GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

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

RE: License #: AS630396128
Investigation #: 2023A0605002
Brandon West

Dear Mr. Burnett:

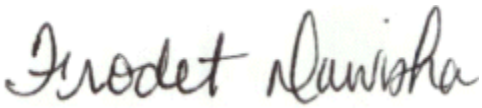
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630396128
Investigation #:	2023A0605002
Complaint Receipt Date:	10/10/2022
Investigation Initiation Date:	10/10/2022
Report Due Date:	12/09/2022
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator/Licensee Designee:	Nicholas Burnett
Name of Facility:	Brandon West
Facility Address:	300 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	08/02/2019
License Status:	REGULAR
Effective Date:	02/02/2022
Expiration Date:	02/01/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left unattended at his job site. No staff supervision.	Yes

III. METHODOLOGY

10/10/2022	Special Investigation Intake 2023A0605002
10/10/2022	Special Investigation Initiated - Telephone Left message for Oakland County Office of Recipient Rights (ORR) worker, Katie Garcia.
10/11/2022	Inspection Completed On-site I conducted an unannounced on-site investigation. Present were Residents A, B, C, D, E, F, the home manager (HM) Ashley Looney and direct care staff (DCS) Judea Boston.
10/11/2022	Contact – Document received Email from ORR Katie Garcia.
10/12/2022	Contact - Telephone call made Left message for DCS Jayla Edelen.
10/12/2022	Contact - Telephone call made Interviewed staff from New Horizons Rehabilitation.
10/13/2022	Contact - Telephone call received DCS Jayla Edelen left message.
10/31/2022	Contact - Telephone call made Left messages for DCS Jayla Edelen and the HM.
10/31/2022	Contact - Telephone call received Call from HM.
11/02/2022	Contact - Telephone call made Left message for DCS Jayla Edelen.
11/03/2022	Contact - Telephone call received Interviewed Jayla Edelen regarding the allegations.

11/15/2022	Exit Conference Left message for licensee Nicholas Burnett requesting a return call to discuss my findings.

ALLEGATION:

Resident A was left unattended at his job site. No staff supervision.

INVESTIGATION:

On 10/10/2022, intake #190846 was referred by Oakland County Office of Recipient Rights (ORR) regarding Resident A was dropped off at his workshop by direct care staff (DCS) Jayla Edelen without confirming if anyone was present at the workshop.

On 10/10/2022, I initiated the special investigation by leaving a voice mail message for ORR worker Katie Garcia.

On 10/11/2022, I received an email from ORR Katie Garcia with Resident A's individual plan of service (IPOS) and crisis plan completed by Macomb-Oakland Regional Center (MORC) effective on 10/01/2022 and the incident report (IR) submitted by New Horizons Rehabilitation.

On 10/11/2022, I reviewed Resident A's IPOS and crisis plan "Resident A should be in direct line-of-sight when in the community as Resident A lacks situational awareness and does not understand stranger-danger and does not observe social boundaries." I also reviewed the IR dated 09/29/2022 at 9:50AM that stated the staff walked into Kensington Church and observed Resident A sitting inside alone without home staff present.

On 10/11/2022, I conducted an unannounced on-site investigation. Present were Residents A, B, C, D, E, F, the home manager (HM) Ashley Looney and direct care staff (DCS) Judea Boston. I interviewed Resident A in his bedroom. Resident A stated he is dropped off to his workshop by staff and then stated, "They (staff) think they do not have to stay with me, so they just drop me off and at the door and leave. They (staff) are supposed to stay with me." Resident A was unable to provide any further information.

I interviewed Resident B outside on the porch. Resident B stated he has been living here for about one-year and seven-months. He stated he has community access but that "all the other residents must have someone with them when they are outside." He was unable to provide any information as to the allegations.

Residents C, E, and F were in their bedrooms and stated they did not want to talk to me. Resident D is non-verbal and was not interviewed regarding the allegations.

I interviewed the HM Ashley Looney regarding the allegations. Ms. Looney has been with this corporation for one-year. Ms. Looney stated whenever staff drop Resident A off

at workshop (Kensington Church) staff must confirm that Resident A's teachers, either Michelle or Courtney are present before leaving. Ms. Looney stated on 09/29/2022, DCS Jayla Edelen dropped Resident A off around 10AM at workshop (Kensington Church) located in Lapeer. Ms. Edelen told the HM, "I (Ms. Edelen) verified that Resident A went inside the building before I left." The HM believes that because Ms. Edelen saw vehicles in the parking lot and that the door was unlocked, there was someone inside the building. Ms. Looney stated that someone from New Horizons Rehabilitation contacted her advising her that when the teacher arrived at Kensington Church, Resident A was sitting inside without anyone present. Ms. Looney stated she contacted Ms. Edelen and informed her that Resident A was sitting inside the building without anyone present. Ms. Edelen told the HM again she (Ms. Edelen) thought someone was inside. Ms. Looney stated she coached Ms. Edelen on Resident A's IPOS/crisis plan, and that Ms. Edelen must confirm there is a teacher present before leaving the premises after dropping Resident A off. Ms. Looney stated this was an isolated incident. Ms. Looney stated she will fax me September staff schedule and the coaching form she completed with Ms. Edelen.

I interviewed DCS Judea Boston regarding the allegations. Mr. Boston has been with this corporation for two years. He too works the first shift from 7AM-3PM. Mr. Boston stated that the protocol for transporting Resident A to workshop is that staff must confirm there is a teacher either inside or outside the building. Mr. Boston stated whenever he transported Resident A to workshop (Kensington Church) Resident A's teacher is standing outside. He stated if the teacher is not outside, then Mr. Boston verifies that there is a teacher inside before he drops Resident A off and leaves. Mr. Boston stated he was not present on 09/29/2022, so he is unsure what happened; however, he heard that Resident A was able to enter the building; therefore, someone must have been inside to unlock the door for Resident A. Mr. Boston stated the workshop doors are always locked.

On 10/12/2022, I interviewed staff member Miranda Riley with New Horizons Rehabilitation via telephone. Ms. Riley stated on 09/296/2022 around 9:50AM, she pulled into the parking lot of Kensington Church and saw Brandon West's transport van pulling out of the lot. Ms. Riley stated she thought Resident A was in the transport van because the staff member did not see any teachers outside to drop Resident A off. Ms. Riley stated she then went inside Kensington Church and saw Resident A sitting inside by himself without anybody present. Ms. Riley stated the doors to Kensington Church are always unlocked and that this is not the first-time staff have dropped Resident A off and left without verifying if someone is present. Ms. Riley stated sometimes she is inside of the building and when she comes outside to get the consumers, Resident A is already dropped off and the transport van has pulled away. Ms. Riley stated other times the staff are observed to be on their cellphones instead of making sure Resident A has gone inside the building. Ms. Riley stated this was an isolated incident where Resident A was left alone inside the church.

On 10/31/2022, I received a fax from the HM with the staff schedule for September 2022 showing that DCS Jayla Edelen was working on 09/29/2022 first shift from 7AM-

3PM. I also received a copy of the Tracking and Performance Feedback for Jayla Edelen that was completed by the HM. The form indicates that coaching was provided to Ms. Edelen regarding Resident A's IPOS/Crisis plan and that when dropping any client off to workshop, staff must make sure the resident is handed off to someone before leaving.

On 11/03/2022, I interviewed DCS Jayla Edelen via telephone regarding the allegations. Ms. Edelen has been with this corporation for two years. She usually works the first shift. On 09/29/2022, she was responsible for transporting Resident A to his workshop. Ms. Edelen stated she arrived at the workshop (Kensington Church) around 9:30AM and observed several cars in the parking lot. She dropped Resident A at the door and left. Ms. Edelen stated since she has worked at Brandon West, she normally drops Resident A off and leaves and has never had to verify that Resident A's teacher was present. She stated, "I did exactly what I was supposed to do." Ms. Edelen stated, she received a call from the HM the next day stating that Resident A's teacher reported to the HM that Resident A was left alone inside Kensington Church as no one was there. Ms. Edelen stated since this incident, she now must confirm Resident A's teacher or at least someone is in the building before dropping Resident A at the door and leaving. Ms. Edelen stated this was an isolated incident.

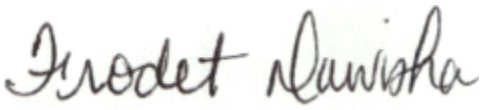
On 11/15/2022, I left a voice mail message for licensee designee Nicholas Burnett requesting a return call to conduct the exit conference with my findings.

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:	Based on my investigation and information gathered, DCS Jayla Edelen did provide supervision and protection on 09/29/2022 as specified in Resident A's IPOS/crisis plan completed by MORC on 10/01/2022. According to the IPOS/crisis plan, "Resident A should be in direct line-of-sight when in the community as Resident A lacks situational awareness and does not understand stranger-danger and does not observe social boundaries." Ms. Edelen dropped Resident A off at his workshop (Kensington Church) without verifying if there was a teacher or someone present. Resident A was observed sitting alone inside the church by a New Horizons staff without any home staff present.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 and information gathered, Resident A's protection and safety was not attended to at all times on 09/29/2022 when DCS Jayla Edelen dropped Resident A off at his workshop (Kensington Church) and left without verifying that there was someone inside the building. Resident A was observed by New Horizons staff to be sitting inside the building alone. Resident A requires supervision by staff when in the community given his lack of situational awareness according to his IPOS and crisis plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

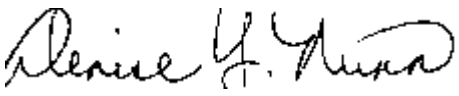
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



11/16/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:



11/17/2022

Denise Y. Nunn Date
Area Manager