GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2022

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

RE: License #: AS250411168
Investigation #: 2022A0580055
Richfield

Dear Mr. Burnett:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Sabrina McGowan

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250411168
Investigation #:	2022A0580055
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/20/2022
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:	Richfield
Facility Address:	6405 Richfield Road Flint, MI 48506
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	05/31/2022
License Status:	TEMPORARY
Effective Date:	05/31/2022
Expiration Date:	11/29/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff broke Resident A's phone.	No
Resident A is being hit by staff.	No
Resident A is not getting his medications.	No

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A0580055
09/21/2022	APS Referral This complaint was opened by APS for investigation.
09/21/2022	Special Investigation Initiated - Letter An email was sent to Ms. Monica Voltz, APS Investigator in Genesee County.
09/28/2022	Inspection Completed On-site An onsite inspection was conducted. Contact made with staff, Ms. Shatoia Golden.
09/28/2022	Contact - Face to Face An interview was conducted with Resident A.
10/10/2022	Contact - Document Received A faxed copy of documents requested was received.
10/17/2022	Contact - Telephone call made A call was made to direct staff, Mr. Jordan Shealy.
10/17/2022	Contact - Telephone call made A call was made to direct staff, Mr. Keonta Fuqua.
10/17/2022	Contact - Telephone call made A call was made to Ms. Madison Vorman, of Kent County CMH.
10/17/2022	Contact - Telephone call made A call was made to Ms. Shauwna DeRosia, Flatrock Program Manager.
10/17/2022	Contact - Document Sent A follow-up email was sent to Ms. Voltz of APS.

10/21/2022	Contact - Telephone call made A call was made to Ms. Patti Lee, Flatrock Clinical Director
10/21/2022	Contact - Telephone call made A call was made to Relative Guardian A.
10/21/2022	Exit Conference An exit conference was held with the license administrator, Ms. Morgan Yarkosky.

ALLEGATION:

Staff broke Resident A's phone.

INVESTIGATION:

On 09/21/2022, I received a complaint via BCAL Online complaints. This complaint was opened by APS for investigation.

On 09/21/2022, I reviewed Incident reports recently received regarding Resident A. An incident report dated 08/30/2022 at 6:30pm indicated that Resident A was upset about a personal outing where he did not have enough money to purchase what he wanted. Resident A threw his phone and returned to his bedroom. Staff heard alarms go off. Resident A had opened his window and broke the screen trying to get out. Staff utilized child control techniques for 3 minutes until Resident A was calm and came back into the home. Resident A indicated that he was sorry and would not do it again. Staff validated Resident A's feelings. Actions taken by staff include child control techniques and validation of feelings. Staff also contacted management staff. Preventative measures indicate that the facility will continue to monitor Resident A's health and safety while following his plan of service.

09/21/2022, I sent an email to Ms. Monica Voltz, assigned APS Investigator in Genesee County, sharing the information in the incident report information in which it was stated that Resident A threw his phone, causing it to break.

On 09/28/2022, I conducted an onsite inspection at Richfield. Contact was made with Ms. Shatoia Golden, Lead Staff. She had no knowledge of who broke Resident A's phone.

On 09/28/2022, I conducted an interview with Resident A while in his room. He indicated that staff, Mr. Kenote Fuqua broke his phone. He does not know how he did it. He denied throwing it himself. He has since gotten a new phone.

On 10/17/2022, I made a call to direct staff, Mr. Keonta Fuqua. He denied the allegations that he broke Resident A's phone. He recalled that Resident A got upset because he did not have any money to go to the store outing. He threw his phone and stormed to his room.

On 10/21/2022, I spoke with Relative Guardian A. She stated that Resident A initially had his phone, then all of a sudden, he did not. When asked what happened to the phone, all he would say is he does not have it. Resident A eventually informed a different family member that staff, Mr. Keonta Fuqua broke his phone and threw it in the trash. His phone has since been replaced.

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:	Based on my investigation, which included a review of the incident report dated 08/30/2022, interviews with direct staff, Mr. Keonta Fuqua and Ms. Shatoia Golden, Resident A, and Relative Guardians A, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that staff, Mr. Keonta Fuqua broke Resident A's phone.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is being hit by staff.

INVESTIGATION:

On 09/28/2022, while onsite, staff, Ms. Golden denied the allegations that Resident A is being hit by staff. She indicated that Resident A is physically aggressive and often attack staff. She shared that Resident A attacked staff, Mr. Jordan Shealy over pizza, and punched staff, Ms. Tanasha Glenn in the nose causing it to bleed. Ms. Glenn is also currently pregnant and has been placed on sick leave as a result. Resident A is diagnosed with epilepsy and has frequent seizures. As a result of his aggressive behavior towards staff at the hospitals, he has been banned from being seen at least 2 in the area.

During his interview on 09/28/2022, Resident A stated that Mr. Fuqua called him names, choked him, and forced him back into his room. No one else witnessed it. He does not feel safe at the facility.

On 10/17/2022, I spoke with staff, Mr. Jordan Shealy. He denied the allegations that staff hit Resident A. He indicated that Resident A is the one that gets physically abusive towards staff and other residents. He shared that when he first began working in August of this year, there was an incident in which Resident A had ordered pizza from his cell phone, however, he did not have enough money to pay for the pizza when it arrived at the home. As a result, Resident A got upset with him, caught him off guard and punched him in the eye. He denied ever witnessing staff, Mr. Keonta Fuqua hit Resident A. He shared that in his opinion, Mr. Fuqua takes a stern approach to Resident A's continued attempts at manipulation of the staff and other residents. Resident A is the higher functioning resident in the home.

On 10/17/2022, Mr. Keonta Fuqua denied the allegations that he hits Resident A. He shared that he has only physically managed Resident A in accordance with his plan. Resident A is very manipulative and physically abusive towards staff and other residents. He is higher functioning than the other residents in the home.

On 10/21/2022, I spoke with Relative Guardian A. She stated that Resident A identified staff, Mr. Keonta Fuqua is the person that is hitting him in the home. He has expressed that he is being physically attacked by this staff.

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 investigation, which included interviews with direct staff members, Resident A, and Relative Guardians A, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that Resident A was hit by staff, Mr. Keonta Fuqua.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not getting his medications.

INVESTIGATION:

On 09/28/2022, Ms. Shatoia Golden denied the allegations that Resident A is not receiving his medication. She shared that Resident A does not refuse his medications. They also check the residents to ensure they aren't cheeking the medication after it is given.

On 09/28/2022, I conducted an interview with Resident A while in his room. He denied that he has not been receiving his medication. He indicated that he receives all of his medication and takes it regularly.

On 10/10/2022, I received a faxed copy of the September 2022 medication log for Resident A. The medication log for September 2022 indicates that Resident A received his medication as prescribed, with the exception of the dates of 09/03/2022-09/13/2022 and 09/17/2022-09/22/2022, while Resident A was out of the facility.

On 10/17/2022, I made a call to Ms. Madison Vorman, of Kent County CMH. She indicated that she only served as the liaison for Resident A's placement at the facility and does not have any direct contact with Resident A. Case management services are contracted with Flatrock. Ms. Nicole Stark is his assigned case manager.

On 10/17/2022, I made a call to Ms. Shauwna DeRosia, Flatrock Program Manager. She shared that Ms. Nicole Stark was the assigned case manager for Resident A, however, she is no longer with the corporation.

On 10/17/2022, I sent an email to Ms. Voltz, informing her of the status of the investigation.

On 10/21/2022, I spoke with Ms. Patti Lee, Clinical Director. She shared that due to Ms. Stark unexpected departure, the role of case manager has to be filled. She is not aware of, nor has she spoken with Resident A regarding the allegations involving Resident A.

On 10/21/2022, I spoke with Relative Guardian A. She indicated that Resident A's seizure activity has increased. She shared that regardless of seizure activity, he has never had to be in the ICU as he been since being at the AFC home. She expressed that in the 3 years of dealing with Resident A being in placement, she has never had so many red flags that don't sit right with her about this facility. In addition, they lack communication as she can never reach his supports coordinator or anyone for that matter.

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:	Based on my investigation, which included a review of the medication log, interviews with direct staff, Resident A, and Relative Guardian A, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that Resident A is not receiving his medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/21/2022, an exit conference was held with the license administrator, Ms. Morgan Yarkosky, sharing the findings of this investigation

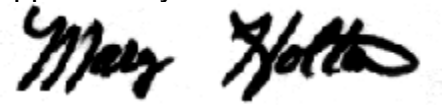
IV. RECOMMENDATION

No changes to the status of the license are recommended.

October 21, 2022

Sabrina McGowan Date
Licensing Consultant

Approved By:



October 21, 2022

Mary E. Holton Date
Area Manager