GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2022

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

RE: License #: AS250388491
Investigation #: 2022A0582013
Ortonville

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.
- 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) 284-9727.

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS250388491
Investigation #:	2022A0582013
Complaint Receipt Date:	12/15/2021
Investigation Initiation Date:	12/17/2021
Report Due Date:	02/13/2022
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
Name of Facility:	Ortonville
Facility Address:	12399 Ray Road Ortonville, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	08/29/2017
License Status:	REGULAR
Effective Date:	02/29/2020
Expiration Date:	02/27/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
A video on an unknown date shows Resident A being physically manhandled by an unknown staff member next to Resident A's bedroom door. Resident A is on the ground with the staff member holding him down by the back of his neck and struggling.	Yes
Staff are prescribing Resident A medicine without reporting it.	No
Additional Findings	Yes

III. METHODOLOGY

12/15/2021	Special Investigation Intake 2022A0582013
12/17/2021	Special Investigation Initiated - Telephone With Complainant
12/17/2021	APS Referral APS Referral sent from Samantha Belanger
12/20/2021	Contact - Telephone call made With Relative A1
12/21/2021	Contact - Face to Face With Relative A1
12/28/2021	Contact - Telephone call made With Samantha Berger, Adult Protective Services
01/05/2022	Inspection Completed On-site
01/05/2022	Contact - Face to Face With Ashley Looney, Home Manager
01/05/2022	Contact - Face to Face With DCW Chae Burnett
01/05/2022	Contact - Face to Face With DCW Tania Brown
01/05/2022	Contact - Face to Face With Resident A

01/05/2022	Contact - Face to Face With Resident B, Resident C, and Resident D
01/05/2022	Contact - Document Sent Text message to Relative A1
01/07/2022	Contact - Document Received Text message from Relative A1 with video
01/07/2022	Contact - Telephone call received Voicemail from Samantha Berger, Adult Protective Services
01/19/2022	Contact - Telephone call made With DCW Ricky Brown
01/20/2022	Contact - Face to Face With DCW Ricky Brown
01/20/2022	Inspection Completed On-site
01/24/2022	Contact - Telephone call made With Deputy Rebecca Stradler, Genesee County Sheriff's Department
01/24/2022	Contact - Telephone call made With Samantha Berger, Adult Protective Services
01/24/2022	Contact - Telephone call made With Ashley Looney, Home Manager
01/24/2022	Exit Conference With Nicholas Burnett, Licensee Designee
01/24/2022	Inspection Completed-BCAL Sub. Compliance
01/26/2022	Corrective Action Plan Requested and Due on 02/11/2022

ALLEGATION:

A video on an unknown date shows Resident A being physically manhandled by an unknown staff member next to Resident A's bedroom door. Resident A is on the ground with the staff member holding him down by the back of his neck and struggling.

INVESTIGATION:

I received this Adult Protective Services referred complaint on 12/15/2021 and contacted the APS referral source (Complainant) on 12/17/2021. Complainant stated that she viewed the video, which was in possession of Relative A1. Complainant stated that Relative A1 would not inform her of who recorded the video but was willing to talk with whoever she needed to for investigation purposes. Complainant stated that she has been to the facility twice and Resident A complained about wanting to leave because someone he referred to as “that big man” was attacking him. Complainant stated that the home manager mentioned that Resident A has had altercations with another resident, which possibly explained the situation. Complainant stated that from the video, it is clear that the incident took place at the facility in front of Resident A’s bedroom door. Complainant stated that Resident A has epilepsy and bipolar disorder, which makes it difficult for him to keep track of and articulate certain details. Complainant stated that the person in the video holding down Resident A was a big guy wearing a white polo shirt. Complainant stated that what she saw in the video was beyond a hold/restraint to keep Resident A safe. Complainant stated that Resident A was being held down by the back of his neck with his face down on the floor. Complainant stated that Resident A tried to get out of the hold and the staff member fell on top of Resident A. Complainant stated that from the video it did not appear that the staff member was properly trained. Complainant provided the contact number for Relative A1.

On 12/20/2021, I interviewed Relative A1, who stated that Resident A continues to reside at the facility, but she is in the process of moving him. Relative A1 stated that the video was provided to her but would not share who recorded it. Relative A1 stated that Resident A cannot explain himself that well but told her that “some big dude whooped his ass.” Relative A1 stated that “Ricky” was the staff member in the video who was “fighting” Resident A. Relative A1 stated that one can clearly see Ricky hit Resident A in the face from the video. Relative A1 stated that what Ricky was doing was not a hold/restraint and the video is self-explanatory. Relative A1 stated that staff have threatened to take the cell phones from residents because of the video recording. Relative A1 stated that she was going to pick up Resident A on 12/22/2021, so he would not be at the facility to interview. Relative A1 stated that she was in touch with a lawyer regarding the situation. Relative A1 stated that she did not want to text the video but would allow me to view it. I arranged to meet with Relative A1 on 12/21/2021.

On 12/21/2021, I met with Relative A1 and viewed the video multiple times. In the video, the setting appears to be the facility, Ortonville, License Number AS250388491. The video begins with a Black male in a white shirt standing over a Black male, who is on the ground on his right side/stomach. The Black male in the white shirt has his right hand on back of the neck of the individual on the ground.

The Black male individual on the ground appears to be struggling, while the Black male in the white shirt is applying pressure to the back of his neck. The individual on the ground attempts to roll away and sit up, but the Black male in the white shirt appears to follow and fall over on him to continue holding him down. The video ends with the Black male in the white shirt standing over the Black male on the ground while he is on his back. Relative A1 identified the black male who was on the ground as Resident A. During this meeting, Relative A1 identified the Black male in the white shirt as “Larry.”

On 12/28/2021, I contacted Samantha Berger, Adult Protective Services. Ms. Berger stated that she went to the facility and attempted to interview Resident A but could not obtain much information from him due to his mental health status. Ms. Berger reported that there were no injuries to Resident A at the time. Ms. Berger stated that she interviewed staff, and they had no knowledge of the complaint.

On 01/05/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Ashley Looney, who stated that she has been manager since July 2021. Ms. Looney stated that there has not been a staff member or resident named “Larry” during her time working at the facility. I attempted to interview Resident A, but the conversation was unintelligible. I observed Resident A in his room, and he appeared to be receiving adequate care and supervision, with no visible bruising.

I interviewed DCW (Direct Care Worker) Chae Burnett, who stated that Resident A has become physically aggressive with other residents in the past, but he is more verbally aggressive lately. Mr. Burnett stated that Resident A has schizophrenia and will come out of his room thinking that others are talking about him. Mr. Burnett stated that Resident A antagonizes others, by say “I’ll beat your ass” and saying, “fuck you.” Mr. Burnett stated that he tries to calm Resident A down by talking him down. Mr. Burnett stated that if Resident A becomes physically aggressive, staff use physical management techniques to keep him and others safe. Mr. Burnett stated that he has never had to perform a hold on Resident A. Mr. Burnett stated that he has never seen another staff member perform a hold on Resident A. Mr. Burnett stated that he was not aware of the incident from the video that I described to him.

I interviewed DCW Tania Brown, who stated that Resident A is primarily verbally aggressive with others. Ms. Brown stated that Resident A will curse at others, insult them, and call others bad names. Ms. Brown stated that she has not had any interactions with Resident A out of the ordinary, or that she has had to perform a hold on Resident A. Ms. Brown stated that she was not aware of the incident from the video that I described to her.

I interviewed Resident B, who stated that he has a phone but has never recorded any incidents that he has seen take place in the home. Resident B stated that he has observed staff use physical management to restrain other residents. Resident B stated that he has observed Resident A being thrown to the ground by a staff

member named Ricky Brown. Resident B stated that Mr. Brown currently works at another Flatrock facility.

I interviewed Resident C, who stated that he has never recorded a video of staff interactions with residents in the home. Resident C stated that he has never observed staff using physical management to restrain a resident.

I interviewed Resident D, who stated that he has a phone and has recorded video of a staff member named Ricky who was trying to restrain Resident A. Resident D stated that he texted the recording to Relative A1. Resident D stated that the manager Ashley Looney and another manager named Brad observed the video, and Ms. Looney deleted the video from his phone.

I followed up my interview with Ms. Looney with additional questions. Ms. Looney stated that she was not aware of a video in which Resident A was being physically handled by a staff member. Ms. Looney stated that she was familiar with a staff member named “Ricky” who previously worked at the facility, but currently works at another facility within the agency, and provided his phone number and current facility where he works.

I reviewed Resident A’s Behavior Treatment Plan, which documented the following:

> **Plan Effective Date**: 10/04/2021
> **Implementation Procedures**: [Resident A] currently resides at Flatrock Manors of Ortonville. This is his second placement with Flatrock since his placement in November 2016. In the past [Resident A] exhibited incidents of physical aggression (toward staff) and verbal aggression towards others. Interpersonal relationships often serve as triggers to aggression. [Resident A] has diagnoses which include: Bipolar Disorder, current episode manic severe with psychotic features, cannabis abuse, and Mild Intellectual Disabilities. His records reflect several health conditions including: Wolf Parkinson Disease/heart problem, “Stephen Johnson Syndrome”/a skin condition, ongoing back pain, seizure disorder, history of brain surgery to stop seizures, and a history of lung collapse. He has a history of multiple psychiatric hospitalizations, participations in ACT services, and criminal-legal involvement associated with assault/altercations with housemates at prior group homes.
>
> **General Interaction Strategies:** [Resident A needs to feel that staff are a working partner with him. It is very important that he feels safe and accepted by staff. Staff should always listen with concern, validate his feelings, and be responsive to his needs. Always try to keep a positive connection with [Resident A]. Keep in mind that [Resident A] has a history of aggressive outbursts toward others and impulsive violence toward others.
>
> **Behavior Chain/Precursor Behavior:** The previous behavior chains staff have witnessed since [Resident A] moved into Flatrock have all started with verbal

aggression. [Resident A] starts coming out of his bedroom saying that someone was talking about him and then he becomes angry and verbally aggressive when people deny saying anything about him. He then becomes angry and verbally aggressive when people deny saying anything about him. Sometimes this verbal aggression progresses into physical aggression. After the situation, [Resident A] will attempt to elope from the home to get away from the situation, or to go for a walk to cool down.

Reaction Strategies: Physical Aggression - [Resident A] is usually more verbal than physical. Once in a while he may strike out at others if he feels that the situation is not going how he would like it to go. Simply block and back away from his reach. If needed, remove others from around him, so as not to give him an audience. Again, remain calm, firm, and consistent with your directions in what you want him to do. Try to minimize any other verbal attention, such as counseling, justifying, coxing, or bribing. Once he is calm, try to problem solve, fist bump, and move on without scolding or counseling.

On 01/05/2022, I contacted Relative A1 and informed her that without having a video to interview and show the accused direct care worker, I could not confirm or deny that he is identified in the video. On 01/07/2022, Relative A1 texted the video to my phone, which I shared with Ms. Berger from Adult Protective Services. Relative A1 stated that it looked as if someone beat up Resident A but did not report it.

On 01/07/2022, I received a phone message from Samantha Berger, Adult Protective Services. Ms. Berger stated that Relative A1 had not been cooperative with her investigation and she had not observed the video. Ms. Berger stated that she made a report to the Genesee County Sheriff's Department and would be meeting an officer at the home on 01/10/2022.

On 01/19/2022, I interviewed DCW Ricky Brown. Mr. Brown stated that he previously worked at the Ortonville home but has worked at his current location for a few months. Mr. Brown stated that he had prior interactions with Resident A. Mr. Brown stated that Resident A would become verbally and physically aggressive with other residents and with staff. Mr. Brown stated that when Resident A would become physically aggressive, staff would use physical management that included blocking techniques and separating him from others. Mr. Brown stated that Resident A has hit him once before. I scheduled a time to meet with Mr. Brown in person.

On 01/20/2022, I interviewed DCW Ricky Brown in person. Mr. Brown stated that he has worked for Flatrock for two years and transferred from Ortonville to the current facility because it was closer to home. Mr. Brown stated that he had no previous disciplinary actions at Flatrock. Mr. Brown stated that Ashley Looney was the home manager at Ortonville when he transferred to work at the current home. Mr. Brown stated that he has received training on various physical management techniques to keep residents and staff safe. Mr. Brown demonstrated various holds that he learned and has utilized. I let Mr. Brown view the video. Mr. Brown identified himself in the

video and stated that he could not recall when the video took place. Mr. Brown stated that before the video, Resident A and Resident D had an altercation. Mr. Brown stated that the was able to separate both residents and calm down Resident D, but Resident A turned his aggression towards him. Mr. Brown stated that he was telling Resident A to calm down, but he kept “coming at me,” which resulted in the action from the video. Mr. Brown stated that he was waiting for backup to assist and put Resident A into a proper hold, but the other staff member was outside with other residents. Mr. Brown stated that he felt bad and frustrated about the incident and left work early afterwards. Mr. Brown stated that he notified the home manager Ashley Looney about the incident. Mr. Brown stated that sometime later, Resident A came and apologized to him about his behavior. Mr. Brown stated that he was typically someone that Resident A could talk to when he was having difficulty. Mr. Brown stated that he is one of the “good workers” and not a bad person.

On 01/20/2022, I conducted an unannounced inspection at the facility. I observed Resident A in his room, and he appeared to be receiving adequate care and supervision, with no visible bruising. I interviewed Resident D and showed him the video. Resident D confirmed that he recorded the video and sent it to Relative A1. Resident D stated that Relative A1 gave him her phone number and asked him to “look out” for Resident A by keeping an eye on him. Resident D stated that he had physical altercations with Resident A in the past, but not during the occasion of the video. Resident D stated that “Quay” was the other staff member working that day. Resident D stated that Resident A was being verbally aggressive with staff, telling them to “shut the fuck up.” Resident D stated that staff would not let Resident A go outside, so he became upset and got in Mr. Brown’s face. Resident D stated that he started recording the incident once Resident A and Mr. Brown became physical. Resident D stated that he texted the video to Relative A1. Resident D stated that he showed the video to a manager named “Brad” and then showed the video to Ms. Looney, who deleted it. Resident D stated that he has been interviewed by the police and “another lady” about the incident and video.

On 01/24/2022, I contacted Police Deputy Rebecca Stradler, Genesee County Sheriff’s Department. Deputy Stradler stated that she interviewed with DCW Ricky Brown and Resident D and determined that the timeline in which the incident occurred was between July and September of 2021. Deputy Stradler stated that Mr. Brown admitted to being “a little aggressive” in the video and took his actions because no other staff was around to conduct a two-person hold. Deputy Stradler stated that Resident A could not tell her that it was him from the video. Deputy Stradler stated that no injuries were reported from the incident, and things in the home seemed to be back to normal according to the other residents she interviewed. Deputy Stradler stated that she submitted her report and the video to the prosecutor’s office, but she doubts if anything will come of it.

On 01/24/2022, I contacted Samantha Berger, Adult Protective Services. Ms. Berger stated that she will be substantiating for abuse in her case.

On 01/24/2022, I interviewed home manager Ashley Looney. Ms. Looney denied knowledge of the video and denied deleting the video from Resident A's phone.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my observation of the video, in conjunction with interviews conducted throughout the investigation, there is sufficient evidence to confirm that on an unknown date/time, Direct Care Worker Ricky Brown used inappropriate physical force in an attempt to manage Resident A's behavior. Mr. Brown identified himself in the video, which showed him holding Resident A down on the floor by the back of his neck and rolling on top of Resident A when he tried to get away from him. Resident A's Behavior Treatment Plan documented that he has extensive mental and physical health challenges to include ongoing back pain, seizure disorder, and brain surgery. Intervention strategies in Resident A's Behavior Treatment Plan, which included "block and back away from [Resident A's] reach", was not practiced in the video.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are prescribing Resident A medicine without reporting it.

INVESTIGATION:

On 01/05/2022, I contacted Relative A1 who stated that the staff are prescribing Resident A medicine without reporting it.

On 01/20/2022, I conducted an unannounced inspection at the facility. I reviewed Resident A's *Medication Administration Record (MAR*) for January 2022 and medications, which were current, appropriately stored, labeled, and in the pharmacy containers. The MAR was initialed to show that Resident A had received his prescribed medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During the investigation, Relative A1 alleged that the staff are prescribing Resident A medicine without reporting it. Based on my review of Resident A's *Medication Administration Record (MAR)* for January 2022 and observation of his current medications, there is no evidence to suggest that staff are prescribing medication to Resident A without reporting it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/05/2022, I interviewed Resident D, who stated that he has a phone and has recorded video of a staff member named Ricky who was trying to restrain Resident A. Resident D stated that he texted the recording to Relative A1. Resident D stated that the manager Ashley Looney and another manager named Brad observed the video, and Ms. Looney deleted the video from his phone.

On 1/05/2022, I followed up my interview with Ms. Looney with additional questions. Ms. Looney stated that she was not aware of a video in which Resident A was being physically handled by a staff member.

On 01/20/2022, I interviewed DCW Ricky Brown in person. Mr. Brown stated that he has worked for Flatrock for two years and transferred from Ortonville to the current facility because it was closer to home. Mr. Brown stated that he had no previous disciplinary actions at Flatrock. Mr. Brown stated that Ashley Looney was the home manager at Ortonville when he transferred to work at the current home. Mr. Brown stated that he has received training on various physical management techniques to keep residents and staff safe. Mr. Brown demonstrated various holds that he learned and has utilized. I let Mr. Brown view the video. Mr. Brown identified himself in the video and stated that he could not recall when the video took place. Mr. Brown

stated that before the video, Resident A and Resident D had an altercation. Mr. Brown stated that the was able to separate both residents and calm down Resident D, but Resident A turned his aggression towards him. Mr. Brown stated that he was telling Resident A to calm down, but he kept “coming at me,” which resulted in the action from the video. Mr. Brown stated that he was waiting for backup to assist and put Resident A into a proper hold, but the other staff member was outside with other residents. Mr. Brown stated that he felt bad and frustrated about the incident and left work early afterwards. Mr. Brown stated that he notified the home manager Ashley Looney about the incident. Mr. Brown stated that sometime later, Resident A came and apologized to him about his behavior. Mr. Brown stated that he was typically someone that Resident A could talk to when he was having difficulty. Mr. Brown stated that he is one of the “good workers” and not a bad person.

On 01/24/2022, I contacted Samantha Berger, Adult Protective Services. Ms. Berger stated that she will be substantiating for abuse in her case.

On 01/24/2022, I interviewed home manager Ashley Looney. Ms. Looney denied knowledge of the video and denied deleting the video from Resident A’s phone.

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:	The inappropriate physical force used by Direct Care Worker Ricky Brown on Resident A was not addressed by the facility after it took place. The investigation could not determine when the video was recorded, and there was no evidence of injuries to Resident A. Although home manager Ashley Looney denied knowledge of the incident and video, Resident D indicated that he informed Ms. Looney and showed her the video, which was deleted by her. Mr. Brown stated that Ms. Looney was the home manager at the time of the incident, and he reported to her what took place. Without the video being recorded, there was no one from the facility to ensure the protection and safety of Resident A was addressed following the incident with Mr. Brown.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/24/2022, I sent the video to Licensee Designee Nicholas Burnett and Administrator Carrie Aldrich and conducted an Exit Conference after they had the opportunity to view the video. Mr. Burnett stated that the video was very unfortunate and inappropriate. Mr. Burnett stated that he would be dismissing Mr. Ricky Brown immediately and asked about corrective actions. Ms. Aldrich stated that staff will receive additional training on proper holds. I informed Mr. Burnett that although home manager Ashley Looney denied viewing and deleting the video, Resident D and Mr. Brown stated that Ms. Looney had knowledge of the video.

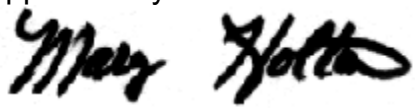
IV. RECOMMENDATION

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

01/26/2022

Derrick Britton — Date
Licensing Consultant

Approved By:



01/27/2022

Mary E Holton — Date
Area Manager