STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 30, 2023

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

RE: License #: AM440388514
Investigation #: 2023A0582053
Elba South

Dear Nicholas Burnett:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388514
Investigation #:	2023A0582053
Complaint Receipt Date:	05/18/2023
Investigation Initiation Date:	05/22/2023
Report Due Date:	07/17/2023
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:	Elba South
Facility Address:	280 North Elba Road Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	02/08/2018
License Status:	REGULAR
Effective Date:	08/08/2022
Expiration Date:	08/07/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
On 05/16/2023, Direct Care Worker (DCW) Alexandra Lewis sat on Resident A for over a minute, who had dropped to the ground after physical management was used on him. While DCW Lewis sat on Resident A, Resident A yelled “Ow! You’re hurting me, I can’t breathe!” Afterwards, Manager Nick Peel dragged Resident A into the home.	Yes

III. METHODOLOGY

05/18/2023	Special Investigation Intake 2023A0582053
05/18/2023	APS Referral Referred from Adult Protective Services
05/22/2023	Special Investigation Initiated - Letter Email from Amanda Dixon, Recipient Rights
05/23/2023	Contact - Face to Face At Facility. Interviews with Resident A, DCW Tiffany Harris, DCW David McCree, DCW Stephanie Davis, Office Manager Ountane Chaney, Home Manager Erica Hilliker
06/28/2023	Contact - Telephone call made With Direct Care Worker Alex Lewis
06/28/2023	Contact - Telephone call made With Direct Care Worker Holly Brewer
06/29/2023	Contact - Document Received From Amanda Dixon, Office of Recipient Rights
06/29/2023	Contact - Document Received From Rose Koss, Adult Protective Services
06/30/2023	Exit Conference With Nicholas Burnett, Licensee Designee

ALLEGATION:

On 05/16/2023, Direct Care Worker (DCW) Alexandra Lewis sat on Resident A for over a minute, who had dropped to the ground after physical management was used on him. While DCW Lewis sat on Resident A, Resident A yelled "Ow! You're hurting me, I can't breathe!" Afterwards, Manager Nick Peel dragged Resident A into the home.

INVESTIGATION:

I received this complaint on 05/18/2023. On 05/22/2023, I received an email from Amanda Dixon, Recipient Rights. Ms. Dixon stated that she had not been to the facility, but conducted all interviews thus far, except for 2 potential witnesses. Ms. Dixon provided photos related to the allegation and stated that APS was assigned and visited the facility on 05/18/2023.

I reviewed the photos that were sent by Amanda Dixon. The photo showed a scene from the courtyard of the facility. There was an individual laying on his right side with his shorts down, partially showing his buttocks. There was a woman who appeared to be sitting on the individuals left side hip area. The woman's left leg was tucked underneath her and pressed against the individual's left side hip area. There is another woman in the photo who appears to be assisting the woman who was sitting on the individual. Finally, there is a hand sticking out of a window that appears to be hanging by its hinges. Ms. Dixon identified the individual on his right side as Resident A, with DCW Lewis sitting on top of Resident A, DCW Holly Brewer standing and leaning towards DCW Lewis, and Manager Erica Hilliker with her hand reaching out of the window.

On 05/22/2023, I reviewed the *AFC Incident Report* related to the allegation, which documented the following:

> **Date of Incident:** 05/16/2023
> **Time:** 10:00 AM
> **Name of Employee Assigned to Resident:** Alex Lewis
>
> **Other Person(s) Involved/Witnesses:** Employees Holly Brewer, Tiffany Harris, Alex Lewis, David McCree, Nick Peel, Stephanie Davis
>
> **Explain What Happened:** On 05/16/2023, [Resident A] was upset due to peer saying something to him he didn't like. [Resident A] became physically aggressive with staff. Staff attempted to validate [Resident A's] feelings which were unsuccessful. Staff utilized blocking techniques and verbal redirection to preferred activity. [Resident A] continued to become physically aggressive which included kicking, biting, punching, grabbing hair, grabbing clothing. Staff utilized outside-inside technique for 4 minutes for [Resident A] did deep breathing and staff released hold. [Resident A] became physically aggressive again once

released from hold, grabbing staff hair, and pulling it. Staff utilized hair removal technique which was successful. [Resident A] continued hitting and attempting to bite staff. Staff attempted to validate [Resident A's] feelings and utilize blocking techniques. [Resident A] continued with his aggression, staff utilized child control technique for 3 minutes before [Resident A] expressed he would like to go smoke. Staff prompted deep breathing exercises before releasing [Resident A] this was successful. [Resident A] and staff went to courtyard to validate feelings and smoke. [Resident A] began smoking in the courtyard and began to get escalated again and continuously tried to grab staff. Staff used blocking techniques and body positioning. [Resident A] then ran to a slightly opened window and began aggressively pulling on it while staff continued using blocking techniques and verbal redirection. As [Resident A] was pulling aggressively on the window, the window hinge snapped off, causing [Resident A] to lose balance, causing him to fall on his side on the ground. Staff then validated [Resident A's] feelings and attempted to help [Resident A] get up. [Resident A] then got up and ran towards the window and picked up a broken metal piece from the window. [Resident A] then began swinging the metal piece at staff. Staff then utilized outside/inside technique for 5 minutes and prompted [Resident A] to do coping skills of deep bre3athing and verbally redirected [Resident A] to a preferred activity of smoking. [Resident A] accepted and began smoking and calmed down. Staff continued to engage in positive activities and closely monitored [Resident A] for health and safety for the rest of the shift.

Action Taken by Staff: Staff utilized outside-inside technique, staff utilized hair removal technique, staff validated feelings, staff verbally redirected [Resident A], staff prompted preferred activity.

Corrective Measures Taken to Remedy and/or Prevent Recurrence: Staff will remind [Resident A] of his goals and encourage him to utilize other forms of coping skills when upset.

On 05/23/2023, I conducted an unannounced, onsite inspection at the facility. I interviewed Resident A about the allegation. Resident A stated that "Alex sat on me." I asked Resident A to further elaborate on what occurred. Resident A stated that another resident was bugging him, and he became upset. Resident A stated that he went outside to the courtyard to smoke. Resident A stated that he became upset again and broke a window. Resident A stated that he was on the ground and "Alex sat on my left arm, and Nick made her get up." Resident A stated that he did not know why DCW Lewis was sitting on him, and it hurt his arm. Resident A denied that Home Manager Nick Peel dragged him into the facility. Resident A stated that Nick Peel told DCW Lewis to get off him. I showed Resident A the picture I received of the incident, and he identified DCW Lewis as sitting on him and DCW Holly Brewer standing next to her.

I interviewed Direct Care Worker (DCS) Tiffany Harris. Tiffany Harris stated that she was in the conference room at the time the incident was occurring. Tiffany Harris

stated that the window was partially open and Resident A broke the window off. DCW Harris stated that Resident A was grabbing at items inside the conference room window while she was trying to shut the window back. DCS Harris stated that the window was hanging on a hinge. Ms. Harris stated that she was picking up broken glass. DCW Harris stated that when she went out to the courtyard, the situation had deescalated. DCW Harris stated that she did not see Resident A being placed in a hold. DCW Harris stated that she did not see DCW Lewis or DCW Brewer physically managing Resident A. DCW Harris stated that she went back inside to help clean up the area in the conference room. DCW Harris stated that Home Manager Nick Peel went out to the courtyard to assist staff.

I interviewed Direct Care Worker David McCree. DCW McCree stated that he works on the “other side” (Elba North), and heard a “Code 3,” which means staff need assistance with a resident’s behavior. DCW McCree stated that Resident A was grabbing at staff by the double doors to the other side of the facility. DCW McCree stated that Home Manager Nick Peel was trying to talk Resident A down, but he was too escalated. DCW McCree stated that he and Mr. Peel used the “outside-inside” technique and let Resident A go after a few minutes. DCW McCree stated that he went back to his side (the other facility) and was not around for any further interactions or physical management with Resident A.

I interviewed Direct Care Worker Stephanie Davis. DCS Davis stated that Resident A was escalated for an extended period, grabbing at staff shirts, trying to pull staff hair. DCW Davis stated that she was trying to calm Resident A down, but he was too riled up. DCW Davis stated that Resident A went out to the courtyard with Direct Care Worker Alex Lewis and Holly Brewer. DCW Davis stated that Resident A was attempted to break the courtyard door and window. DCW Davis stated that she heard Resident A screaming, and when she looked out into the courtyard, she observed DCW Lewis sitting on Resident A. DCW Davis stated that Resident A was on his right side while DCW Lewis was sitting on his left side. DCW Davis stated that DCW Lewis was sitting on Resident A for “maybe a minute.” DCW Davis stated that Resident A was saying “you’re hurting me!” DCW Davis stated that Home Manager Nick Peel was initially standing there, but then grabbed Resident A and pulled him into the home.

I interviewed Office Manager Ountane Chaney. Ountane Chaney stated that she was in the office when a “Code 3” was called. Ountane Chaney stated that when she arrived to assist, Resident A was being physically managed by Nick Peel and David McCree. Ountane Chaney stated that she relieved Mr. McCree and continued the hold on Resident A. Ountane Chaney stated that Resident A dropped to the floor, calmed down, and they let go of the hold. Ountane Chaney stated that once they let go, Resident A “started up again.” Ountane Chaney stated that Resident A grabbed her hair. Ountane Chaney stated that she used the “hair pull release” technique to get out of Resident A’s grip. Ountane Chaney stated that Resident A was exclaiming “I want Nick, I want Nick,” who had left the area. Ountane Chaney stated that she went back to the office after staff was with Resident A. Ountane Chaney stated that

she was not present for the interactions with Resident A in the courtyard but heard about the window being broken.

I interviewed Elba North Home Manager Erica Hilliker. Erica Hilliker stated that she was in the conference room during the incident when Resident A broke the window off the hinges. Erica Hilliker stated that other staff were in the courtyard with Resident A at the time. Erica Hilliker stated that Resident A was grabbing at items on the window ledge, broke a picture frame, pulled the blinds, and anything else he could reach. Erica Hilliker stated that she Home Manager Nick Peel went outside to assist staff. Erica Hilliker stated that she did not see any physical management of Resident A, as she was occupied with cleaning up glass, trying to fix the window, and cleaning other things in the conference room with DCW Tiffany Harris.

On 06/28/2023, I interviewed Home Manager Nick Peel. Nick Peel stated that Resident A was upset for a lot of the morning that day. Nick Peel stated that Resident A required a CPI hold a few times that morning, as he was physically aggressive with staff. Nick Peel stated that while he was in the conference room, Resident A was in the courtyard with staff and began “tearing the window off.” Nick Peel stated that immediately went out to the courtyard and Resident A was on the ground. Nick Peel stated that Direct Care Worker Alex Lewis was “sitting on” Resident A for about 30 seconds. Nick Peel stated that he grabbed Ms. Lewis’ shirt to pull her off him. Mr. Peel stated that DCW Lewis was sitting on Resident A’s lower back/side area. DCW Peel stated that Direct Care Worker Holly Brewer was also in the area, trying to calm Resident A down. DCW Peel denied dragging Resident A into the facility, stating that he simply led him inside after helping him up from the ground.

On 06/28/2023, I interviewed Direct Care Worker (DCW) Alex Lewis. DCW Lewis stated that Resident A was having behaviors most of the morning to include grabbing at staff shirts, hair, hitting, kicking, and spitting. DCW Lewis stated that Resident A was “destroying the house” for about two hours. DCW Lewis stated that she took Resident A to the courtyard to smoke, and he grabbed the conference room window attempted to pull it off. DCW Lewis stated that the window was dangling on one hinge, and Resident A tripped and fell while pulling it. DCW Lewis stated that Resident A was grabbing at staff and screaming as he fell, and she tripped over him. DCW Lewis stated that Resident A grabbed her shirt, pants, shoes, and laces, preventing her from getting off the ground. DCW Lewis state that she and Resident A got “wrapped up” on the ground for about 30 seconds at the most. DCW Lewis stated that she eventually got to her feet and made sure that Resident A was calm. DCW Lewis stated that Home Manager Nick Peel and DCW Holly Brewer were present at the time. DCW Lewis denied sitting on Resident A. DCW Lewis stated that she has worked at Flatrock for three years and is trained in CPI holds. DCW Lewis stated that she could understand how others could view that she was sitting on Resident A, but she would never do that. DCW Lewis stated that she is currently on a leave of absence due to the incident.

On 06/28/2023, I interviewed Direct Care Worker Holly Brewer. DCW Brewer stated that Resident A was having behaviors for about three hours that day. DCW Brewer stated that she and Direct Care Worker Alex Lewis were in the courtyard with Resident A who was escalated at the time. DCW Brewer stated that Resident A was ripping the courtyard window from the hinges. DCW Brewer stated that Resident A then began attacking DCW Lewis, hitting her, holding, and holding her shirt. DCW Brewer stated that both DCW Lewis and Resident A fell to the ground. DCW Brewer stated that Resident A was preventing Resident A from getting off the ground by holding her. DCW Brewer denied that DCW Lewis was purposely sitting on Resident A. DCW Brewer stated that it just happened to be the circumstance of both Resident A and DCW Lewis falling to the ground and Resident A grabbing her.

On 06/29/2023, I received an email from Amanda Dixon, Office of Recipient Rights. Amanda Dixon documented that she substantiated “Unreasonable Force” by Direct Care Worker Alexandra Lewis and the use of Block Pads with their recipients to include Resident A, as blocking pads are not an “approved device” through North Country Community Mental Health [NCCMH] Office of Recipient Rights.

On 06/29/2023, I received an email from Rose Koss, Adult Protective Services. Ross Koss stated that she substantiated against the staff who sat on the resident.

Special Investigation Report #2023A0582011, dated 12/29/2023, cited violation of R 400.14305(3) due to DCW Joshua Johnson hitting a resident multiple times, resulting in a black eye and slight fracture of his nose. DCW Johnson admitted to hitting the resident in the face, which was confirmed and witnessed by the resident and Direct Care Workers Hannah Boursaw, James Ewell, John Ryder, and Holly Brewer, who all stated that DCW Johnson kneed Resident A in the back. Resident A was sent to the hospital for his injuries. The Corrective Action Plan (CAP), dated 01/17/2023, was signed by Nicholas Burnett. The CAP documented that DCW Joshua Johnson was terminated from employment and further staff training was implemented on abuse and neglect. Additionally, Flatrock updated their Neglect and Abuse policy to improve qualifications for employees.

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:	Based on interviews and documentation, there is sufficient evidence to suggest that on 05/16/2023, Direct Care Worker Lewis sat on Resident A while Resident A having behavioral issues. DCW Lewis denied the allegation, stating that amid Resident A breaking the conference room window, DCW Lewis tripped and fell. During the fall, DCW Lewis alleges that Lewis

	tripped over Resident A as he grabbed DCW Lewis, and they were “wrapped up” on the ground for about 30 seconds. However, Home Manager Nick Peel and Direct Care Worker Stephanie Davis admitted to DCW Lewis sitting on Resident A during the intervention. This is consistent with the picture that was provided by Amanda Dixon, Office of Recipient Rights, who substantiated “Abuse, Class II – Unreasonable Force” in her investigation. Additionally, Adult Protective Service Worker Rose Koss substantiated abuse against Direct Care Worker Alex Lewis
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0582011 dated 12/29/2023.**

On 06/30/2023, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. I informed Nicholas Burnett of the findings from the investigation.

IV. RECOMMENDATION

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

06/30/2023

Derrick Britton Date
Licensing Consultant

Approved By:

06/30/2023

Mary E. Holton Date
Area Manager