STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 1, 2023

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

RE: License #: AM250402509
Investigation #: 2023A0582020
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) 643-7960.

Sincerely,

Derrick L. Britton

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 #:	2023A0582020
Complaint Receipt Date:	12/06/2022
Investigation Initiation Date:	12/08/2022
Report Due Date:	02/04/2023
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. ALLEGATIONS

	Violation Established?
Resident A was inappropriately touched on her buttocks by Resident B, while Resident A was sleeping on the couch. Staff did not do enough to protect Resident A.	Yes
Resident A left the facility on her own free will with an unknown male friend after her guardianship expired on 12/08/2022. Resident A has schizoaffective disorder (bipolar type) and mild intellectual disability, and the facility did not provide her with her prescribed medication upon her leaving.	No

III. METHODOLOGY

12/06/2022	Special Investigation Intake 2023A0582020
12/06/2022	APS Referral Referred from APS
12/08/2022	Special Investigation Initiated - Telephone With Resident A
12/12/2022	Contact - Document Received Email from Morgan Yarkosky, Administrator
12/12/2022	Contact - Telephone call made With Julia Perry, Case Manager
12/15/2022	Inspection Completed On-site Interviews with Resident A and Resident B
01/03/2023	Contact - Telephone call made With Patti Lee, Flatrock Clinical Director
01/25/2023	Contact - Telephone call made With Tiffany Williams, Adult Protective Services
01/25/2023	Contact - Telephone call made With Direct Care Worker Mariah Mayes
01/25/2023	Contact - Telephone call made With Direct Care Worker Amanda Maguire

01/25/2023	Contact - Telephone call made With Direct Care Worker Tyler Hunter
01/25/2023	Contact - Telephone call made With Najsha Fox, Home Manager
01/27/2023	Contact - Telephone call made With Direct Care Worker Ananda Wakefield
01/29/2023	Contact - Document Received Case Report from Fenton Police Department
01/30/2023	Contact - Telephone call made With Guardian A
01/31/2023	Exit Conference With Nicholas Burnett, Licensee Designee
01/31/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was inappropriately touched on her buttocks by Resident B, while Resident A was sleeping on the couch. Staff did not do enough to protect Resident A.

INVESTIGATION:

I received this complaint on 12/06/2022. On 12/08/2022, I contacted Resident A. Resident A stated that on Thanksgiving Day at around 8:30 PM, she was in the living room area laying on the couch. Resident A stated that Resident B came from behind her unexpectedly, put his hand on her buttocks and slid his hand up her back inside of her shirt. Resident A stated that she was on her side and Resident B came over to her saying he wanted to have sex with her and touching her. Resident A stated that she was fully dressed at the time. Resident A stated that she told Resident B to stop and said she would hit him if he continued. Resident A stated that Direct Care Worker Tyler Hunter was in the area at the time but was on his phone and did not see the incident occur. Resident A stated that she told DCW Tyler Hunter what happened. Resident A stated that Resident B stopped touching her that day, and nothing else happened. Resident A stated that the next few days, Resident B continued to make sexual and threatening comments to her, saying that he wanted to “rape and kill” her. Resident A stated that she was getting fed up with Resident B’s threats and attempts to touch her, so she hit Resident B in his head. Resident A stated that she called the police to press charges against Resident B.

Resident A stated that the police came out and spoke with her and Resident B. Resident A stated that staff were aware that Resident B was threatening her but did not do anything about it.

On 12/15/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Resident A in person, to see if she had anything else to add from my interview. Resident A stated that she has a concern with Resident B being around her, but she has nowhere else to go. Resident A stated that Resident B has not touched her or said anything sexually inappropriate to her since she hit him, and the police came out. Resident A stated that she hopes the police can do something about Resident A's behavior.

On 12/15/2022, I interviewed Resident B, who admitted to touching Resident A's buttocks and asking her to have sex with him. Resident B stated that Resident A became upset with him because he touched her butt. Resident B stated that he touched Resident A's butt on purpose, and it was no accident. Resident B stated that Resident A tried to press charges against her. Resident B stated that the police came and talked with him as well as Adult Protective Services. Resident B stated that "I learned my lesson" and would not touch Resident A again.

I reviewed Resident B's *Assessment Plan*, which documented the following:

> [Resident B] is diagnosed with Autism Spectrum Disorder, Schizoaffective Disorder, Mild Intellectual Disability, Personality Disorder NOS.
>
> **Controls Sexual Behavior**: [Resident B] has a history of exposing genitalia towards others when overly excited or agitated. [Resident B] also has a history of inappropriately touch others, such as attempting to grab or touch staff/peer thigh area, genitalia, buttocks, or breast. All these stated behaviors have been observed since his stay at Flatrock Manor. Staff working with [Resident B] will encourage appropriate boundaries with others and will verbally redirect immediately should this behavior occur. [Resident B] has a history of inappropriately contacting 911 and requesting sexual acts from dispatcher. A positive behavior support plan is in place to assist [Resident B] in this area of challenges (restricted access to personal cell phone).

I reviewed Resident B's *Behavior Treatment Plan*, which documented the following:

> **Profile:** [Resident B] has a history of displaying inappropriate sexual behavior including exposing genitalia, attempting to touch others inappropriately (i.e., grabbing breasts, leg/thigh, and/or buttock). This may occur toward staff and/or peers depending on who is present when experiencing greater levels of anxiety/agitation.
>
> **Preventative Strategies.** Supervision/Restrictions: Because of the frequency and severity of [Resident B's] inappropriate sexual behavior, physical aggression,

property destruction and verbal aggression, the following restrictions are in place: community supervision, locked kitchen and laundry room, and restrictive access to cell phone.

Past interventions that have been tried and been unsuccessful have included positive reinforcement strategies for lack of challenging behavior, participation in constructive activity, structure daily routine, encouraging us of coping skills, collaborating problem solving strategies, medication to stabilize thought and mood, and less restrictive residential settings. These restrictions are safety/protection strategies to help keep him and others safe.

Reaction Strategies: Inappropriate Sexual Behavior (comments, actions) [Resident B] will occasionally make inappropriate comments or expose himself to others. It is important that staff firmly, but calmly interrupt the behavior and tell him that the behavior is inappropriate and then redirect his attention into another activity. If he is not responsive, then simply walk away from him, give him a couple of minutes, and then try redirecting again.

On 01/25/2023, I contacted Tiffany Williams, Adult Protective Services. Ms. Williams stated that she believed she would be substantiating neglect due to the facility not having a solid plan for protecting other residents from Resident B. Ms. Williams stated that she received an Incident Report from the facility, as well as a Case Report from the Fenton Police Department. Ms. Williams stated that during her interview, Resident A informed her that Resident B touched her butt and put his hand up her back. Ms. Williams stated that Resident A informed her that she told Direct Care Worker Tyler Hunter about Resident B touching her inappropriately, but nothing was done about it. Ms. Williams stated that she would forward the Incident Report and Fenton Police Case Report, which documents Resident B being sexually inappropriate with the officers who responded to the scene by removing his pants, exposing his genitalia, and exclaiming that he wanted to rape the officers.

I reviewed the *Incident Report* related to the police response on 11/26/2022, which documented the following:

Date of Incident: 11/26/2022
Time: 9:39 AM
Employees: Mariah Mayer, Amanda Maguire
Location: Dining Room
Explain What Happened: [Resident A] was escalated due to a peer being verbally inappropriate toward her. [Resident A] hit the peer. Staff verbally redirected and no marks were found on peer. [Resident A] left the common area and went to her room and contacted the police. The police arrived to the home and talked with [Resident A] and staff. [Resident A] informed police she would like to press charges on the peer and was given a case number for the incident and to give them a call if anything else happens. Staff assisted [Resident A] in validating her feelings and assisted in getting the peer involved in an activity to

separate the two from getter into another altercation. Staff informed management of the incident and the police arrive and will continue to monitor [Resident A] and validate her feelings throughout the day.
Staff Actions: Verbal redirection, talking with police, informing management
Corrective Action: Staff will work to notice [Resident A's] trigger before it escalates and help to de-escalate.

I reviewed the Fenton Police Department Case Report, which documented the following:

Report Date/Time: 11/26/2022, 9:27 AM
Subject: CSC 4th Degree-Forcible Contact
Occurrence Date/Time: 11/26, 9:27 AM
Narrative: On 11/26/2022 at approximately 0927 hours, Officers Bryant and Grace were dispatched to Flatrock Manor for a CSC (forcible contact) that occurred on a previous date. Dispatch notified officers that the caller and victim was [Resident A], and the suspect was [Resident B]. Dispatch also informed officers that there had been a possible assault between [Resident A] and [Resident B], both who are residents at Flatrock Manor.

Upon arrival, officer made contact with staff who permitted officers inside of the location. While inside the living room area, sexual remarks were instantly made towards officers by a male sitting on a chair. This male was later identified as [Resident B], who is the suspect of the CSC. [Resident A], who was the victim of the CSC, was in the same living room laying on the couch, approximately 8 feet from where [Resident B] was sitting. Staff members were also in the mentioned room with [Resident A], [Resident B], and additional residents. Contact was then made with [Resident A] who spoke with officers in her room. [Resident A] stated that on Thanksgiving Day she was laying on her side while on the couch in the previously mentioned living room. [Resident A] was approached by [Resident B] while she was on the couch and [Resident B] stated he wanted to have sex with her. [Resident B] then placed his hand on [Resident A's] clothed buttocks and then slid his hand up the inside of her shirt along her back. [Resident A] stopped [Resident B] from further touching and threatened [Resident B] with assault. [Resident A] stated no further sexual assault occurred and after that incident she notified staff. [Resident A] stated that the incident occurred between 2030 hours and 2100 hours. [Resident A] informed Officer Grace that the only staff in the room during the assault was Tyler. [Resident A] stated that Tyler was on the phone and did not witness the incident but addressed [Resident A] and [Resident B] when [Resident A] stated that she was going to assault [Resident B]. [Resident A] mentioned that since the incident, [Resident B] had been continuing to make sexual threats/remarks towards [Resident A] and has been spitting on her. [Resident A] stated that [Resident B] specifically stated to her that he was going to "rape and kill" her. [Resident A] also mentioned that today, the same statement was made to her by [Resident B]. In response to this statement,

> [Resident A] hit [Resident B] with an open hand in the back of his head. After the incident, [Resident A] contacted the police.
>
> Contact was made with [Resident B] after speaking with [Resident A]. Officer Grace asked [Resident B] if he touched [Resident A] and he stated he did. [Resident B] was asked if he touched [Resident A's] buttocks, [Resident B] confirmed that he did. [Resident B] was asked how he touched [Resident A], and [Resident B] motioned to the officers a grabbing motion with an open hand. Officers had a very difficult time speaking with [Resident B] due to his behavior during the interview. [Resident B] began to remove his pants to expose his genital region and had to be told several times to stop. [Resident B] later turned around and also attempted to expose his buttocks prior to being told to stop. In addition, [Resident B] stated that he wanted to rape Officer Bryant and Officer Grace while they were speaking with him.

On 01/25/2023, I interviewed Direct Care Worker Mariah Mayes. Ms. Mayes stated that she was working on 11/26/2022 when she heard Resident A yelling and telling Resident B to stop touching her and making inappropriate comments. Ms. Mayes stated that Resident B was laughing and stated that he touched Resident A's butt. Ms. Mayes stated that Resident A hit Resident B. Ms. Mayes stated that she was able to separate Resident A from Resident B and took her to her room. While in her room, Ms. Mayes stated that Resident A exclaimed that she was going to call the police on Resident B. Ms. Mayes stated that she told Resident A that it is her right to call the police. Ms. Mayes stated that Resident A told her that Resident B had touched her butt the day prior. Ms. Mayes stated that the manager Najsha Fox stated that something had occurred the day prior, but she was not sure what happened between Resident A and Resident B. Ms. Mayes stated that Resident B said he touched Resident A's butt the day prior. Ms. Mayes stated that the police arrived after Resident A called them and interviewed Resident B. Ms. Mayes stated that Resident B continued to be escalated even while the police were there, saying he was going to rape them and their kids. Ms. Mayes stated that Resident B has a history of inappropriate sexual language and attempting to inappropriately touch other residents. Ms. Mayes stated that staff typically try to redirect Resident B's behavior and remove him away from other residents.

On 01/25/2023, I interviewed Direct Care Worker Amanda Maguire. Ms. Maguire stated that she was not present during the incident in which the police were called to the home to address Resident B's behavior towards Resident A. I informed Ms. Maguire of statements that were attributed to her in the Fenton Police Case Report. Ms. Maguire denied giving statements to the police, although her name is listed in the report. Ms. Maguire stated that the police may have confused her with Direct Care Worker Ananda Wakefield. Ms. Maguire stated that Resident B does make inappropriate comments, but only when he is upset. Ms. Maguire stated that this behavior by Resident B does not happen too often while she is working.

On 01/25/2023, I interviewed Direct Care Worker Tyler Hunter. Mr. Hunter stated that he was working on Thanksgiving (11/24/2022) when Resident A accused Resident B of touching her buttocks inappropriately. Mr. Hunter stated that he did not witness the incident but addressed both residents being verbally aggressive with each other. Mr. Hunter stated that Resident B is known for making inappropriate remarks towards others. Mr. Hunter stated that he verbally redirected both Resident A and Resident B, then informed the lead worker (whose name he could not remember) that Resident A accused Resident B of touching her inappropriately. Mr. Hunter stated that he does not know what happened after he informed the lead worker and assumed that the lead worker handled the situation.

On 01/26/2023, I interviewed Najsha Fox, former Home Manager. Ms. Fox stated that she had no knowledge of the allegation. Ms. Fox stated that the allegation was never reported to her by staff. Ms. Fox stated that she resigned from the facility on 11/28/2023.

On 01/27/2023, I interviewed DCW Ananda Wakefield, who stated that she called off on 11/26/2023, and was not present when the police came to interview Resident A and Resident B. Ms. Wakefield stated that when she came back to work, Resident A informed her of what took place between her and Resident B touching her inappropriately. Ms. Wakefield stated that she asked Resident A if she told anyone what occurred, and Resident A stated that she told staff who was working. Ms. Wakefield stated that she assumed that the situation was handled, as the allegation was made days prior.

On 01/29/2023, I received a Fenton Police Department Case Report regarding the incident, which documented the following:

> …due to the degree of the allegations and [Resident B's] mental capacity, officers would not be arresting [Resident B]. [Resident B] is known to call the police department at times and make similar sexual threats. Officer Grace is requesting that this report be sent to the Prosecutors Office for possible warrant authorization for [Resident B].
>
> Detective Bemus review the LEIN information for the suspect in this case, [Resident B]. LEIN shows [Resident B] has two mental orders…both show he is legally incapacitated. His CCH shows he was convicted of two different counts of Assault and Battery in 2011...and a conviction for Assault and Battery in 2012. He was charged but the cases eventually were dismissed.
>
> On 01/10/2023, Detective Bemus received this case back from Genesee County Prosecutor's Office. The case was denied for prosecution because the suspect is mentally incapacitated. Further, the prosecutor stated it could not be proven intent of sexual gratification and the suspect stopped when the victim told him to.

On 01/31/2023, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. I informed Mr. Burnett of the findings from the investigation. Mr. Burnett stated that sexually inappropriate behaviors are “the baseline” for both Resident A and Resident B, and it is possible that they had sex in the past.

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 interviews with Resident A, Resident B, staff, APS, and a review of documents, there is evidence to confirm that Resident B touched Resident A inappropriately on her buttocks and slide his hand up her back. Resident B admitted to the allegation, which is also documented in the Fenton Police Department Case Report. Resident A stated that the contact was unexpected, unwanted and she informed staff. There was no indication that anything was done to correct the issue, as Resident B continued with inappropriate behavior towards Resident B, which resulted in Resident A hitting Resident B and contacting the police. The incident report submitted only addressed corrective actions to notice Resident A’s trigger before she escalates, with no corrective actions to address Resident B’s inappropriate behavior, which is well documented. Resident B’s Behavior Treatment Plan documents “Reaction Strategies” by staff for Resident B’s inappropriate sexual behavior (comments, actions), which include interrupting the behavior, telling him that it is inappropriate, and redirecting him to another activity. This is an inadequate intervention to address Resident A touching someone in a sexually inappropriate manner. Police only became involved after Resident A contacted them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A left the facility on her own free will with an unknown male friend after her guardianship expired on 12/08/2022. Resident A has schizoaffective disorder (bipolar type) and mild intellectual disability, and the facility did not provide her with her prescribed medication upon her leaving.

INVESTIGATION:

On 12/08/2022, I contacted Resident A. Resident A stated that staff informed her that she was her own guardian, and she had to sign a treatment plan. Resident A stated that she decided to leave the facility because she did not want to be there any longer. Resident A stated that she took some of her belongings when she left the facility. Resident A stated a friend came and picked her up, so she left with him on the same day.

On 12/12/2022, I emailed Morgan Yarkosky, Administrator. Ms. Yarkosky stated that Resident A was refusing to sign her behavior treatment plan and no longer wanted to live with Flatrock after becoming her own guardian. Ms. Yarkosky stated that they were going to give Resident A an appropriate discharge notice, but a friend picked [Resident A] up from the facility unannounced. Ms. Yarkosky stated that Resident A's previous guardian filed for guardianship within the 24 hours and became guardian once again. Ms. Yarkosky stated that Resident A called Flatrock the previous night (12/11/2022) and requested to come back. Ms. Yarkosky stated that Guardian A is once again the legal guardian and approved Resident A to return to the facility.

On 12/12/2022, I conducted an unannounced, onsite inspection at the facility. I observed Resident A, who appeared to be receiving proper care and supervision. Resident stated that when she left the facility

On 12/12/2022 I contacted Julia Perry, Case Manager. Ms. Perry stated that Resident A's guardianship, which was established in August 2021, was not renewed. Ms. Perry stated that Resident A was informed that she was no longer under guardianship, and neither she nor the facility staff could stop Resident A from leaving. Ms. Perry stated that Resident A left with a friend on 12/08/2022, who picked her up from the facility and help move her belongings. Ms. Perry stated that the facility did not provide Resident A with her medications, which she needed. Ms. Perry stated that she made an appointment with CMH in the county that Resident A moved to establish services for her. Ms. Perry stated that an emergency guardianship was filed and was granted. Ms. Perry stated that Resident A returned to the facility on Sunday, 12/11/2022.

On 12/16/2022, I reviewed the guardianship order for Resident A, which documented an order date of 07/30/2019 and expiring on 07/30/2024. Further, I reviewed a petition and order to change venue to Genesee County, dated 05/08/2020.

On 01/03/2023, I interviewed Patti Lee, Flatrock Clinical Director. Ms. Lee stated that she was involved in the guardianship confusion of Resident A. Ms. Lee stated that Flatrock has a guardianship order on file that expires in 2024. Ms. Lee stated that in September 2022, Flatrock's case manager informed her that Resident A's case was being moved to Genesee County. Ms. Lee stated that she received a call from

Recipient Rights asking if they were aware of what was occurring with Resident A's guardianship. Ms. Lee stated that she contacted Genesee County Clerk's office on 12/07/2022 and was Resident A's guardianship was expired. Ms. Lee stated that the county let something lapse, and Guardian A was petitioning to re-establish guardianship. Ms. Lee stated that on 12/07/2022, Flatrock staff informed Resident A that she was her own guardian. Ms. Lee stated that Resident A refused to sign a new behavior treatment plan and decided that she wanted to leave the facility immediately. Ms. Lee stated that Resident A left the facility on 12/08/2022. Ms. Lee stated that they did not let Resident A leave the facility with her prescribed medication. Ms. Lee stated that once she was settled, she would get the pharmacy script changed to a pharmacy closer to where Resident A was living. Ms. Lee stated that Resident A returned to the facility on 12/11/2022.

On 01/30/2023, I interviewed Guardian A, who stated that Resident A previously resident in Emmett County but wanted to move back to Flatrock. Guardian A stated that Emmett County wanted to change venues to Genesee County. Guardian A stated that there must have been some miscommunication between the two counties. Guardian A stated that she found out that Resident A's guardianship was expiring through her case manager. Guardian A stated that Genesee County had no record of her being guardian. Guardian A stated that she does not know how Resident A found out that her guardianship would expire, and she did not want her to know because of her history of poor decision making. Guardian A stated that once Resident A found out, she "took off" and "ran away" from the facility with a "friend" who was not appropriate. Guardian A stated typically a facility would have time to plan for a discharge, but did not for Resident A, who left with the friend immediately. Guardian A stated that she reapplied and received temporary guardianship a few days later. Guardian A stated that Resident A "got high and had sex" with the friend that she left with. Guardian A stated that Resident A called and wanted to return "home" to the facility, which she was allowed to be re-admitted.

On 01/31/2023, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. I informed Mr. Burnett of the findings from the investigation. Mr. Burnett stated that Resident A abruptly decided to leave the facility on 12/08/2022 and called a friend to pick her up. Mr. Burnett stated that Resident A did not take all of her belongings, but made it known that she did not want to stay at the facility any longer after becoming aware that her guardianship expired.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.

ANALYSIS:	Based on interviews with Flatrock staff, Resident A, Guardian A, and Ms. Perry, Resident A was notified that she was her own guardian on 12/08/2022. Resident A decided that she wanted to leave the facility of her own free will after calling a friend to pick her up. This did not provide the facility with time to properly discharge her, to include packaging her medications and giving her instructions on appropriate use.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Derrick L. Britton 02/01/2023

Derrick Britton Date
Licensing Consultant

Approved By:

Mary Holton 02/01/2023

Mary E. Holton Date
Area Manager