GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 5, 2024

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

RE: License #: AM250388519
Investigation #: 2024A0569046
Flint Township North

Dear Nicholas 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 #:	AM250388519
Investigation #:	2024A0569046
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/30/2024
Report Due Date:	09/24/2024
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 eloped and the whereabouts of the resident was unknown on 7/17/2024.	Yes

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A0569046
07/30/2024	APS Referral Referral to APS.
07/30/2024	Special Investigation Initiated - Telephone Contact with Pat Shepard, RRO.
08/15/2024	Inspection Completed On-site
08/27/2024	Contact - Telephone call made Attempted contact with Jade Gaskins, staff person. Left voicemail requesting return phone call.
09/04/2024	Contact - Telephone call made Contact with Pat Shepard.
09/04/2024	Contact - Telephone call made Attempted contact with Jade Gaskins. Left voice mail.
09/04/2024	Contact - Telephone call made Contact with Lorresha Johnson, staff person.
09/05/2024	Inspection Completed-BCAL Sub. Compliance
09/05/2024	Exit Conference Exit conference with Nick Burnett, licensee designee.
09/05/2024	Corrective Action Plan Requested and Due on 09/20/2024

ALLEGATION:

Resident A eloped and the whereabouts of the resident was unknown on 7/17/2024.

INVESTIGATION:

This complaint was received via the on-line complaint portal The complainant reported that on 7/17/24, Resident A eloped from this facility and the staff were not aware that Resident A was missing. The complainant reported that Resident A was returned to the facility by police around 11:00pm.

Pat Shepard, recipient rights officer, stated on 9/4/24 that she investigated this complaint. Pat Shepard stated that she interviewed Resident A on 8/1/24 and that Resident A reported that sometimes the alarm on the east end door of the facility does not work. Pat Shepard stated that Resident A reported that he exited the door to go find returnable bottles and cans to take to the gas station nearby the facility. Pat Shepard stated that Resident A reported that police then found him at the gas station and returned him to the facility. Pat Shepard stated that Resident A's plan of service documents that staff are to conduct safety/bed checks every 15 minutes and Resident A's whereabouts are to be known by staff at all times. Pat Shepard stated that she interviewed Jade Gaskins, staff person, on 7/24/24. Pat Shepard stated that Jade Gaskins reported that she was the staff person responsible for Resident A's supervision during the second shift on 7/17/24. Pat Shepard stated that Jade Gaskins reported that her shift ended at 11:00pm, but she did not check on Resident A after 10:30pm and that she did not conduct a bed check at 10:45pm as required by Resident A's plan of service. Pat Shepard stated that Resident A's whereabouts were unknown between 10:30pm and 11:00pm when police returned Resident A to the facility. Pat Shepard stated that she has substantiate a violation of Resident A's resident rights.

An unannounced inspection of this facility was conducted on 8/15/24. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that after staff had checked on him around 10:30pm, he went out of the east end door to look for bottles and cans to take back to the gas station so he could get some snacks. Resident A stated that he had found some cans and went to the gas station. Resident A stated that police officers then came to the gas station and took him back to the facility. Resident A stated that he did not know exactly how long he was gone from the facility. Resident A stated that he was not injured during this incident.

Resident A's file was reviewed. Resident A's plan of service documents that, "On premises of Flatrock Manor, [Resident A's] whereabouts should be known at all times. Staff will conduct safety / bed checks at least every 15 minutes according to all instructions of Flatrock Manors Policies and Procedures". Resident A's file contains an incident report (IR) dated 7/17/24. The IR documents that staff conducted a 15-minute

bed check on Resident A at an unknown time and Resident A was observed to be missing. The IR documents that “staff completed a head count and perimeter check. Staff notified management and began a search outside’. The IR documents that Resident A was returned to the facility by police and staff increased supervision of Resident A for the remainder of the shift. The corrective measures for the IR document that staff completed a head count, perimeter check, notified management, and increased supervision”.

Attempts have been made to contact Jade Gaskins for a statement. The voice mail requests for a return call have not been successful. Jade Gaskins no longer works at this facility.

An exit conference was conducted with Nick Burnett, licensee designee, on 9/5/24. Nick Burnett stated that he is aware of this incident and that the staff did not supervise Resident A as required by Resident A’s plan of service. Nick Burnett stated that he would submit a corrective action plan to address this incident.

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:	Resident A eloped from this facility on 7/17/24. Jade Gaskins admitted to Pat Shepard, recipient rights officer, that she did not conduct a 15-minute bed check for Resident A at 10:45pm as required by Resident A’s plan of service. Resident A was found by police and returned to the facility around 11:00pm on 7/17/24. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

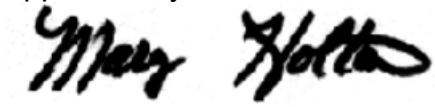
IV. RECOMMENDATION

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

9/5/24

Kent W Gieselman Date
Licensing Consultant

Approved By:



9/5/24

Mary E. Holton Date
Area Manager