GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2023

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

RE: License #: AM250388519
Investigation #: 2023A0580037
Flint Township North

Dear Burnett:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. 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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250388519
Investigation #:	2023A0580037
Complaint Receipt Date:	05/12/2023
Investigation Initiation Date:	05/16/2023
Report Due Date:	07/11/2023
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:	Flint Township North
Facility Address:	2360 Stonebridge Drive Flint, MI 48532
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	11/16/2017
License Status:	REGULAR
Effective Date:	12/22/2022
Expiration Date:	12/21/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/8/2023, Resident A stabbed herself in the stomach with glass from a perfume bottle. On 5/11/2023, Resident A was taken Ascension GENESYS hospital after stabbing herself in the stomach with a piece of plastic from a CD case. There are concerns that Resident A is not being supervised and that she has access to items that she can use to harm herself.	Yes
Alleged that Resident B digitally penetrated Resident A's vagina.	No

III. METHODOLOGY

05/12/2023	Special Investigation Intake 2023A0580037
05/12/2023	APS Referral This complaint was opened by APS for investigation.
05/16/2023	Special Investigation Initiated - On Site An onsite inspection was conducted. Contact was made with the administrative assistant, Sharielle Patton.
05/16/2023	Contact - Face to Face Interview with Resident A.
05/16/2023	Contact - Document Received A copy of the incident reports were received.
05/17/2023	Contact - Document Received Documents received.
05/17/2023	Comment Intake #195218 was added to this investigation.
06/13/2023	Contact - Telephone call made Call to Penny Thom, assigned Genesee Health Systems (GHS) case manager

06/21/2023	Contact - Telephone call made Call to Michelle Salem of Recipient Rights.
06/27/2023	Contact - Telephone call made Call to staff, Kierra Gillard.
06/27/2023	Contact - Telephone call made Call to staff, Javion Miller.
06/27/2023	Contact - Telephone call made Call to Mikalya Newall, former staff.
06/27/2023	Contact - Telephone call made Call to staff, Norman Jones.
06/27/2023	Contact - Telephone call made Call to Dan Spalthoff of APS.
06/28/2023	Inspection Completed On-site Follow-up interview with Resident A.
06/30/2023	Exit Conference Exit conference with the license administrator, Morgan Yarkosky.

ALLEGATION:

On 5/8/2023, Resident A stabbed herself in the stomach with glass from a perfume bottle. On 5/11/2023, Resident A is at Ascension GENESYS hospital after stabbing herself in the stomach with a piece of plastic from a CD case. There are concerns that Resident A is not being supervised and that she has access to items that she can use to harm herself

INVESTIGATION:

On 05/12/2023 I received a complaint via BCAL Online complaints. This complaint was opened by APS for investigation.

On 05/16/2023, I conducted an onsite inspection at Flatlock Flint Township North. Contact was made with Sharille Patton, administrative assistant. Patton could not provide information regarding the allegations. She was able to provide a copy of the incident reports detailing what occurred.

The incident report dated 05/08/2023 states that on Monday 05/08/2023, staff noticed Resident A with an open wound on the right side of her stomach, where she'd once has

a colostomy bag. Resident A had taken a bottle of women's perfume and smashed it on the bathroom floor. Resident A took a piece of the broken glass and inserted into her stoma site. Resident A requested to go the hospital. Staff inquired where the glass was located. Staff then performed a search and seizure of Resident A's room. Pencils and pens were located. Staff contacted the medical coordinator, who instructed staff to clean the wound to observe the extent of the damage. Once the wound was observed, staff transported Resident A to the hospital for wound care. Corrective measures included reminding Resident A of her goals and utilized coping skills and increasing supervision.

The incident report dated 05/11/2023 states that on 05/11/2023, staff noticed blood on Resident A's shirt. When asked, Resident A stated that her boyfriend broke up with her and she wanted to harm herself. Staff observed a wound and noticed her stoma site had been opened. Staff asked what object she used, however, Resident A refused to identify the object. Moments later a resident informed staff that there was blood on the bathroom door. Staff notified the medical coordinator and began to administer first aid to the wound, while another staff checked the bathroom. Staff observed a broken CD in the toilet with blood on it. Resident A then admitted that she used the CD to harm himself. Moments later, police arrived at the home due to receiving a call from Resident A stating that she'd harmed herself. Resident A stated that she wanted to go to the hospital. Resident A was transported via ambulance while staff followed in the company vehicle. Staff notified the home manager, medical coordinator. While at the hospital staff completed a search and seizure to remove any remaining items of risk. Resident A was given an x-ray to the abdomen and treated with laceration care. Resident A was transported back the AFC home and provided with 1:1 supervision the remainder of the evening as a corrective measure.

Search and Seizure form, dated 5/11/2023, conducted in Resident A's room, at 8:56pm. Obtained were 4 chargers, 2 microphones and 30 CD's. This form was signed by staff, Javion Miller.

On 05/16/2023, while onsite, I spoke with Resident A. She admitted that she tried to cut herself with both glass and plastic. She would not share where she obtained these items. Resident A stated that she did it due to being upset about another resident bothering her on Facebook. Resident A stated that the other resident resides in a different facility. She stated that staff has since assisted her in blocking him on her Facebook page.

On 05/17/2023, I spoke with Michelle Salem of Recipient Rights, Genesee County. She shared that there is concern that Resident A was able to cut herself due to staff at the AFC not following Resident A's plan.

On 05/17/2023, I received a faxed copy of Resident A's AFC Assessment plan. The plan indicates that Resident A has a history or self-injurious behavior. Because of her history of self-harm, personal property is restricted as follows: 1. Restricted items with no access whatsoever-items small enough to be inserted into body cavities and items worth parts which can be easily removed or easily broken to create small parts,

including CDs, DVD's and VHS tapes are no longer part of any Titration Plan and are simply a restricted item at this time.

The Behavior Treatment Plan (BTP) created by Genesee Health Systems for Resident A, dated 01/19/2023, states that situations or events that should trigger a Search and Seizure are as follows: If Resident A is known or suspected to be in possession of restricted items described, or has utilized a previously unused type of item to engage in self-injurious behavior, then staff will follow Search & Seizure procedures for items of risks and remove them.

For supervision, the BTP states that Resident A is entering the community and going into places/events in which she is going to be meeting/interacting/socializing with other people (not including housemates or staff or family) then Resident A needs to be provided with 1:1 supervision by staff (with line-of sight supervision).

On 06/13/2023, placed a call to Penny Thom, assigned Genesee Health Systems (GHS) case manager for Resident A. Thom stated that staff are unsure how Resident A obtained the CD's, however, she did spend $100 at Goodwill during an outing earlier in the day. Thom reports that A new Behavior Treatment Plan has been established effective 05/27/2023, adding a 1:1 staff at all times.

On 06/21/2023, I conducted a follow-up call to Michelle Salem of Recipient Rights. She shared that in her interview with Resident A, she admitted that she obtained the CD's found during the search and seizure of her room on 05/11/2023, from friends while visiting other AFCs identified as Woodbridge and Burton East. Per Resident A's plan, both of these activities require 1:1 supervision, which was not provided. In addition, on or about 5/7 or 5/8, Resident A was transported by staff, Mikayla Newall, to a shopping outing at Goodwill, where she also purchased a CD as well. During the interview conducted with Newall, she was not aware of the plan which states that Resident A cannot purchase these items. She adds that while it is hard to pinpoint how she got all 30 CDs, it is safe to say that the CDs were in her possession on 5/8/2023, when the Search and Seizure of her room was completed by staff, Javion Miller. She also adds that during the interview with Javion Miller, while he was hesitant to provide information, he did indicate that he did not remove the CDs from her room as he was not looking for them at the time.

On 06/27/2023, I placed a call to staff, Javion Miller. There was no answer.

On 06/27/2023, I placed a call to staff, Kierra Gillard. She recalled that on 05/08/2023, Resident A came to her after she'd cut herself with glass from a broken perfume bottle. She recalled contacting the medical coordinator and tending to the wound. She did not conduct the search and seizure of her room.

On 06/27/2023, I placed a call to staff, Tamia Redwine. There was no answer.

On 06/27/2023, I spoke with Mikalya Newall, former Flatrock staff. She recalled that she was asked to assist in transporting the 3 residents, which included Resident to a

community outing at Goodwill, even though she typically works on the other side at Flint Township South. She stated that she specifically asked were there any restricted items the residents could not buy and was not told about the CD restriction. She recalled that Resident A purchased CD's while on the outing, even showing her manager what she purchased when she returned.

On 06/27/2023, I spoke with Dan Spalthoff of APS. He shared that he substantiated the case of neglect against the facility for not providing a 1:1 staff for Resident A after she initially cut herself on 05/08/2023.

On 06/28/2023, I conducted a follow-up interview with Resident A. She confirmed that she purchased CDs at her Goodwill outing. She also borrowed some while visiting friends at Woodbridge and Burton East. identified as other AFC facilities.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that Resident A is not being supervised and that she has access to items that she can use to harm herself. Resident A. She confirmed that she purchased CDs at her Goodwill outing and borrowed some while visiting friends at Woodbridge and Burton East. The incident report dated 05/08/2023 stated staff noticed Resident A with an open wound caused broken glass. Staff performed a search and seizure of Resident A's room, removing pencils and pens. Resident A was transported to the hospital for wound care. The incident report dated 05/11/2023 states that staff observed a wound caused by a broken CD. Staff completed a search and seizure to removing Obtained were 4 chargers, 2 microphones and 30 CD's. Resident A was transported to the hospital for wound care. The AFC assessment plan for Resident A states that she has a history or self-injurious behavior. Because of her history of self-harm, personal property is restricted as follows: 1. Restricted items with no access whatsoever-items small enough to be inserted into body cavities and items worth parts which can be easily removed or easily broken to create small parts, including

	CDs, DVDs, and VHS tapes are no longer part of any Titration Plan and are simply a restricted item at this time. The Behavior Treatment Plan (BTP) created by Genesee Health Systems for Resident A, dated 01/19/2023, states that situations or events that should trigger a Search and Seizure are as follows: If Resident A is known or suspected to be in possession of restricted items described, or has utilized a previously unused type of item to engage in self-injurious behavior, then staff will follow Search & Seizure procedures for items of risks and remove them. Penny Thom, assigned Genesee Health Systems (GHS) case manager for Resident A, stated that staff are unsure how Resident A obtained the CD's. Michelle Salem, of Recipient Rights, stated that Resident A was transported to a shopping outing at Goodwill, where she also purchased a CD as well, which should have been seized during the 05/08/2023 search and seizure. Staff, Javion Miller stated that he did not remove the CDs from her room on 05/08/2023, as he was not looking for them at the time. Staff, Mikayla Newall, recalled that she transported Resident A to a community outing at Goodwill, specifically asking if there were any restricted items the residents could not buy and was not told about the CD restriction. She observed that Resident A purchased CD's while on the outing. Dan Spalthoff of APS shared that he substantiated the case of neglect. Based on the interviews conducted with Resident A, case manager, Penny Thom, Recipient Rights Investigator, Michelle Salem, direct staff members, Javion Miller and Mikalya Newall, a review of incident reports and Search and Seizures dated 5/8 and 5/11/2023, the current AFC Assessment and Behavior Treatment Plans for Resident A, there is sufficient evidence to substantiate the rule violation. Resident A was allowed to purchase a restricted item. After the 5/8/2023 incident which Resident A attempted to cut herself with glass, the CDs were not removed from her room during the Search and Seizure, per the plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Alleged that Resident B digitally penetrated Resident A's vagina.

INVESTIGATION:

On 05/17/2023, Michelle Salem stated that to her knowledge, Resident A had a visit with a member of the opposite sex, a resident who resides in a different unlicensed Flatrock home. This resident had a 1 on 1 staff who was present during the visit, identified as Norman Jones. Norman Jones stated to her, that while Resident A and her visitor were under the covers. He did observe them kissing. Norman Jones did not see his hand move, nor did he hear Resident A say stop. She will not be opening an investigation due Resident B residing in an unlicensed home.

On 06/13/2023, Penny Thom, case manager, stated that Resident A has a history of making these types of allegations. She also shared that it was discovered that Resident A has been juggling 5 boyfriend relationships at various other Flatrock facilities.

On 06/27/2023, I spoke with staff, Norman Jones, identified as the 1:1 staff for Resident B. He recalled that on 05/08/2023, he transported Resident B from his AFC home to visit Resident A. Upon arriving they were allowed to visit in her room. Resident A was sitting on her bed watching something on her tablet. Resident B asked if he would sit down, and Resident A told him yes. Eventually they both laid down while under the covers, still watching television. He stated that they were fine, talking and some kissing. He never heard Resident A say no, stop, or don't. Afterwards she walked him to the van and gave him a kiss goodbye. It is his understanding that Resident B broke up with her the next day. After that the allegations were made.

On 06/27/2023, Dan Spalthoff stated that based off his interviews and Residents A, B and direct staff, Noman Jones, he denied the allegations of sexual abuse. A referral was made to law enforcement.

On 06/28/2023, I conducted an onsite inspection at Flint Township North for a follow-up interview with Resident A. When questioned, Resident A admitted that she lied when she made the allegation that Resident B digitally penetrated her vagina. I spoke with Resident A regarding the importance of being truthful when making allegations.

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:	It was alleged that Resident B digitally penetrated Resident A's vagina. Penny Thom, case manager, stated that Resident A has a history of making these types of allegations. Staff, Norman Jones denied that he saw anything, or heard Resident A say no, stop, or don't during the visit with Resident B. Dan Spalthoff of APS in Genesee County stated that he denied the allegations of sexual abuse. Resident A admitted that she lied about the allegations. Based off the interviews with Resident A, Staff, Norman Jones, Case manager, Penny Thom, and Dan Spalthoff of APS, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 06/30/2023, I conducted an exit conference with the license administrator, Ms. Morgan Yarkosky. She was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan June 30, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton June 30, 2023

Mary E. Holton Date
Area Manager