GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2022

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

RE: License #:	AM440388514
Investigation #:	2022A0123032 Elba South

Dear Mr. Burnett:

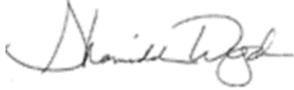
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9700.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607

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 #:	2022A0123032
Complaint Receipt Date:	04/12/2022
Investigation Initiation Date:	04/15/2022
Report Due Date:	06/11/2022
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:	08/08/2020
Expiration Date:	08/07/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/03/2022, Resident A wanted a question answered and got upset with staff's response. Resident A began punching staff in the face. Staff punched Resident A in the face and grabbed Resident A's face and neck like a choke and threw Resident A on the wall. Resident A has a mark and bruising on his right-side cheek, hip, and stomach.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/12/2022	Special Investigation Intake 2022A0123032
04/13/2022	APS Referral Information received regarding APS referral.
04/15/2022	Special Investigation Initiated - Telephone I spoke with adult protective services worker Rose Koss via phone.
04/21/2022	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
04/21/2022	Contact- Document Sent I sent an email requesting documentation, including Resident A's assessment plan, health care appraisal, staff names and numbers, incident report, staff shift notes, and behavioral intervention chart for Resident A.
04/22/2022	Contact - Telephone call made I made a follow-up call to APS worker Rose Koss.
05/04/2022	Contact- Document Sent I sent an email to program director Bradley Jacobi requesting a copy of April and May 2022 staff schedule, and an email requesting contact information for Guardian 1 and Resident A's case manager.
05/04/2022	Contact- Document Received

	I received an email from Mr. Jacobi with Resident A's case manager and Guardian's contact information.
05/05/2022	Contact- Document Received I received an email response from Mr. Jacobi regarding contact information for the case manager and guardian.
05/12/2022	Contact - Telephone call made I interviewed staff Scott Jones via phone.
05/12/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Emmanuel Fletcher.
05/12/2022	Contact - Telephone call made I interviewed staff Tamela Carney via phone.
05/12/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Bridney Gibbs.
05/12/2022	Contact - Telephone call made I made an attempted call to staff Tarayah Thornton. The number was not in service.
05/12/2022	Contact - Telephone call made I made a call to Resident A's case manager Andrea Banomo. I left a message requesting a return call.
05/12/2022	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's Guardian 1.
05/12/2022	Contact - Telephone call received I received a call from Resident A's case manager, Andrea Banomo.
05/16/2022	Contact- Telephone call received I received a voicemail from Guardian 1.
05/21/2022	Contact- Telephone call received Staff Bridney Gibbs left a voicemail requesting a return call.
05/23/2022	Contact- Telephone call made I spoke with recipient rights investigator Elizabeth Simon.
05/23/2022	Contact- Document Sent

	I sent a follow-up email requesting the incident report for 04/03/2022.
05/23/2022	Contact- Telephone call made I spoke with program director Bradley Jacobi via phone.
05/25/2022	Contact- Telephone call made I spoke with Staff Gibbs via phone.
05/25/2022	Contact- Telephone call made I made a second attempt at contacting staff Tarayah Thornton. The phone was not in service.
05/27/2022	Contact- Document Sent I sent an email to administrator Morgan Yarkosky regarding Staff Thornton and Staff Fletcher needing to be interviewed.
05/27/2022	Contact- Document Received I received an email response from Morgan Yarkosky.
05/31/2022	Contact- Document received I received a copy of Resident A's behavioral plan via fax.
05/31/2022	Contact- Telephone call received I spoke with Staff Emmanuel Fletcher. I informed him that I would call him back.
05/31/2022	Contact- Telephone call made I spoke with Staff Fletcher via phone.
05/31/2022	Contact- Telephone call received I received a voicemail from staff Taraya Thornton.
05/31/2022	Contact- Telephone call made I spoke with Staff Thornton via phone.
06/01/2022	Exit Conference I spoke with licensee designee Nicholas Burnett via phone.

ALLEGATION: On 04/03/2022, Resident A wanted a question answered and got upset with staff's response. Resident A began punching staff in the face. Staff punched Resident A in the face and grabbed Resident A's face and neck like a choke and threw Resident A on the wall. Resident A reported the incident to the home manager. Resident A has a mark and bruising on his right-side cheek, hip, and stomach.

INVESTIGATION: On 04/13/2022, I spoke with Lapeer County adult protective services (APS) investigator Ross Koss via phone. Ms. Koss stated that Resident A has a guardian. She stated that Resident A is usually home around 3:30 pm, and she is going to see Resident A tomorrow.

On 04/21/2022, I conducted an unannounced visit to the facility. I interviewed home manager Joey Hoffner in a conference room. He denied having knowledge of the allegations and denied having knowledge of Resident A having any marks or bruising. He stated that Resident A does exaggerate at times. He denied that Resident A reported the alleged incident to him. As I was leaving this on-site, I asked Staff Hoffner a second time if he was sure he had no knowledge of this alleged incident. He again reiterated that he does not.

On 04/21/2022, I interviewed Resident A at the facility. Resident A stated that staff touched him first, and that it was staff Scott Jones. He stated that staff Emmanuel Fletcher was present in the home but was not a witness. Resident A stated that the incident occurred on 04/03/2022. He stated that he approached staff and asked about his tokens. He stated that the staff person got out of his chair and was joking around. Resident A asked Staff Jones to stop joking as he did not like that. Staff Jones replied with "I don't give a fuck about your tokens anymore." Resident A stated that Staff Jones got physical, punched him in the right eye, and scratched his neck, but the marks are gone now. Resident A stated that he had to defend himself. He stated that Staff Jones also slammed his speedway cup out of his hand. He stated staff Taraya Thornton and a staff person named "Bri" were witnesses. He stated that Staff Jones still works there. He stated that he reported the incident to several people including Staff Hoffner. He denied having to go to the hospital and stated that staff refused to take him. He denied punching the staff person in the face and stated that he would not do that because he does not want any warrants. He stated that Ms. Koss of APS saw the scratch on his neck. Resident A stated that staff do not restrain him, they threaten to break his arm, they sit on his stomach and back. He stated that staff come to work with a bad attitude all the time.

On 04/22/2022, I made a follow-up call to Ms. Koss of APS. Ms. Koss stated that Resident A told her that Staff Fletcher hit him. She stated that she asked Staff Hoffner how Resident A's face got bruised up, and that Staff Hoffner was not forthcoming. Ms. Koss stated that she saw bruising right above Resident A's chin that appeared yellow in color, and a scuff on his neck. She stated that you could tell the bruise was fading. She stated that Staff Hoffner told her that he did recall an

incident report about bruising only after she informed Staff Hoffner that she had photos of the bruise.

On 04/22/2022, I received emailed documentation including an Antecedent-Behavior-Intervention Chart for April 2022. An entry for 04/03/2022 at 9:45 pm states that Resident A was "*upset at staff for not checking his tokens quickly enough*" under *What seemed to cause the behavior?* section. "*Hitting staff, spitting at staff, fighting staff*" is noted under *Describe the Behavior*, and "*compliance trials body positioning*" is noted under the *Describe intervention* section. No injuries were noted. Resident A's Assessment Plan for AFC Residents dated 12/31/2021 states in the Communicates Needs section that *"[Resident A] is verbal and is able to communicate wants/needs in an appropriate manner. When agitated, [Resident A] may act out to communicate wants/needs in a maladaptive manner*."

On 05/12/2022, I made a call to staff Scott Jones. Staff Jones reported the following:

Resident A has physical behaviors where he assaults staff and other residents. He denied that that Resident A was punched by him, and denied seeing any bruises on Resident A. He stated that a lot of physical altercations is resident to resident and that he and Resident A get along well. He stated that Resident A makes up accusations. He stated that Resident A did ask him about his tokens. Resident A had knocked on the door and asked if Staff Jones had his board. Staff Jones stated that he was doing paperwork at the time. He stated that Resident A's behavior escalated, and when he (Staff Jones) walked out of the office, Resident A punched him in the face. Staff Jones stated that he tried physical management. He denied saying "I don't give a fuck about your tokens." Staff Jones stated that Resident A had a coffee cup in his hand, and the cup was knocked out of his hand, but he does not recall how that happened. He stated that he thinks staff Tarayah Thornton reported the incident to Staff Hoffner. He stated that he did not write an incident report and does not know if anyone else did.

On 05/12/2022, I interviewed staff Tamela Carney. Staff Carney stated that she does not recall how the incident on 04/03/2022 began, but that Resident A was out of hand. Staff Jones tried to do CPI but that did not work. She stated that Staff Jones had to get Resident A on the ground. She stated that other staff including her tried to get Staff Jones into the office and separated from Resident A, as you could tell that Staff Jones was becoming visibly irritated after he and Resident A got up from the ground. Staff Carney stated that multiple residents were having behaviors that day, and that Resident A was irritated. She stated that Staff Jones did have Resident A up against the wall, but not "in any type of way," just that Staff Jones was having a hard time trying to control Resident A with CPI. Staff Carney stated that she does not remember Staff Jones slamming Resident A, that Staff Jones did not punch Resident A, and that she did not hear Staff Jones tell Resident A "I don't give a fuck about your tokens anymore." Staff Carney stated that Resident A has good days and bad days, but Resident A and Staff Jones are usually okay with one another. She stated that she is unsure who wrote the incident report, and that staff Taraya

Thornton was the lead staff. She stated that it is her understanding that the lead staff persons write the incident reports. She stated that Resident A's face was red, but she thinks it was from fighting Staff Jones, and not from any marks or bruising.

On 05/12/2022, I spoke with Community Mental Health case manager Andrea Banomo via phone. She stated that she is aware of the allegations and that Livingston County recipient rights investigated. She stated that it is possible the allegations occurred, but there has been instance where Resident A says things have happened, and it did not. She denied having any recent concerns regarding Resident A's care and stated that her last face to face with Resident A was on 04/20/2022. She stated that Resident A has assaulted staff in the past.

On 05/12/2022 and 05/25/2022, I made attempts to contact staff Tarayah Thornton via phone. The phone number for her was not in service.

On 05/16/2022, I received a voicemail from Guardian 1. Guardian 1 stated that she has no concerns about Resident A's care. She stated that Resident A has some issues, but the facility is the best place for him to be.

On 05/23/2022, I spoke with recipient rights officer Elizabeth Simon via phone. She stated that it does not appear that the allegations occurred. Resident A reportedly had bruising on his neck. She stated that Staff Joey Hoffner stated that no physical management occurred. She stated that Resident A also changed the name of the staff person who allegedly did it. Resident A originally said he hit Staff Jones in the face first. She stated that it is difficult to determine when Resident A is reliable, as he will admit later in some instances that he makes things up because he was upset. She stated that Resident A will tell a story at times and omit his part in the situation. She stated that unless there is another witness to what happens it is hard to say if it happened.

On 05/25/2022, I spoke with staff Bridney Gibbs via phone. Resident A stated in his interview that a staff person named "Bri" was a witness. Staff Gibbs stated that she is a first shift worker and does not know anything about the allegations. She stated that she does not work with Staff Jones.

On 05/31/2022, I interviewed staff Emmanuel Fletcher via phone. Staff Fletcher stated that he heard about the incident. He stated that he does not think he worked that day. He stated that he heard that Staff Jones tried to do CPI on Resident A, because Resident A was in the middle of a behavior. He stated that it was the first-time hearing about Staff Jones doing CPI, and that Staff Jones gets along with Resident A. He denied seeing any bruising or marks on Resident A. He denied having any knowledge of Resident A punching staff or getting pushed against a wall or choked.

On 05/31/2022, I interviewed staff Tarayah Thornton via phone. She stated that on 04/03/2022, Resident A asked her who had his token board. Resident A came back

to her and said that Staff Jones had it. She stated that Resident A then walked away. She stated that Resident A was pounding on an office door, Staff Jones opened the door and asked Resident A what he wanted. She stated that Resident A kept cursing, and Staff Jones told Resident A to “get the fuck out of my face.” She stated that Scott Jones tried to close the door, but Monty got in and attacked Staff Jones. She stated that she then heard yelling and saw coffee was all over the floor. She stated that she saw Staff Jones with his arms up covering his head blocking blows from Resident A. She stated that she and a staff person named Brianna (who no longer works there) went to assist. She stated that they got Resident A off Staff Jones, and Resident A was spouting racial slurs. She stated that Resident A then went into his room and was throwing stuff around in his room. She stated that Staff Jones clocked out and left. She stated that Resident A does lie a lot and does not like Staff Jones. She stated that Staff Jones is chill and comes in and does his job. She stated that she does not think Staff Jones hit Resident A. Staff Thornton stated that she does not recall Resident A having any scratches or bruising but heard that he mentioned it later that night. She stated that Resident A may have gotten scratched when she intervened because she does have long nails, but there were no marks observed on him at the time of the incident. She stated that she was not the lead staff, and that Staff Fletcher did not work that day. She stated that Staff Carney was present that day. Staff Thornton stated that she reported the incident to home manager Joey Hoffner, and he said he would follow up. She stated that Staff Hoffner did pull Scott Jones into the office.

On 05/31/2022, I obtained a copy of Resident A’s *Positive Behavior Support Plan* dated for 11/04/2021. In this plan, it outlines how staff should go about handling Resident A’s behaviors. Under section II*. General Interaction Strategies* it states:

A. *Staff need to model appropriate personal space, language, and how to converse with others. When [Resident A] starts to become too loud or invades others personal space, calmly remind him “let’s calm down” and model talking and behaving calmly. Do not appear critical or rejecting. When we guide him, the staff can say, “I’m okay, you’re okay.” Begin interactions with “Hey bud, ___” and/or giving a five or fist bump, to signify to him that you are accepting of him. Remind [Resident A] of personal space and not interrupting others.*

E. *When [Resident A] has a question or concern, he tends to seek out multiple people until he receives the response that he would like. If [Resident A] has a question/concern, he should first approach a staff member and if they are unable to [Resident A] a response then he may ask a lead staff member. If the lead staff is unable to give him a response, then they will approach the home manager. Uncertainty may cause [Resident A] anxiety and staff should stay a working partner with [Resident A] to assist him in finding a response.*

Under section *III. Reaction to Strategies When Upset* it states:

A. *Verbal Outbursts:*

When frustrated/angry, [Resident A] may become verbally aggressive (see above). It is important that staff stay calm but in control.

1. *Acknowledge and validate that [Resident A] is upset and then help him solve the problem if he is calm enough and is willing to talk.*
2. *Ask [Resident A] to define what the real problem is and what we can do to resolve it. If too upset, try getting him to do some coping skills.*
3. *If he is unwilling to do coping skills, give [Resident A] the option to calm down in his room and let you know when he is ready to talk.*
4. *Do not scold or counsel [Resident A] when he is upset. Simply stay calm, matter of fac and consistent with the boundaries.*

B. Physical Aggression:

Physical aggression towards others often happens after verbal aggression with [Resident A]. If staff are not able to calm him when engaging in verbal aggression, it may very likely turn into physical aggression.

1. *If [Resident A] does become physically aggressive, back away from his reach. Firmly and calmly say "[Resident A], stop and sit down." Ask peers to back away.*
2. *If [Resident A] continues to engage in physical aggression towards others, staff should use blocking techniques and redirect as possible, while focusing on what you want him to do. Don't use a lot of words. Remain calm in expression and words. Tell him what you want him to do and repeat, calmly, and about twice per minute.*
3. *Implement emergency guidelines if necessary.*

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 was interviewed and reported that there was a physical altercation between him and staff Scott Jones after he approached Staff Jones regarding his tokens. He stated that Staff Jones cussed at him. He denied punching Staff Jones in the face. He stated that he did not like Staff Jones' response to his questioning about his tokens. Staff Jones stated that Resident A did ask him about his tokens, and things escalated with Resident A when he tried physical management. He denied cussing at Resident A. He stated that Resident A punched him in the face. Staff Carney stated that Staff Jones attempted CPI, Staff

	Jones was visibly irritated, and did have Resident A up against the wall trying to control Resident A with CPI. She denied that Staff Jones punched Resident A. Staff Fletcher was interviewed. He denied being a witness but stated that he heard that Staff Jones did CPI on Resident A. He denied seeing any marks or bruising on Resident A. Staff Thornton stated that there was an altercation between Staff Jones and Resident A. She stated that Staff Jones did cuss at Resident A. She denied seeing any marks or bruising. A copy of Resident A's Positive Behavior Support plan was reviewed. It outlines in detail how staff are supposed to handle Resident A's behaviors, specifically when he has questions or concerns as uncertainty may cause Resident A to have anxiety. His behavior plan also outlines how staff are to handle his verbal outburst and physical aggression. Based on the interviews conducted with staff and Resident A, it does not appear that Staff Jones followed Resident A's Positive Behavior Support plan guidelines. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/21/2022, I conducted an unannounced visit to the facility. I interviewed home manager Joey Hoffner in a conference room. He denied having knowledge of the allegations.

On 04/21/2022, I interviewed Resident A at the facility. He stated that he reported the incident to several people including Staff Hoffner.

On 04/21/2022, I sent an email to staff Joey Hoffner requesting an incident report for 04/03/2022. I also forwarded this same email to program director Bradley Jacobi.

On 04/22/2022, I made a follow-up call to Ms. Koss of APS. She stated that Staff Hoffner told her that he did recall an incident report about bruising only after she informed Staff Hoffner that she had photos of the bruise.

On 04/22/2022, I received emailed documentation including an Antecedent-Behavior-Intervention Chart for April 2022. An entry for 04/03/2022 at 9:45 pm states that Resident A was "*upset at staff for not checking his tokens quickly enough*" under *What seemed to cause the behavior?* section. "*Hitting staff, spitting at staff, fighting staff*" is noted under *Describe the Behavior*, and "*compliance trials body positioning*" is noted under the *Describe intervention* section. No injuries were noted.

On 05/12/2022, I made a call to staff Scott Jones. He stated that he thinks staff Tarayah Thornton reported the incident to Staff Hoffner. He stated that he did not write an incident report and does not know if anyone else did.

On 05/12/2022, I interviewed staff Tamela Carney. She stated that she is unsure who wrote the incident report, and that staff Taraya Thornton was the lead staff. She stated that it is her understanding that the lead staff persons write the incident reports.

On 05/23/2022, I spoke with recipient rights officer Elizabeth Simon via phone. Staff Joey Hoffner stated that no physical management occurred.

On 05/23/2022, I sent a follow-up email to Mr. Jacobi, requesting a copy of the incident report. I spoke with Mr. Jacobi via phone who informed me that there was no incident report written regarding the incident that took place between Resident A and Staff Jones on 04/03/2022.

On 05/31/2022, I interviewed staff Tarayah Thornton via phone. Staff Thornton stated that she reported the incident to home manager Joey Hoffner, and he said he would follow up. She stated that Staff Hoffner did pull Scott Jones into the office.

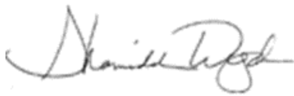
APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	During this investigation, I inquired about an incident report regarding the physical altercation that occurred between Staff Jones and Resident A on 04/03/2022. I was informed that there was no incident report on file. There is a preponderance of evidence to substantiate a rule

	violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/01/2022, I conducted an exit conference with licensee designee Nicholas Burnett. I informed him of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC medium group home license (capacity 12).



06/01/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:

06/01/2022

Mary E Holton Date
Area Manager