GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2021

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

RE: License #: AM250388518
Investigation #: 2021A0871014
Flushing

Dear Mr. 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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250388518
Investigation #:	2021A0871014
Complaint Receipt Date:	02/05/2021
Investigation Initiation Date:	02/05/2021
Report Due Date:	04/06/2021
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett, Designee
Name of Facility:	Flushing
Facility Address:	7012 River Road Flushing, MI 48433
Facility Telephone #:	(810) 867-4637
Original Issuance Date:	11/09/2017
License **Status:**	REGULAR
Effective Date:	05/09/2020
Expiration Date:	05/08/2022
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On February 4, 2021, Resident A was presented at Hurley Medical Center with midshaft humerus fracture to his right arm as well as significant bruising to his back.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/05/2021	Special Investigation Intake 2021A0871014
02/05/2021	APS Referral From Genesee County MDHHS
02/05/2021	Special Investigation Initiated - Letter Received information from Adult Protective Service Worker Cynthia Badour
02/05/2021	Contact - Document Received Received AFC Licensing Division Incident-Accident Report from Licensing Consultant Crecendra Brown
02/08/2021	Inspection Completed On-site Interviewed Staff Naszaria Morgan
02/10/2021	Contact - Telephone call made Telephone call to Home Manager Doron White
02/11/2021	Inspection Completed On-site Interviewed Staff Julian Green and Ruby Taylor, Residents B-C
02/24/2021	Contact - Telephone call made Telephone call to Hurley Hospital Social Worker Jennifer Edwards
02/25/2021	Contact - Telephone call made Telephone call to Recipient Rights Director Lisa Jolly
03/02/2021	Inspection Completed On-site Along with Recipient Rights Director Lisa Jolly, Interviewed Resident A and Staff Doron White

03/11/2021	Contact - Document Received Received medical records from Hurly Medical Center
03/13/2021	Contact - Document Received Received Resident A's medical records from Hurley Medical Center
03/15/2021	Contact - Telephone call made Telephone call to Staff Jerome Lyons
03/16/2021	Exit Conference Telephone exit conference with Licensee Nicholas Burnett

ALLEGATION:

On February 4, 2021, Resident A was presented at Hurley Medical Center with midshaft humerus fracture to his right arm as well as significant bruising to his back.

INVESTIGATION:

On February 5, 2021, Licensing Consultant Crecendra Brown forwarded me a copy of an *AFC Licensing Division – Incident/Accident Report* that was sent to her on February 5, 2021. The report indicates what happened "The lead on the shift were in the basement in the medication room finishing up passing medications. The staff upstairs was in the living room calming another client down when [Resident A] and another peer was having a verbal altercation in the dining room. Staff then heard a loud noise, so the lead immediately ran upstairs and saw [Resident A] walking to his bedroom. Staff was checking on [Resident A] and saw that his right arm looked abnormal. Staff then notified the medical coordinator and management and then spoke to [Resident A] and the peer involved, and they said they've been arguing all day, the peer got upset because [Resident A] was recording him on his tablet and the peer punched [Resident A] and pushed him down on the ground. Once the medical coordinator checked out [Resident A's] arm the medical coordinator instructed staff to transport [Resident A] to the hospital to get checked out. Staff did not witness the incident between [Resident A] and peer." Staff actions indicates "Staff was calming another client down, lead immediately ran upstairs, checked on [Resident A], staff then notified the medical coordinator and management. Staff then spoke to [Resident A] and peer." Corrective measures indicate "Staff will report to the medical coordinator and management with injuries and monitor [Resident A] for his health and safety." The *AFC Licensing Division - Incident/Accident Report* was written on 02/04/21 and signed by Licensee Nicholas Burnett. The staff involved indicate Julian Green and Katia Moore. I was advised that Katia Moore was no longer employed at the facility.

On February 11, 2021, I conducted an unannounced onsite investigation and interviewed Staff Julian Green. Mr. Green stated he was coming up from passing meds in the basement. Mr. Green said he came up and went into the kitchen and Staff Ruby Taylor was in the kitchen and stated, “he is at it again.” Ms. Taylor told Mr. Green Resident B attacked Resident A from behind. Ms. Taylor stopped Resident B from attacking Resident A. Mr. Green said he brought Resident A’s meds upstairs and passed them and Resident B then left Resident A alone. After passing Resident A’s meds, Mr. Green went back downstairs and “I didn’t hear too much when I was downstairs.” Mr. Green said he finished passing meds and Resident A went to his room. Mr. Green indicated Staff Doron White noticed Resident A’s arm and that it was broken. Mr. Green indicated he did not know what happened.

I then interviewed Staff Ruby Taylor on February 11, 2021. Ms. Taylor indicated Resident A had a med review and was upset about it when he came back to the facility that day. Ms. Taylor stated it was about 5 o’clock and she asked Resident A what he wanted for dinner and he was still upset. Ms. Taylor said Resident A was upset and his behavior started to escalate and he “got into it with [Resident B].” Ms. Taylor said she went back into the kitchen and was still serving dinner. Ms. Taylor said his behavior “escalated some more and I heard things going on.” When she came out of the kitchen, “food was everywhere, and everybody was getting triggered.” Ms. Taylor said she tried to keep others from escalating in their behaviors. Ms. Taylor indicated she stood by Resident C “because he is a choker” and tried to calm the residents down. Ms. Taylor said she got Resident A to his room and he “came back out in a huge rage, throwing things, wasn’t saying anything.” Ms. Taylor said she went back into the kitchen and she “thinks [Resident B] hit [Resident A]” but she could not tell because she was in the kitchen. Ms. Taylor said she gave Resident A time to calm down and she again escorted Resident A back to his room. Ms. Taylor said he did not come back out, so she went back to his room to see if he wanted to eat. Resident A did not want to eat, and she saw him laying in his chair. Resident A did not want anything to eat and she noticed his arm was swollen. Ms. Taylor said she put ice on it and waited for the med coordinator to arrive at the facility. Ms. Taylor said the med coordinator advised her that he needed to go to the hospital. Ms. Taylor said she drove her personal car to the hospital because the roads were slippery, and she trusted her own vehicle over the van. Ms. Taylor said they x-rayed Resident A and was advised he had a broken arm. Ms. Taylor said she does not know how Resident A got a broken arm and said, “all I knew was that he needed medical attention.”

On February 11, 2021, I then interviewed Resident B. When I asked Resident B about the incident, he replied “[Resident C] knows what happened.”

I then interviewed Resident C. When I asked Resident C about the incident, he indicated he “did not really see anything.” Resident C said he saw the food fight but was not paying attention. Resident C said “what I know was Resident A fell when

staff was managing him" but he is not sure. Resident C then said, "I really don't remember."

On February 11, 2021, I telephone Hurley Medical Center Social Worker Jennifer Edwards. Ms. Edwards said the type of fracture that Resident A had "was like a shatter." Ms. Edwards said staff gave several different stories about what happened.

On February 25, 2021, I received a phone call from Recipient Rights Director Lisa Jolly. Ms. Jolly stated she spoke with Resident A's Guardian 1. Ms. Jolly said Guardian 1 admitted something happened to Resident A, but she really does not want to move him. Guardian 1 said Resident A has lived in that facility for 8-9.

On March 2, 2021, Recipient Rights Director Lisa Jolly and I conducted an unannounced onsite investigation and interviewed Resident A. Resident A is very limited in his speech, but Ms. Jolly asked him if another resident or a staff member broke his arm. Resident A replied "staff." Ms. Jolly asked him if it was "Doron, Julian, Jerome?" Resident A answered "Jerome." Ms. Jolly asked him three times and every time Resident A replied "Jerome." Resident A pointed to the wall and floor and indicated that is where it happened.

On March 2, 2021, Staff Julian Green was also interviewed and indicated on February 4, 2021, Staff Jerome Lyons was walking with Resident A to his room.

On March 15, 2021, I telephoned Mr. Jerome Lyons. Mr. Lyons reported that "things were hectic" and something happened between Resident A and Resident D. Mr. Lyons said Resident D came out with his dinner plate and hit Resident A in the head with it. Mr. Lyons indicated Resident A was up and "kind of defending himself." Mr. Lyons said Resident D went to his room and Mr. Lyons went with him. Mr. Lyons then heard a "boom and thought someone dropped something." Mr. Lyons indicated Resident A was on the floor by the dining room table, trying to get up to the table. Mr. Lyons did not see Resident A fall and does not know how he fell or if he was attached by another resident. Mr. Jerome Lyons said Mr. Doron White and Mr. Julian Green came up from the basement and tried to figure out what was going on. Mr. Lyons said they were trying to make sure everyone was okay. Mr. Lyons said he walked Resident A back to his room and had his hand on his back because he did not know what kind of mood Resident A was in and did not want to get slapped. Mr. Lyons said when he got Resident A to his room, Resident A took his jacket off and he noticed an injury on Resident A's arm. Mr. Lyons said Mr. White and Mr. Green then came into the room and Mr. Green wrote an incident report.

I received a copy of Resident A's Plan of Service that was completed on March 19, 2020. Resident A does not require direct supervision. It indicates that Resident A has a physical aggressive episode about once a month "but overall is doing well in the home." It also indicates "[Resident A] requires group supervision when outside

in or in community." For Resident A's aggression, it indicates "Staff will use redirection whenever [Resident A] is aggressive."

I also received a copy of Resident D's Individual Plan of Service. Resident D's Safeguard Plan does not indicate that Resident D needs direct supervision at all times. Resident D "is responsible for following guidelines that are outlined in policies." It does not mention that Resident D has aggressive behavior.

On March 11, 2021, I received a copy of Resident A's medical reports. The report written by Physician Assistant Charles Pumklin on February 4, 2021, indicates "Staff member reports patient had become disruptive in the home today and was restrained by male staff members using "CPI maneuvers." Patient has bruising noticed to the right upper arm and does not use active range of motion of the right arm at the elbow secondary to pain. Staff member reports patient has had previous episodes that has required restraint." He also reported "triage RN reports initial story provided by staff had been changed multiple times during triage. It was reported patient had altercation with another resident. Then story was altered to state staff members had to restrain patient. Staff member became more elusive and stated she would not provide any names of her coworkers regarding the injury."

PA Pumklin' s findings indicate Resident A had "Bruising and ecchymosis present." He also indicted "Patient has swelling, and ecchymosis noticed to the right upper extremity distal aspect. Patient has no further complaints. Patient has abrasion/ecchymosis noted to his right upper back."

Social Worker Jennifer Edwards also wrote in the report "Per direct care worker (Ruby Taylor) pt. was upset around dinner time (5:00pm/5:30pm) and asked another resident to try and explain why he was upset (pt. has developmental delays and poor speech). Ruby stating the other resident (Ruby refusing to provide the name of the other resident) became irritated and 'attacked' [Resident A] hitting him the head. Ruby then noticed the situation diffused and at an unknown time later another resident (name of the resident was also refused by Ruby to be provided) again attacked [Resident A] causing staff worker Jerome, activity coordinator, (last name unknown) to physically manage [Resident A] to his room."

On March 16, 2021, I conducted a telephone exit conference with Licensee Nicholas Burnett. I informed Licensee Burnett there were several rule violations cited with this complaint.

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:	Resident A was presented at Hurley Medical Center with a fractured right arm and bruising on his back. Staff Members Julian Green, Ruby Taylor and Jerome Lyons did not know how this occurred. There was a lack of supervision. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Staff Ruby Taylor reported to Social Worker Jennifer Edwards that Staff Jerome Lyons physically managed Resident A. Resident A was insistent that Mr. Lyons pushed him to the floor that resulted in a broken arm and bruising on his back. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 2, 2021, Recipient Rights Director Lisa Jolly and I noted a strong urine smell in Resident A's bedroom.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	Recipient Rights Director Lisa Jolly and I noted a strong urine smell in Resident A's bedroom. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

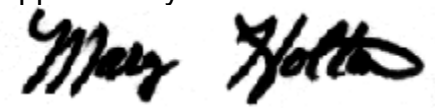
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-11).

03/23/2021

Kathryn A. Huber Date
Licensing Consultant

Approved By:



03/23/2021

Mary E Holton Date
Area Manager