GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2022

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

RE: License #: AL250388515
Investigation #: 2023A0569005
Burton East

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 (517) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL250388515 |
| | |
| **Investigation #:** | 2023A0569005 |
| | |
| **Complaint Receipt Date:** | 10/11/2022 |
| | |
| **Investigation Initiation Date:** | 10/11/2022 |
| | |
| **Report Due Date:** | 12/10/2022 |
| | |
| **Licensee Name:** | Flatrock Manor, Inc. |
| | |
| **Licensee Address:** | 7012 River Road<br>Flushing, MI 48433 |
| | |
| **Licensee Telephone #:** | (810) 964-1430 |
| | |
| **Administrator:** | Morgan Yarkosky |
| | |
| **Licensee Designee:** | Nicholas Burnett |
| | |
| **Name of Facility:** | Burton East |
| | |
| **Facility Address:** | 3490 Greenly St.<br>Burton, MI 48529 |
| | |
| **Facility Telephone #:** | (810) 877-6932 |
| | |
| **Original Issuance Date:** | 07/24/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 01/04/2021 |
| | |
| **Expiration Date:** | 01/03/2023 |
| | |
| **Capacity:** | 15 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| **Resident A was physically assaulted by other residents on 10/9/22.** | No |
| **Additional Findings** | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/11/2022 | Special Investigation Intake<br>2023A0569005 |
| 10/11/2022 | APS Referral<br>Complaint received from APS. |
| 10/11/2022 | Special Investigation Initiated - Letter<br>Email to Amanda Doyle, Burton City Attorney. |
| 10/26/2022 | Inspection Completed On-site |
| 10/26/2022 | Contact - Telephone call made<br>Attempted contact with Khyra Robinson, staff person. Voicemail full. |
| 12/05/2022 | Contact - Telephone call made<br>Attempted contact with Khyra Robinson, staff person. Voicemail full. |
| 12/05/2022 | Inspection Completed-BCAL Sub. Compliance |
| 12/05/2022 | Exit Conference<br>Exit conference with Nick Burnett, licensee designee. |
| 12/07/2022 | Contact -Telephone call made<br>Attempted contact with Khyra Robinson, staff person. Voicemail was full. Sent text message requesting a return phone call. |
| 12/07/2022 | Contact- Telephone call made<br>Contact with Autumn Wallace, staff person. |
| 12/07/2022 | Contact- Telephone call made<br>Contact with Stacey Florence, staff person. |

| | |
|---|---|
| 12/07/2022 | Contact- Telephone call made<br>Contact with KaDaiza Gadison, staff person. |

**ALLEGATION:**

**Resident A was physically assaulted by other residents on 10/9/22.**

**INVESTIGATION:**

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A was taken to the emergency room on 10/9/22. The complainant reported that Resident A had a bite mark on her arm. The complainant reported that Resident A had stated that she "was jumped" by several other residents while at the facility and that staff did nothing to protect her.

An incident report was submitted to the department on 10/11/22. The incident report (IR) was completed by Khyra Robinson, staff person, and dated 10/9/22. The IR documents that Resident A was in the dining room when she "suddenly" became upset due to a comment that Resident B had made about her. The IR documents that Resident A and Resident B became verbally aggressive with each other, and Ms. Robinson attempted to verbally redirect both residents to deescalate the situation. The IR documents that Resident A then started physically attacking Resident B so Ms. Robinson was using "body positioning" to separate the residents. The IR documents that Resident B then punched Resident A in Resident A's face. The IR documents that Ms. Robinson was then able to separate the residents and Resident A started calming down. The IR documents that Resident A then "suddenly" attacked Resident B again, so Ms. Robinson used body positioning and "blocking techniques" to separate the residents again. The IR documents that Resident A was deescalating again, then attacked Resident B for a third time. The IR documents that Resident B then called the police, and the police arrived at the facility. The IR documents that when the police arrived, Resident A expressed suicidal ideations, so she was transported to the emergency room for evaluation. The IR documents that Resident A did have "superficial scratches" to her face from this incident. The IR documents that the corrective measures were that Resident A received a psychological evaluation while at the emergency room, and that all recommendations will be followed to maintain Resident A's health and safety.

An unannounced inspection of this facility was conducted on 10/26/22. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed. Resident A was observed to have a healing bite mark on her arm, but no other injuries were observed. Resident A stated that the bite mark on her arm was self-inflicted. Resident A stated that she was in the dining room of this facility "minding my own business" when Resident B suddenly started hitting Resident A and kicking Resident A in her back. Resident A stated that she does not know why Resident B

attacked her. Resident A stated that she does not remember if she had any injuries. Resident A stated that she does not think staff did anything to intervene, but she didn't remember for sure. Resident A stated that she did not have any additional information to share regarding this incident.

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that it was Resident A who started the fight. Resident B stated that Resident A is "always running her mouth" and will hit, bite, and pull hair of other residents. Resident B stated that Resident A hit her "for no reason" while they were in the dining room, so Resident B "started fighting back". Resident B stated that she is tired of Resident A always staring fights and arguments, then blaming everyone else for the conflicts. Resident B stated that Ms. Robinson did intervene several times by verbally redirecting Resident A, blocking Resident A, and getting between Resident A and Resident B, Resident B stated that she does not know if Resident A was injured, but that she was taken to the hospital because she told the police that she wanted to kill herself after the police had arrived.

Autumn Wallace, Stacey Florence, and KaDaiza Gadison, all staff persons, were interviewed on 12/7/22. All of the staff interviewed confirmed that Ms. Robinson did intervene appropriately using verbal redirection, body positioning and blocking techniques to separate Resident A and Resident B on 10/9/22. All of the staff interviewed stated that Resident A frequently causes conflict with other residents, then will blame the other residents for the conflict. All of the staff interviewed denied that any staff person at this facility has ever refused to intervene when residents are having conflicts.

Resident A's care plan was reviewed. Resident A's care plan documents that she does not require 1:1 staffing ratio or any other increased level of supervision. Resident A's care plan also documents that Resident A has a history of physically attacking other residents and a reward system is currently in place to address Resident A's impulse control issues.

Multiple attempts have been made to interview Ms. Robinson. Ms. Robinson's voicemail has been full, and no message could be left for her to return the phone call. A text message was sent to Ms. Robinson's phone on 12/7/22 requesting a return phone call.

Clayton Burnett, facility manager, stated on 10/26/22 that Resident A frequently causes conflict with other resident at this facility, then blames the other residents for the conflict. Mr. Burnett stated that Resident A was taken to the emergency room on 10/9/22 for a psychological evaluation due to suicidal ideations. Mr. Burnett stated that Ms. Robinson did intervene appropriately to separate Resident A and Resident B on 10/9/22.

| APPLICABLE RULE | |
|---|---|
| **R 400.15305** | **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:** | Resident A reported that she was “jumped” by several other residents when being treated at the hospital on 10/26/22 9/22 and that staff did nothing to intervene. Resident A changed that account when interviewed on 10/26/22 and stated that she got into a physical altercation with Resident B only. Resident A did not give a detailed account of the incident when interviewed and stated that she “could not remember” specific details. Resident B stated that Resident A had physically attacked her, and she only “fought back”. Resident B stated that Ms. Robinson did intervene in several ways to try to separate the residents. The IR documents that Resident A physically attacked Resident B and that Ms. Robinson attempted to verbally redirect Resident A, then used “body positioning” and “blocking techniques” to separate the residents. Resident A’s plan of service documents that Resident A has a history of causing conflict with peers and has a current treatment goal to address this behavior. Based on the statements given, documentation reviewed, and observations made, it is determined that Ms. Robinson did appropriately intervene on 10/9/22 and there has been no violation of this rule. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Resident B was interviewed in her bedroom on 10/26/22. Resident B’s mattress and box spring were observed resting on the floor of her bedroom with no bedframe. Resident B stated that her bed frame broke “a while ago” when she and another resident “jumped on the bed” while watching a movie. Resident B stated that her bed frame had been broken for “about a month”.

Clayton Burnett stated on 10/26/22 that he was not aware that Resident B’s bed frame was missing from Resident B’s room. Mr. Burnett stated that he did not know how the bedframe was broken.

Nick Burnett, licensee designee, stated on 10/26/22 that Resident B has a history of breaking the furniture in her bedroom. Mr. Burnett stated that Resident B's bed frame would be replaced the same day. Mr. Burnett submitted photos of Resident B's bedframe on 10/26/22 to document that Resident B's bed was in her bedroom and in working order.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15410** | **Bedroom furnishings.** |
| | **(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.** |
| **ANALYSIS:** | Resident B's mattress and box spring were observed to be resting directly on the floor of her bedroom on 10/26/22. Resident B stated that she had broken her bed frame "a while ago" and estimated that it had been a month since she had a bed frame. Nick Burnett, licensee designee, submitted photos on 10/26/22 documenting that Resident B's bed frame has been replaced. Based on the observation made, it is determined that there was a violation of this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

An exit conference was conducted with Nick Burnett, licensee designee, and Morgan Yarkosky, administrator on 12/6/22. The findings in this report were reviewed.

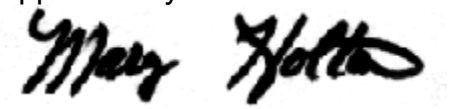
## IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

12/07/2022

Kent W Gieselman — Date
Licensing Consultant

Approved By:



12/07/2022

Mary E. Holton — Date
Area Manager