GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 22, 2023

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

RE: License #:	AM250402026
Investigation #:	2023A0123023-**AMENDED**
	Goodrich North

Dear Mr. Burnett:

Attached is the **AMENDED** Special Investigation Report for the above referenced facility. Amendments were made to pages 9, 10, 20, 21, 22, 23, and 27. Information was added to page 9-10 regarding medical records. Information and clarification was added to page 20-21 to a staff's interview. Additional analysis information to R310(4) was added to page 22 and 23. Clarification in the analysis of R310(2) was added on page 27. 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:

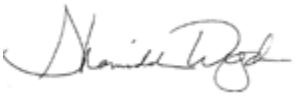
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250402026
Investigation #:	2023A0123023
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/07/2023
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:	Goodrich North
Facility Address:	7280 State Rd. Goodrich, MI 48438
Facility Telephone #:	(810) 636-9372
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2022
Expiration Date:	06/22/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident C was assault by Resident D during first shift on 02/05/2023. Resident C sat in a wheelchair all day, and was brought to Hurley Medical Center about 11:00 pm. Resident C has a fractured left femur, bruised legs, swollen black eye, and complaints of abdominal pain. Staff did not notify the guardian, and staff at the hospital could not provide the guardian's contact information. Management was not informed until 10:00pm.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A0123023
02/06/2023	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
02/06/2023	Contact - Document Sent I sent an email request to Hurley Medical Center requesting Resident C's hospital records.
02/07/2023	APS Referral Received information regarding APS referral.
02/07/2023	Inspection Completed On-site I conducted an unannounced on-site visit with APS worker Kelly Clark-Huey.
02/07/2023	Contact - Telephone call made I left a voicemail requesting a return call from Guardian 1.
02/07/2023	Contact - Telephone call made I left a voicemail message requesting a return call from GHS case manager Penny Thom.
02/07/2023	Contact - Telephone call received I spoke with case manager Penny Thom via phone.
02/07/2023	Contact - Telephone call made I spoke with APS worker Kelly Clark-Huey via phone.
02/09/2023	Contact- Document Sent I sent licensee designee Nick Burnett an email.

02/10/2023	Contact - Telephone call received I received a voicemail from Guardian 1.
02/10/2023	Contact - Telephone call made I spoke with Guardian 1 via phone.
02/10/2023	Contact - Telephone call made I spoke with recipient rights investigator Pat Shephard via phone.
02/15/2023	Contact- Document Sent I re-sent the email from 02/09/2023 to the licensee designee and administrator due to not receiving a response.
02/16/2023	Contact- Document Received Requested documentation was received from director Jeff Selle via email.
02/21/2023	Contact - Telephone call made Virtual interviews were conducted with staff via Microsoft Teams.
03/03/2023	Contact- Document Sent I sent a request for a copy of the police report to the Genesee County Sherriff's Office.
03/07/2023	Contact- Document Received- I received a copy of the police report.
03/13/2023	Exit Conference I spoke with licensee designee Nicholas Burnett via phone.

ALLEGATION: Resident C was assault by Resident D during first shift on 02/05/2023. Resident C sat in a wheelchair all day, and was brought to Hurley Medical Center about 11:00 pm. Resident C has a fractured left femur, bruised legs, swollen black eye, and complaints of abdominal pain. Staff did not notify the guardian, and staff at the hospital could not provide the guardian's contact information. Management was not informed until 10:00pm.

INVESTIGATION: On 02/06/2023, I spoke with Complainant 1 via phone. Complaint 1 reported the following:

Resident C's femur is totally broken in half per the x-ray. The incident occurred on first shift, and the staff that went to the hospital with Resident C could not say what time the incident occurred. The staff person also could not provide the guardian's contact information, and did not have any of the resident's documentation on hand at the hospital. No staff from the facility called and notified the guardian. Home manager Erin Eickhoff was not informed of the incident until 10:00 pm. Resident C

was observed at the hospital shaking because Resident C was in so much pain. Resident C is developmentally delayed, but was clearly in pain, and needs surgery. Staff kept saying that Resident D is a really strong guy. Resident C is heavy set. Resident C's left eye is swollen shut, and there is a lot of visible bruising on her legs. The ER (Emergency Room) doctor was upset as it was clear that someone beat up Resident C. It was a third shift staff person that brought Resident C into the hospital, because this staff person read on the board in the home that Resident C had been physically assaulted by Resident D. It was reported that Resident C had sat in a wheelchair all day, and she is probably not a regular wheelchair user. Resident C arrived to the emergency room by ambulance.

On 02/06/2023, I made a call to Hurley Medical Center. I spoke with hospital social worker Brittany Fearn. Following this call, I sent a request to Ms. Fearn for a copy of Resident C's medical records from Hurley Medical Center.

On 02/07/2023, I spoke with adult protective services worker Kelly Clark-Huey via phone. Mrs. Clark-Huey stated the following:

Resident D assaulted Resident C on 02/04/2023 and on 02/05/2023, even though Resident D has a one on one staff assigned to him. Staff did not contact a home manager Erin Eickhoff until 10:00 pm on 02/05/2023 for the assault that occurred that day. Staff contacted the medication coordinator (Faith Carpenter) after the assault on 02/04/2023 because Resident C complained that her ankle hurt. A call was made for a mobile x-ray to come out for Resident C at 5:30 pm on 02/04/2023, and they showed up the next day on 02/05/2023 at 1:30 pm. At some point, Resident D attacked Resident C again on 02/05/2023 during first shift. Resident D choked Resident C, then Resident D fell on Resident C's leg as staff were trying to get him to stop choking her. Resident D moved into the facility on 01/13/2023. Genesee Health System's (GHS) intent was to pay for a one to one staff for the first 30 days of Resident D's stay at Goodrich North. Staff at the facility never made any calls to GHS recipient rights or to Resident C's Guardian 1. Guardian 1 received a voicemail on 02/06/2023 from Hurley Medical Center informing her that Resident C was having surgery. Resident C was not able to get the surgery because the hospital staff had to do a scope of Resident C's esophagous because she was choked badly by Resident D. Resident C had surgery today, and she had to have pins inserted into her femur bone. Resident C does not have a history of any issues with her bones that would make them fragile. Resident D is violent. The Genesee County Sherriff's Office is involved, but no arrest was made because the police stated that Resident D is not competent. Resident C appears to be being targeted by Resident D, and the one to one staffing does not appear to be sufficent. Resident C receives services through Sanilac County Community Mental Health. Staff Eichoff reported that the ambulance was not called until about 10:30 pm on 02/05/2023. Staff were trying to get Resident C in bed, but she fell on the floor and staff could not get her up off of the floor. The ambulance was called because Resident C could not bear weight on her leg to get into bed.

On 02/07/2023, I met with APS worker Kelly Clark-Huey at the facility. We interviewed medication coordinator Faith Carpenter and home manager Erin Eickhoff.

Staff Carpenter reported that on first shift, the team lead staff person Tiana Naylor called her on 02/04/2023 at 11:24 am regarding an incident from 4:30 am that morning. The incident was Resident D pushing Resident C into the wall. Resident C hurt her ankle. Staff provided ice, and elevated the ankle. Staff on second shift that day called (at 5:30 pm) and reported that the ankle was getting worse. Staff Carpenter then reached out to staff Danielle Thompson (supervisor), who then reached out to Flatrock's primary care physician to order an x-ray. Staff Nick Terrell was Resident D's one to one staff person on 02/04/2023 third shift (02/04/2023 Friday night to Saturday morning 02/05/2023). Guardian 1 was not reached out to right away because they did not know the severity of the injury. She stated that she (and management) were not aware there were two assaults until yesterday morning (02/06/2023) after a debriefing with staff. She stated that on 02/05/2023, staff had a hard time getting Resident C up from the floor. She stated that she does not know if Resident C "fell" on the floor, but she was on the floor. She stated that Resident C weighs 245 lbs, and Resident D weighs 199 lbs.

Staff Eickhoff stated Resident D just started targeting Resident C. Resident D is triggered by loud noises. Resident C "wails." Resident D flails, runs, and he is quick. Resident D is autistic and non-verbal. Resident D hits, kicks, head butts, and fights. Male staff have a hard time with Resident D, and Resident D was going after female staff when he first moved into the facility. She stated that the attacks from Resident D toward staff have not led to any staff seeking medical attention. When asked how they plan to keep Resident C and others safe, she stated that the plan is to do "in-depth" CPI retraining repeately, body positioning between the two residents, and that a suggestion was made for Resident C to have a one to one staff. The police responded, but will not be able to do anything. Guardian 1 was upset about possibly having to move Resident C. Resident C does have a wheelchair. She stated that she was not informed of anything until 10:00 pm on 02/05/2023 when Staff Carpenter reached out to her.

During this on-site, I observed Resident D at the facility. Resident D was standing in the common room area of the home. He appeared clean and appropriately dressed. Resident D was not interviewed due to being non-verbal.

I obtained a copy of Resident D's assesment plan dated for 01/13/2023. Resident D's assessment plan states that he requires one to one supervision both in the facility and in the community as he engages in self harm, and is physically aggressive towards others (biting, pushing, hitting). Resident D is non-verbal. In the "*controls aggressive behavior*" section it states "*[Resident D] experiences deficits in attention, concentration, organization, impulse control, and frustration tolerance. These deficits contribute to mild aggressive behaviors such as hitting, pushing, or punching peers or staff. [Resident D] may also destroy property by throwing objects*

and/or hitting/kicking walls/doors. Staff working with [Resident D] will monitor for mood changes and will provide verbal redirection when necessary. In the even these measures are unsuccessful, staff are trained in Crisis Prevention Institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills." A copy of Resident D's *Interim Behavioral Treatment Plan* dated for 01/12/2023 stated that Resident D is diagnosed with Autism Spectrum Disorder, Intellectual Disability, and ADHD. He has challenging behavior's that include self-injurious behavior, physical aggression, and property destruction. The plan indicates that Resident D requires a one to one staffing, line of sight within four to six feet, and supervision 24 hours of the day for his first 30 days in the facility while in the common area of the home. This staff person must also be in his room with him, and in the bathroom, but he can use his personal bathroom independently.

Resident C was not observed during this on-site as she was hospitalized. Her assessment plan dated 12/12/2022, states that she is diagnosed with moderate intellectual disabilities, autistic disorder, nocturnal enuresis (bed wetting), etc. It states that she is independent with walking and climbing stairs, and has no assistive devices. A copy of her *Health Care Appraisal* dated 10/11/2022 states that she is fully ambulatory, has a risk for falls, and is diagnosed with autistic disorder, anxiety, moderate intellectual disability, nocturnal enuresis, schizophrenia, etc. A copy of her medication administrator records were obtained on 02/16/2023. The records indicate that staff passed Resident C Acetamniophen Tab 325 mg one time as a PRN at 1:52 pm on 02/04/2023 for "*pain in foot*."

On 02/07/2023 during this on-site, I obtained copies of multiple incident reports. I requested incident reports regarding the incidents that took place on 02/04/2023 and 02/05/2023, as well as all incident reports for Resident D since 01/13/2023, the day Resident D moved into the facility. A summary of each incident report is as follows:

An *AFC Licensing Division- Incident/Accident Report dated* 01/15/2023, and signed by staff Dre'Von Holloway details an incident where Resident D had started to eat his own baby wipes. Staff intervened by removing the wipes from Resident D's bedroom. Resident D then became aggressive with staff by hitting, biting, and scratching at staff. Staff attempted body positioning and blocking techniques. Resident D began crawling on the floor, grabbed staff and pulled staff to the ground. Resident D then got up and ran after a female staff, hitting her in the head. Resident D continued to attack staff by biting, hitting, and scratching. Verbal redirection was unsuccessful. Staff then did a two person transport and guided him to the sensory room, where he essentially calmed down.

An *AFC Licensing Division- Incident/Accident Report* dated 01/22/2023, and signed by staff Tianna Naylor details an incident where Resident D got agitated in the dining room and began yelling and hitting staff. Staff used blocking pads and blocking techniques. Resident D then charged a table of residents and began hitting them. One resident was hit in the face, and was bruised. Staff used blocking pads to create space between Resident D and the other residents. Resident D was then able to hit

another resident. Resident D then complied with staff and went to the sensory room. It took Resident D about 30 minutes to completely calm down after staff gave him a snack and his tablet. The incident report states that "*staff will continue to closely monitor to ensure the health and safety of the residents*."

An *AFC Licensing Division- Incident/Accident Report* dated 01/29/2023, and signed by staff Mela Allen details an incident where Resident D became upset after another resident went into a behavior. Resident D became physically aggressive towards his one to one staff by hitting and kicking. Verbal redirection was unsuccessful, and he continued punching and kicking staff. He then attempted to run after two other residents. Staff "*attempted outside/inside but was unsuccessful*." Staff continued verbal redirection and using blocking pads. They redirected Resident D to a bounce house where he eventually calmed down after receiving a snack.

An *AFC Licensing Division- Incident/Accident Report* dated 02/04/2023 (at 4:30 am), and signed by staff Anthony Schneider states *"[Resident C] was in the hallway by the kitchen when a peer ran up to her and pushed [Resident C] against the wall, [Resident C] then slid down gradually on her right side. Staff immediately assisted [Resident C] by checking for injuries, staff observed a bruise on [Resident C's] left foot. Staff asked if [Resident C] was okay. [Resident C] stated that she was in pain and need assistance walking, staff helped her to a chair. Staff contacted med coordinator and asked if it was okay to give her a PRN. Med coordinator approved, staff gave [Resident C] acetaminophen tab. Med coordinator order mobile xray. Staff then prompted [Resident C] to preferred activity of watching TV. [Resident C] complied*." Staff action was noted to be "*contacted med coordinator; gave PRN; prompted preferred activity. Staff will continue to monitor for health and safety*."

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 2:30 pm), signed by staff Chloe Baxter states "[*Resident D] was sitting at the table when staff sat near him with food. [Resident D] began swinging at staff and chasing staff around the home even after the food was put away. Staff used blocking pads and body positioning to try and redirect [Resident D] but was unsuccessful. [Resident D] continued to be physically aggressive towards staff, staff continued to use the blocking pads and body positioning techniques. Staff continued to try and verbally redirect [Resident D] & he started to show signs of calming down when he then grabbed another resident by the throat wrapping his arm around her neck. Staff immediately interveneed using body positioning and blocking pads. [Resident D] lost his footing and fell onto the other residents legs, he then got up on his feet and ran over and knocked the trash can over on the floor. [Resident D] continued to yell and act physically aggressive for 5 minutes before showing signs of calming down, he proceeded to sit at the table. And ate a snack and remained calmed. Blocking pads, body positioning, verbal redirection, preferred activity. Staff will continue to ensure the health and safety of the resident*."

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 2:30 pm), signed by staff Chloe Baxter states *"[Resident C] was laying on the floor relaxing*

when a peer charged her and began choking her from behind. Staff immediately intervened using body positiong and blocking pads which was successful. [Resident C] began crying so staff validated her feelings and let her know everything would be okay. Staff then prompted her to do her preferred activity of watching TV in her room in which she complied. Body positioning; blocking pads; validating feelings; prompted preferred activity. Staff will continue to closely monitor to ensure the health and safety of the residents."

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 9:00 pm), signed by staff Kayla Dumas states "*While completing 15 minute bed checks, [Resident C] had attempted to get out of bed and fell. Staff tried to assist [Resident C] off the floor but could not lift her. Staff reached out to med coordinator letting her know that [Resident C] had fell. Staff communicated immediately and let her know that [Resident C] was unable to get up. Med Coordinator reached out to 911 for assistance and that EMT would be arriving soon. EMT's showed up at 9:25 pm to get [Resident C]. [Resident C] was transported to Hurley Medical Center. Staff validated [Resident C] feeling. Staff reached out to med coordinator. Staff reached out to 911. Staff sat with [Resident C] until EMS arrived. Staff will continue to complete 15 minute checks to ensure health and safety. Addendum: [Resident C] was admitted to Hurley and is scheduled for ortho surgery today 2/6 and also had an Esophogram done for subcutaneous tissue and possible air leak due to strangulation."*

On 02/07/2023, I spoke with Resident D's GHS case manager Penny Thom via phone. Ms. Thom stated that she has not been notified by the facility directly regarding the assault. Resident D has a one to one staff. She questions where staff were at the time, that gave Resident D enough time to choke Resident C that bad. Resident D has a psych evaluation tomorrow. Resident D is aggressive enough that GHS offered one to one with staff at move in. Resident D has a history of phsyical agression, including put his mother's head through a wall. Resident D's psychologist is going to look into noise cancellation muffs for Resident D for his triggers with loud noises. Resident D was an emergency placement in a sense.

On 02/09/2023, I sent an email to licensee designee Nicholas Burnett. It stated that due to the severity of Resident C's injuries, what corrective measures have been or wil be put into place to ensure the safety and protection of the residents in the home, and for Resident C. I re-sent this email on 02/15/2023 to Mr. Burnett and CC'ed administrator Morgan Yarkosky due to no response. On 02/16/2023, I received an email response from Flatrock Inc. program director Jeff Selle. It states "…*we are working with the county to have her [Resident C] transferred to a different care home at Flatrock which will provide her a good opportunity to live with other clients close to her level. This will give her more opportunities to pursue more social opportunities while at the same time separating her from [Resident D]. Once approved by the county we look to have her discharged from the physical therapy facility to move to her new location. We expect to see a behavioral change after a few adjustments. [Resident D] receiving a recent medication review to help update him from his last*

placement. [Resident D] will also be attending school very soon. He has been going to school previously to Flatrock and we believe during the gap of enrolling him in a new school may have disrupted his schedule he was accustomed to."

On 02/09/2023, I obtained a copy of Resident C's medical records from Hurley Medical Center. The medical records are 114 pages long.

On page five of the document, it states " *31-year-old female presents as above. Her cognitive delays limit her ability to provide a history, however the patient does not appear to have suffered just a fall. She appears to have been a victim of significant trauma/assault. She has pattern and ecchymosis over her leg, and the abraisons around her neck as well as the crepitus from eye to neck to chest are concerning for strangulation injury plus-minus potential rupture of esophagus or tracheal damage*. *The patient is controlling her airway."*

On page six it continues with *"She is tachycardic, has a displaced femoral fracture, and complains of abdominal pain. Tachycardia could be from pain, hemorrhage, bowel injury. The patient is noted to have 1-1/2 drop of hemoglobein over the course of less than 2 hours in the emergency department and at transfusion of 1 unit of packed red blood cells are given. She is given medication for pain." "Final impression: Acute polytrauma with concern for injury to air digestive tract, femoral fracture, diffuse ecchymosis, blood loss anemia likely secondary to femur fracture, strangulation injury with subcutaneous emphysema, troponin elevation likely secondary to trauma/pneumomediastinum. Addmitted to the trauma service."*

On page 14 of the hospital medical records it states "*Multiple areas of ecchymoses overlying the bilateral thighs with the left worse than the right, there is abraisons to the left lateral side of her neck."*

On page 20 it states "*Acute horizontal fracture of the mid left femoral shaft with sever lateral displacement of the distal femur*." On the next page it continues with "*Pneumomediastinum. Subcutaneous emphysema in the soft tissues of the neck extending to the level of the skull base*. *Extensive subcutaneous emphysema in the soft tissues of the face and neck extending to the left orbit. Extensive subcutaneous emphysema in the soft tissues of the neck and periorbital soft tissues extending to the left orbit. Acute completely displaced transverse fracture of the distal left femoral diaphysis*".

On page 23 it states "[*Resident C] is a 31 y.o. female s/p assault at her group home. Patient is a 31 yo F who is developmentally delayed and minimally verbal. She is accompanied by her care taker who is unfamiliar with what happened. Vague details from chart review include an assault by another member of the group home. Patient is minimally ambulatory at baseline. But as the staff were trying to get her to walk, they notice she was not putting weight on her leg. Multiple bruises scattered throughout body. Patient is visibly agitated and anxious. She is having muscle spasms about the Left leg*."

On page 25 it states "*From an ortho standpoint, she has a midshift femur fracture that is shortened and displaced. She also has scattered abraisons/ecchymosis on her bilateral forearms and elbows as well as Right femur. Patient was also found to have pneumomediastinum from a trauma perspective. Patient is minimally ambulatory and verbal at baseline. She was having intense muscle spasms and agitation. Unknown time of injury. Traction pin was placed with some difficulty due to patient moving and having muscle spasms, inhibiting patella from being parallel with the floor. Pin was placed and 25 lbs of traction were applied*."

On page 33 it states *"the direct care worker Antionette reports the assault occurred on first shift on 2/5/23 and was not brought into the hospital until 3rd shift however she does not know why the staff did not see medical attention earlier. She was not present when the assault occurred however it was written on the "board" that she had been assaulted by [Resident D]."*

On page 39 it states *"sustained a closed left femur fracture, pneumomediastinum with subcutaneous emphsyema to the bilateral neck and left orbital region, scattered abraisons and ecchymosis. Placed in traction by ortho in ED. Patient underwent an esophagram that was negative for leak."* (Per a Google search, pneumomediastinum is an uncommon condition that can be caused by injury or disease, but most often occurs when air leaks from any part of the lung or airways into the mediastinum. Subcutaneous emphsyema is when air gets trapped in the tissues under the skin. It is rare, but can occur as a result of trauma, injury, infection, etc. Ecchymosis is a discoloration of the skin resulting from bleeding underneath, typically caused by bruising.)

On page 76, in the summary of a radiology lab report it states under findings *"Soft tissues: Extensive subcutaneous emphysema in the soft tissues of the neck and periorbital soft tissues extending to the left orbit."*

During the course of this investigation, I obtained via mail colored photo copies of Resident C's injuries that were taken by Hurley Medical Center staff. The photos appear to show large bruising on Resident C's left thigh above her knee. The brusing covers a large area of her thigh. A second photo shows swelling around her left eye, and a dried unknown substance on her bottom lip. A third photo shows about three red marks on the left side of her neck. A fourth photo show brusing on the back of her right upper thigh area. A fifth photo shows bruising on the back side of her thigh.

On 02/10/2023, I interviewed Resident C's Guardian 1 via phone. Guardian 1 stated that Resident C is being moved to a rehabilitation floor. Resident C will not be able to go back to Goodrich North, as they cannot seem to move Resident D to a new placement. Resident C has been in the facility for two years, and Resident D just moved in. She stated that she has heard that Resident C has been doing well and is in good spirits. Resident C had surgery and has a cast on her leg. The hospital tried

calling her Sunday night, but she did not have her phone by her. She stated that she called back the next morning and spoke to a nurse, then she called Goodrich North. Guardian 1 stated that she was informed by adult protective services that Resident C was attacked two days in a row. The facility did not inform her that Resident C was attacked twice. Guardian 1 stated that she does receive incident reports, but has not received anything yet regarding the incidents between Resident C and Resident D. Guardian 1 stated that prior to this, she had not had any concerns regarding Resident C's care. She stated that Resident C has the mentality of a five year old child. She stated that Staff Eickhoff told her that Resident C was pushed up against a wall, and fell to the floor, and the second time, Resident C was laying down somewhere and Resident D got on Resident C. She stated that then Resident C went to the hospital, and it was found that her femur was fractured. She stated that she was told Resident C was choked, as there were issues with her esophagous. She stated that right now Resident C has a blood clot forming. She stated that Resident C now has a fear of men, and this is a new behavior. She stated that prior to these assaults, Resident C was never afraid of anyone.

On 02/10/2023, I spoke with GHS recipient rights investigator Pat Shephard via phone. She stated that she interviewed staff Chloe Baxter who was Resident D's one to one staff person during the second assault on Resident C. She stated that Staff Baxter reported that she was right there when it happened. Resident D was agitated, and when Resident D saw Resident C he bolted, and it happened fast. She stated that Staff Baxter reported that all of the staff were there, and Resident C was on the floor. Resident D grabbed Resident C in a chokehold and was trying to hold her up, then staff went after Resident D, and that is when Resident D fell on Resident C.

On 02/21/2023, I conducted interviews with adult protective services investigator Kelly Clark-Huey, along with recipient rights investigator Pat Shephard of GHS (Genesee Health Systems) virtually on Microsoft Teams. Genesee County Sherriff's Department's Sargent James Vernier was on the call as well, but had to exit due to connectivity issues. The following staff interviews are as follows:

Staff Anthony Schnieder was interviewed. He stated that he started working at the facility in April 2022. Staff Schnieder stated that he is a lead staff person who worked on 02/04/2023 on third shift. Staff Schneider stated that Resident D was walking to the kitchen, and Resident C was walking to the couch. Resident D bolted after Resident C. Resident C was attacked by Resident D, and she slowly fell down the wall. Staff Nick Terrell was Resident D's assiged one to one staff at the time of the incident. Staff Terrell was behind Resident D at the time by a couple of feet (within an arm's reach), and could not get to Resident D. Staff Terrell was able to verbally redirect Resident D afterwards. Resident C was about three inches from the wall. Staff assisted Resident C up, and got her to the couch. Resident C was able to walk. Resident C was checked for marks and brusing, and she stated that her leg hurt. Staff Schnieder stated that Resident C regularly complains of leg pain. Staff Schneider stated that there were about four staff present, but he and Staff Terrell

were the only witnesses. He stated that Resident C is very inactive (in general), and she stayed on the couch for the rest of the shift. He stated that he checked her from her torso to her legs for bruising, and the top of her feet and arms. He stated that the incident reports that were written up, were combined, and at the time of the incident, he did not observe any bruising. When asked what trigged Resident D, he stated that Resident D ran out of his snack, then saw Resident C walking by. He denied that Resident C complained of any leg pain at the time of the incident, and denied ever seeing Resident D attack Resident C prior to this incident. He stated that Resident C makes a loud screeching cry noise, and it bothers Resident D. He stated that he does not think Resident C broke her leg from this incident. He stated that Resident C has an unsteady gait, and she will ask for pain medication when in pain. He stated that Resident C falls at times on a regular basis.

Staff Dy'mond Davis was interviewed. She stated that she is a direct care worker and has been working in the facility for about seven months. Staff Dy'mond stated that she worked on 02/04/2023, on third shift. She stated that she did not witness the incident. When she came out of another resident's bedroom, Resident C was sitting on the floor, with one leg folded in, and the other leg extended out straight. She stated that Resident C was crying, and she thinks Resident C was crying due to being startled by Resident D. She stated that staff helped Resident C up, and Resident C walked on her own. She stated that she does not recall Resident C complaining of pain, just verbally expressing how Resident D pushed her. She stated that she thinks Staff Schnieder and staff Deontae Lowe checked Resident C over for marks and bruises. She stated that she does not recall Resident C asking for pain medication, and she does not recall hearing that Resident C had any bruising after being pushed by Resident D.

Staff LeChaun Hill was interviewed. Staff Hill stated that he is a direct care worker and has worked at the facility for about two years. He stated that he worked third shift on 02/04/2023. He stated that he was scheduled to be on shift that night, but was pulled from the facility to go work at another home. He stated that no other staff came in to replace him that night. He stated that he left between 12:30 am and 1:00 am. He stated that he heard that Resident D attacked Resident C, and that Resident D broke Resident C's leg. He stated that he has seen Resident D get slightly agitated, and that Resident D came at him one time. He stated that he had to use his hands to protect himself. He stated that he has not witnessed anything major like the incident that happened with Resident C. He stated that he has not witnessed Resident D shove, choke, or push anyone.

Staff Rolaunde McCree was interviewed. Staff McCree stated that he is a direct care worker who works first shift. He stated that he has worked in the facility since July 2022. Staff McCree stated that he worked first shift on 02/05/2023. He stated that Resident C was laying on the living room floor. Resident D went into a behavior and starting ripping things and grabbing stuff. Staff McCree stated that he and staff Dre'Von Holloway had taken over supervising Resident C because his assigned one on to staff person (staff Chloe Baxter) could not handle Resident D. He stated that

Resident D calmed down at the table, then got up, ran toward Resident C, and got Resident C in somewhat of a headlock. He stated that Resident D was trying to get his hands to lock. He stated that staff tried CPI on Resident D, then Resident D fell backwards on Resident C. Resident C started crying, and then not much happened after that. He stated that Resident D got up from the floor, and staff used blocking pads to get Resident D away from Resident C. He stated that this incident occurred around 2:45 pm, no earlier than 2:30 pm. He stated that afterwards, Resident D was still riled up. The female staff were with Resident C, and he and Staff Holloway were with Resident D. He stated that Resident C's cry is a scream, she does this regularly, and after the incident it was her usual screaming. He stated that Resident D is unpredictable. He stated that when Resident D bolted, he (Staff McCree) was acting as his one on one staff. Staff McCree stated that he was behind Resident D's chair, and Staff Holloway was at the other side of the table. He stated that he did follow Resident D, and was able to stay with him, it just happened so quickly. He stated that when Resident D fell on Resident C's legs, staff had to let him go. He stated that Resident C was the closest thing to Resident D at the time right before the assault. He stated that Resident D did not fall hard, and he was already kind of low to the ground when he fell onto Resident C's legs. He stated that Resident D was in a straddle position over Resident C before the fall happened. He stated that Resident C's eye was swollen at the beginning of the shift on 02/05/2023, at 7:00 am. He stated that no other injuries were noted at that time, and Resident C was walking around unassisted prior to the assault. He stated that at med pass time that morning, Resident C did not want to get up, that is when staff saw that her eye was swollen, and it looked like someone had hit her. He stated that Staff Holloway noted that it may have been caused by Resident C lying in a pee puddle (in her bed). He stated that staff found Resident C laying in a significant amount of urine, and staff had to change her sheets. He stated that Resident C usually has to be prompted, but she will go to the bathroom on her own, and it is normal for her to wet the bed at night. He stated that he did not observe any marks on Resident C's neck or bruising on her legs at that time. He denied that Resident C has a wheelchair. He stated that Resident C was sitting on the couch at the end of his shift, and he does not think the injuries she sustained were caused by the phyiscal assault that occurred on his shift. He stated that he thought maybe something happened on the next shift because Resident C was not injured on first shift.

Staff McCree stated that prior to the incident on 02/05/2023, Resident D would go after Staff Baxter when he would go into behaviors and tries to hit Staff Baxter. He stated that Staff Baxter cannot effectively desecalate Resident D, and that is why he and Staff Holloway stepped in to assist. He stated that when Resident D has a behavior, female staff persons cannot do CPI holds on him because Resident D is strong. He stated that it was brought up to supervision about female staff not being able to maintain Resident D, and management said it could be both male and female one to one staff. This was after they initially had only male one to one staff. He stated that he heard that on one shift, there were all female staff working and they had a hard time doing CPI on Resident D. He stated that he does not know what triggered Resident D. He stated that after being assaulted, Resident C was laying

there crying, and he is not sure if Resident C was able to get up (from the floor) on her own. He stated that there were a lot of staff by Resident C, and she probably needed assistance due to her size. He stated that he is not sure if Resident C was checked over for marks or bruising.

Staff Taylor Heller was interviewed. She stated that she has worked for Flatrock Inc. since June 2022. She stated that she has worked in this facility since December 2022, and is a direct care worker. Staff Heller stated that she worked first shift on 02/05/2023. She stated that they were all in the dining room, and it was about 30 to 40 minutes before the end of the shift. A second shift staff person (staff Ashley Davis) came into the facility with food. Resident D obsessed over the outside food, then over the trash can after the Staff Davis threw something away. Staff Heller stated that Resident D was then pacing back and forth, she thought he was going to sit down, but Resident D went towards Resident C, as Resident C was the closest person to him. She stated that she witnessed staff trying to get Resident D off of Resident C. Resident D was behind Resident C, and he held her head up (from behind) arching her neck. Staff Heller stated that Resident C came up off of the floor because of that, then plopped back onto the floor once staff intervened and Resident D let Resident C go. She stated that she thinks Resident D lost balance as staff was trying to get him off of Resident C. Resident D then fell onto Resident C. She stated that Resident D did not fall from a standing position, but did fall backwards onto Resident C's legs. Staff Heller stated that Resident C was doing her normal "whining." Shes stated that she and staff Chionny Cooper helped Resident C up, but it was difficult to get Resident C up to a standing position due to her weight. She stated that Resident C did move both legs and walked unassisted to the couch. She stated that Resident C was crying "my leg hurts." She stated that she is unsure which staff checked for bruises. She stated that she is also unsure who Resident C's assigned staff person was at that time, but it may have been Staff Cooper. She stated that Staff Holloway and Staff McCree were using blocking pads. She stated that Resident D was choking Resident C for no longer than a minute. She stated that Staff Naylor was the lead staff on shift, and she cannot recall if Resident C asked for any pain medication. She stated that she did not see Resident C in a wheelchair after the assault, and stated that Staff Baker and Staff Cooper walked Resident C back to her room. She stated that staff had Resident C's arms but she walked on her legs. She stated that Resident C's eye was swollen and puffy at the start of the shift, and that she did not have a black eye, but her eye was closed shut, and there was discharge in Resident C's eye. She stated that she was informed that at the start of the shift by staff Tianna Naylor that Resident C had been laying in urine. She stated that Staff Naylor should have contacted the medication coordinator about Resident C's eye being swollwen. She denied seeing a red mark on Resident C's neck or any bruising. She stated that she also did not observe any bruising on Resident C's foot and that Resident C was barefoot during her shift. She stated that she did not hear of Resident C complaining of foot pain prior to the assault that happened on her shift, and that Resident C was walking with her normal gait, but maybe a little limp, but not excessive. She stated that in the moment after Resident D assault Resident C, she did not think that Resident C needed medical attention. When asked if she

thought Resident D fell hard enough to break Resident C's leg she stated yes, and that it was his weight.

Staff Dre'Von Holloway was interviewed. Staff Holloway stated that he is a direct care worker and has worked at the facility since April 2022. He stated that he worked first shift on 02/04/2023 and on 02/05/2023. He stated that on 02/04/2023, the first time he saw Resident C on that shift was when he was called in her room for assistance to get Resident C off of the floor. Resident C could bear weight at that time, and walked to the common area on her own. He stated that someone from management named Nadia Clark called him into Resident C's room, and that Ms. Clark was there conducting a "pop up" visit. He stated that this occurred around 11:30 am that day. He stated that he does not think Resident C came out of her room that morning for breakfast, and that he did not observe anything abnormal about her.

Staff Holloway stated that on 02/05/2023, around 2:30 pm, another staff from second shift came in with food. Resident D was ripping paper and tearing down pictures. Resident C was laying on the floor. Resident D went to Resident C and got around her neck, and choked Resident C in an upwards motion. Staff then came over to help Resident C, and Resident D fell. He stated that after Resident D got up, his behavior was pretty much over. Staff Holloway stated that Staff Baxter was Resident D's one to one staff at the time, and was within arm's reach of Resident D. He stated that he and another staff person stepped in when Resident D choked Resident C. Staff provided Resident D with verbal direction prior to, (Resident C being choked) possibly by Staff Baxter and Staff McCree. He stated that he believes staff did have blocking pads, but not after Resident D had already choked Resident C. He stated that blocking pads may have been used prior to the choking. He stated that he was at the table with another resident. He denied being a stand in one to one staff for Resident D at that time. He stated that Resident D had a grip on Resident C's neck for about 20 to 30 seconds, and that Staff Baxter (Resident D's one to one) was behind him and Staff McCree at that time. He stated that he thinks Staff Baxter was close enough to prevent the assault from happening. He stated that there are a lot of staff that are intimidated by Resident D, and that it is left up to the male staff to calm Resident D's behaviors. He stated that when Resident D is too mad, there is nothing Staff Baxter can do. He stated that staff are supposed to verbally redirect Resident D during a behavior, and that sometimes Resident D is unpredictable. He stated that staff is aware that bringing outside food in can be a trigger for the residents. Staff Holloway stated that afterwards, Resident C did scream a little. Staff got Resident C up, and helped her to her room. He stated that he thinks Resident C walked on her own. He denied having any knowledge of Resident C needing medical attention after the incident. He stated that on 02/05/2023, Resident C's eye was swollen but there was no discoloration. He stated that he knows that Resident C urinated in her bed, and the urine was in her face. He stated that the swollen eye could have been from the urine. He stated that staff got Resident C to the shower, and assisted Resident C by bearing her weight for her. He stated that he has not seen Resident C with a wheelchair, and that Resident C does complain of leg and foot pain regularly. He

stated that Resident D's fall was hard, but he does not think the fall was hard enough to break Resident C's leg. He stated that Resident D was standing slouched over before he fell on Resident C. He stated that prior to this, Resident C was walking with a limp. He stated that Resident C wearing a gown at the time that was knee length. He denied seeing any bruising.

Staff Chionny Cooper was interviewed. Staff Cooper stated that she is a direct care worker and has worked at the facility since June 2022. Staff Cooper stated that she worked first shift on 02/05/2023 from 7:00 am to 3:00 pm. She stated that she was assigned to Resident C. She stated that at the start of the shift, Resident C was observed that morning face down laying in her urine. She saw that Resident C's face was puffy on the left side. She stated that she does not know if it is normal for Resident C to be incontient. She stated that this was the first time she observed this, and Resident C's eye also looked like it was draining. She denied seeing any marks on Resident C's neck at the time. She stated that she put Resident C in the shower, and observed a cut on Resident C's stomach, but no bruising. She stated that Resident C walked to the bathroom for her shower on her own. She stated that Resident C was "perfectly fine" the entire day. She stated that the lead staff person that day was aware of Resident C's eye. She stated that Staff Holloway and Staff McCree witnessed Resident C's eye as well. She stated that she does not know if management was notified of Resident C's swollen eye.

Staff Cooper stated that (later in the shift), Resident C was on the floor laying down, on her way to sleep. She (Staff Cooper) was in the dining room, and Resident D was watching television. Everyone started yelling at Resident D to stop, then Staff Cooper saw that Resident D was on Resident C's neck. She stated that everyone rushed over to Resident C and Resident D. Staff Baxter was Resident D's assigned one to one staff person. She stated that Resident D had been walking around pacing, and Staff Baxter was on the couch within arm's reach of Resident D. She stated that it was food brought in by a second shift staff that set Resident D off. She stated that staff is aware that Resident D is triggered by food, and he has been since moving in. She stated that the staff person, staff Ashley Davis, took her food to the kitchen, after Resident D chased her. She stated that at this time, she does not remember where Staff Baxter was. She stated that she also does not recall staff using blocking pads. She stated that she does not know if Resident D pulled Resident C by the neck, but that Resident D did fall on the floor by Resident C's legs. She stated that Staff Baxter and Staff Heller assisted her in getting Resident C back to her room. She denied that there were any signs Resident C needed any medical attention. She stated that at the end of the shift, Resident C's eye swelling had went down. She stated that there was nothing on the board for Resident C at the start of her shift, but that she did document the swollen eye and the cut on her stomach. She stated that she did not document the assault at the end of the shift, because it happened at kind of at the start of second shift.

Staff Chloe Baxter was interviewed. Staff Baxter stated that she has been a direct care worker since September 2022. Staff Baxter worked first shift on 02/04/2023 and

on 02/05/2023. She was Resident D's one to one staff on 02/05/2023. Staff Baxter stated that on 02/04/2023, Resident C slept most of the day, and Resident D did not really have any behaviors. She stated that later in the day, Resident C came out of her room, ate, was walking fine, and she did not observe any bruises. Staff Baxter stated that Resident C had a swollen eye on 02/05/2023. She denied seeing any eye draining and did not see any red marks on Resident C's neck. She stated that it is normal for Resident C to complain of soreness. She stated that on 02/05/2023, she helped the X-ray tech with Resident C's foot. She stated that the x-ray was done on the wrong foot. She denied seeing any bruising. She stated that the left foot was supposed to be x-rayed, but they x-rayed the right foot. She stated that she was unaware the x-ray was scheduled, and staff were not told which foot needed the x-ray. She stated that she does not know why the x-ray tech was called.

Staff Baxter stated that on 02/05/2023, at med passing, Resident C's bed was wet and she was laying face down in her urine. She stated that it is normal for Resident C to pee in the bed when she sleeps hard. She stated that Staff Cooper got Resident C to the shower. She stated that Resident C walked to the bathroom unassisted, and that Staff Cooper noted a cut on Resident C but no bruising. Staff Baxter stated that she was Resident D's one to one staff and that she was with Resident D for his entire behavior until she switched with other staff to help Resident C up. She stated that she left the CPI physical management up to the male staff because it is very hard for female staff to do CPI with Resident D. She stated that this issue has been brought to management's attention and they were told to at least try.

Staff Baxter stated that on 02/05/2023 a second shift staff person came in with food from Wendy's. Resident D got food aggressive. Resident D got up, tried to go after the food, and chased the staff person with the Wendy's. Male staff tried to redirect Resident D, but Resident D got aggressive. Staff redirected with a snack. When Resident D went to throw his trash away, he saw the Wendy's bag and got re-triggered. She stated that staff redirected Resident D, then he started walking around the dining room, and then went after Resident C. She stated that staff is aware that Resident D is very triggered by food, but they did not know how severe the food obsession was. She stated that Resident C was laying on the floor when Resident D pulled Resident C up in a chokehold. Resident D grabbed Resident C by the neck with the inside of his arm. She stated that Resident D did not have Resident C by the neck for long, and that staff tried CPI unsuccessfully on Resident D. Staff tried to do a CPI child control hold on Resident D. She stated that the incident happened so fast, and that she did not swap out of the one to one with Resident D until she assisted getting Resident C up. She stated that Resident C had been laying on her stomach, and it looked like Resident D's butt landed sideways on Resident C's butt when Resident D fell. When Resident D got up, she trasferred Resident D to staff Tianna Naylor. She stated that when assisting Resident C up, it was not difficult, and Resident C walked unassisted to her room. She stated that Resident C was crying, but there were no signs of limping or pain. She stated that she is not sure which staff used blocking pads, nor when the blocking pads were

used. She stated that there were no signs that Resident C needed immediate medical attention. She stated that they were all shocked that Resident C ended up with a broken femur, or any injury. She stated that there is no wheelchair in the facility.

Staff Tianna Naylor was interviewed. Staff Naylor stated that she is a first shift lead staff person and she works from 7:00 am to 3:00 pm. She stated that she has worked for about two years. Staff Naylor stated that on 02/04/2023 Resident C was asleep at the start of the shift. She stated that Resident C received her 8:00 am meds, but did not eat breakfast. Resident C fell during the shift, and a manager, Ms. Nadia Clark, did a pop up visit at about 12:00 pm. Ms. Clark found Resident C on the floor. She stated that she thinks Resident C probably fell trying to get out of bed. Staff Holloway and Staff McCree helped Resident C up. She stated that there was a small bruise about the size of a nickel on Resident C's left ankle, and Resident C asked for a Tylenol for her ankle. She stated that she was aware of the incident that happened on the previous shift (when Resident D shoved Resident C). She stated that it is normal for Resident C to complain of soreness. She denied noticing any significant change in Resident C's gait, and that Resident C stood up acting like she didn't want to walk but did walk. She stated that Ms. Clark witnessed the fall, and had to get staff to assist. She stated that Resident C was fine after receiving Tylenol, and was walking with no issues.

Staff Naylor stated that on 02/05/2023, on first shift, she was about to pass medications, and saw Resident C laying in her urine. She stated that she informed the medication coordinator staff Faith Carpenter. She stated that Resident C's eye was puffy, and she was instructed to use a warm compress. She stated that Resident C's eye had discharge and was crusted. She stated that staff got Resident C up, got her showered, and bed linens changed. Resident C remained in the common area for most of the shift. Staff Cooper assisted Resident C with her shower, and Resident C walked to the shower unassisted. She stated that later on in the shift, a staff person (Ashley Davis) came in with outside food. Resident D obsessed because of it. Staff Davis threw her fast food bag away, then went to the kitchen with the food. Resident D then obsessed over the trash can and became physically aggressive toward Staff Baxter and other staff. The male staff intervened. Resident D calmed down, received a snack, then got up and started walking around in circles. Staff were watching Resident D, and his one to one staff was with him. Resident D darted over to Resident C, wrapped his arm around her neck and snatched her up from the floor. Staff tried to put Resident D in a child control hold. Resident D fell, Resident C started to cry. Resident D was followed by staff until he calmed down. Staff Naylor stated that Resident D only had Resident C in a hold for about three to four seconds, and staff were close to him to intervene. She stated that Staff Baxter was Resident D's one to one. She stated that she switched to Resident D's one to one while Staff Baxter helped Resident C. She stated that the male staff were around as well, and staff were around before and after Resident D assaulted Resident C. She stated that Resident D fell backwards onto Resident C's lower body, and that Resident C had already been laying on the floor with a pillow. She

stated that it is CPI policy that once a resident loses their footing, that staff have to fall back because they cannot pin a resident to the floor. She stated that it is not easy to do CPI on Resident D because he fights back. She stated that staff validated Resident C's feelings, and got her a glass of water. She stated that Resident C ambulated on her own afterwards. She stated that she left the facility about 10 to 15 minutes past 3:00 pm. She stated that she did not write an incident report, but that the second shift lead staff notified the medication coordinator. She stated that she did not contact the guardian as that is the medication coordinator's responsibility. She stated that she cannot remember if blocking pads were used. She denied that there is a wheelchair in the facility.

Staff Ashley Davis was interviewed. She stated that she is a direct care worker who has been working since November 2022. Staff Davis stated that she worked on 02/05/2023 second shift. She stated that she arrived at the facility at about 2:30 pm with food. She stated that Resident D started coming at her. She stated that staff were on Resident D, and she went to the kitchen and ate her food. She stated that she came out of the kitchen and saw four to five staff by Resident D. She stated that Resident D had grabbed Resident C by the neck, staff grabbed Resident D, and tried redirecting him. She stated that Resident C had been sitting up watching television, and after being choked, Resident C still did not go to her room. She stated someone asked everyone to clear out of the area before that, but Resident C did not leave. She stated that she thinks Resident C had been on the couch when choked initially, but Resident D was on the back of Resident C when she saw them. She stated that she did not see the whole incident. She denied seeing Resident D falling on Resident C. She stated that Staff McCree and Staff Holloway had blocking pads after she came in with the food. She stated that staff had used child control CPI on Resident D. She stated that staff walked Resident C to her room, then said that Resident C did not want to move, then eventually laid on the couch. She stated that she saw Resident C's eye leaking yellow fluid at the start of her shift, and heard that she had peed in her bed. She stated that she assumed Resident C's eye was infected. She stated that around 8:00 pm, staff Kayla Dumas was passing medications, and she called her (Staff Davis) in to Resident C's room. She stated that they called staff Faith Carpenter and was told to get Resident C to the hospital. She stated that Resident C was not crying or anything. She stated that the home manager was contacted about 10:00 pm, and that the medication coordinator called the home manager. She stated that she thinks Staff Carpenter called 911, and the paramedics came around 9:00 pm. She stated that Resident C was taken to the hospital. She was not listening to staff, and not standing up. She denied that there were any incidents between Resident C and Resident D since he choked her around 2:30 pm that day, and 8:00 pm when Resident C was on the floor and could not stand up. She stated that the ambulance and EMT's got to the home between 9:00 pm and 9:30 pm, then said maybe 10:00 pm. She stated that she does not remember any marks or bruises on Resident C's neck at this time. She stated that she and Staff Dumas completed incident reports, and that everyone on first shift should have done incident reports as well.

Staff Kayla Dumas was interviewed. She stated that she is a lead staff worker on second shift, and she worked on 02/04/2023 and 02/05/2023. She stated that on 02/04/2023, she reached out to staff Faith Carpenter, the med coordinator about Resident C's foot, because of swelling around the ankle, and Resident C complaining of pain. Staff Dumas stated that this occurred around 5:00 pm at dinner time on 02/04/2023. Resident C had complained of pain, and she did not come down to eat. She stated that staff tried to get Resident C out of bed, and Resident C winced in pain but was able to stand. She stated that Resident C then started crying, so she had Resident C lay back down (because her cry did not appear to be a normal cry/complaint), and Resident C then stayed in her room. Staff stated that the medication coordinator was contacted around 5:00 pm and she sent Staff Carpenter a photo of Resident C's foot. The foot looked weird as there was swelling around her ankle, and more fluid around it than usual. She stated that there was no bruising, just swelling of the left foot. When asked if she gave Resident A a PRN, she stated that she thinks a PRN for Tylenol was given the next day on 02/05/2023, but was not sure. She stated that it was not given on 02/04/2023 because Resident C did not request it, and just wanted to get in bed and lay down. (Per Resident C's medication administration records for February 2023, there was no PRN given on 02/05/2023. The only PRN Tylenol documented was passed on 02/04/2023 at 1:52 pm.)She stated that nothing out of the ordinary happened on the shift.

Staff Dumas stated that during her shift on 02/05/2023 at 5:00 pm (dinner time), Resident C was still in her room. She refused dinner. She stated that the staff person assigned to Resident C had told her something was wrong. So they came back to her room at snack time to see if she wanted a snack. She (Staff Dumas) went to Resident C's room to assess the problem. She stated she went down to Resident C's room at 8:00 pm to see if Resident C wanted to eat, because she hadn't ate dinner. Resident C told her she did not want to get up because her legs hurt. She stated that Resident A also fell at about 8:00 pm. She stated that just prior to the fall, Resident C was trying to position herself to come towards her (Staff Dumas), so she could assist her to get dressed. Staff Dumas stated that she observed the outer part of Resident C's leg to be bruised around 9:00 pm, so she called the medication coordinator (to ask her if anyone had communicated these things to the med coordinator already). She stated she found the brusing while she was getting Resident C dressed to go to the hospital. She stated that Resident C was telling staff that her leg hurt (while getting dressed). She stated that EMS arrived at about 9:29 pm. She stated that Resident C was still on the floor when EMS arrived an hour to an hour and a half later after falling. She stated that they tried to get Resident C up after the fall, but she (Staff Dumas) felt like they were making the situation worse, so she called the medication coordinator because they needs assistance getting Resident C up from the floor. She stated that the ambulance was called because staff needed assistance to get her up. When asked if anyone noticed any bruising before the EMT's arrived, she stated that Resident C was fully dressed, and had spent most of the day in her room. Resident C did not want to move around much, so staff had been just doing checks on her every 15

minutes. She stated that staff sat with Resident C until the EMT's arrived at 9:26 pm. She stated that she had heard that Resident D fell on Resident C's leg in the midst of staff doing CPI and having to let Resident D go.

On 03/07/2023, I obtained a copy of the Genesee County Sherriff's Office report. The "*File Class/Offense*" is noted as *13002 Aggravated/Felonious Assault Assault-Mayhem*. The case number is 2312500449. Resident C is listed as the victim. Resident D is listed as the suspect. The report notes that Deputy Corey Sheroski recevied a call about Resident C having sustained a broken femur, black eye, and ligature marks on her neck. An attempt was by Deputy Sheroski to interview Resident C at the hospital, but she was asleep. Brittany Fearn of Hurley Medical Center informed the police that per medical notes, Resident C arrived at the emergency room on 02/05/2023 around 2200 (10:00 pm) hrs via ambulance. The next day, Deputy Sheroski attempted to interview Resident C, but her demeanor changed, and the deputy did not continue questioning. On 02/06/2023, the deputies questioned Staff Eichoff at the facility. She informed them that Resident D got upset over food, then attacked Resident C, wrapping his arms around her neck. Resident D then fell on top of Resident C after staff attempted to intervene.

On 09/22/2022, AFC Licensing Consultant Derrick Britton concluded Special Investigation Report #2022A0582050. The allegations were that Resident A had excessive bruising and bite marks on his legs, arms, chest, clavicle, stomach, and thighs, caused by Resident B and the issue was ongoing with no resolution. R400.14305(3) was substantiated due to a preponderance of evidence that Resident B had been assaulting other residents from 06/02/2022 through 08/31/2022. The report notes that none of the corrective actions put in place were successful in preventing further incidents. The corrective action plan, dated for 10/20/2022 stating that staff would be in-serviced on Resident B's behavioral plan and IPOS, the resident would be moved to a new smaller location, and progress would be monitored. Continuing compliance was noted to be "*bi-weekly core meetings conducted in care home, monthly all staff meetings*."

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:	Incident reports dated for 01/22/2023, and 01/29/2023 summarize incidents where Resident D attempted or actually physically assaulted other residents. Incident reports from 02/04/2023 at 4:30 am and 02/05/2023 at 2:30 pm noted that Resident C was assaulted twice by Resident D. The incident reports stated that staff will continue to ensure

	the health and safety of the residents. On 02/05/2023, Resident C sustained serious injuries after being physically assaulted by Resident D and had to be hospitalized. Staff Schneider, Staff Hill, Staff Holloway, Staff Heller, Staff McCree, Staff Holloway, Staff Cooper, Staff Baxter, Staff Naylor, Staff Davis, and Staff Dumas all reportedly either witnessed Resident D assault Resident C or was informed of the assault(s). Staff Naylor stated that it is difficult to do CPI on Resident D because Resident D fights back. Staff Baxter stated that she left the CPI physical management up to the male staff because it is very hard for female staff to do CPI with Resident D. Staff McCree stated that when Resident D has a behavior, female staff persons cannot do CPI holds on him because Resident D is strong. There is a preponderance of evidence to substantiate a rule violation in regard to staff's failure to provide protection and safety at all times for Resident C.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A00582050, dated September 22, 2022**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Complainant 1 stated that on 02/05/2023, they observed Resident C's x-rays, and her femur bone was broken in half. Resident C was in the emergency room shaking due to being in so much pain. Resident C's left eye was also observed to be swollen shut, as well as a lot of visible bruising on her legs. Complainant 1 stated that the emergency room doctor was upset about Resident C's condition. Incident reports from 02/04/2023 4:30 am and 02/05/2023 at 2:30 pm noted that Resident C was assaulted twice by Resident D. An incident report dated 02/05/2023 at 9:00 pm notes that EMS did not arrive until 9:25 pm. Per Dr. Kristin Swor-Wolf, MD's notes in Resident C's medical

	records obtained from Hurley Medical Center, Resident C did not appear to have just suffered a fall. The medical records also note that Resident C appeared to be the victim of significant trauma/assault. Photos of Resident C show that she had marks on the left side of her neck, as well as significant bruising on her legs. Resident C's assessment plan and *Health Care Appraisal* noted that she was fully ambulatory with no assistive devise use. Staff Holloway, Staff Heller, Staff McCree, Staff Cooper, Staff Baxter, Staff Naylor, and Staff Davis were all interviewed and reported that Resident C had been laying in her own urine at the beginning of first shift on 02/05/2023. Staff reported that Resident C's eye appeared swollen shut, with yellow discharge, that it looked like someone hit her, and that her eye was crusted. Staff Naylor reported that she was instructed to put a warm compress on Resident C's eye by the medical coordinator. Staff Ashley Davis stated that she assumed Resident C's eye was infected and that she noticed yellow discharge leaking from the eye. Staff did not indicate that Resident C's physician or a licensed health care professional was consulted regarding Resident C's eye. Staff Holloway, Staff Heller, Staff McCree, Staff Holloway, Staff Cooper, Staff Baxter, Staff Naylor, and Staff Davis all reported that they witnessed Resident C being grabbed by the neck and choked by Resident D. Staff Naylor, lead staff on 02/05/2023, reported that she did not write an incident report, and the second shift team lead reported the assault to management. Home manager Erin Eickhoff stated that she was not informed of anything until 10:00 pm on 02/05/2023. Per staff Kayla Dumas, Resident C was on the floor for over an hour before EMS arrive. She fell at approximately 8:00 pm. Staff Ashley Davis also reported that Resident C fell at 8:00 pm. Staff called the medical coordinator first, then 911 was called about 9:00 pm. Staff were not able to get Resident C off of the floor. The EMT's did not arrive until 9:26 pm. I spoke with Guardian 1 who stated that Resident C had a broken femur, and due to also being choked, there was issues

	with her esophagus. She stated that Resident C had surgery on her leg, and Resident C is going to rehabilitation. There is a preponderance of evidence to substantiate a rule violation. Resident C was last assaulted around 2:30 pm on 02/05/2023. Staff did not seek immediate medical care for her extensive injuries and called the medication coordinator before calling 911. EMS arrived at the home after 9:00 pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: On 02/07/2023 during this on-site, I obtained copies of multiple incident reports. I requested incident reports regarding the incidents that took place on 02/04/2023 and 02/05/2023, as well as all incident reports for Resident D since 01/13/2023, the day Resident D moved into the facility. The following is a summary of each incident report regarding Resident D assaulting another resident:

An *AFC Licensing Division- Incident/Accident Report* dated 01/22/2023, and signed by staff Tianna Naylor details an incident where Resident D got agitated in the dining room and began yelling and hitting staff. Resident D then charged a table of residents and began hitting them. One resident was hit in the face, and was bruised. Staff used blocking pads to create space between Resident D and the other residents. Resident D was then able to hit another resident. Resident D then complied with staff and went to the sensory room. It took Resident D about 30 minutes to completely calm down after staff gave him a snack and his tablet. The incident report states that "*staff will continue to closely monitor to ensure the health and safety of the residents*."

An *AFC Licensing Division- Incident/Accident Report* dated 01/29/2023, and signed by staff Mela Allen details an incident where Resident D became upset after another resident went into a behavior. Resident D became physically aggressive towards his one to one staff by hitting and kicking. Verbal redirection was unsuccessful, and he continued punching and kicking staff. He then attempted to run after two other residents. Staff "*attempted outside/inside but was unsuccessful*." Staff continued verbal redirection and using blocking pads. They redirected Resident D to a bounce house where he eventually calmed down after receiving a snack.

An *AFC Licensing Division- Incident/Accident Report* dated 02/04/2023 (at 4:30 am), and signed by staff Anthony Schneider describes Resident D pushing Resident C into a wall. Resident C complained of pain and needed assistance walking. Staff action was noted to be "*contacted med coordinator; gave PRN; prompted preferred activity. Staff will continue to monitor for health and safety*."

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 2:30 pm), signed by staff Chloe Baxter states "[*Resident D] was sitting at the table when staff*

sat near him with food. [Resident D] began swinging at staff and chasing staff around the home even after the food was put away. Staff used blocking pads and body positioning to try and redirect [Resident D] but was unsuccessful. [Resident D] continued to be physically aggressive towards staff, staff continued to use the blocking pads and body positioning techniques. Staff continued to try and verbally redirect [Resident D] & he started to show signs of calming down when he then grabbed another resident by the throat wrapping his arm around her neck. Staff immediately interveneed using body positioning and blocking pads. [Resident D] lost his footing and fell onto the other residents legs, he then got up on his feet and ran over and knocked the trash can over on the floor. [Resident D] continued to yell and act physically aggressive for 5 minutes before showing signs of calming down, he proceeded to sit at the table. And ate a snack and remained calmed. Blocking pads, body positioning, verbal redirection, preferred activity. Staff will continue to ensure the health and safety of the resident."

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 2:30 pm), signed by staff Chloe Baxter states *"[Resident C] was laying on the floor relaxing when a peer charged her and began choking her from behind. Staff immediately intervened using body positiong and blocking pads which was successful. [Resident C] began crying so staff validated her feelings and let her know everything would be okay. Staff then prompted her to do her preferred activity of watching TV in her room in which she complied. Body positioning; blocking pads; validating feelings; prompted preferred activity. Staff will continue to closely monitor to ensure the health and safety of the residents."*

An *AFC Licensing Division- Incident/Accident Report* dated 02/05/2023 (at 9:00 pm), signed by staff Kayla Dumas states "*While completing 15 minute bed checks, [Resident C] had attempted to get out of bed and fell. Staff tried to assist [Resident C] off the floor but could not lift her. Staff reached out to med coordinator letting her know that [Resident C] had fell. Staff communicated immediately and let her know that [Resident C] was unable to get up. Med Coordinator reached out to 911 for assistance and that EMT would be arriving soon. EMT's showed up at 9:25 pm to get [Resident C]. [Resident C] was transported to Hurley Medical Center. Staff validated [Resident C] feeling. Staff reached out to med coordinator. Staff reached out to 911. Staff sat with [Resident C] until EMS arrived. Staff will continue to complete 15 minute checks to ensure health and safety. Addendum: [Resident C] was admitted to Hurley and is scheduled for ortho surgery today 2/6 and also had an Esophogram done for subcutaneous tissue and possible air leak due to strangulation."*

On 02/07/2023, I obtained a copy of Resident D's assesment plan dated for 01/13/2023. Resident D's assessment plan states that he requires one to one supervision both in the facility and in the community as he engages in self harm, and is physically aggressive towards others (biting, pushing, hitting). Resident D is non-verbal. In the "*controls aggressive behavior*" section it states "*[Resident D] experiences deficits in attention, concentration, organization, impulse control, and*

frustration tolerance. These deficits contribute to mild aggressive behaviors such as hitting, pushing, or punching peers or staff. [Resident D] may also destroy property by throwing objects and/or hitting/kciking walls/doors. Staff working with [Resident D] will monitor for mood changes and will provide verbal redirection when necessary. In the even these measures are unsuccessful, staff are trained in Crisis Prevention Institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills." A copy of Resident D's *Interim Behavioral Treatment Plan* dated for 01/12/2023 stated that Resident D is diagnosed with Autism Spectrum Disorder, Intellectual Disability, and ADHD. He has challenging behavior's that include self-injurious behavior, physical aggression, and property destruction. The plan indicates that Resident D requires a one to one staffing, line of sight within four to six feet, and supervision 24 hours of the day for his first 30 days in the facility while in the common area of the home. This staff person must also be in his room with him, and in the bathroom, but he can use his personal bathroom independently.

On 02/07/2023, I spoke with Resident D's GHS case manager Penny Thom via phone. Resident D is aggressive enough that GHS offered one to one with staff at move in.

On 02/21/2023, I conducted interviews with adult protective services investigator Kelly Clark-Huey, along with recipient rights investigator Pat Shephard of GHS (Genesee Health Systems) virtually on Microsoft Teams. Genesee County Sherriff's Department's Sargent James Vernier was on the call as well, but had to exit due to connectivity issues.

Staff Rolaunde McCree was interviewed. Staff McCree stated that he and staff Dre'Von Holloway had taken over supervising Resident D (on 02/05/2023) because his assigned one on to staff person (staff Chloe Baxter) could not handle Resident D. He stated that when Resident D has a behavior, female staff persons cannot do CPI holds on him because Resident D is strong. He stated that it was brought up to supervision about female staff not being able to maintain Resident D, and management said it could be both male and female one to one staff. This was after they initially had only male one to one staff. He stated that he heard that on one shift, there were all female staff working and they had a hard time doing CPI on Resident D.

Staff Chloe Baxter was interviewed. She stated that on 02/05/2023, Resident D grabbed Resident C by the neck with the inside of his arm. She stated that Resident D did not have Resident C by the neck for long, and that staff tried CPI unsuccessfully on Resident D. Staff tried to do a CPI child control hold on Resident D. Staff Baxter stated that she was Resident D's one to one staff and that she was with Resident D for his entire behavior until she switched with other staff to help Resident C up. She stated that she left the CPI physical management up to the male staff because it is very hard for female staff to do CPI with Resident D. She stated

that this issue has been brought to management's attention and they were told to at least try.

Staff Tianna Naylor was interviewed. She stated that it is not easy to do CPI on Resident D because he fights back.

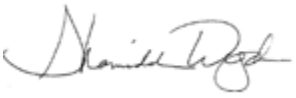
APPLICABLE RULE	
R 400.14301	**Resident protection.**
	(2) A licensee shall not accept or retain for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of these following provisions: **(c) The resident appears to compatible with other residents and members of the household.**
ANALYSIS:	Incident reports dated for 01/22/2023, and 01/29/2023 summarize incidents where Resident D attempted or actually physically assaulted other residents. The incident report for 01/22/2023 states that staff will continue to closely monitor to ensure the health and safety of the residents. Incident reports from 02/04/2023 4:30 am and 02/05/2023 at 2:30 pm noted that Resident C was assaulted twice by Resident D. The incident reports stated that staff will continue to ensure the health and safety of the residents. On 02/05/2023, Resident C sustained serious injuries after being physically assaulted by Resident D and had to be hospitalized. Resident D's assessment plan states *"Staff working with [Resident D] will monitor for mood changes and will provide verbal redirection when necessary. In the event these measures are unsuccessful, staff are trained in Crisis Prevention Institute (CPI) non-violent crisis intervention foundational course including disengagement and holding skills."* Staff Naylor stated that it is difficult to do CPI on Resident D because Resident D fights back. Staff Baxter stated that she left the CPI physical management up to the male staff because it is very hard for female staff to do CPI with Resident D. Staff McCree stated that when Resident D has a behavior, female staff persons cannot do CPI holds on him because Resident D is strong. There is a preponderance of evidence to substantiate a rule

	violation in regard to Resident D's incompatibility with Resident C, due to his assaultive behaviors and staff's demonstrated failure to provide the level of supervision necessary to manage Resident D's behaviors and keep Resident C safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/13/2023, I conducted an exit conference with licensee designee Nicholas Burnett via phone. I informed him of the findings and conclusions.

IV. RECOMMENDATION

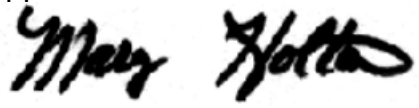
Contingent upon the receipt of an acceptable corrective action plan, a provisional license is recommended.



05/22/2023

Shamidah Wyden Date
Licensing Consultant

Approved



05/22/2023

Mary E. Holton Date
Area Manager