GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 26, 2023

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

RE: License #: AM250388519
Investigation #: 2023A0569045
Flint Township North

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.

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

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 #:	AM250388519
Investigation #:	2023A0569045
Complaint Receipt Date:	05/22/2023
Investigation Initiation Date:	05/22/2023
Report Due Date:	07/21/2023
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:	Flint Township North
Facility Address:	2360 Stonebridge Drive Flint, MI 48532
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	11/16/2017
License Status:	REGULAR
Effective Date:	12/22/2022
Expiration Date:	12/21/2024
Capacity:	12

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Resident A was physically mistreated by a staff person on 5/21/23.** • **Resident B was physically mistreated by a staff person on 5/30/23.**	Yes No
• **Resident C was not properly supervised per her care plan on 6/11/23.**	Yes

III. METHODOLOGY

05/22/2023	Special Investigation Intake 2023A0569045
05/22/2023	Special Investigation Initiated - Telephone Phone contact with Kim Nguyen-Forbes, RRO.
06/21/2023	Inspection Completed On-site
06/22/2023	Contact - Telephone call made. Contact with Kim Nguyen-Forbes, RRO.
06/22/2023	Contact - Telephone call made. Contact with JaQuay King, staff person.
06/22/2023	Contact - Telephone call made. Contact with Leslie Gray, staff person.
06/22/2023	Inspection Completed-BCAL Sub. Compliance
06/26/2023	Exit conference. Exit conference with nick Burnett, Licensee designee.
06/26/2023	Contact- Document sent. Email sent to Nick Burnett, licensee designee.

06/26/2023	APS referral Referral made to APS.

ALLEGATION:

- **Resident A was physically mistreated by a staff person on 5/21/23.**
- **Resident B was physically mistreated by a staff person on 5/30/23.**

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A was acting out in a physically aggressive manner on 5/21/23. The complainant reported that during the incident on 5/21/23, a staff person "stomped on [Resident A's] head and kicked her in the face". The complainant reported that on 5/22/23, JaQuay King, staff person, choked resident A. The complainant reported that the staff person also threw water on Resident A when she refused to take a shower.

A second complaint was received via the on-line complaint portal on 5/31/23. The complainant reported that Leslie Gray, staff person, threw a shoe at Resident B on 5/30/23. The complainant reported that the shoe hit Resident B in his head, leaving a red mark on Resident B's head.

Resident A is hearing impaired and requires an interpreter who is certified in American sign language to be interviewed. Resident A has a history of self- harm, specifically hitting her head against a wall or floor, then accusing staff of causing her injuries. Resident A has made several allegations of staff mistreating her in previous investigations.

Kim Nguyen- Forbes, recipient rights officer, stated on 6/22/23 that she is investigating this complaint. Ms. Nguyen-Forbes stated that she interviewed Resident A on 5/23/23 with the assistance of an interpreter who is certified in American sign language. Ms. Nguyen-Forbes stated that during the interview on 5/23/23 Resident A stated that she was trying to pull the fire alarm in the facility and that Resident A admitted that she was upset and "having a behavior". Ms. Nguyen-Forbes stated that Resident A stated that staff were trying to redirect her and that Resident A then threw herself to the floor and was lying on her back. Ms. Nguyen- Forbes stated that Resident A stated that Leslie Gray, staff person, then stomped on Resident A's head. Ms. Nguyen- Forbes stated that Resident A originally identified a different staff person, then changed the staff person to Ms. Gray. Ms. Nguyen- Forbes stated that she observed Resident A to have a knot on her forehead and left temple with some bruising around the knots. Ms. Nguyen- Forbes stated that she has investigated several previous allegations made by Resident A that staff physical mistreat Resident A, and that Resident A does have a history of hitting her own head on the floor or walls. Ms. Nguyen- Forbes stated that the behavior on 5/21/23

could be consistent with Resident A's head injuries. Ms. Nguyen- Forbes stated that Resident A was also observed with a bruise on her neck and bruising on her lip when interviewed on 5/23/23. Ms. Nguyen- Forbes stated that Resident A then reported that on 5/22/23 JaQuay King, staff person, threw water on Resident A when Resident A refused to take a shower. Ms. Nguyen- Forbes stated that Resident A stated that Mr. King also punched her in her mouth and choked her with his hand. Ms. Nguyen- Forbes stated that Resident A stated the incident occurred in the back hallway of the facility and that there were no other witnesses to this incident. Ms. Nguyen- Forbes submitted a photo taken of Resident A's neck on 5/23/23. The photo documents that Resident A has a bruise on her neck, consistent with the size of a thumb print. The photo documents that the bruise is on the right side of Resident A's neck in a position that would not be possible for Resident A to have done to herself. Ms. Nguyen- Forbes stated that she lightly ran her finger over the bruise on Resident A's neck on 5/23/23 and Resident A "winced in pain".

An unannounced inspection of this facility was conducted on 6/21/23. Resident A was observed during this inspection. Resident A was appropriately dressed and groomed. Resident A did not have any injuries on her head, face, or neck when observed on 6/21/23. Due to Resident A's hearing impairment, Resident A could not give a statement on 6/21/23. An incident report (IR) was completed on 5/22/23 by Heidi Creason, staff person. The IR documents that Ms. Creason observed a "quarter sized" Knot on Resident A's left temple. The IR documents that Ms. Creason asked Resident A how she obtained the injury, and Resident A responded that she had "banged her head" while "having a behavior" on 5/21/23.

Ms. Creason stated on 6/21/23 that she did observe the injury to Resident A's head on 5/22/23. Ms. Creason stated that she is able to communicate with Resident A using "simple sign language". Ms. Creason stated that Resident A reported that she had sustained the injury the prior day (5/21/23) by banging her head on the floor when she was "having a behavior". Ms. Creason stated that she did not work on 5/21/23 and did not observe the 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 he was not hit in the head with a shoe. Resident B stated that he was sitting in a chair, and Leslie (Gray), staff person, threw a basketball to him. Resident B stated that the basketball hit him in his head because he didn't catch the ball. Resident B stated that he was not injured from this incident. Resident B stated that he feels safe in Ms. Gray's presence. Resident B stated that Ms. Gray did not intentionally try to harm him by throwing the ball. Resident B stated that he likes Ms. Gray and all of the other staff at this facility. Resident B stated that he has not observed Ms. Gray physically mistreat any of the other residents. Resident B stated that he did not observe Mr. King physically mistreat Resident A.

JaQuay King, staff person, stated on 6/22/23 that he has never physically mistreated any of the residents in this facility. Mr. King denied that he punched or choked Resident

A. Mr. King stated that he has observed bruising on Resident A's arm in the past, but he does not know the cause of the bruising. Mr. King stated that Resident A "bangs ger head" at times when she becomes upset. Mr. King denied throwing water on Resident A. Mr. King stated that he has never observed any injuries on Resident A. Mr. King stated that he has never observed any of the other staff physically mistreating Resident A or any of the other residents. Mr. King stated that he has not observed Resident A with any knots or bruising on her head, face, or neck.

Leslie Gray, staff person, stated on 6/22/23 that she has never mistreated any of the residents in this facility. Ms. Gray stated that she has never observed Mr. King or any of the other staff physically mistreat any of the residents in this facility. Ms. Gray stated that she has never thrown anything at Resident B or any of the other residents. Ms. Gray stated that Resident A has a history of lying about staff mistreating her. Ms. Gray stated that she has observed Resident A with a black eye in the past but does not know how Resident A sustained the injury. Ms. Gray stated that she does not know anything about any injuries that Resident A has had.

Anthony Strong, staff person, stated on 6/21/23 that he was working on 5/22/23 with Mr. King. Mr. Strong stated that he observed Resident A trying to get into the staff office while Mr. King was trying to get the medication cart ready to administer Resident medications. Mr. Strong stated that Mr. King had placed several small cups of water on the cart to give the residents when administering the medications. Mr. Strong stated that Mr. King was trying to verbally redirect Resident A to keep her from entering the office area. Mr. Strong stated that Resident A then pushed her way into the office, knocking the cups of water off of the medication cart and onto herself. Mr. Strong stated that Mr. King did not throw the water on Resident A. Mr. Strong stated that he did not observe any other interactions between Resident A and Mr. King during the shift. Mr. Strong stated that he has not observed Mr. King or Ms. Gray mistreat any of the residents in this facility. Mr. Strong stated that he did observe the bruise on Resident A's neck. Mr. Strong stated that the bruise on Resident A's neck was "about the size of a thumb" and Mr. Strong stated that he does not believe that Resident A could have caused the bruise to herself, but Mr. Strong does not know how the bruise was caused.

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:	Resident A has stated to Ms. Nguyen-Forbes that Ms. Gray stomped on Resident A's head when Resident A was lying on her back on 5/21/23. Ms. Gray denied that she physically mistreated Resident A. Ms. Nguyen- Forbes stated that she interviewed and observed Resident A on 5/23/23 and that Resident A had a knot on her forehead and left temple with bruising around the knots. Ms. Nguyen- Forbes stated that Resident A admitted to throwing herself to the floor while having a behavior on 5/21/23 that could possibly account for the knots on Resident A's head. Resident A has a history of harming herself while acting out by banging her head against walls, floors, and other surfaces. Ms. Nguyen- Forbes stated that Resident A originally stated a different staff person stomped on her head, then changed the allegation to Ms. Gray. Ms. Creason stated that she observed the knot on Resident A's head on 5/22/23 and when she asked Resident A how she was injured, Resident A stated that she had banged her head on the floor on 5/21/23 when she was "having a behavior". Ms. Nguyen- Forbes also observed Resident A to have a bruised lip and a bruise on her neck on 5/23/23. Ms. Nguyen-Forbes stated that Resident A stated that Mr. King caused the injuries on 5/22/23 when he punched her and choked her after throwing water on her for not taking a shower. Mr. King denies that he punched or choked Resident A. A photo of Resident A's neck on 5/23/23 documents that Resident A did have a thumb print sized bruise on her neck in a position that Resident A could not have caused the injury to herself. Resident A stated on 5/23/23 that there were no other witnesses to Mr. King punching and choking her because it happened in a back hallway. Mr. King and Ms. Gray denied physically mistreating Resident A or any other residents. Mr. king and Ms. Gray stated that they have observed bruises on Resident A, but do not know what caused the bruising. Mr. King then stated that he has not observed Resident A with any bruises. Mr. Strong stated that he observed Resident A knock over a tray with water cups in the staff office on 5/21/23 spilling the water on Resident A. Mr. Strong stated that Mr. King did not throw the water on Resident A. Mr. Strong stated that he also observed the bruise on Resident A's neck and that it resembled a thumb print but that he did not observe how the bruise occurred. Based on the statement given by Resident A that Mr. King punched her and choked her on 5/22/23, and the injuries consistent with Resident A's statement observed by Ms.

	Nguyen- Forbes and documented in a photograph, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	A second complaint was received alleging that Ms. Gray threw a shoe at Resident B on 5/30/23 and hit Resident B in the head. Resident B denied that Ms. Gray threw a shoe at him but did throw a basketball to him while he was sitting in a chair. Resident B stated that the ball him in the head because he failed to catch it. Resident B stated that he does not believe that Ms. Gray was trying to intentionally harm him, and he was not injured from the incident. Resident B stated that he likes Ms. Gray and gets along with her and all of the staff. Resident B stated that he feels safe in this facility. Ms. Gray denied that she threw anything at Resident B and has never physically mistreated Resident B. There is not substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident C was not properly supervised per her care plan on 6/11/23.**

INVESTIGATION:

This allegation was received via the on-line complaint portal. The complainant reported that Resident C was able to take batteries from a television remote control on 6/11/23 and insert them into her vagina and rectum. The complainant reported that Resident C is on a 1:1 staffing ratio as documented in Resident C's assessment and behavior plan for a history of self-harm.

During the inspection completed on 6/21/23, Resident C was interviewed. Resident C was alert and oriented to person, place, and time. Resident C was appropriately dressed and groomed with no visible injuries. Resident C was observed being supervised by a 1:1 staffing ratio. Resident C was agitated during the interview and was upset that staff would not give her money to go on an outing. Resident A stated that Aryana Berry was her 1:1 staff person on 6/21/23. Resident C stated that Ms. Berry went to Resident C's room with her to watch her television, and that Ms. Berry grabbed the television remote from the staff office. Resident C stated that Ms. Berry gave Resident C the remote to use to choose the movie that Resident C wanted to watch. Resident C stated that Ms. Berry was with Resident C the whole time and that Resident C was never without 1:1 supervision. Resident C stated that she then held the remote under her covers and was able to remove the batteries and inserted them into her vagina and rectum. Resident C stated that the batteries eventually "fell out" and that she was not injured. Resident C stated that she did not require medical attention.

Resident C's file was reviewed. Resident C's written assessment is dated 1/19/23. Resident C's assessment documents that Resident C has been diagnosed with schizoaffective disorder and borderline personality disorder. The assessment documents that Resident C cannot move independently in the community without staff supervision to a history of unsafe behavior and attempted elopements as well as seeking unnecessary medical treatment. The assessment documents that "[Resident C] does have a history of self-injurious behavior of cutting self as parasuicidal. behavior, not suicidal attempts; as well as at times placing items in her rectum or vagina. Inserting items into rectum or vagina is the most frequently occurring self-injurious behavior exhibited by [Resident C] at this time. She will during periods of emotional dysregulation state that she has inserted items into rectum or vagina; but medical follow-up/tests often find absence of any foreign objects in rectum or vagina. [Resident C] self-injurious behaviors of inserting foreign objects into vagina and rectum have resulted in some permanent damage to her body. She has previously had a colostomy bag (which has since been reversed) which was placed due to removal of intestines. Her pattern of continued insertion of foreign objects into rectum and vagina place her at serious risk for the possibility that she will need a colostomy again in the future or that she will experience other serious medical complications. In the past, the consequences of [Resident C] self-injurious behaviors have included hospital admissions for surgical procedures to remove foreign objects inserted into body. Risk for serious injury and additional chronic medical problems (e.g., need for a colostomy) is significant during these times. [Resident C] has a history of inserting a soap piece, coaxial cable, and a piece of a soap dispenser. At the time of this

Assessment Plan update being written, the 1:1 staffing is required 24 hours per day; but this is subject to a reduction plan that is detailed in the behavior treatment plan. Note that the behavior treatment plan details how this reduction plan is to occur; and that behavior treatment plan should be followed. Because of [Resident C] history of self-harm, personal property is to be restricted as follows:

Restricted Items with No Access Whatsoever: CDs, DVDs, video tapes, all sharps such as knives, razors/disposable razors (not including battery or electric razors). scissors; hair clips; all glass objects; batteries/items requiring batteries; combs; items. small enough to be inserted into body cavities; and any long objects which may. be readily inserted into body. Items which are restricted as such will be stored in a designated locked area."

Resident C's individual plan of service (IPOS) is also dated 1/19/23. The IPOS documents Resident C's history of self-harm requiring a 1:1 staff ratio. The IPOS also documents that Resident C is restricted from "batteries/ items requiring batteries" with no access "whatsoever". Resident C's file did not contain an incident report for this incident.

Aryana Berry, staff person, stated on 6/21/23 that Resident C's 1:1 staff person needed a break during the first shift on 6/11/23. Ms. Berry stated that she gets along with Resident C well, so she decided to relieve the other staff person. Ms. Berry stated that Resident C asked if Ms. Berry would go to her room with her to watch a movie, so Ms. Berry grabbed a television remote from the staff office and went to Resident C's room with her. Ms. Berry stated that she maintained the 1:1 supervision at all times. Ms. Berry stated that when they got to Resident C's room, she gave the remote to Resident C to select a movie that Resident C wanted to watch. Ms. Berry stated that Resident C then had the remote under her blankets, and removed the batteries, inserting them into her vagina and rectum. Ms. Berry stated that she did not realize that Resident C had done this until Resident C informed Ms. Berry that she had done this. Ms. Berry stated that the batteries "fell out" after a few minutes, and Resident C was not injured.

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:	The complainant reported that Resident C inserted batteries from a television remote into her vagina and rectum on 6/11/23 in spite of being supervised on a 1:1 staffing ratio. Resident C admitted that she was able to get the batteries from the remote that Ms. Berry had given to her to use and inserted the batteries into her vagina and rectum. Ms. Berry admitted to giving the remote, with batteries inside, to Resident C on 6/11/23 while supervising Resident C on a 1:1 ratio. Resident C's assessment and IPOS both document that Resident A is prohibited from every being given and batteries or devices with batteries due to her history of using them to harm herself. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Nick Burnett, licensee designee, on 6/26/23. The findings in this report were reviewed.

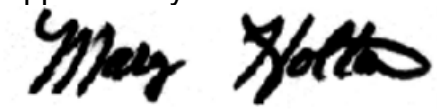
IV. RECOMMENDATION

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

6/26/23

Kent W Gieselman Date
Licensing Consultant

Approved By:



6/26/23

Mary E. Holton Date
Area Manager