GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 4, 2024

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

RE: License #: AS630391550
Investigation #: 2025A0612003
Brandon 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 (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadilac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630391550
Investigation #:	2025A0612003
Complaint Receipt Date:	10/08/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/07/2024
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Nicholas Burnett
Licensee Designee:	Nicholas Burnett
Name of Facility:	Brandon East
Facility Address:	301 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/24/2018
License Status:	REGULAR
Effective Date:	10/24/2024
Expiration Date:	10/23/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents are eloping and trespassing onto neighbor's property.	Yes
Strenuous situations are not deescalated and as a result neighbors get threatened and residents elope.	Yes
Resident A was observed having a purple bruised left eye and purple bruising to his left upper arm he reported it was caused by direct care staff Kiarah Keels.	No

III. METHODOLOGY

10/08/2024	Special Investigation Intake 2025A0612003
10/08/2024	Special Investigation Initiated - Letter I made a referral to Oakland Community Health Network - Office of Recipient Rights via email.
10/08/2024	Contact - Document Sent Email sent to Adult Protective Services (APS) worker, Taneisha Sims to coordinate. Additional intakes forwarded for review.
10/08/2024	Contact - Document Received Facility file reviewed: Resident A and Resident B's emergency discharge.
10/10/2024	Contact - Document Received Email received - three photos of Resident A's injuries.
11/06/2024	Contact - Document Received I received a copy of Monroe Community Mental Health - Office of Recipient Rights Report of Investigative Findings regarding Resident A.
11/07/2024	Contact – Telephone Call Made Telephone interview completed with direct care staff Kiarah Keels. Telephone call to direct care staff Kyla Cummings unable to leave voicemail.

11/08/2024	APS Referral Notification received on 10/08/24, that the allegation regarding Resident A is being investigated by APS. I forwarded the additional intakes to APS worker Taneisha Sims and on 11/08/24, I made an APS referral via electronic file for the additional allegations. APS denied the referrals for investigation.
11/13/2024	Inspection Completed On-site I conducted an unscheduled onsite investigation. I interviewed home manager, Tyler Hunter.
11/15/2024	Contact - Document Received Facility documentation received via email: incident reports, Resident B and Resident C's Individual Plan of Service.
11/18/2024	Contact - Telephone call made Telephone interviews completed with reporting source 1, reporting source 2, reporting source 3, and reporting source 5.
11/18/2024	Contact - Document Received Video evidence received via text message from reporting source 1 and reporting source 2.
11/18/2024	Contact - Document Received Newspaper articles received via text message from reporting source 2.
11/19/2024	Contact - Document Received Video evidence received via email from reporting source 3. Video evidence received via text message from reporting source 5.
11/21/2024	Contact - Document Received Facility documentation received via email: incident reports.
11/22/2024	Contact – Telephone Call Made Telephone call to direct care staff Kyla Cummings unable to leave voicemail. Followed up with a text message requesting a return call.
11/22/2024	Contact – Telephone Call Made Telephone call to administrator, Morgan Yarkosky. Left voicemail requesting a return call. No return call received.
11/25/2024	Exit Conference Telephone call to licensee designee Nicholas Burnett to conduct an exit conference.

11/26/2024	Contact - Document Received Telephone call from APS worker Taneisha Sims.
11/27/2024	Exit Conference Telephone call to licensee designee Nicholas Burnett to conduct an exit conference.

ALLEGATION:

Residents are eloping and trespassing onto neighbor's property.

INVESTIGATION:

On 10/08/24, I received five intakes from three different reporting sources regarding Resident A, Resident B, and Resident C. On 10/29/24, I received a sixth intake from a fourth reporting source regarding Resident C. On 11/14/24, I received a seventh intake from a fifth reporting source regarding Resident C. All the intakes will be addressed in this report.

On 10/08/24, I initiated my investigation by making a referral to Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR) via email. On 10/10/24, OCHN – ORR indicated that they do not have jurisdiction over the residents involved in these allegations. OCHN – ORR further indicated that the allegations involving Resident A will be investigated by Monroe Community Mental Health - Office of Recipient Rights. OCHN – ORR emailed me three photos of Resident A's injuries. On 10/08/24, I received written notification that the allegation regarding Resident A is also being investigated by Adult Protective Services (APS). The assigned APS worker is Taneisha Sims. On 10/08/24, I emailed APS worker Taneisha Sims to coordinate, I forwarded the additional intakes to Ms. Sims for review and follow up as needed. On 11/08/24, Ms. Sims stated an APS referral to centralized intake was needed for the additional allegations. I made a referral to APS via electronic file on 11/09/24. On 11/21/24, I received written notification from APS that indicated the allegations were not assigned for investigation.

I reviewed this facilities file; Resident A was issued an emergency discharge from this facility on 02/16/24. The discharge was issued due to the facility being unable to meet Resident A's medical needs. Resident B was issued an emergency discharge on 09/06/24, due to physically assaulting and threating peers and neighbors.

In summary, Reporting Source 1 (RS1) indicated the following in their written complaint:

On Sunday, 08/04/24, at 8:46 am, Resident A entered our property via our driveway from our private road (Saddle Lane). He then came onto our front porch and banged heavily on our front door while also violently trying to open our front door (locked) in an aggressive manner, frightening my wife and I as we sat on our back deck. The banging was loud, disturbing, and frightening. We ran to the front door and saw a large man,

breathing heavily, sitting on a rocker on our front porch while two caregivers were trying to get him off our front porch. Our home camera recorded the entire ordeal. We immediately called 911, fearing for our lives. We both feel that Resident A should not have been allowed to “escape” the group home so easily and approach our home in such a threatening manner without his caregivers (it took them some time to catch up with him). He is clearly not properly supervised. We felt threatened by his aggressive presence on our property, and we have been living in fear since then.

Note: RS1 provided video evidence of this incident. Licensing consultant reviewed. In summary, Resident A can be seen coming onto RS1’s front porch banging heavily on the front door while trying to open the door. Initially, there are no staff present in the video. Resident A sits down in a chair and two staff later arrive and escort him off the porch.

In summary, Reporting Source 3 (RS3) indicated the following in their written complaint:

On 7/31/23, Resident C trespassed into my yard, running from the caregiver. First, he sat down on my patio furniture and then ran up the stairs breaking into our home. He was unproperly supervised and was finally removed after at least 10 minutes when four to five other caregivers showed up. This incident was very upsetting to my wife and I as we were simply trying to experience some quiet enjoyment on our patio.

Note: RS3 provided video evidence of this incident and several others. Licensing consultant reviewed.

Video 1: 08/01/24 Resident C is observed sitting on RS3’s patio furniture. Six staff are present to assist Resident C off the property.
Video 2: 08/28/24 Resident C entered RS3’s backyard and sat down on the patio furniture. A staff followed him onto the property. Four additional staff arrive to assist with removing Resident C.
Video 3: 07/30/23, Resident C ran into RS3’s backyard and was approaching the door to their home. A staff followed him and escorted him off the property.
Video 4: 07/30/23, Resident C ran inside of RS3’s house. Five staff assisted in removing Resident C from RS3’s living room. Resident C was inside of RS3’s living room for over 10 minutes.
Video 5: 07/31/23, Resident C is observed sitting on RS3’s patio furniture. Six staff are present and assist Resident C off the property.

In summary, Reporting Source 5 (RS5), indicated the following in their written complaint:

Resident C attempted to enter my home through the front door. A female caregiver ran up on my porch to get him. It took some time to get him to leave. I had just turned the shower off when I heard all this banging, pounding and yelling. I was scared out of my witts. It sounded like someone was going to come through my window. The reporting source further indicated that the staff often taunt, tease, use explicit language, ridicule, and egg the residents on until they explode. The staff think this is funny and laugh.

Note: RS5 provided video evidence of this incident and others. Licensing consultant reviewed.

Video 1: On 03/08/24, Resident C is seen running onto RS5's front porch. A female staff follows him, and a male staff arrives to assist with removing Resident C.
Video 2: On 10/23/24, Resident C is seen walking into RS5's front yard then going around the side of the house to the backyard. Resident C jumps over the locked patio gate and tries to open their sliding glass door. There is no visible staff in the video.

On 11/13/24, I completed an unscheduled onsite investigation I interviewed home manager, Tyler Hunter. Resident A was not home during the time of this onsite investigation. While onsite I obtained a copy of Resident A's Behavioral Treatment Plan.

On 11/13/24, I interviewed home manager, Tyler Hunter. Mr. Hunter stated Resident B and Resident C both moved out of this facility in September 2024. They are both living in different facilities in Genesee County. Resident A was also issued an emergency discharge however, alternative placement has not been found. Mr. Hunter stated he started in his role as the home manager in July 2024, however when he first started, he was often training at multiple homes and therefore, he was not present for many of the alleged incidents and has limited knowledge about what occurred. Mr. Hunter stated Resident B and Resident C eloped often. The staff followed their behavior plans when they eloped however, Resident C was difficult to redirect and physically manage due to his size.

On 11/18/24, I interviewed RS1 via telephone. RS1 confirmed the details reported in her written complaint. RS1 further explained that on 08/04/24, Resident A came to her front porch and banged heavily on the front door while trying to open the door. The door was locked however, usually it is unlocked. Resident A sat down in a chair and refused to get up. Staff eventually arrived and removed Resident A however, it took them some time to catch up with him. RS1 stated she contacted the police and made a police report regarding this incident. RS1 further stated she was informed by her neighbors that just two days prior to this incident they observed Resident A punching her car. RS1 stated that she has observed several incidents involving residents from the group home including, but not limited to, a resident flicking a lighter in the pasture while it was dry outside. Due to the concern that this may cause a fire RS1 contacted the police.

On 11/18/24, I interviewed RS3 via telephone. RS3 confirmed the details reported in his written complaint. RS3 stated on 07/31/23, Resident C trespassed into his yard. Initially, he sat down on his patio furniture and then he ran up the stairs breaking into his home. Resident C was removed after at least 10 minutes when four to five other caregivers showed up. A police report was made. RS3 stated there have been several occasions where residents run into his yard. RS3 remarked, the pattern is similar people show up uninvited. RS3 stated he has also witnessed residents eloping down the main road and staff racing after them in the van. RS3 stated it appears that the staff do not have a lot of control over the residents and because of this he does not feel safe. RS3 stated that he is surprised that the State of Michigan would allow so many group homes in a small

rural area and remarked that the homeowners in this area pay high taxes. RS3 stated the facility has a dumpster that is in view and unsightly. RS3 suggested that there should be rules to prohibit this as to not decrease the property value in the area.

On 11/18/24, I interviewed RS5 via telephone. RS5 confirmed the details reported in her written complaint. RS3 stated this is the second time Resident C has attempted to enter her home through the front door. A female caregiver ran up on the porch to get him. It took some time to get him to leave. RS5 stated residents eloping from this facility occurs often. It is very scary and frightening. Then, staff trespass onto her property to get the resident back. RS5 stated the residents are not being properly supervised which is a safety concern for herself and the residents. The staff taunt and tease residents then they explode. RS5 stated she has obtained records that indicate there have been over 110 police calls to this facility. RS5 stated Resident A has been a bad problem he has extremely foul language. He uses the “N word” which then provokes staff. Also, on 09/05/24, Resident B was outside swearing and arguing with staff. Resident B was yelling at RS5’s neighbor and her husband saying, “I am going to kill you.” RS5 stated the staff egged him on saying go ahead and do it, you will go back to jail. RS5 stated her neighbor recorded the incident and the police were contacted. RS5 made additional complaints which included an incident on 09/08/24, when Resident B was running around outside half-dressed, and the police were called. Also, on 08/04/24, Resident A attempted to break into her home, the police were called, and Resident A was arrested. RS5 stated the employees play basketball outside and therefore are not supervising the residents they also take breaks in their cars which is disturbing to the neighbors as they have their headlights and music on at all hours.

I reviewed Resident A’s Behavioral Treatment Plan. In summary, the plan indicates, Resident A has poor impulse control, self-harms, displays physical aggression, verbal aggression, and property destruction. Resident A requires supervision in the community, delayed egress exit doors, and as needed medication due to the strong potential for harm to himself and others. Resident A will receive field of vision supervision in the community meaning that any time the staff person providing Resident A with supervision in the community should be able to immediately, as needed, make visual contact, speak with him, and provide assistance.

I reviewed Resident B’s Individual Plan of Service. In summary, the plan indicates because of the frequency and severity of Resident B’s physical aggression, verbal aggression, property destruction, and eloping, the following restrictions are in place: supervision in the community and delayed egress exit doors. Because of the strong potential for harm to himself and others, these restrictions are needed to maximize safety. Resident B has a history of eloping from the supervision of staff as such, he will receive field of vision supervision, meaning that any time the staff person providing Resident B with supervision in the community should be able to immediately, as needed, make visual contact, speak with him, and provide assistance.

I reviewed Resident C’s Individual Plan of Service. In summary, the plan indicates he is an elopement risk and vulnerable due to his frequency and severity of physical

aggression, property destruction and self-injurious behavior. Resident C has a 1:1 caregiver who will accompany him during community activities. Resident C is at risk of elopement every time he walks out the door. Resident C needs staff to be within arms' reach when he goes out. Staff need to ensure they have eyes on him at all times. He is obsessed with police and will do anything to get them called on him. Staff should be cautious of where they take Resident C especially if they are alone. Resident C should be engaged by his caregiver constantly throughout the activity to avoid any risk of elopement or safety risks. They will praise him for remaining with staff/the group and tell him they are proud of him and that he is safe with them.

I reviewed the following relevant Incident Reports (IR)

- IR dated 08/04/24 – Resident A, involved staff Kyla Cummings and Joplin Brady. In summary the IR states, Resident A held the door handle down and exited the facility. Staff used body positioning to try and redirect, but he pushed through and pulled the staff's hair. Resident A walked up to the neighbor's house. Staff attempted to verbally redirect and validate his feelings. The neighbor's called the police. When the police arrived, Resident A punched the officer. Resident A was arrested and taken to Oakland County Jail.
- IR dated 08/01/24 – Resident C, involved staff Mya Harris and Taaliyah Welch. In summary, the IR states, Resident C ran towards the front door. Staff used blocking techniques, but Resident C pushed through staff and ran out of front door and into the neighbor's backyard.

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:	Based on the information gathered through my investigation there is sufficient information to conclude residents are eloping and trespassing onto neighbor's property. Resident A's and Resident C's Individual Plans of Service indicate that they are an elopement risk and vulnerable due to their frequency and severity of physical aggression, property destruction, and self-injurious behavior. Seven videos showed Resident C eloping into neighbors' yards, climbing over locked fences, attempting to open the doors to their homes, and on one occasion successfully entering the neighbor's home. In the video from RS5 dated 10/23/24, there is no staff present while Resident C is seen walking into RS5's front yard, going around the side of the house to the backyard, jumping over the locked patio gate and trying to open their

	sliding glass door. Additionally, there is video evidence of Resident A eloping onto a neighbor's front porch and attempting to open their front door. Initially, there are no staff present in the video. Two staff later arrive and escort him off the porch. Although there is proactive measures in place to prevent elopements, Incident Reports reflect that the residents are holding down the delayed egress doors and pushing past staff to exit the home. Staff are attempting to redirect the residents during elopements however these attempts are unsuccessful. It is important to note that due to these ongoing behaviors, Resident C was discharged from this home in September 2024. Resident A was also issued an emergency discharge in February 2024. However, an alternative placement has not been found. Repeat elopements place the residents, community members and staff at risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Strenuous situations are not deescalated and as a result neighbors get threatened and residents elope.

INVESTIGATION:

In summary, Reporting Source 2 (RS2) indicated the following in their written complaint(s):

On 09/05/24, a very intense and violent altercation between two group home residents took place in the front yard of the home. My neighbor and myself were standing in the street in front of our own homes recording the incident. One of the residents noticed us recording and started walking aggressively in our direction screaming profanities and threatening us ("beat us up" and "we would be sorry for calling the cops"). All caught on tape. The inadequately trained staff were unable to de-escalate the situation and did not even bother trying to stop Resident B from approaching us, in fact encouraging him to "go beat em up! So, they can send your a** back to jail". The staff are not qualified to handle these residents and fail to intervene when necessary. They continuously fail to de-escalate strenuous situations and as a result we get threatened and residents elope. Our peaceful living has been disturbed and I am in constant fear of my family's safety.

On 10/23/23, Resident C escaped his caretakers and trespassed onto my neighbor's property trying to enter their home through their back door. Fortunately, it was locked, but when confronted by my neighbor, he ran onto my property and tried entering my back sliding door with much force, breaking the screen door in the process. He was not

able to enter the glass sliding door where my one-year-old son was right on the other side of it playing. He then proceeded to sit on my deck for several minutes before five or six caretakers came to escort him off my property. All caught on camera. The staff are not qualified to handle these residents and fail to intervene when necessary. They continuously fail to de-escalate strenuous situations and as a result we get threatened and residents elope. Our peaceful living has been disturbed and I am in constant fear of my family's safety due to the negligence of owner and staff.

On 06/23/24, I was outside in my yard I heard yelling/profanities being screamed by Resident B. I could also hear the laughing of two separate female voices (who I would presume are workers, group home is all male). The laughing increased the intensity of the situation as Resident B continued to get angrier. In concern of Resident B, I went out to the street and began videoing. I was able to capture Resident B's episode and screaming and him mentioning "They're messing with me!!" when confronted with one of the male staff members that was trying to calm him down. Unfortunately, this is not the first time staff has been heard antagonizing residents, so in this case I made sure to try to document it the best I could on video. The inadequately trained staff cannot de-escalate situations and, in this case, appeared to be causing it. The owners complete lack of ability to hire adequate and caring staff is obvious. I am fearful that their poor actions will result in a resident getting hurt or harming someone else.

Note: RS2 provided video evidence of all three reported incidents. Licensing consultant reviewed.

Video 1: Resident B is observed outside at his home yelling profanities directed toward a female staff. A male staff is observed engaging verbally with him to redirect. Resident B is heard telling the male staff “they're bugging me..."
Video 2: Resident C is observed on RS2’s back patio staff did not arrive to remove Resident C for 1 – 2 minutes.
Video 3: Resident B is observed on the property at his home yelling profanities. There were multiple staff present. Resident B is observed walking towards RS2 when a male staff said, “go beat them up, I dare you so they can take your ass back to jail. Is that what you want?” Resident B was redirected by another staff, Resident B remained on his property and went inside of the house.

On 11/18/24, I interviewed RS2 via telephone. RS2 confirmed the details reported in his written complaint. RS2 stated on 09/05/24, an altercation between two group home residents took place in the front yard of the home. He and his neighbor were standing in the street in front of their homes recording the incident. One of the residents noticed him recording and started walking aggressively in their direction screaming profanities and threatening them by saying, "beat us up" and "we would be sorry for calling the cops.” RS2 further reported on 10/23/23, Resident C eloped and trespassed onto RS2’s neighbor's property trying to enter their home through their back door. He then ran onto his property and tried entering my back sliding door, breaking the screen door in the process. He was not able to enter the glass sliding door where his one-year-old son was on the other side playing. Resident C then sat on his deck for several minutes before

five or six staff came to escort him off my property. RS2 stated on 06/23/24, he was outside in his yard, and he heard Resident B screaming profanities. He could also hear two female staff laughing. RS2 stated in addition to the complaints that he reported there was a dumpster on fire a few weeks ago at this facility. The incident was published in The Citizens Newspaper. The newspaper also issued a story regarding a resident of this facility soliciting sex from a minor. RS2 stated this is of concern to him as he has children, and he is afraid to have his children outside. RS2 stated the staff seem young and incapable of properly handling the residents. RS2 has witnessed staff reacting when residents call them the “N word.”

On 11/13/24, I completed an unscheduled onsite investigation I interviewed home manager, Tyler Hunter.

On 11/13/24, I interviewed home manager, Tyler Hunter. Mr. Hunter stated Resident B and Resident C both moved out of this facility in September 2024. They are both living in different facilities in Genesee County. Mr. Hunter stated he started in his role as the home manager in July 2024, however when he first started, he was often training at multiple homes and therefore, he was not present for many of the alleged incidents and has limited knowledge about what occurred. Mr. Hunter stated Resident B and Resident C eloped often. The staff follow their behavior plan and are trained in Crisis Prevention Institute (CPI) however, Resident C was difficult to redirect and physically manage due to his size.

I reviewed the following relevant Incident Reports:

- IR dated 09/05/24 – Resident B, involved staff Hailey Barrington. While playing basketball outside with peers, they began to tease one another. Staff attempted to separate Resident B from peers. Resident B threw a rock. The neighbors came outside and started to record while staff were attempting to deescalate and called the police. The police issued Resident B three misdemeanor citations. Staff practiced coping skills with Resident B and contacted support staff.
- IR dated 10/23/23 – Resident C, involved staff Paris Walker and Carol Aruther. Resident C broke peers bedroom window and climbed out. Staff followed behind him while radioing for assistance and providing verbal redirecting. Resident C went to the neighbor’s house on their back porch and broke their door wall.

I reviewed Resident B’s antecedent – Behavioral – Intervention Chart. In summary, on 06/23/24, Resident B held down the door handle to go outside, punched staff and attempt to fight peers. Resident B was screaming, spitting, threatening staff, and calling staff names.

The following is a summary of two stories written in The Citizen Newspaper:

On 11/05/24, at 2:25 am deputies responded to reports of arson. Deputies observed a dumpster with smoke coming out of it. Brandon Fire was already on scene putting the fire out. The staff on shift stated she put the residents to bed and started to smell smoke. She observed the dumpster on fire and called 911. One of the residents stated

he took the trash out hours prior but denied starting a fire. The case was turned over to the fire investigator.

On 10/26/24, at 4:45 am, Brandon deputies responded to reports of suspicious circumstances. The caller stated that she works for an organization trying to expose people who are trying to engage in sexual activities with minors. One of the residents had engaged with the caller's boss who was posing as a 12-year-old. Deputies advise to take away the resident's phone. The case was forwarded to the compute crimes division.

I reviewed Resident B's Individual Plan of Service. In summary, the plan indicates because of the frequency and severity of Resident B's physical aggression, verbal aggression, property destruction, and eloping, the following restrictions are in place: supervision in the community and delayed egress exit doors. Because of the strong potential for harm to himself and others, these restrictions are needed to maximize safety. Resident B has a history of eloping from the supervision of staff as such, he will receive field of vision supervision, meaning that any time the staff person providing Resident B with supervision in the community should be able to immediately, as needed, make visual contact, speak with him, and provide assistance.

I reviewed Resident C's Individual Plan of Service. In summary, the plan indicates he is an elopement risk and vulnerable due to his frequency and severity of physical aggression, property destruction and self-injurious behavior. Resident C has a 1:1 caregiver who will accompany him during community activities. Resident C is at risk of elopement every time he walks out the door. Resident C needs staff to be within arms' reach when he goes out. Staff need to ensure they have eyes on him at all times. He is obsessed with police and will do anything to get them called on him. Staff should be cautious of where they take Resident C especially if they are alone. Resident C should be engaged by his caregiver constantly throughout the activity to avoid any risk of elopement or safety risks. They will praise him for remaining with staff/the group and tell him they are proud of him and that he is safe with them.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.

ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude that interventions to address unacceptable behavior were not successful and therefore did not ensure the safety of the residents, staff, and/or community members. As such, Resident B and Resident C were discharged from this home in September 2024. Resident B's and Resident C's Individual Plans of Service indicate that they are an elopement risk and have a strong potential for property destruction, harm to self, and others. As such, there are measure in places including enhanced staffing and delayed egress exit doors to prohibit elopements. These measures were unsuccessful as evident by video evidence of Resident B and Resident C eloping onto neighbor's property, being verbally aggressive towards neighbors, and engaging in property destruction (breaking RS2's door wall). Moreover, there is video evidence of Resident B yelling profanities while approaching RS2. A male staff can be heard saying "go beat them up, I dare you so they can take your ass back to jail. Is that what you want?" This response from staff is not an appropriate intervention to address unacceptable behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was observed having a purple bruised left eye and purple bruising to his left upper arm he reported it was caused by direct care staff Kiarah Keels.

INVESTIGATION:

In summary, Reporting Source 4 (RS4,) Adult Protective Services (APS) indicated the following in their written complaint:

Resident A's diagnosis is developmentally delayed, antisocial personality disorder, GERD, hypothyroidism, obesity, and autistic spectrum disorder. Resident A has a legal guardian, and she has been informed about this call that is being made. Resident A has a history of being violent towards others he went to jail for physically beating someone up and he is a bigger man weighing 276 pounds a lot of people have to use self-defense. Resident A was observed having a purple bruised left eye, purple bruising to his left upper arm, and he reported it was caused by staff where he lives at, and he did name someone it is believed that her name is Kenteria. The nurse practitioner reached out to the group home and spoke with Tyler the home manager and he reported that Resident A instigates fights with other residents and that is how the bruises occurred not from staff. Resident A has lived there since 2021. The nurse practitioner does not believe it was staff that did this to Resident A because he beats staff up at the group

home most times and he has thrown rocks at their windows to their cars, and they are good to him. Resident A came back to the hospital because he beat up an ambulance worker and they do have to have caution with Resident A, but he is in route home.

I reviewed three photos of Resident A, which showed bruising to his side, arm, and eye.

On 11/06/24, I spoke to APS worker, Taneisha Sims. Ms. Sims stated that she received clarification that the allegation was regarding direct care staff Kiarah Keels, not Kenteria as indicated in the APS referral. The facility does not have a staff by that name. Ms. Sims stated her investigation is ongoing. ORR completed their investigation; they did not substantiate. Ms. Sims forwarded me a copy of the ORR report. Ms. Sims stated she interviewed Resident A on 11/06/24, he indicated that he was beat up by other residents causing his injures. On 11/26/25, I received a telephone call from Ms. Sims, she stated that she was advised by Detective Nault with the Oakland County Sheriff's Office that the police investigation was closed 10/09/24. The case was unfounded, Resident A got into an altercation with a peer.

I reviewed Monroe Community Mental Health – Office of Recipient Rights Report of Investigative Findings. The allegation was not substantiated. Per the written report Resident A was interviewed on 10/10/24, and he stated the bruises to his left eye and left arm were caused by a peer because direct care staff Kiarah Keels told the peer to beat him up. Upon further questioning, he then stated that during the incident direct care staff Kiarah Keels hit him with a belt and direct care staff Kyla Cummings threw him against the wall. Ms. Keels and Ms. Cumming denied the allegation.

On 11/07/24, I completed a telephone interview with direct care staff Kiarah Keels. Ms. Keels stated she and direct care staff Kyla Cummings worked with Resident A around the time this allegation was made. Ms. Keels denied that she ever told residents to beat up Resident A, hit him with a belt, or harmed him. Ms. Keels denied witnessing Ms. Cummings throw Resident A against the wall or harm him. Ms. Keels stated Resident A often makes false allegations when he is upset. Ms. Keels stated Resident A is attention seeking and his injuries likely resulted from his fights with peers or his self-injurious behavior.

On 11/13/24, I completed an unscheduled onsite investigation I interviewed home manager, Tyler Hunter.

On 11/13/24, I interviewed home manager, Tyler Hunter. Mr. Hunter stated Resident A engages in aggression towards himself and others, he has a history of making false allegations and blaming others for his own behaviors. Mr. Hunter stated on 10/07/24, Resident A had bruises on his left bicep and left eye. The injuries were caused by him hitting himself in the face and getting into fights with peers, assaulting a nurse, and an ambulance driver which were documented via Incident Reports. Mr. Hunter stated Resident A’s story has changed several times about what occurred, including first saying Ms. Keels assaulted him then saying it was a peer. Mr. Hunter stated he does not suspect any staff caused Resident A’s injuries.

I reviewed the following relevant Incident Reports:

- IR dated 09/28/24 - Resident A repeatedly struck himself in the face, which resulted in bruising around his left eye.
- IR dated 09/29/24 - Resident A had a physical altercation with an unspecified peer who punched Resident A in the left eye.
- IR dated 10/06/24 - There were three IR's written on 10/06/24, in summary, Resident A had a physical altercation with an unspecified peer, which resulted in bruising to Resident A arms and legs. Then, he threatened the neighbors and attempted to elope, resulting in staff using physical management to prevent a risk of harm. That same evening Resident A called 911 and was transported by ambulance to the hospital for evaluation where he physically assaulted a nurse.

I reviewed the Oakland County Sheriff's Witness statement completed by direct care staff Kyla Cummings regarding the incidents that occurred on 10/06/24. Ms. Cummings indicated Resident A attempted to elope from the home blocking techniques were utilized. Resident A got into a physical altercation with a peer the blocking pad was used. Peer pushed Resident A to the ground. Resident A had a scratch on his neck and bruising to his left arm and leg. Resident A was given a PRN medication. Resident A took a nap. When he woke up, he attempted to elope from the home. Body positioning was used to block him, he pushed past staff. A CPI technique was used successfully, Resident A remained in the home. Later that evening Resident A called a crisis hotline, they called the police, and Resident A was transported out of the home via ambulance.

On 11/25/24, I placed a telephone call to licensee designee Nicholas Burnett to conduct an exit conference. There was no answer. I left a voicemail informing Mr. Burnett that there were two rule violations found and notified him that a corrective action plan is required. I requested a return call to discuss the allegations at length. On 11/27/24, I placed a second telephone call to licensee designee Nicholas Burnett to conduct an exit conference. I spoke to Mr. Burnett and Flatrock Chief Operation Officer, Carrie Aldrich. I reviewed the allegations, evidence, community complaints, and citations with Mr. Burnett and Ms. Aldrich. I indicated that a corrective action plan is required. Mr. Burnett acknowledged. Ms. Aldrich stated Flatrock has a 'high needs list' which allows for additional oversight and advanced clinical perspective for residents who have higher needs. Resident A is on the high needs list.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	Based on the information gathered through this investigation there is insufficient information to conclude Resident A's injuries were caused by direct care staff Kiarah Keels. Resident A alleged this occurred however the APS referral indicated the nurse practitioner did not believe it was staff that did this to Resident A. When interviewed direct care staff Kiarah Keels denied the allegation. Incident Reports and Oakland County Sheriff's Witness statement completed by direct care staff Kyla Cummings indicated that Resident A had a physical altercation with a peer which resulted in bruising to Resident A's arms and legs. Resident A repeatedly struck himself in the face resulting in bruising around his left eye. Monroe Community Mental Health – Office of Recipient Rights, Adult Protective Services, and the Oakland County Sheriff's Department investigated this allegation and did not substantiate.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

11/27/2024

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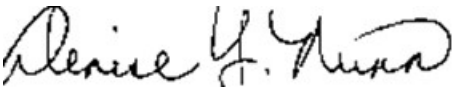
Johnna Cade — Date
Licensing Consultant

Approved By:



12/04/2024

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Denise Y. Nunn — Date
Area Manager