with urinals and stalls. Mr. McCree stated that the stalls have doors, but the shower area is not enclosed. Mr. McCree stated that the bathroom has a door but is generally kept open for residents to use. Mr. McCree stated that residents use the bathroom while another resident may be in the shower.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on interviews with staff and personal observation, the bathroom where Resident B attacked Resident A does not provide for privacy while a resident is showering. While one cannot see directly into the shower when standing in the bathroom, there is no shower curtain or other covering to prevent someone in the bathroom from going to the shower area and seeing an individual who is showering. Staff interviewed stated that the shower area is "open," and Lead Worker David McCree stated that other residents use the bathroom while another resident may be in the shower and the bathroom door is generally open. This does not allow for individual privacy and personal dignity for residents who are showering.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/27/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. I informed Mr. Burnett of the findings from the investigation, and the need for a Corrective Action Plan.

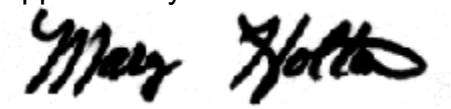
IV. RECOMMENDATION

Contingent on an acceptable Corrective Action Plan, I recommend no change in the license status.

12/27/2022

Derrick Britton Date
Licensing Consultant

Approved By:



12/28/2022

Mary E. Holton Date
Area Manager