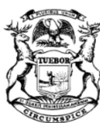


GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 30, 2023

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

RE: License #: AS250407223
Investigation #: 2023A0569066
Pierson

Dear Nicholas Burnett:

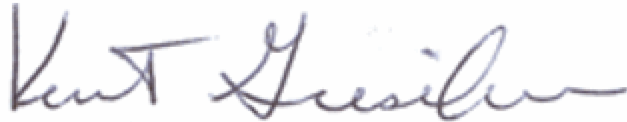
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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,



Kent W Gieseelman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250407223
Investigation #:	2023A0569066
Complaint Receipt Date:	09/14/2023
Investigation Initiation Date:	09/15/2023
Report Due Date:	11/13/2023
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:	Pierson
Facility Address:	6376 E. Pierson Road Flint, MI 48506
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/21/2021
License Status:	REGULAR
Effective Date:	10/21/2021
Expiration Date:	10/20/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Resident A inserted a plastic knife into her anus on 9/10/23 while requiring one-on-one supervision.**	Yes

III. METHODOLOGY

09/14/2023	Special Investigation Intake 2023A0569066
09/15/2023	APS Referral Complaint received from APS.
09/15/2023	Special Investigation Initiated - Telephone Contact with ORR.
10/26/2023	Inspection Completed On-site
10/30/2023	Contact - Telephone call made. Contact with Mercedez Watkins, staff person.
10/30/2023	Contact - Telephone call made. Contact with Kalani Thompson, staff person.
10/30/2023	Inspection Completed-BCAL Sub. Compliance
10/30/2023	Exit Conference Exit conference with Nicholas Burnett, licensee designee.

ALLEGATION:

Resident A inserted a plastic knife into her anus on 9/10/23 while requiring one-on-one supervision.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A requires a 1:1 staffing ratio due to a history of self-harming behaviors. The complainant reported that Resident A was able to insert a plastic knife into her anus on 9/10/23. The complainant reported that Resident A was taken to the hospital to have the object removed.

An unannounced inspection of this facility was conducted on 10/26/23. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that on 9/10/23 the first shift staff assigned to be her 1:1 staff was Mercedez Watkins. Resident A stated that Mercedez Watkins had gotten some food from McDonald’s and was eating it in Resident A’s room while supervising Resident A. Resident A stated that at the end of the first shift, Mercedez Watkins then left her bedroom while the second shift 1:1 staff, Kalani Thompson, came to her room to supervise Resident A. Resident A stated that Mercedez Watkins left a cup and a plastic knife in her room, and Resident A was able to grab the knife and hide it during the time between Mercedez Watkins leaving her room and Kalani Thompson entering her room. Resident A stated that she was alone in her bedroom for a couple of minutes. Resident A stated that she hid the knife under her pillow. Resident A stated that during the second shift, she broke the knife in half, and inserted the blade part of the knife into her anus while under her blankets. Resident A stated that Kalani Thompson kept asking Resident A why she was moving around so much, and then Kalani Thompson then pulled back the blankets and Resident A then told Kalani Thompson that she had inserted the knife into her anus. Resident A stated that she was taken to the hospital for treatment after reporting that she was experiencing pain and the knife was removed by a doctor.

An incident report (IR) was submitted on 10/25/23 for review. The IR was completed on 9/10/23 and documents that Kalani Thompson, staff person, was Resident A’s 1:1 staff person. The IR documents that Kalani Thompson was in Resident A’s bedroom supervising Resident A and observed Resident A “moving around excessively”. The IR documents that Kalani Thompson asked resident A why Resident A was moving around so much and Resident A then informed Kalani Thompson that she had just inserted the plastic knife into her anus. The IR documents that Resident A’s room was searched, and a package of plastic “silver wear” was found. The IR documents that the plastic knife from the package was observed to be “broken in half” and Resident A identified that object as the object she inserted into her anus. The IR documents that Resident A was then given milk of magnesia. The IR documents that the corrective measures taken was “staff monitored [Resident A] for changes throughout the shift. A second IR was

also completed on 9/10/23 documenting that Resident A was then taken to the emergency room for medical examination and treatment due to complaints of pain. The corrective measure documented was to "continue to monitor [Resident A] for changes and update the medical coordinator with updates".

Resident A's written assessment was reviewed. The assessment is dated 8/8/23. Resident A's assessment documents;

Exhibits Self Injurious Behavior: [Resident A] has 1:1 supervision to keep her safe due to a long history of engaging in a variety of self-injurious behavior. [Resident A] has a history of cutting herself with sharp objects including scissors and silverware. She has burned herself with a curling iron. She has threatened to ingest cleaning supplies, such as nail polish remover. She has a history of ingesting items in her environment to inflict pain (such as earrings). She has tied articles of clothing around her neck in an attempt to suffocate herself. Stephanie has intentionally tried to expose herself to bees (she is allergic to bee bites). Stephanie has a long history of binging and purging (bulimia) from the age of 9 until recently (within the last 6 months). [Resident A] has a history of threatening suicide, apparently, to be taken to the hospital. She has a history of suicidal gestures. Staff working with [Resident A] should encourage her to use appropriate and healthy coping skills when it is evident that he is becoming anxious or agitated.

Resident A's behavior plan was reviewed. Resident A's behavior plan is dated 9/7/23. The behavior plan documents;

Crisis Plan: Supervision/Restrictions – Because of the frequency and severity of [Resident A's] self-harm, and calling 911, the following restrictions are in place. 1:1 staffing for 24 hours to decrease attempts at self-harm. Self-harm behaviors exhibited by [Resident A] include ingesting inedible items and engageing in SIB. Supervision in the community, delayed egress exit doors, locked kitchen and laundry room, and supervised access to personal items that are smaller than a tennis ball, as she is known to swallow. Due to her potential self-harm, these restrictions are needed to maximize her safety.

Kalani Thompson, staff person, stated on 10/30/23 that she did work the second shift on 9/10/23 and was Resident A's assigned 1:1 staff person. Kalani Thompson stated that when she entered Resident A's bedroom, she observed a McDonald's cup in Resident A's room that had been left by Mercedez Watkins, the first shift 1:1 staff person. Kalani Thompson stated that she did not observe the plastic knife when she entered Resident A's bedroom. Kalani Thompson stated that during the second shift, Resident A was expressing that she was upset about her weight and after exercising for a while, she laid down in her bed and covered herself with her blanket. Kalani Thompson stated that Resident A then began moving around a lot, so she asked Resident A what she was doing, and Resident A responded that she was scratching an itch. Kalani Thompson stated that she then pulled back Resident A's covers and Resident A then admitted to inserting the knife into her anus. Kalani Thompson stated that Resident A was then taken to the hospital and had the knife removed. Kalani Thompson stated that Resident

A informed her that the previous shift staff person had left the knife in her room, and she was able to hide it before Kalani Thompson entered her room. Kalani Thompson stated that she has observed items left in Resident A's room by first shift staff on other occasions that were prohibited items.

Mercedez Watkins, staff person, stated on 10/30/23 that she worked the first shift on 9/10/23 and was assigned as Resident A's 1:1 staff person. Mercedez Watkins stated that she did not have any McDonalds during her shift but did observe a McDonald's cup in Resident A's room. Mercedez Watkins stated that she did not observe a plastic knife during her shift and did not leave a plastic knife in Resident A's room. Mercedez Watkins stated that Resident A "had a good day" during her shift and that Resident A was never left alone. Mercedez Watkins stated that she did not know where Resident A obtained the plastic knife.

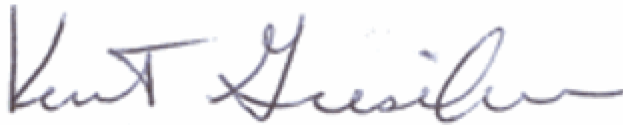
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's assessment and behavior plan document that she is currently on a 1:1 staffing ratio due to exhibiting self-injurious behaviors. Resident A's assessment documents that Resident A has a long history of self-harm and that she is on a 1:1 staffing ratio to prevent her from getting items that she can use for self-harm. Resident A stated that on 9/10/23 there was a period of "a couple of minutes" that she was alone in her room following Mercedez Watkins leaving and Kalani Thomson arriving. Resident A stated that Mercedez Watkins had eaten some food in her room during the first shift and had left the plastic knife in her room when she left. Resident A stated that she was able to grab the knife and hide it when there was no staff in the room. Kalani Thompson stated that she did observe a McDonalds cup in Resident A's room when she arrived for her shift at 3:00pm but did not observe the knife. Kalani Thompson stated that Resident A then informed her that Resident had inserted the knife into her anus while lying under her blankets. Mercedez Watkins denied leaving the knife in Resident A's room or having anything to eat but did also state that she observed the McDonald's cup. Resident A was able to hide a plastic knife that was left in her room on 9/10/23 while there was no staff person present in her room as required by Resident A's assessment and behavior plan. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.

CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Nicholas Burnett, licensee designee, on 10/30/23. The findings in this report were reviewed. A corrective action plan was requested to address the violation cited in this report.

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.



10/30/2023

Kent W Gieselman Date
Licensing Consultant

Approved By:

10/30/2023

Mary E. Holton Date
Area Manager