



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

December 29, 2022

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

RE: License #: AM440388514  
Investigation #: 2023A0582011  
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.
- 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,

A handwritten signature in cursive script that reads "Derrick L. Britton".

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**

<b>License #:</b>	AM440388514
<b>Investigation #:</b>	2023A0582011
<b>Complaint Receipt Date:</b>	11/14/2022
<b>Investigation Initiation Date:</b>	11/15/2022
<b>Report Due Date:</b>	01/13/2023
<b>Licensee Name:</b>	Flatrock Manor, Inc.
<b>Licensee Address:</b>	7012 River Road Flushing, MI 48433
<b>Licensee Telephone #:</b>	(810) 964-1430
<b>Administrator:</b>	Morgan Yarkosky
<b>Licensee Designee:</b>	Nicholas Burnett
<b>Name of Facility:</b>	Elba South
<b>Facility Address:</b>	280 North Elba Road Lapeer, MI 48446
<b>Facility Telephone #:</b>	(810) 877-6932
<b>Original Issuance Date:</b>	02/08/2018
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/08/2022
<b>Expiration Date:</b>	08/07/2024
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION**

	<b>Violation Established?</b>
Resident A has a significant dark bruise on his left eye as the result of Direct Care Worker Joshua Johnson, who punched him several times in the face during physical intervention on 11/13/2022.	Yes

**III. METHODOLOGY**

11/14/2022	Special Investigation Intake 2023A0582011
11/14/2022	APS Referral Referred from APS
11/15/2022	Special Investigation Initiated - Letter Email from Rose Koss, Adult Services Specialist
11/16/2022	Contact - Document Received Email from Elizabeth Simon, Office of Recipient Rights
11/16/2022	Contact - Telephone call made With Rose Koss, Adult Protective Services
11/16/2022	Inspection Completed On-site Interviews with Resident A, DCW James Ewell, DCW Holly Brewer
11/17/2022	Contact - Document Received Reviewed Incident Report dated 11/13/2022
11/17/2022	Contact - Document Received Interview transcript from Elizabeth Simon, Office of Recipient Rights
11/17/2022	Contact - Telephone call made With DCW Hannah Boursaw
11/17/2022	Contact - Telephone call made With DCW John Ryder
11/18/2022	Contact - Telephone call made With DCW Joshua Johnson

12/08/2022	Contact - Document Received Report of Investigative Findings from Elizabeth Simon, Office of Recipient Rights
12/27/2022	Exit Conference With Nicholas Burnett, Licensee Designee
12/27/2022	Inspection Completed-BCAL Sub. Compliance
12/28/2022	Corrective Action Plan Requested and Due on 01/12/2023
12/29/2022	Contact – Document Received Lapeer County Sheriff’s Office – Case Report

**ALLEGATION:**

Resident A has a significant dark bruise on his left eye as the result of Direct Care Worker Joshua Johnson, who punched him several times in the face during physical intervention on 11/13/2022.

**INVESTIGATION:**

I received this Adult Protective Services referral on 11/14/2022. Before receiving this complaint, I received a phone message from Joey Hoffner, Home Manager, on 11/13/2022. Mr. Hoffner reported that on that day, Resident A was involved in an altercation with a peer. Staff intervened and Resident A became physically aggressive towards staff. Resident A sustained a black eye and a scratch, claiming that staff punched him.

On 11/15/2022, I received a picture of Resident A from Rose Koss, Adult Services Specialist. The picture showed Resident A with a dark purple bruise around his right eye and red mark on the bridge of his nose.

On 11/16/2022, I received phone contacts for staff who had information about the incident from Elizabeth Simon, Office of Recipient Rights.

On 11/16/2022, I interviewed Rose Koss, Adult Services Specialist. Ms. Koss stated that a police report would be filed regarding the incident. Ms. Koss stated that Elizabeth Simon, Office of Recipient Rights, conducted interviews and confirmed that the incident took place.

On 11/16/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Resident A. Resident A had a dark purple bruise around his right eye

and mark on the bridge of his nose. Resident A stated that the incident occurred on Sunday at the end of first shift. Resident A stated that he was getting into a fight with Resident B, who threw a big cup of ice at him. Resident A stated that he chased Resident B down the hallway and caught him by the pool room. Resident A stated that he hit Resident B, and staff intervened, sending he and Resident B to their rooms to separate them. Resident A stated that he was upset while in his room and threw his coffee maker out of his room toward staff, because they broke of the fight between he and Resident A. Resident A stated that he came out of his room and went to Resident B's door. Resident A stated that he started scratching at Resident B's door to get him to come out. Resident A stated that Resident B came out and pushed him, so he started chasing Resident B. Resident A stated that Direct Care Worker Joshua Johnson pushed him into the wall, so he grabbed DCW Joshua Johnson's throat and hair. Resident A stated that DCW Johnson drove him into the ground, kned him in his back, and punched him in his head and eye 6-7 times. Resident A stated that DCW Johnson dragged him down the hallway to his room as he was trying to kick DCW Johnson off him. DCW Johnson stated that DCW Johnson told DCW Holly Brewer and DCW Hannah Boursaw to open the door to his room. Resident A stated that he was sent to the hospital and was feeling dizzy lightheaded.

On 11/16/2022, I interviewed DCW James Ewell, who stated that Resident A and Resident B were arguing when Resident B threw ice and Resident A threw coffee at each other. DCW Ewell stated that both residents were separated to their rooms, where Resident A began breaking items and throwing things. DCW Ewell stated that Resident A went to Resident B's room to get him to come out, and Resident B came out with Resident A chasing him trying to hit him. DCW Ewell stated that staff attempted a hold to intervene and stop Resident A from continuing his physical aggression towards Resident B. DCW Ewell stated that DCW Joshua Johnson was assisting with the "outside/inside technique," with staff behind Resident A and holding his wrist to control his movement. DCW Ewell stated that Resident A was able to get a hold of DCW Johnson's ponytail and would not let go. DCW Ewell stated that DCW Johnson and DCW Holly Brewer attempted the "hair release technique" to try to get Resident A to release DCW Johnson's hair. DCW Ewell stated that Resident A would not let go of DCW Johnson's hair, and out of nowhere DCW Johnson began punching Resident A in the face with both hands. DCW Ewell stated that it was as if DCW Johnson "blacked out" and lost it. DCW Ewell stated that Resident A let go of DCW Johnson's hair and began crying. DCW Ewell stated that DCW Johnson kned Resident A in his back as he was getting up. DCW Ewell stated that he did not observe DCW Johnson dragging Resident A down the hallway to his room. DCW Ewell stated that in addition to DCW Johnson and DCW Brewer, DCW John Ryder and DCW Holly Boursaw were also witness to the incident.

On 11/16/2022, I interviewed DCW Holly Brewer. DCW Brewer stated that Resident A and Resident B were fighting when staff intervened to get control of the situation. DCW Brewer stated that Resident A got ahold of DCW Joshua Johnson's hair as they were trying to apply a CPI hold to Resident A. DCW Brewer stated that staff

went to the ground with Resident A as he was holding on to DCW Johnson's hair, and she along with DCW James Ewell tried to pry open Resident A's hands from DCW Johnson's hair. DCW Brewer stated that DCW Johnson then started punching Resident A in the face. DCW Brewer stated that Resident A let go of DCW Johnson's hair, and DCW Johnson kned Resident A in his back as he was getting up from the floor.

I reviewed Resident A's clinical record, which documented that he was seen at McLaren Hospital Emergency Room and received a "slight" fracture of his left nasal bone, soft tissue contusion along his left eye, and concussion.

On 11/17/2022, I reviewed the Incident Reports related to complaint, which documented the following:

**Date of Incident:** 11/13/2022, **Time:** 10:30 AM

**Explain What Happened:** [Resident A] was pacing the halls prior to the incident occurring. [Resident A] started becoming verbally aggressive towards a peer. Staff verbally redirected [Resident A] away from peer. [Resident A] then charged toward peer and attempted to hit and kick peer. Staff used body positioning and attempted outside/inside. In the midst of attempting outside/inside [Resident A] got ahold of staff's hair. While staff were attempting to release [Resident A's] hands from staff's hair, the peer proceeded to hit a staff in the back of the head twice. Staff attempted to redirect the peer. Staff witnessed another staff using improper physical management, which resulted in [Resident A] having a black eye and a superficial scratch on his nose. The medical coordinator was contacted as well as the home manager. The police were contacted [Lapeer Police Department] and [Resident A] was take to the hospital [Lapeer McLaren] by staff.

Resident A came back to the care home and relaxed in the courtyard after the incident occurred. Staff will increase checks on [Resident A] for his health and safety.

On 11/17/2022, I received interview transcript with DCW Joshua Johnson (JJ) from Elizabeth Simon, Office of Recipient Rights, which documented the following:

Confirmed the information provided to Hanna about [Resident A] having an altercation with another resident. [Resident A] came out of his room and was scratching at the other resident's door wanting him to come out. [Resident A] was agitated. The resident opened the door and ran out past [Resident A] to where Joshua (JJ) was standing. The resident was seeking protection from [Resident A] by hiding behind JJ. [Resident A] was in front of JJ trying to get to the other resident. JJ tried to put [Resident A] into the "child Pose" for physical management by grabbing [Resident A's] wrist. The other resident ran away "leaving me alone to deal with [Resident A]."

JJ had a hold of [Resident A's] left wrist and [Resident A] used his right hand to grab JJ's hair by the ponytail and began pulling. JJ's sweater went up over his head and he couldn't see. JJ had a hold of [Resident A's] wrist and [Resident A] would not let go of his hair. His co-workers "tried everything to get [Resident A] to let go." JJ said, "I had to protect myself and his hand out of my hair." JJ then started to punch [Resident A] in the left eye. "The first few hits I really thought he was going to let go because I did not want to hurt [Resident A]." JJ did not know how many times he hit [Resident A]. "I left [Resident A] sitting on the floor crying." JJ was asked if he said anything to [Resident A] and he responded "I probably did say a few things. I told him to fight me like a man like we do in the gym." JJ denied kneeing him in the back. JJ pulled [Resident A] into his bedroom by his feet and ankles. JJ said he pulled [Resident A] into his bedroom because he was not getting up and kept crying. Other residents were coming into the area, and he wanted JJ to move. JJ said, "I felt like a monster, and I did not want the others to look at me that way." JJ and [Resident A] were in the bedroom alone and JJ told [Resident A] that he did not like to fight. JJ told [Resident A] that he was upset and [Resident A] apologized to him. Holly came and checked on them a couple of times. [Resident A] and JJ did deep breathing exercises to calm down. JJ said he did not know what he could have done differently. JJ said "I'm not going to be bullied by anybody, but he was not going to let [Resident A] pull out my hair."

On 11/17/2022, I interviewed DCW Hannah Boursaw, Lead Worker. DCW Boursaw stated that there was an altercation between Resident A and Resident B. DCW Boursaw stated that the altercation was broken up by staff, who separated both residents into their rooms. DCW Boursaw stated that Resident A came out of his room trying to get to Resident B, chasing him to the dining room and trying to become physically aggressive. DCW Boursaw stated that staff tried to put Resident A in a hold, and Resident A grabbed DCW Johnson's ponytail. DCW Boursaw stated that staff went to the ground with Resident A, and Resident B hit her in the back trying to get to Resident A. DCW Boursaw stated that DCW Johnson began hitting Resident A in his face repeatedly. DCW Boursaw stated that she tried stopping DCW Johnson from hitting Resident A and tried getting Resident A to release DCW Johnson's hair. DCW Boursaw stated that Resident A finally released DCW Johnson's hair and turned over on his side. DCW Boursaw stated that DCW Johnson kned Resident A in his back while getting off the floor. DCW Boursaw stated that she called the home manager who came out and staff attended to Resident A. DCW Boursaw stated that DCW Johnson was told to leave the facility after the incident. DCW Boursaw stated that Resident A was sent to the hospital and had a concussion.

On 11/17/2022, I interviewed DCW John Ryder. DCW Ryder stated that Resident A and Resident B were arguing, when Resident B threw a cup of ice on Resident A and Resident A threw coffee on Resident B. DCW Ryder stated that staff got in between the two residents and separated them to their rooms. DCW Ryder stated that Resident A came out of his room and broke his coffee pot. DCW Ryder stated that Resident A used the plastic handle from his coffee pot to scratch the door at



Resident B's room. DCW Ryder stated that Resident B came out of his room and ran toward staff with Resident A chasing him. DCW Ryder stated that DCW Joshua Johnson intervened and tried to put Resident A into a CPI "child control" hold. DCW Ryder stated that Resident A grabbed DCW Johnson's ponytail, and they fell to the ground. DCW Ryder stated that he, DCW James Ewell, and DCW Holly Brewer went to help DCW Johnson and tried getting Resident A's hand out of DCW Johnson's hair. DCW Ryder stated that he was near Resident A's feet to prevent him from kicking. DCW Ryder stated that DCW Johnson started swinging and hitting Resident A in the face with both of his hands. DCW Ryder stated that he and other staff were in shock at what was happening. DCW Ryder stated that Resident A got hit a few times before he finally let go of DCW Johnson's hair. DCW Ryder stated that DCW Johnson kned Resident A in his back and Resident A was crying saying he was "sorry." DCW Ryder stated that Resident A was sent to the hospital to be checked and returned with a concussion diagnosis and ibuprofen. DCW Ryder stated that DCW Hannah Boursaw, who was the lead worker, sent DCW Johnson home after the incident.

11/18/2022, I interviewed DCW Joshua Johnson. DCW Johnson confirmed the statements he made to Elizabeth Simon, Office of Recipient Rights. DCW Johnson stated that hitting Resident A was a bad reaction to Resident A grabbing his hair. DCW Johnson stated that the Lapeer County Sheriff was called to the facility and took a statement from him. DCW Johnson stated that he did not mean to harm Resident A.

On 12/08/2022, I received the Report of Investigative Findings from the Office of Recipient Rights/Livingston County from Elizabeth Simon, which substantiated abuse by Direct Care Worker Joshua Johnson towards Resident A.

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 an acceptable corrective action plan. Mr. Burnett informed me that DCW Joshua Johnson was terminated from employment with Flatrock.

On 12/29/2022, I received the Lapeer County Sheriff's Office Case Report from Cpl. D. Beebe related to the complaint, which documented the following:

**Report Date/Time:** 11/13/2022, 1:30PM

**Dispatched Offense:** Assault/Battery/Simple

**Narrative:** Caller is the Program Director and he is on site. 2 clients were fighting this morning, one of the residents attacked staff, staff member hit the resident and injured him. Staff member is Joshua Johnson, he was directed to leave by management, so he is no longer there. Resident is [Resident A], he is at McLaren Lapeer with another staff member. [Resident A] is his own guardian and does not want to press charges – Admitted starting fight and Josh was just defending himself.

**INFORMATION:** On 11/12/22 at approximately 1320 hrs. I, Deputy Cummings was dispatched to 300 N. Elba Rd (Flatrock Manor) for a fight complaint. Upon arrival the Program Director, Charles Zimmer advised one of the residents was transported to ER for injuries from a fight with staff and other residents, that just occurred. Charles said [Resident A] was fighting with another resident when staff member Joshua broke up the fight. Charles said when Joshua broke up the fight, [Resident A] grabbed Joshua's hair and wouldn't let go. Charles said this went on for a while and Joshua started forcing [Resident A] to let go and may have hit him. Charles said [Resident A] may have a black eye from the incident and sent him to ER to check for any further injuries. Charles advised per policy Joshua was sent home.

I spoke with [Resident A] at ER. [Resident A] advised he was fighting with another resident and Joshua broke up the fight. [Resident A] said he likes Joshua and said he was sorry for pulling Joshua's hair. [Resident A] said he has never had problems with Joshua and hopes he was ok. [Resident A] advised he is his own guardian and did not want to press charges against Joshua.

Joshua did not respond to several phone calls and messages.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on interviews, observation of Resident A, a review of the Incident Report, and Resident A's clinical record, there is sufficient evidence to confirm that on 11/13/2022, DCW Joshua Johnson hit Resident A multiple times, resulting in a black eye and slight fracture of his nose. DCW Johnson admitted to hitting Resident A in the face, which was confirmed and witnessed by Resident A and Direct Care Workers Hannah Boursaw, James Ewell, John Ryder, and Holly Brewer, who all stated that DCW Johnson kneed Resident A in the back. Resident A was sent to the hospital for his injuries.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14204</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on DCW Joshua Johnson's admittance of his inappropriate actions, which was witnessed by four staff, DCW Johnson has shown to be unfit to meet the needs of residents in his care. DCW Johnson used physical aggression by hitting Resident A in his face to handle a crisis.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



12/29/2022

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Derrick Britton  
Licensing Consultant

Date

Approved By:



12/29/2022

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Mary E. Holton  
Area Manager

Date