GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 28, 2024

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

RE: License #: AL250388515
Investigation #: 2024A0623013
Burton East

Dear Nicholas Burnett:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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,

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250388515
Investigation #:	2024A0623013
Complaint Receipt Date:	09/18/2024
Investigation Initiation Date:	09/19/2024
Report Due Date:	11/17/2024
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:	Burton East
Facility Address:	3490 Greenly St. Burton, MI 48529
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	07/24/2018
License Status:	REGULAR
Effective Date:	01/04/2023
Expiration Date:	01/03/2025
Capacity:	15
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/13/2024, staff attempted to restrain Resident A, and staff ended up hitting Resident A on the head.	Yes

III. METHODOLOGY

09/18/2024	Special Investigation Intake 2024A0623013
09/19/2024	APS Referral
09/19/2024	Special Investigation Initiated - Telephone I contacted Flatrock Manager Nicholas Brazeal
09/25/2024	Contact - Document Received AFC Documentation
09/27/2024	Inspection Completed On-site Observation and interviews
10/17/2024	Contact - Telephone call made I contacted APS worker Samantha Belanger
10/17/2024	Contact - Telephone call made I contacted direct care worker Tazhia Prewitt
10/17/2024	Contact - Telephone call made I contacted direct care worker Kyah Grimsley
10/17/2024	Contact - Telephone call made I contacted direct care worker Amber Tiggs
10/17/2024	Contact - Telephone call made I contacted Guardian A
10/18/2024	Contact - Telephone call made I contacted Recipient Rights investigator Kevin Motyka
10/18/2024	Contact – Document Received Medical Documentation

10/25/2024	Inspection Completed-BCAL Sub. Compliance
10/25/2024	Exit Conference I contacted Licensee Nicholas Burnett
10/25/2024	Corrective Action Plan Requested and Due on 11/09/2024

ALLEGATION: On 9/13/2024, staff attempted to restrain Resident A, and staff ended up hitting Resident A on the head.

INVESTIGATION: On 9/19/2024, I contacted Flatrock manager Nicholas Brazeal who provided me with information regarding the incident and contact information.

On 9/25/2024, I received a copy of the incident report. The incident report indicated: On 9/13/2024, staff went into Resident A's room to administer 8 am medications and noticed that Resident A was agitated. Staff attempted to calm Resident A however, they were not successful. Resident A threw the medications, a cup of water and a remote at staff while yelling profanities and throwing punches in the air. Resident A then proceeded to punch and kick staff. Staff attempted an outside inside hold, however it was not successful and Resident A was hit on the head. Staff were able to verbally redirect Resident A to another activity. Staff contacted the medical coordinator about the refused medications and possible bruise on Resident A's head. The medical coordinator examined Resident A, and they were sent to the hospital for further evaluation. Staff continued to monitor Resident A for health and safety for the remainder of the shift. Resident A was treated for a possible head injury and released to follow up with primary care provider.

I also reviewed Resident A's plan regarding physical aggression and how to address them. Resident A's plan included the following:

- Staff will provide verbal prompts for Resident A to stop and to use calming activities.
- If Resident A continues to engage in physical aggression towards others, staff should use blocking techniques and redirect, when possible, while focusing on what you want them to do.
- If Resident A is too upset to talk, acknowledge and validate. Give Resident A space and time to calm down then offer again to problem solve.

On 9/27/2024, I conducted an unannounced onsite inspection of Burton East. I interviewed Resident A, Home Manager (HM) Leanda Ivy and the Medical Coordinator (MC) Tracy Delling.

I interviewed Resident A in their bedroom. Resident A appeared alert and oriented to person, place and time. Resident A appeared relaxed, neatly groomed and dressed for

the weather. Resident A appeared to lose focus and stated that “The FBI is watching my sister.” Also, “I bought this place.” Meaning the AFC home. Resident A made two statements about the incident with staff during morning medication pass, “I broke Tazhia’s glasses.” Also “Tazhia punched my head.” Resident A then pointed to the top of their head. Resident A stated they went to the hospital and then came back home. Resident A stated that they are not scared of staff and their head doesn’t hurt. I was unable to observe any bruising on or around Resident A’s head, face, or neck. Resident A was getting agitated, so I ended the interview.

On 9/27/2024, I interviewed both HM Ivy and MC Delling in their shared office in Burton East.

HM Ivy stated that they were informed of the incident right after it occurred. HM Ivy stated that she spoke with DCW Prewitt who confirmed that she hit Resident A after DCW Prewitt’s glasses were broken. HM Ivy stated that DCW Prewitt was sent home.

MC Delling stated that she examined Resident A and sent Resident A to McLaren for possible head injury. MC Delling stated that Resident A was examined and discharged home. MC Delling stated that Resident A was then seen for follow up via Tele-Health call with primary care provider.

On 10/17/2024, I contacted APS Samantha Belanger. APS Belanger stated that APS will be substantiating physical abuse by staff Tazhia Prewitt against Resident A. APS Belanger stated that DCW Prewitt admitted to hitting back at Resident A after the glasses were broken. APS Belanger stated that a complaint for physical abuse was referred to law enforcement.

On 10/17/2024, I contacted DCW Tazhia Prewitt. DCW Prewitt stated that she had started working at the facility in April or May. DCW Prewitt stated that she was working with another staff Kyah, who was training her on passing meds. DCW Prewitt stated that there were no problems passing meds to the other residents, however when they got to Resident A’s room, she appeared agitated. DCW Prewitt stated that Resident A was sitting in their chair, next to the window, with their bed between them and staff. DCW Prewitt stated that she walked to the foot of the bed, Resident A threw their water, pills and remote, then grabbed at her face knocking the glasses off her face. DCW Prewitt denied hitting Resident A and insisted that she just tried to put Resident A in a hold, along with assistance from DCW Kyah Grimsley. DCW Prewitt stated that she went to HM Ivy and told her what happened. DCW Prewitt stated she was sent home after that and has not been scheduled to work.

On 10/17/2024, I contacted DCW Kyah Grimsley. DCW Grimsley stated that she was passing morning meds with DCW Prewitt when they got to Resident A’s room, they could tell Resident A was agitated. DCW Prewitt stated that they both tried to calm Resident A, however it was not successful as Resident A threw their water, pills and remote at DCW Prewitt. DCW Grimsley stated that Resident A was punching the air and then grabbed at DCW Prewitt. DCW Grimsley stated that both her and DCW Prewitt

attempted to do an inside outside hold on Resident A, however it was unsuccessful. DCW Grimsley stated that Resident A snatched DCW Prewitt's glasses off her face and balled them up in their hand and threw them at the door. DCW Grimsley stated that after that there was an immediate altercation between Resident A and DCW Prewitt. DCW Grimsley stated that DCW Prewitt hit Resident A on the head. DCW Prewitt stated that DCW Amber Tiggs came over to assist, however the incident was over.

10/17/2024, I contacted DCW Amber Tiggs. I identified myself and the phone call disconnected. I attempted to call back and left a voice mail requesting contact.

10/17/2024, I contacted Resident A's guardian, Guardian A. Guardian A stated he was notified of the incident. Guardian A stated that he visits Resident A once a month. Guardian A reported that they are not concerned with the care Resident A receives at the home.

10/18/2024, I contacted the Bay Arenac County Recipient Rights and spoke with Recipient Rights (RR) investigator Kevin Motyka. RR Motyka stated that it was reported to him that DCW Prewitt hit Resident A in the face with a closed fist. RR Motyka stated that it appears the injury to Resident A was minor, however at this time he believes Abuse II will be substantiated due to staff hitting Resident A.

10/18/2024, I received medical documentation for Resident A.

- McLaren Flint Emergency Department,
  Discharge Instructions for Resident A.
  Reason for Visit: Assault
  Final Diagnosis: 1. Assault,
  2. Head Injury, closed, without LOC (loss of consciousness)
  Visit Date: 9/13/2024 11:48:21
  Follow-up Instructions: Treated today on an emergency basis; it may be wise to contact your primary care provider to notify them of your visit today. You may have been referred to your regular doctor or specialist, please follow up as instructed. If your condition worsens or you can't get in to see the doctor, contact the Emergency Department.

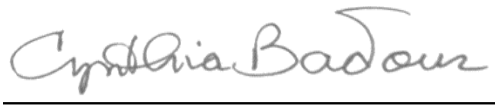
On 10/25/2024, I conducted an exit conference with Licensee Designee Nicholas Burnett. I discussed the results of my investigation and explained the rule violation I am substantiating. LD Burnett agreed to complete and submit a corrective action plan.

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:	On 9/13/2024, Resident A became agitated during morning medication pass and threw her pills, water and remote at staff. Staff attempted to calm and redirect Resident A, however that was not successful. Resident A then began to physically attack staff which they then attempted to complete a hold, however that was unsuccessful. Resident A grabbed DCW Prewitt's eyeglasses and threw them at the door. DCW Prewitt then hit Resident A on the head. DCW Prewitt was sent home after the incident and has not been scheduled to work during the investigation. Resident A was sent to the hospital, assessed and released back to the home. A follow-up with the primary care provider was conducted over a Tele-Health call. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

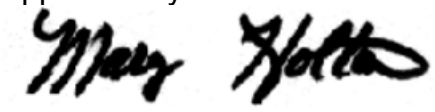
Contingent upon the receipt of an acceptable corrective action plan, no change in license status is recommended.



10/28/2024

Cynthia Badour — Date
Licensing Consultant

Approved By:



10/28/2024

Mary E. Holton — Date
Area Manager