GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

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

RE: License #: AM440388514
Investigation #: 2024A0580002
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. 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM440388514
Investigation #:	2024A0580002
Complaint Receipt Date:	08/29/2023
Investigation Initiation Date:	08/30/2023
Report Due Date:	10/28/2023
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(S)

	Violation Established?
Residents are being aggressive, and staff are unable to keep them safe. Resident A was poked in the cheek with a pen by Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

08/29/2023	Special Investigation Intake 2024A0580002
08/30/2023	Special Investigation Initiated - Telephone Call to the referral source.
09/19/2023	Contact - Face to Face Visit to Strive Transition School.
09/19/2023	Inspection Completed On-site Onsite inspection at Elba South. Interview with Resident A.
09/19/2023	Contact - Face to Face In-person interview with staff, Briana Selph.
10/19/2023	Contact - Telephone call made Call to Tearra Pouncil, Home Mgr. Documents requested.
10/24/2023	Contact - Document Sent Email sent o Morgan Yarkosky, License Admin.
10/25/2023	Contact - Document Received Documents requested received via email.
10/26/2023	Contact - Telephone call made Call to Andrea Bonomo, Livingston Co CMH Case Manager.
10/27/2023	Contact - Telephone call received Call from Andrea Bonomo, Livingston Co CMH Case Manager.

10/30/2023	Contact - Document Received Copy of the LCSD police report received.
10/30/2023	Inspection Completed On-site Unannounced onsite.
10/30/2023	Contact - Telephone call made Call to Tracey Meade, CMH-Jackson Co assigned case manager for Resident B.
10/31/2023	Contact - Telephone call made Call to Officer Chomert of the LCSD.
11/01/2023	Exit Conference exit conference with the license administrator, Morgan Yarkosky.

ALLEGATION:

Residents are being aggressive, and staff are unable to keep them safe. Resident A was poked in the cheek with a pen by Resident B.

INVESTIGATION:

On 08/30/2023, I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation.

On 08/30/2023, I placed a call to the complainant who stated that something happened at the facility which has made Resident A express that he doesn't want to reside at the facility any longer. She believes that Resident A was attacked by another resident in the home. She adds that Resident A is good guy, who is able to hold a job and has lots of potential, however, there has been a huge change in Resident A over the last year.

On 09/19/2023, I conducted an onsite visit to Strive Transition school, located at 1175 S Lapeer Rd in Lapeer, MI. Resident A was not in attendance. While onsite I spoke with staff, who stated that Resident A last attended on 09/12/2023. His attendance has been sporadic, and he may be dropped from the rolls.

On 09/19/2023, I conducted an onsite inspection at Elba South. While onsite I conducted an interview with Resident A. Resident A initially stated that he really didn't remember what happened. Resident A went on to state that Resident B [poked] him with a pen she had in her hand. It left a mark, and he called the police however, they stated that they can't do anything to Resident B due to her mental health. Resident A stated that he went to the hospital the next day. He adds that he is sick of both the staff and the residents in this home. He showed me the area on his cheek where he was

physically assaulted. The mark was located on his left cheek, light pink in color, The mark was circular and small, appearing as bump or pimple.

On 09/19/2023, while onsite, I interviewed staff Breanna Selph, who recalled that Resident C was having a behavior in the hall, trying to get Resident B due to being upset. When Resident C could not get to Resident B, he turned his anger towards Resident A. Staff separated Residents A and C and attempted to calm both of them down. Resident A then began yelling at Resident B who was nearby. Resident A was placed in a (Crisis Prevention Institute) CPI hold to calm him down. Resident B then poked Resident A in the face with a pen. Resident B's 1:1 staff did not see the pen in Resident B's hand. Staff, Ericka Hilliker cleaned Resident A's face and allowed him to call the police.

On 10/19,2023, I spoke with manager, Tearra Pouncil, who stated that was not working during the reported incident. She is not sure of the actual details of the event as she does not have access to the facility documents at this time. Copies of the AFC Assessment and Behavior Plans for Residents A and B., the IR (Incident Report) regarding Resident A being injured and hospital discharge instructions for Resident A were requested.

On 10/24/2023, I sent a follow-up email requesting documentation to the license administrator, Morgan Yarkosky.

On 10/25/2023, I received email copies of the AFC Assessment and Behavior Plans for Residents A and B., the IR (Incident Report) regarding Resident A being injured with a pen and hospital discharge instructions for Resident A. The incident report dated 08/17/2023, at 1:30pm, states that Resident A was sitting on the hallway floor prior to the incident occurring. Resident A and Resident C were crisis generating. Resident A stood up and attempted to punch Resident C. Staff quickly used verbal redirection and body positioning, which were successful. Staff then utilized inside/outside technique for 5 minutes while prompting coping skills of deep breathing. While staff were implementing outside/inside technique, Resident B approached Resident A, grabbing an ink pen off the table, attempting to [poke] Resident A in the face. Staff released hold and tried blocking technique but was unsuccessful. Resident A was struck in the face causing a laceration on his left cheek. Staff then quickly prompted Resident A to move to a safe place, to which he complied. Staff then prompted coping skills which were successful. Staff cleaned and bandaged Resident A's injury and contacted the medical coordinator. After Resident A calmed down, he asked for the phone to contact the police. Staff handed him the phone. When the police arrived Resident a gave them a statement. Officer then spoke with Resident B to obtain a statement. Corrective measures listed on the incident report that that staff will continue to monitor Resident A for health and safety for the rest of the shift.

An additional incident report received, dated 08/17/2023, at 1:30pm, states that Resident B was sitting at the dining room table prior to incident. Resident B was crisis generating along with Resident A. During crisis generating, Resident B started walking

towards Resident A. Staff used verbal redirection and body positioning but was unsuccessful. Resident B grabbed a pen off the table and attempted to [poke] Resident A in the face. Staff used blocking techniques, but Resident B was still able to cause a laceration to Resident A's left cheek. Staff verbally redirected Resident B to a preferred activity, and she complied. Resident B then tried to stab staff with the pen. Staff used blocking techniques and verbally redirected Resident B to give up the pen. Staff reminded Resident B of her plan.

An additional incident report received, dated 08/18/2023, at 5:32pm, states that the medical coordinator contacted staff to take a picture of the puncture wound under Resident A's left eye. Staff took a picture after utilizing basic first aid and sent to medical coordinator. Staff was instructed to take Resident A to the hospital to receive the proper medical care. Resident A was treated at the hospital and discharged with antibiotics to ensure that he does not get infected. Staff will continue to monitor Resident A to ensure his health and safety.

There are no other reported physical aggression incidents between Residents A and B.

The McLaren Lapeer Regional Emergency Department discharge instructions for Resident A state that Resident A was seen and treated on 08/18/2023 at 17:50:47 (military time) for facial pain, cut of face. Resident A was diagnosed as having a puncture wound. He was provided with an antibiotic prescription of Cephalexin 500mg-1 Capsule Oral every 8 hours, standard times for 7 days.

The AFC assessment plan for Resident A states that he has a history of becoming easily agitated and may become physically aggressive towards others. Resident A will hit, kick, punch, bite, and spit on peers/staff. He can be very friendly and desires interaction with others but also does not seem to understand the social constructs of personal space so he can become intrusive of others (peers/staff). Staff working with Resident A will monitor for mood changes and will verbally redirect when needed. His aggressive behavior is chronic but intermittent in occurrence. In severity, it is characterized as moderate as he has not injured anyone seriously but is strong and has hurt others physically. 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.

The Behavior Treatment Plan for Resident A, effective 04/23/2023, states that he has a history of physical aggression, which includes hitting, kicking, and throwing objects at others. Resident A is usually more verbal than physical. When experiencing greater levels of agitation/anxiety, he may strike out at others if he feels that the situation is not going how he would like it to go. Staff should block and back away from him. While talking with Resident A be calm, when trying to redirect him, do not talk to him like a child.

The AFC assessment plan for Resident B states that she has a history of becoming agitated and is often impulsive in her actions. Resident B has a history of becoming

physically aggressive toward staff and/or peers (hitting, kicking, punching), elopement, property destruction (breaking windows, hitting doors). Resident B's aggressive behavior is infrequent to moderate in occurrence, depending on Resident B's behavior cycling (happening a couple times a month when infrequent to 5-7 times a week when severe) and moderate to severe in intensity as it has caused serious harm to others, requiring medical care. Staff working with Resident B will work towards identifying early signs/symptoms of agitation and redirect/suggest healthy coping strategies versus maladaptive behavior. Staff will assist Resident B with problem solving. Should interventions outlined in the behavior plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, staff is trained in CPI, an approved emergency intervention, which may be implemented if necessary.

Resident B's Behavior Treatment Plan dated effective 11/04/2022, states that staff will provide verbal prompts for Resident B to stop and to use her calming activities. If Resident B accepts and stops the behavior, staff should verbally praise her for accepting an alternative means of dealing with frustration/anger. Minimize attention given to the aggressive behavior while focusing on what you want Resident B to do. Try to problem solve, if there is a specific issue, use coping skills if agitated and/or redirect into a constructive activity. If Resident B continues to engage in physical aggression towards others, staff should use blocking techniques and redirect as possible, while focusing on what you want her to do. Staff should work towards verbally redirecting other residents away from Resident B as to remove an audience or additional attention she is receiving. Should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented. Resident B will have a 1:1 supervision 24 hours a day. Besides accompanying Michelle throughout her day, the 1:1 will accompany Michelle in the bedroom and into the bathroom at all times to prevent her from self-injury.

Resident B's Behavior Treatment Plan dated effective 10/24/2023, states that if Resident B continues to engage in physical aggression towards others, staff should use blocking techniques and redirect as possible, while focusing on what you want Resident B to do. Staff should work towards verbally redirecting other residents away from Resident B as to remove an audience or additional attention Resident B is receiving. Should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented. Because of the frequency and severity of challenging behaviors, Resident B currently has 2:1 staffing 24 hours a day. Because of the severity of self-harm, staff are to be with her at all times, including in her bedroom and bathroom.

On 10/26/2023, I placed a call to Andrea Bonamo, assigned, Livingston Co CMH Case Manager for Resident A. A voice mail message was left requesting a return call.

On 10/27/2023, I spoke with case manager Andrea Bonomo. She stated that Resident A's school attendance has been a big issue for the past year and boils down to his not wanting to attend.

Andrea Bonomo did receive a copy of the incident report reporting Resident A having been injured with a pen. She shared that Resident A and Resident B have a lot of conflict in the home. She adds that he has a lot of conflict with most of his peers as he feels they are not his peers due tohis higher level of functioning. She has explored different placements for Resident A with limited options other than moving to another Flatlock facility, however, the opportunity has not presented itself.

With the repeated conflict between Resident A and Resident B, in the past it was determined that it would be up to staff to keep the two separated as much as possible. She has also spoken with Resident A regarding avoiding Resident B. She believes that the staff try their best to keep Resident A safe. She has no other immediate concerns with the home.

On 10/30/2023, I received an emailed copy of the police report completed by Officer L. Chomert of the Lapeer County Sheriff's Department (LCSD). The report dated 08/17/2023 at 13:38 states that the officer was dispatched for Assault/Battery. Resident A reported that he had gotten into an argument with Resident B, who picked up a pen and [poked] him in the left cheek area. Resident A was observed as having a small cut on his left cheek area. Resident B reported that she had gotten into an argument with Residents A and C. She then stated that she grabbed a pen off the table and [poked] Resident A in the face and Resident C in the arm. Resident B was calm and compliant at the time of the interview. Resident C had an apparent minor injury, a small cut to his forearm. He is nonverbal and unable to be interviewed. The report also states that there are many reported and not reported cases with suspect Resident B.

On 10/30/2023, I conducted an onsite inspection at Elba North to interview Resident B. Staff, Hailey Barrington stated that she was one of the 2:1 staff assigned to Resident B. The other staff was not present. She was identified as Kyah Grimsley and was reportedly in the bathroom. The interview was conducted in Resident B's room. She recalled that she and Resident A were arguing on the day in question. Resident B called her a nigger and she jabbed him with the pen, telling him to "shut the fuck up". Resident B stated that Resident C was having a behavior, attacking everyone, so she jabbed him with the same pen, to get him to stop. Pens have now been added as a restricted item. Resident B stated that she and Resident A are getting along very well and are now boyfriend and girlfriend. Resident B still does not get along with Resident C. Resident B adds that she intends to be moving from the facility, hopefully next month.

On 10/30/2023, I spoke with Tracey Meade, CMH-Jackson Co assigned case manager for Resident B. She shared that she does recall the incident in which it was reported to her that Resident B had physically assaulted another resident in the cheek with a pen. Resident B was issued an emergency discharge notice on 10/20/2023, requesting that she be moved from the facility. Tracey Meade has been seeking a new placement with no success. An extension has been granted; however, she is not sure where Resident B will be placed next. Resident B is higher functioning than most of the residents there and does not feel that she is amongst her peers. Resident B's placement options are

limited. Tracey Meade believes that Resident B requires state hospitalization, to which her public guardian agrees, however, the final approval, which lies with Lifeways of Jackson, has not been approved. Tracey Meade adds that while at Flatrock Resident B has had numerous episodes of harming others, escaping the facility, and swallowing harmful objects. Tracey Meade has had multiple meetings with the management at Flatrock brainstorming different methods to keep both Resident B and the other residents safe. Resident B is currently required to have 2:1 staffing while in the home, while in the community, and while in transit. Tracey Meade adds that she does not believe that the home follows her treatment plan, which allows for some of the occurrences, in addition to the instability of the numerous changes in home managers, staff, behavior psychologist, and medical coordinators.

On 10/31/2023, I placed a follow-up call to Officer Chomert of the LCSD. He stated that the report has been submitted to the prosecutor's office, however, there have been several assault incidents involving Resident B which have not amounted to charges. In all likelihood, due to her mental health, a prosecution is unlikely.

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 Residents are being aggressive, and staff are unable to keep them safe. The complainant who stated that something happened at the facility which has made Resident A express that he doesn't want to reside at the facility any longer. She believes that Resident A was attacked by another resident in the home. Resident A stated that Resident B poked him with a pen she had in her hand. He called the police however, they stated that they can't do anything. Staff Breanna Selph recalled that Resident C was having a behavior in the hall, trying to get Resident B due to being upset. When Resident C could not get to Resident B, he turned his anger towards Resident A. Staff separated Resident A and C and attempted to cam both of them down. Resident A then began yelling at Resident B who was nearby. Resident A was placed in a CPI hold to calm him down. Resident B then poked Resident A in the face with a pen. Resident B's 1:1 staff did not see the pen in Resident B's hand. Staff, Ericka Hilliker cleaned Resident A's face and allowed him to call the police.

	Both incident reports dated 08/17/2023 state that the residents were crisis generating. In the process, Resident B approached Resident A, grabbing an ink pen off the table, and [poked] him in the face. Staff released hold and tried blocking technique but was unsuccessful. Resident A was struck in the face causing a laceration on his left cheek. The incident report dated 08/17/2023, at 1:30pm, states that Resident A was treated at the hospital and discharged with antibiotics to ensure that Resident A does not get infected. The McLaren Lapeer Regional Emergency Department discharge instructions for Resident A states that Resident A was seen and treated on 08/18/2023 at 17:50:47 (military time) for facial pain, cut of face. Resident A was diagnosed as having a puncture wound. He was provided with an antibiotic prescription of Cephalexin 500mg-1 Capsule Oral every 8 hours, standard times for 7 days. The Behavior Treatment Plan for Resident A, effective 04/23/2023, states that he has a history of physical aggression, which includes hitting, kicking, and throwing objects at others. Resident A is usually more verbal than physical. When experiencing greater levels of agitation/anxiety, he may strike out at others if he feels that the situation is not going how he would like it to go. Staff should block and back away from him. While talking with Resident A be calm, when trying to redirect him, do not talk to him like a child. Resident B's Behavior Treatment Plan dated effective 11/01/2022, states that staff will provide verbal prompts for Resident B to stop and to use her calming activities. If Resident B accepts and stops the behavior, staff should verbally praise her for accepting an alternative means of dealing with frustration/anger. Minimize attention given to the aggressive behavior while focusing on what you want Resident B to do. Try to problem solve, if there is a specific issue, use coping skills if agitated and/or redirect into a constructive activity. If Resident B continues to engage in physical aggression towards others, staff should use blocking techniques and redirect as possible, while focusing on what you want her to do. Staff should work towards verbally redirecting other residents away from Resident B as to remove an audience or additional attention she is receiving. Should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

	The Lapeer County Sheriff's Department police report states that Resident B reported that she'd gotten into an argument with Residents A and C. She then stated that she grabbed a pen off the table and [poked] Resident A in the face and Resident C in the arm. Resident B stated that she and Resident A were arguing on the day in question. He called her a nigger and she [jabbed] him with a pen, telling him to "shut the fuck up". Resident B stated that Resident C was having a behavior, attacking everyone, so she jabbed him with a pend to get him to stop. Ms. Tracey Meade, CMH-Jackson Co assigned case manager for Resident B stated that Resident B has had numerous episodes of harming others, escaping the facility, and swallowing harmful objects. She has had multiple meetings with the management at Flatrock brainstorming different methods to keep both she and the other residents safe. She does not believe that the home follows Resident B's treatment plan, which allows for some of the occurrences, in addition to the instability of the numerous changes in home managers, staff, behavior psychologist, and medical coordinators. Based on the interviews conducted with the complainant, Resident A, staff Breanna Selph, assigned case manager for Resident A, Andrea Bonomo, Resident B, assigned case manager for Resident B, Tracey Meade, a review of the AFC Assessment and Behavior Treatment Plans for both Resident A and B, and the incident reports dated 08/17 and 08/18/2023, the McClaren Lapeer Regional Emergency Department discharge instructions, and the LCSD police report, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/25/20023 I reviewed the Behavior Treatment Plan for Resident B, dated effective 10/24/2023, which states that because of the frequency and severity of challenging behaviors, Resident B currently has 2:1 staffing 24 hours a day. Because of the severity of self-harm, staff are to be with her at all times, including in her bedroom and bathroom.

On 10/30/2023, I conducted an unannounced onsite inspection at Elba South, for an interview with Resident B. Staff, Hailey Barrington stated was identified as one of the 2:1 staff assigned to Resident B. The other staff was not present. This interview lasted an estimated 7 minutes. Staff Grimsley did not arrive prior to ending the interview.

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:	The Behavior Treatment Plan for Resident B states that Resident B should have 2:1 staffing 24 hours a day, at all times, including in her bedroom and bathroom. During the unannounced onsite inspection conducted on 10/30/2023, Resident B was observed as having 1:1 staffing. There is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/01/2023, I conducted an exit conference with the license administrator, 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 November 1, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton November 1, 2023

Mary E. Holton Date
Area Manager