GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 1, 2022

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

RE: License #: AM250402509
Investigation #: 2022A0582048
Fenton 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.
- 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

I. IDENTIFYING INFORMATION

License #:	AM250402509
Investigation #:	2022A0582048
Complaint Receipt Date:	07/08/2022
Investigation Initiation Date:	07/13/2022
Report Due Date:	09/06/2022
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:	Fenton South
Facility Address:	Suite 2 17600 Silver Parkway Fenton, MI 48430
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/09/2021
License Status:	REGULAR
Effective Date:	09/09/2021
Expiration Date:	09/08/2023
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION

	Violation Established?
On 07/03/2022, Resident A swallowed two batteries, although she has a one-on-one staff due to putting dangerous things in her mouth and swallowing them. Resident A has swallowed many other items while having one-on-one staff.	Yes

III. METHODOLOGY

07/08/2022	Special Investigation Intake 2022A0582048
07/13/2022	Special Investigation Initiated - On Site Attempted interview with Resident A, Interview with Najsha Fox, Manager
08/23/2022	Contact - Telephone call received From DCW Amanda McGuire
08/24/2022	Inspection Completed On-site Attempted interview with Resident A
08/24/2022	Contact - Document Received Assessment Plan and Behavior Treatment Plan Progress Review
08/24/2022	Contact - Document Received Email from Daniel Spalthoff, Adult Protective Services
08/25/2022	Contact - Document Received Resident A's Behavior Treatment Plan
08/25/2022	Contact - Telephone call made With Guardian A
08/30/2022	Exit Conference With Nicholas Burnett, Licensee Designee
08/31/2022	Contact – Document Received Email from Patti Lee, Clinical Director, Flatrock Manor, Inc.

ALLEGATION:

On 07/03/2022, Resident A swallowed two batteries, although she has a one-on-one staff due to putting dangerous things in her mouth and swallowing them. Resident A has swallowed many other items while having one-on-one staff.

INVESTIGATION:

I received this complaint on 07/08/2022. On 07/11/2022, I reviewed the AFC Licensing Division-Incident/Accident Report related to the complaint, which documented the following:

> **Date of Incident**: 07/03/2022 **Time**: 10:45 PM
> **Explain What Happened**: Staff was talking to [Resident A] in her room when she claimed to have swallowed two triple A batteries. Staff followed swallow protocol and asked [Resident A] when [she] had swallowed and validated [her] feelings as well. [Resident A] claimed it had just occurred. Staff notified the medical coordinator and management. Medical Coordinator reached out to PCP. Staff were instructed to take [Resident A] to Hurley where she was given an X-ray and discharged with instructions to pass batteries.
> **Staff Action**: Swallow protocol, validated feelings, informed medical coordinator, and management.
> **Corrective Measures**: Staff will remind [Resident A] of their goals and will continue to monitor [Resident A] for their health and safety.

On 07/13/2022, I conducted an unannounced, onsite inspection at the facility. I attempted to interview Resident A, but she refused to speak with me.

I interviewed Home Manager Najsha Fox. Ms. Fox stated that it is possible that Resident A retrieved the batteries from a remote control in the common area. Ms. Fox stated that Resident A is not allowed to have anything in her room that she can swallow, and her room must be cleared before entering. Ms. Fox stated while in the common area, if another resident brings items there, staff cannot prevent other residents from having their own electronics by removing those items. Ms. Fox stated that 1:1 staff for Resident A should be arm's length from her. Ms. Fox stated that Resident A can be very "sneaky," and as soon as staff look away from her, she can grab something. Ms. Fox stated that Resident A was taken to the hospital and was instructed to pass the batteries. Ms. Fox stated that the doctor informed Resident A of the dangers of swallowing batteries. Ms. Fox stated that Resident A's goal is to go to the hospital. Ms. Fox stated that Direct Care Worker Amanda McGuire was the 1:1 staff member assigned to Resident A at the time of the incident.

On 08/23/2022, I interviewed DCW Amanda McGuire. Ms. McGuire stated that she was the 1:1 staff when Resident A informed her that she swallowed batteries. Ms. McGuire stated that Resident A did not tell her where she got the batteries. Ms.

McGuire stated that she they were going through their nightly routine, where Resident A goes out for a smoke, crafts/journals/watches television, takes a shower, then goes to bed. Ms. McGuire stated that she does not know where Resident A retrieved the batteries. Ms. McGuire stated that she turned her back for a quick second to grab Resident A's dirty clothes while they were both in the bathroom. Ms. McGuire stated that after the shower, Resident A told her that "you're going to be upset with me; I swallowed two batteries." Ms. McGuire stated that Resident A could have gotten the batteries in the common area, because she had nothing in her room that can be swallowed due to prior attempts at self-injurious behavior. Ms. McGuire stated that there are other residents who have items with batteries that they bring into the common area. Ms. McGuire stated that Resident A's room was cleared before they went in. Ms. McGuire stated that Resident A is very sneaky, and fast when trying to get an item to swallow. Ms. McGuire stated that there are times when she calls a "Code 1," meaning she needs to go to the bathroom, and she is relieved by another staff member. Ms. McGuire stated that she called a "Code 1" before Resident A's shower. Ms. McGuire stated that Resident A looks for opportunities to grab items to swallow. Ms. McGuire stated that she took Resident A to the hospital for the incident, where all the staff knew Resident A. Ms. McGuire stated that she asked Resident A why she swallowed the batteries, and Resident A stated that she wants to be hospitalized because she likes the way the mask feels when the doctor puts her under.

On 08/24/2022, I conducted an unannounced, onsite inspection at the facility. I attempted to interview Resident A, who refused to speak with me.

I reviewed Resident A's *Assessment Plan for AFC Residents*, which documented the following:

> **Moves Independently in Community:** [Resident A] has a history of seeking items in the community to engage in self-harm by inserting items into body (i.e., Ears, eyes) and/or by means of swallowing inedible objects.
>
> **Alert to Surroundings:** [Resident A] is alert to her surroundings, but during periods of emotional dysregulation, she may fail to recognize or ignore dangers and risks. Judgment and insight can become impaired. During periods of impaired judgment, [Resident A] may begin looking for ways to get her needs met inappropriately (i.e., Items to use for self-injurious behavior, create opportunity to elope, or become aggressive toward staff if unable). Communal areas will be searched/cleared to reduce access to risk items prior to [Resident A] accessing these locations in the home. Staff working with [Resident A] will provide room search/seizure at the end of first and second shift.
>
> **Controls Aggressive Behavior:** Since [Resident A's] stay at Flatrock Manor, she has engaged in breaking of writing utensils to engage in self injurious behavior (swallowing) which has resulted in medical intervention (i.e., scope surgery to remove pieces). Staff working with [Resident A] will work toward

identifying early signs/symptoms of agitation and encourage healthy coping strategies versus maladaptive behavior, when necessary. 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.

Exhibits Self Injurious Behavior: History of swallowing inedible objects, inserting objects into body such as eyes and ear canals, cutting self, biting self, and head banging. Since [Resident A's] stay at Flatrock, she has engaged in episodes of biting herself which has resulted in medical intervention (i.e., stitches being required), swallowing of inedible objects which has resulted in medical intervention (i.e., battery/pen removed during scope procedure and surgery was required on one instance to remove foreign object), and has engaged in head banging/hitting self during more significant episodes of self-harm. [Resident A] has attempted to grab rocks to swallow, however, she was unsuccessful due to staff blocking techniques. There have not been any known instances of inserting objects into eyes and/or ear canals. Due to the extent of her self-injurious behaviors, [Resident A] is on 1:1 supervision at all times. Staff working with [Resident A] will remain a working partner with [Resident A] and encourage her of appropriate and healthy coping strategies when experiencing feelings of sadness. Staff will monitor for health and safety and will provide verbal redirection and problem solving with [Resident A] when needed.

Smokes: [Resident A] has a history of swallowing cigarette butts and/or vaporizers. [Resident A] will not have access to vaporizers due to the danger of swallowing this item. If/when [Resident A] choses to consume nicotine by smoking cigarettes, she will be monitored closely by her 1:1 staff. [Resident A] will be reminded to safely dispose of the cigarette when she is done.

Toileting: [Resident A] is a 1:1 for supervision, therefore, she will be monitored while using the bathroom, as well, due to long history of engaging in self-injurious behaviors.

Bathing: [Resident A] is able to complete independently, however, bathing/hygiene items are restricted in [Resident A's] bedroom/bathroom due to past history of using hygiene items, particularly with caps, to self-harm. Hygiene products will be brought down by another staff person (not assigned to [Resident A]) when she wishes to shower. Her 1:1 staff will stay within arm's reach throughout shower/hygiene process and provide [Resident A] with soap, shampoo, conditioner, one at a time.

Grooming: Able to complete independently, however, due to extensive history of SIB, all hygiene items will be restricted and kept in secure area. [Resident A's] hygiene items (toothbrush) have been modified with OT material (thicker material to increase size of object and to reduce the risk of self-injury- swallowing). No

other access to hygiene items. Staff will squeeze toothpaste onto toothbrush. Hairbrush with larger handle.

Personal Hygiene: Due to history of SIB and inserting foreign objects into ears/eyes, and/or swallowing, [Resident A] will be monitored closely by her 1:1 staff when completing personal hygiene needs. Toothbrush is modified with OT material to reduce the risk of swallowing these personal hygiene items.

Other Difficulties: [Resident A] is prescribed glasses to correct vision, however, she has an extensive history of breaking glasses to self-harm (i.e., History of breaking glasses and swallowing arm of glasses). Case manager/guardian is aware of ongoing concern regarding bifocal glasses due to history of self-harm with personal glasses. At the time of this assessment, [Resident A] does not have glasses due to breaking them in effort to self-harm.

I reviewed Resident A's *Behavior Treatment Plan Progress Review*, which documented that "the majority of [Resident A's] behaviors were self-injurious behaviors. She was able to swallow a pen, a pen cap, and 2 batteries during this review period. With having her 1:1 present, staff were able to block the swallowing on 11 separate instances… [Resident A's] current restrictions include 1:1 supervision in home and community, restricted access to high-risk items, restricted to use of specific hair/make up supplies, modified eating and writing utensils, room clearings before entering, room search and seizure, restricted to pawn shops and internet, buying/selling/trading with peers, delayed egress on exit doors. All of these restrictions are still needed for [Resident A] due to her successful and attempts at swallowing inedible items."

Incidents documented in the Behavior Treatment Plan Progress Review include the following:

Incidents:
5/4/22: Staff noticed [Resident A] was coughing and [Resident A] said that she swallowed a pen. She was transported to a hospital to have it removed.
5/28/22: [Resident A] swallowed a pen cap and was taken to the hospital.
6/5/22: [Resident A] was taking a shower and started coughing and coughed up a bottle cap. [Resident A] continued to cough and spit up blood and staff took her to the hospital.
6/17/22: Staff noticed that had [Resident A] taken her pen out of her modification. Staff prompted to give the pen to them and [Resident A] refused. [Resident A] attempted to swallow the pen and staff utilized blocking techniques and the child control hold for 2 minutes. After the 2 minutes, [Resident A] released the pen.
6/17/22: Staff noticed that [Resident A] put a lighter in her pants. Staff asked [Resident A] to give them the lighter and [Resident A] became escalated and attempted to swallow the lighter. Staff had to utilize the child control hold for approximately 10 seconds and [Resident A] released the lighter.

6/26/22: [Resident A] hid a pen in her bed and took it apart and swallowed parts of it. [Resident A] was admitted to the hospital.
7/3/22: [Resident A] claimed to staff that she swallowed 2 batteries. [Resident A] was transported to the hospital.
7/13/22: X-rays came to the home to check on the status of the batteries and [Resident A] refused. After staff validated her feelings, she let the x-ray team take an x-ray of her and it showed that the batteries were not present anymore.
7/26/22: The x-ray team came to take an x-ray of [Resident A] and it was determined that there was no foreign body present.
7/27/22: Staff were asked to take [Resident A] to the hospital to perform a scope and she was admitted.

On 08/24/2022, I received an email from Daniel Spalthoff, Adult Protective Services. Mr. Spalthoff stated that he substantiated on the 1:1 when [Resident A] swallowed a battery because she was in her bedroom with just the 1:1 and [Resident A]. Mr. Spalthoff stated that the 1:1 admitted she took her eyes off [Resident A]. Mr. Spalthoff stated that when she swallowed a popsicle stick, he did not substantiate because it was in a crowded common room and multiple residents had popsicle sticks.

On 08/25/2022, I reviewed Resident A's Behavior Treatment Plan, dated 10/18/2021. The plan documented that Resident A is diagnosed with Schizoaffective Disorder Bipolar type, Posttraumatic Stress Disorder, Borderline Personality Disorder, and Mild Intellectual disability. The plan outlined the following strategies for Resident A's self-injurious behaviors:

In Home Supervision: [Resident A] will be provided with "line-of-sight" supervision of a one-to-one staff person at all times (that is whenever not on a leave of absence from Flatrock Manor such as a hospital admission or visits away from the group home approved by her guardian). Such supervision will be provided continuously on a 24 hour per day basis. "Line-of-sight" supervision means that at any time the staff person providing [Resident A] with supervision should remain in continuous visual contact with her. Additionally, staff must remain within four feet of [Resident A] at all times. Exceptions to the standard include when in appointments/ meetings to which staff are not invited (e.g., medical procedures/ appointments; speaking with Recipient Rights Officer; other important appointments in which [Resident A] and the person with whom she is meeting both agree that staff are not needed). Regardless, it is strongly encouraged that any such meetings do occur in area which has been previously cleared of all potentially dangerous objects that she might use for self-injury prior to the meeting. Resume "Line-of-Sight" supervision when [Resident A] exits the meeting.

Environmental Engineering and "Clearing" Rooms of potential risk items before Entering: Staff are to be aware of what [Resident A] has in her possession at any given time, which she may use to engage in self-injury. Self-

> injury may occur by cutting self, inserting objects into self, or by swallowing inedible items. Staff are to be aware of items in shared areas of the group home which may present increased risk for [Resident A]. This includes items listed above, as well as any item that is small enough to swallow or could be readily used for self-injury (e.g., loose screws). A staff person as assigned should walk through the shared areas of the group home at the beginning of each shift to review possible risk factors. This may also include staff prompting [Resident A] to perform a 'hand check' to prompt [Resident A] to show her hands, should she have her hands hidden under blankets, within her clothing, etc. This may become necessary due to [Resident A's] history of engaging in self-harm under blankets or under her clothing (i.e., Picking wounds, pulling out stitches, or attempting to swallow items underneath bedding, etc.). If she does not choose to show her hands, this cannot be forced.

On 08/25/2022, I interviewed Guardian A. Guardian A stated that Resident A has an extensive behavior plan and has a long history of swallowing items. Guardian A stated that Resident A is "very fast, extremely opportunistic, and extremely manipulative." Guardian A stated that Resident A "creates opportunities" to sneak items to swallow. Guardian A stated that if there is a fight or commotion with other residents, Resident A will get in the middle of it to distract staff. Guardian A stated that Resident A has created distractions between staff and other residents to get items to swallow. Guardian A stated that regardless of having a 1:1 staff at arm's length, Resident A continues to find a way to get items to swallow. Guardian A stated that all it takes is a second for Resident A to make a move to grab and swallow an item. Guardian A stated that Resident A can be "sweet," and manipulates new workers. Guardian A stated that Resident A can get items in the common area, because staff cannot remove items that other residents use. Guardian A stated that she regularly communicates with staff and management at the facility about Resident A's self-injurious behaviors, and she feels that they are doing the best they can. Guardian A stated that Resident A will break items to swallow pieces. Guardian A stated that HCBS rules limit the interventions staff can do if they suspect that Resident A has an item to swallow. Guardian A stated that there are no other placements that will accept Resident A due to these behaviors. Guardian A stated that no one will pay for Resident A to be in a "rubber room." Guardian A stated that Resident A swallowed a fish hook about four years prior, which put a hole in her esophagus, filled her lung cavity with air, and resulted in a collapsed lung. Guardian A stated that Resident A had to have a feeding tube because of this incident, and it almost killed her. Guardian A stated that Resident A knows that swallowing dangerous items will kill her at some point, but she does not care. Guardian A stated that hospital staff make the situation worse, and they make Resident A's hospital visits "a day at the spa." Guardian A stated that Resident A likes having an oxygen mask on her face. Guardian A stated that Resident A receives over the top attention at the hospital and has even has nurses give her money. Guardian A stated that Resident A has stated that she cannot wait to see "her friends" at the hospital, referring to social workers, nurses, and doctors. Guardian A stated that hospital staff reaffirm Resident A's "bad behavior" and need

to be more “medicinal” and “matter of fact” with Resident A. Guardian A stated that Resident A has told her that she will swallow items again and again to get to the hospital.

Guardian A further stated that she has routinely talked with hospital staff about Resident A every time she is hospitalized and has shared her behavior treatment plan, but hospital staff have called Adult Protective Services claiming that she does not care about Resident A. Guardian A stated that there is one doctor who reported her to APS and told her that he will no longer treat Resident A for these issues because she is going to die. Guardian A stated that Resident A has had over 100 esophagogastroduodenoscopies (EGDs), a procedure in which a flexible tube with a light and camera at the end is put down her throat to examine her stomach. Guardian A stated that Resident A has been “opened up” many times and has extensive scar tissue. Guardian A stated that Resident A has abdomen problems and hernia repair. Guardian A stated that Resident A will also lie about swallowing an item; an attempt to “cry wolf” and get to the hospital. Guardian A stated that if staff at the facility were to respond every time Resident A said she swallowed something, they would have to take her to the hospital every day. Guardian A stated that mobile x-rays are done to check out Resident A before sending her to the hospital. Guardian A stated that Resident A no longer has a gag reflex, and items are swallowed without a sound and down her throat before the item is seen. Guardian A stated that she and her staff regularly talk with Resident A throughout the week. Resident A stated that the staff at the facility care and try their best, but she does not know what more they can do to keep these incidents from occurring.

On 08/30/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. Mr. Burnett was not in agreement with a violation. Mr. Burnett feels that the swallowing by Resident A is a “targeted behavior” just as any other behavior that residents in his facility have, and discharging the resident is not the answer because there is no place for her to go to. Mr. Burnett feels that the focus for Resident A should be on the actions the staff are taking to provide care and supervision, because residents attention seeking behaviors such as Resident A will find a way to do the behavior. Mr. Burnett stated that they cannot feasibly eliminate everything Resident A tries to swallow, because they would then be infringing on the rights of other residents to have items.

On 08/31/2022, I received an email from Patti Lee, Clinical Director for the Licensee, Flatrock Manor, Inc. Ms. Lee stated the following:

> [Resident A] swallowed a AA battery and notified staff of the object she swallowed. As soon as staff were advised of the battery, they notified the medical coordinator for medical direction. The medical coordinator consulted with PCP which advised to send [Resident A] to the hospital for further medical attention. At the hospital it was confirmed that [Resident A] had swallowed a battery and was sent home with directions to monitor and let the battery pass through stool. Staff monitored each bowel movement for signs of a battery. A follow up mobile

x-ray was ordered to come to the care home to further confirm if the battery had passed.

[Resident A] has a typical behavior of swallowing objects within her reach including batteries. The batteries that [Resident A] has swallowed are exclusive to AA or AAA batteries. Each incident of swallowing batteries includes Flatrock consulting with PCP and sending to the hospital for further medical attention. Each hospital visits results in the medical professionals directing Flatrock to monitor [Resident A] stool, provide M.O.M. if needed and follow up to confirm passing. AA and AAA batteries have a significant different interaction within the body compared to button batteries. Button batteries have a thin outer coating which can dissolve at a faster pace, while AA and AAA batteries have a thicker protective coating which prevents materials in the battery to release in the body with proper medical attention.

According to WebMD: If it shows the battery is in the stomach, the person may not need medical treatment. The battery should pass through their stool. However, if they are back home and develops fever, abdominal pain, vomiting, or blood in the stools, go to the emergency room immediately. This explains the lower risk of ingested batteries but as precaution Flatrock will always seek out medical advice for proper direction.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	According to reports and interviews, Resident A has a well-known and extensive history of self-injurious behaviors, in which she attempts to swallow dangerous items. It is confirmed that on 07/03/2022, Resident A swallowed two batteries and was hospitalized, with discharge instructions to pass the batteries. Resident A's Behavior Treatment Plan documents that while in the home, Resident A will be provided with "line-of-sight" supervision of a one-to-one staff person at all times.

	Additionally, the plan documents that “staff are to be aware of what Resident A has in her possession at any given time, which she may use to engage in self-injury.” DCW Amanda McGuire, who was the 1:1 staff member during the incident, stated that she turned her back for a second to retrieve Resident A’s dirty clothes while they were both in the bathroom after Resident A’s shower. Daniel Spalthoff, Adult Protective Services worker, also confirmed through his interview with DCW McGuire that she admitted she took her eyes off Resident A. The corrective measure listed in the AFC Incident/Accident Report documents, that “staff will remind [Resident A] of [her] goals and will continue to monitor [Resident A] for [her] health and safety.” This corrective measure has not been successful. Interventions to prevent Resident from gaining access to items to swallow have been unsuccessful, as documented by prior incidents in Resident A’s Behavior Treatment Plan Review. The facility is unable to provide the supervision and protection needed to prevent self-injurious behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

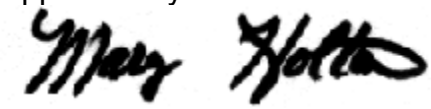
IV. RECOMMENDATION

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

09/01/2022

Derrick Britton Date
Licensing Consultant

Approved By:



09/01/2022

Mary E. Holton Date
Area Manager