GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 13, 2025

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

RE: License #: AS630396128
Investigation #: 2025A0611011
Brandon West

Dear Mr. Burnett:

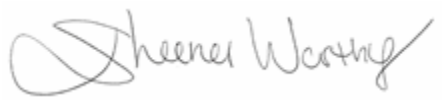
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630396128
Investigation #:	2025A0611011
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	02/04/2025
Report Due Date:	03/24/2025
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 West
Facility Address:	300 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	08/02/2019
License Status:	REGULAR
Effective Date:	02/02/2024
Expiration Date:	02/01/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Camoni Warren threw water in Resident M's face. On 12/29/24, Resident M was punched in the face but, it is unknown by who. On Thanksgiving day, staff member Mya Harris choked Resident H and stomped on his face.	No
Resident M has glaucoma in his left eye and the AFC group home and his insurance would not pay for him to have surgery. The residents do not complete any of their ADL's and staff do not encourage them to do so.	No
Resident D swallowed three razor blades and inserted three razor blades up his butt. Staff are expected to pick up the razors when the residents are done using them but they didn't. Resident D was taken to the hospital and now uses a colostomy bag.	Yes
The staff were recording that they were passing medications to a dead person. Staff member Jessica Fryer was stealing Resident D's medication.	No

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A0611011
01/23/2025	APS Referral According to the intake email, Adult Protective Services (APS) denied investigating these allegations.
02/04/2025	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed staff member Skyler Wright. I spoke to the home manager Tyler Hunter via telephone. I observed Resident M's eye drops.
02/06/2025	Contact - Telephone call made I made a telephone call to the home manager Tyler Hunter. The allegations were discussed.

02/06/2025	Contact - Telephone call made A voice message was left for the Executive Director Stevie Walton requesting a call back.
02/07/2025	Contact - Telephone call received I received a telephone call from the medical coordinator Keo Riouse-Russey. The allegations were discussed.
02/07/2025	Contact - Document Received I received a copy of Resident M and Resident D MAR for the month of January and a copy of Resident D discharge paperwork from his hospitalization.
02/12/2025	Contact - Telephone call made I made a return phone call to the licensee designee Nicholas Burnette. The allegations were discussed.
02/12/2025	Contact - Document Received I received a copy of the incident report dated 12/30/24.
02/12/2025	Contact - Document Received I received a copy of Resident D's assessment plan.
02/12/2025	Contact - Telephone call made I made a telephone call to staff member Camoni Warren. The allegations were discussed.
02/12/2025	Contact - Telephone call made I left a voice message for staff member Mya Harris requesting a call back.
02/12/2025	Contact - Telephone call made I made a telephone call to the AFC group home. I attempted to interview Resident H however; he was asleep. I interviewed Resident D.
02/12/2025	Contact - Telephone call made I made a telephone call to staff member Mya Harris. The allegations were discussed.
02/12/2025	Contact - Telephone call made I made a telephone call to the licensee designee Nicholas Burnett. Mr. Burnett provided additional information.

02/12/2025	Contact - Document Sent I sent an email to Laurie Depillars who is the corporate office program director at Flatrock. Ms. Depillars provided information regarding Mya Harris transfer to another AFC group home.
02/12/2025	Contact - Document Sent I sent an email to recipient rights specialist Katie Garcia to inquire about any investigation at Brandon West regarding Mya Harris and Resident H. A response was received from Ms. Garcia.
02/13/2025	Contact - Telephone call made I attempted to contact staff member Jessica Fryer however; the phone number was disconnected.
02/13/2025	Contact – Telephone call made I made a telephone call to the AFC group home. I spoke to Resident D and interviewed Resident H.
02/13/2025	Exit Conference I completed an exit conference with the licensee designee Nicholas Burnett via telephone.

ALLEGATION:

- **Staff member Camoni Warren threw water in Resident M's face. On 12/29/24, Resident M was punched in the face but, it is unknown by who. On Thanksgiving day, staff member Mya Harris choked Resident H and stomped on his face.**
- **Resident M has glaucoma in his left eye and the AFC group home and his insurance would not pay for him to have surgery. The residents do not complete any of their ADL's and staff do not encourage them to do so.**

INVESTIGATION:

On 01/23/25, a complaint was received and assigned for investigation alleging the following: On 01/12/25, staff member Camoni Warren threw water in Resident M's face. Resident M will vomit water. Camoni let Resident M fill up a cup of water. Camoni then threw the water in his Resident M face. Resident M was punched in the face on 12/29/24. It is unknown who punched him in the face. It was reported in-house. No one checked on his black eye (right), no report made, no documentation in his records, and no doctor/ER visit. There was no explanation about how Resident M received the black eye. It was all swept under the rug. The black eye has been healing but it took 16 days for it to heal. He does have two scratches left, one on top and one on the bottom of the eye. It is unknown how much of those have healed. Resident M's left eye has glaucoma. The home and the insurance company would not pay for surgery, so

Resident M's eyeball has died. The eyeball is still in the socket. Eye drops are being put in the left eye however; he is blind in one eye. The residents do not want to do any of their ADL's. Staff do not encourage them to do them either.

There were 15 deaths in 2024 in the company homes. Staff were recording that they were passing meds to a dead person. They would record it as if they were passing the meds like normal however, the meds were still in the drawer. That resident was dead for over 34 hours. Another resident was covered in feces. None of the staff wanted to or would clean her up. She was eating her feces. She was not taken to the hospital or doctors. Staff did nothing to help her. She was dead for 23 hours before anyone found her. The cause of her death was ruled as natural causes. There have been people that have died from choking in the company homes.

On Thanksgiving Day, Mya Harris was having a conversation with another staff member. Resident H was in the same room eating his Thanksgiving dinner. When she told him to leave, he stomped upstairs and threw his plate. She went and choked him because of it. Then another resident held Resident H down while Mya stomped on Resident's face. Recipient Rights was called. Mya was found not guilty. Mya started bragging about the incident, so it is being brought back up and she was taken off the schedule. Resident H's neck was red, and his glasses were broken.

Jessica Fryer was stealing Resident D's medications. On 1/14/25, Resident D was in pain and staff could not give him any relief because the meds were not there. The med coordinator did not catch that the count was off when they should have. This was reported to HR. Staff was not supervising Resident D as he was taken to the hospital for surgery and walked out with a colostomy bag. He swallowed three razor blades and inserted three razor blades up his butt. Another resident had shaved and staff are supposed to pick up the razors when residents are finished but, they didn't. Resident D took a walk afterwards and did not tell staff that he was dying until he was dying.
On 02/04/25, I completed an unannounced onsite. I interviewed staff member Skyler Wright. I spoke to the home manager Tyler Hunter via telephone. I observed Resident M's eye drops.

On 02/04/25, I completed an onsite and interviewed staff member Skyler Wright. Ms. Wright has worked at the AFC group home for three months. Ms. Wright previously worked at another AFC group home located in Flint, MI within the same company. Ms. Wright normally works the afternoon shift but today she is working the day shift. There are six residents residing at the AFC group home. Ms. Wright stated all the residents were at an indoor water park except Resident B who was asleep in his bedroom. Resident B was not feeling well. Resident B has multiple personalities and a history of being aggressive. Regarding the allegations, Ms. Wright stated she does not know staff member Camoni Warren nor does she know about any incident regarding Ms. Warren throwing water at Resident M. Ms. Wright is not aware of any incident resulting in Resident M having a black eye. Ms. Wright stated she does not think Resident M has any marks or bruises on him. Resident M is partially blind as he cannot see out of his left eye. Ms. Wright is not sure if Resident M has glaucoma. Resident M is prescribed a

variation of eye drops. Ms. Wright stated on the afternoon shift, Resident M is administered eye drops at 4:00pm, 5:00pm, and 8:00pm.

Ms. Wright stated all of the residents are considered high functioning except Resident M. Resident M is the only resident that requires some assistance with completing his ADL's. Resident M is capable of putting soap on his body however; he does not grasp the concept of how to clean his body. Resident M also lacks motor skills and he is not well coordinated. The staff does provide assistance to help Resident M with bathing as well as washing his hair. The staff are working on helping Resident M with becoming more independent. Resident M does not have the capacity to be interviewed as the only words he uses is profanity. Ms. Wright stated the other residents do complete their ADL's.

I observed Resident M's eye drops. Resident M is prescribed Clear Eyes four times a day in both eyes, Prednisolone Acetrate Ophthalmic Suspension USP for his left eye four times a day, Erythromycin Ophthalmic Ointment for both eyes in the evening.

Ms. Wright stated she is not aware of any incident where a resident was covered in feces.

Ms. Wrights stated since she has worked for the company, two residents have passed away last year that she is aware of. Ms. Wright stated the deaths did not involve any of the residents that reside at Brandon West. Ms. Wright does not know the name of the homes where the deaths occurred nor does she know the cause of deaths. Ms. Wright stated one of the residents that passed away was a female who lived at a home in Flint, MI. Ms. Wright stated the female was being neglected but she did not know any details. Ms. Wright stated she worked at the home during the afternoon shift the day the female resident passed away. Ms. Wright stated during her shift, the female resident was sick but, she was conscious and talking. Ms. Wright stated when her shift ended, the female resident was found dead hours after she passed away. Ms. Wright stated the staff thought she was asleep when in fact she was dead. Ms. Wright cannot remember what month this incident occurred.

Ms. Wright stated she was not present regarding the allegations pertaining to Resident H. Ms. Wright stated she does not believe Resident H would lie. Ms. Wright stated she knows staff member Mya Harris. Ms. Wright described Ms. Harris as mean and rude to the residents. The residents would complain about how Ms. Harris would treat them all the time. Ms. Wright stated Ms. Harris is the type of person who would hit a resident as she treats the resident like "shit". Resident H kept reporting the incident however; initially no one took him seriously until one day Ms. Harris was no longer working at the group home. Ms. Wright does not know if Ms. Harris was fired. Ms. Wright stated she was told by Resident D that Ms. Harris gave him six tokens to beat up Resident H and he did it. Ms. Wright stated she does not know if this is true or not. Ms. Wright explained that tokens are considered currency that residents earn for completing choirs and exercising. Ms. Wright has never seen any marks or bruises on Resident H however; he

is clumsy and falls down a lot. Ms. Wright stated none of the residents like Ms. Harris because of what she did to Resident H.

On 02/06/25, I made a telephone call to the home manager Tyler Hunter. Mr. Hunter has worked at the AFC group home for about eight months. Regarding the allegations, Mr. Hunter stated he is not aware of an incident involving staff member Camoni Warren throwing water in Resident M's face. Mr. Hunter stated given that Resident M is non-verbal he does not foresee any of his staff members throwing water in his face. Mr. Hunter is not aware of Resident M having a black eye or any marks or bruises. Ms. Warren is still employed at the AFC group home. Mr. Hunter stated Ms. Warren is a good staff member and she was also voted employee of the month. Mr. Hunter does not know Resident M's diagnosis regarding his eye but, he is partially blind. Mr. Hunter does not know how long Resident M has been partially blind but, he has been partially blind since he started working for the AFC group home. Mr. Hunter stated he does not think any surgery can fix Resident M's eyesight. Therefore, as far as he knows the insurance company and/or the home did not refuse to pay for any surgery.

Mr. Hunter stated the staff prompt each resident on every shift to complete their ADL's. Mr. Hunter stated all of the residents comply with completing their ADL's however; Resident M requires staff assistance. Resident M does not know how to properly clean himself. Mr. Hunter is not aware of any staff member passing medication to a resident that was deceased.

Mr. Hunter stated no one has died at Brandon West. Mr. Hunter does not know if the allegation about there being 15 deaths last year within the company is true or not. Mr. Hunter is not aware of any resident being covered in feces. Mr. Hunter stated none of the residents at Brandon West defecate on themselves. Mr. Hunter is not aware of any female resident being dead for 23 hours and/or any residents passing away from choking within the company. There are only male residents at Brandon West.

Mr. Hunter stated staff member Mya Harris no longer works at Brandon West but she still works for the company. Mr. Hunter stated if the allegation against her was true she would have been fired. Mr. Hunter denied being aware of any incident between Ms. Harris and Resident H. Mr. Hunter stated there is no incident report regarding an altercation between Ms. Harris and Resident H. Mr. Hunter stated he worked the following day after Thanksgiving and he did not observe any marks or bruises on Resident H. Resident H is good at communicating and he would have told Mr. Hunter if something happened.

On 02/07/25, I received a telephone call from the medical coordinator Keo Riouse-Russey. Mr. Russey has been the medical coordinator since April 2024. Regarding the allegations, Mr. Russey stated he is not aware of any incident regarding Resident M and staff member Camoni Warren. Mr. Russey is not aware of anyone punching Resident M or about him having a black eye and/or scratches. Resident M has glaucoma in his left eye. Resident M has not been recommended to have surgery on his eye. Resident M is partially blind but, Mr. Russey does not know how long Resident M has been partially

blind. Mr. Russey stated the residents do complete their ADL's. Mr. Russey explained that some of the residents are excited to complete their ADL's and some residents take their time and/or need prompting from staff.

Mr. Russey is not aware of there being 15 deaths within the company in 2024. Mr. Russey confirmed that no resident has died at Brandon West. Mr. Russey is not aware of any female resident being covered in feces. Mr. Russey confirmed that there are only male residents at Brandon West. Mr. Russey does not know anything about a female resident being dead for 23 hours before she was found. Mr. Russey does not know anything about anyone dying within the company from choking.

Mr. Russey is not aware of the incident involving Resident H and staff member Mya Harris. Ms. Harris no longer works at Brandon West and Mr. Russey does not know what happened to her after she was taken off the schedule. Mr. Russey denied ever seeing any marks or bruises on Resident H. Mr. Russey is present in the AFC group home everyday Monday through Friday.

On 02/12/25, I made a return phone call to the licensee designee, Nicholas Burnett. Regarding the allegations, Mr. Burnett stated he is not aware of any incident involving Resident M and staff member Camoni Warrant. Mr. Burnett visits his AFC group homes at least once a month. Mr. Burnett denied seeing Resident M with a black eye or with any scratches. Resident M does not need surgery on his eye and his eye is not life threatening. Mr. Burnett believes that when Resident M was admitted into the AFC group home, he already had issues with his eye. Resident M is prescribed eye drops as this has been a long-term issue and it is well documented.

Mr. Burnett stated Brandon West is a behavioral home and at times some of the residents may refuse to complete their ADL's but, overall all the residents complete their ADL's. Furthermore, the staff encourage the residents to complete their ADL's.

Mr. Burnett confirmed that no one has died at Brandon West in 2024 or 2025.
Mr. Burnett denied there being 15 deaths within the company in 2024. Mr. Burnett denied any resident dying from choking in 2024. Mr. Burnett stated the allegation about a resident being covered in feces in not true.

Mr. Burnett stated there was a female resident that was found dead in 2024 at Burton East AFC group home located in Genessee County. Mr. Burnett stated the resident passed away in the evening time. This resident was exceptionally psychotic and her baseline was to sleep all day. Mr. Burnett stated this resident would often refuse to eat and take her medication. During the day of the incident, this resident was asleep in her bedroom with the covers over her head. When the afternoon shift came in to check on her, it was discovered that she had passed away in her sleep. Mr. Burnett immediately contacted his licensing consultant Kent Gieselman and notified him of the situation. Mr. Burnett does not believe an investigation took place. The death was ruled as natural causes.

Mr. Burnett is not aware of any incident involving Resident H and staff member Mya Harris. Mr. Burnett denies seeing any marks or bruises on Resident H. Mr. Burnett stated there was an employee who essentially quit after she was transferred to work at several different group home per her request and; got upset when she was not allowed to return to her initial assigned group home. The employee stated that she would retaliate against the company. Mr. Burnett does not remember the name of the employee. Mr. Burnett stated he believes these allegations were reported due to this employee being upset.

On 02/12/25, I made a telephone call to staff member Camoni Warren. Regarding the allegations, Ms. Warren stated the allegations against her are not true. Ms. Warren works the dayshift from 7:00am to 3:00pm. Ms. Warren stated when she arrived on shift Resident M was asleep. When Resident M woke up there was no incident or any issues with him. Resident M did drink water that day but, it was a normal day. Ms. Warren has worked at the AFC group home for three years and she takes care of Resident M as if he is her own child. Ms. Warren denied ever having any problems with Resident M. Ms. Warren stated these allegations are coming from a previous worker by the name of Shayla Walker. Ms. Walker use to work the midnight shift. Ms. Warren stated when she arrived on shift on the day in question, Ms. Walker was present but she never saw her. Ms. Walker is known for telling stories about the co-workers she worked with because she has a vendetta against Flatrock. Ms. Warren stated she had a nice working relationship with Ms. Walker.

Ms. Warren described an instance where Ms. Walker accused Mya Harris of hitting Resident H on Thanksgiving day. Ms. Warren stated these allegations are not true because she was present. Ms. Warren stated Resident H and Ms. Harris had words and Resident H threw a dustpan at Ms. Harris. Ms. Harris utilized CPI towards Resident H. The other co-workers re-directed the other residents to prevent the incident from escalating. Resident H calmed down and another staff took him outside to smoke. Ms. Warren stated this occurred during shift change. Ms. Warren stated she does not know why Resident H threw a dustpan at Ms. Harris. Ms. Warren stated Ms. Harris did not choke Resident H or did anything outside of properly utilizing CPI.

On 02/12/25, I made a telephone call to the AFC group home. I attempted to interview Resident H however; he was asleep. I interviewed Resident D. Resident D stated he gets along with Resident H as he is like a little brother to him. When asked if he is aware of anyone hitting Resident H, Resident D stated yes and that person has been transferred to a different home. Resident D identified that person as Mya. Resident D confirmed the allegations against Mya Harris on Thanksgiving day. Resident D stated on the day in question, Resident H was talking on his cell phone and Ms. Harris said something smart to Resident H which made him mad. Ms. Harris tried to fight Resident H. Resident D stated Ms. Harris stepped on Resident H face with her boot on. This incident occurred in the kitchen. Ms. Harris also punched Resident H in the face. Ms. Harris told Resident H that she is “not the one”.

Resident D stated Ms. Harris paid him six tokens to beat up Resident H. Resident D admitted to agreeing to beat up Resident H and he did so right then and there. Resident D stated within seconds of Ms. Harris hitting Resident H he then started to beat him up. Ms. Harris was watching and encouraging it. Resident D stated afterwards he helped clean up Resident H's injuries. Resident H had a bloody nose and busted lip. Resident D stated there was other staff members present but he does not remember who. Resident D stated none of the other staff members witnessed the incident as there were a lot of fights happening that day with other residents and the other staff members where handling those situations.

On 02/12/25, I made a telephone call to staff member Mya Harris. Regarding the allegations, Ms. Harris stated she was transferred from Brandon West to another AFC group home because a lead staff member was needed at another home. Ms. Harris stated the allegations are not true. On the day in question, Ms. Harris said that Resident H threw a trash bin at her and then started to charge towards her. Ms. Harris utilized CPI with Resident H. Ms. Harris confirmed that Camoni Warren was also present along with two other staff members (Jayla Eden, A. Harland). The other staff members were re-directing the residents. Ms. Harris stated before the incident took place, Resident H went upstairs calmly. Ms. Harris denied telling Resident H to go upstairs. Ms. Harris heard Resident H yelling upstairs and she went to check on him. Ms. Harris stated while she was upstairs, Resident H still had his plate in his hand and he charged passed her. Resident H then went downstairs and threw the trash bin at Ms. Harris. Ms. Harris does not know why Resident H threw the trash bin at her. Ms. Harris stated after she applied CPI with Resident H he calmed down and went outside to smoke. Ms. Harris denied any physical altercation with Resident H. Ms. Harris denied giving Resident D tokens to have him beat up Resident H. Ms. Harris stated Resident D has a history of lying.

Ms. Harris stated she was contacted by recipient rights on 12/26/24 and she spoke to someone on 01/14/25. Ms. Harris was asked by recipient rights if she choked Resident H, if she stomped on Resident H, and if she called his mother a Bitch. Ms. Harris stated her answer was no to all the questions.

On 02/12/25, I made a telephone call to the licensee designee Nicholas Burnett. Mr. Burnett was asked to verify the reason why Ms. Harris was transferred to another AFC group home. Mr. Burnett quickly contacted human resources and was informed that Ms. Harris was transferred because a lead worker was needed at another home. Mr. Burnett also stated that the lead workers at Brandon West were toxic and needed to be separated. Mr. Burnett stated whenever a complaint of abuse is made, the staff is taken off the schedule until the recipient rights investigation is completed. Mr. Burnett denied there being an investigation regarding Ms. Harris and Resident H.

On 02/12/25, I sent an email to Laurie Depillars who is the corporate office program director at Flatrock regarding verification as to why Ms. Harris was transferred and if it had anything to do with an altercation between her and Resident H. A copy of Ms. Depillars response is below:

"Mya was transferred due to us needing a lead at the location she was moved to, I have not heard of any fight with a client. The move took place on 1/15/25".

On 02/12/25, I sent an email to recipient rights specialist Katie Garcia to inquire about any investigation at Brandon West regarding Mya Harris and Resident H. A copy of Ms. Garcia response is below:

"*I just looked up historical complaints and I did not see any complaint since 2022 at that facility".*

On 02/13/25, I made a telephone call to the AFC group home. I spoke to Resident D and interviewed Resident H. Resident D confirmed that he completes his ADL's on a daily basis. Resident D stated he does not need prompting from staff members to complete his ADL's. Resident D stated the other residents in the home complete their ADL's as well. Resident D stated they are pretty clean at the AFC group home.

On 02/13/25, Resident H stated he completes his ADL's on a daily basis. Resident H stated sometimes he is reminded by staff to complete his ADL's. Resident H stated some of the residents do their ADL's daily and some do not. Resident H stated he almost got into a fight yesterday with Resident T, because Resident T threw food and a cup at him. Resident H stated on Thanksgiving day, he got into an argument with Ms. Harris. Resident H stated Ms. Harris threw him against the wall and the ground. Ms. Harris also stomped on Resident H face. Resident H stated Resident D witnessed the incident. Resident D held Resident H back to prevent him from hitting Ms. Harris. Resident H stated he would have put Ms. Harris in the hospital. Resident H denied Resident D hitting or hurting him. Resident H referred to Resident D as his brother. Resident H stated Ms. Harris was transferred to a different home following this incident. Resident H stated he does not know why Ms. Harris hit him. Resident H stated he was in a car accident and received a concussion therefore; he has memory loss.

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 my investigation and the information gathered, there is no evidence to support the allegation against staff member Camoni Warren or staff member Mya Harris. Resident M does not have the capacity to be interviewed. However, Ms. Warren stated she treats Resident M as if he was her own child. Ms.

	Warren denied ever having any problems with Resident M. There were no witnesses that could confirm that there was an incident between Resident M and Ms. Warren or that he had a black eye. During my investigation, I received conflicting information regarding whether or not Ms. Harris assaulted Resident H. Ms. Harris denied the allegation. Ms. Harris stated Resident H threw a trash bin at her, which resulted in her utilizing CPI to de-escalate the situation. Ms. Warren was present during this incident and confirmed that Ms. Harris did not choke Resident H or did anything outside of properly utilizing CPI. Resident D confirmed the allegations, including beating up Resident H in exchange for six tokens given to him by Ms. Harris. Resident D admitted to beating up Resident H despite the fact he refers to him as his little brother. Resident H also confirmed the allegation but, he denied Resident D beating him up or hurting him. Resident D and Resident H stated Ms. Harris was transferred to another group home due to this incident. I confirmed with the licensee designee Nicholas Burnett and the corporate office program director, Laurie Depillars that Ms. Harris was transferred because another home needed a lead worker. Moreover, I confirmed with recipient rights specialist Katie Garcia that there was not an investigation pertaining to Ms. Harris and Resident H as the last investigation was completed in 2022.
CONCLUSION:	VIOLATION NOT ESTABLISHED

R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is no evidence to support the allegation. The staff and the residents interviewed confirmed that ADL's are completed in the home on a daily basis and staff prompt and/or provide assistance if needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident D swallowed three razor blades and inserted three razor blades up his butt. Staff are expected to pick up the razors when the residents are done using them but they did not. Resident D was taken to the hospital and now uses a colostomy bag.

INVESTIGATION:

On 02/04/25, Ms. Wright stated she was not present before the incident occurred regarding Resident D. Ms. Wright stated she thinks during the dayshift Resident M was shaving and when he finished, he put the razor in the bathroom drawer. Ms. Wright stated the staff are supposed to retrieve the razor once a resident finishes shaving but, the staff failed to do so. Ms. Wright assumes Resident D took the razor broke it and swallowed the plastic part. Resident D then took three razors and placed them inside his butt hole. Ms. Wright stated when her shift started, she noticed that something was off about Resident D. Resident D would not tell Ms. Wright what was wrong. Ms. Wright stated when she and Resident D were outside in the driveway, he told her what he had done. Resident D then started to pace around the driveway. Ms. Wright contacted the medical coordinator (Keo Riouse-Russey) and was instructed to contact EMS. Ms. Wright stated when Resident D told her about what he had done it took about 45 minutes for EMS to arrive and to transport him to the hospital in Pontiac, MI. Ms. Wright stated the staff are now required to lock up razors in the staff closet. Ms. Wright does not know if any staff members were held accountable for not retrieving the razor after Resident M finished shaving. Resident D was required to have surgery which is why he has a colostomy bag. Ms. Wright stated Resident D has a history of doing things of this nature to get attention.

On 02/06/25, Mr. Hunter stated the incident regarding Resident D occurred prior to him being placed on 1:1 supervision. Prior to this incident, Resident D was allotted access in the community without supervision. Resident D was allowed to be outside of the AFC group home and; the staff would check on him every 30 minutes. On the day in question, Resident D came inside the AFC group home and he showed no signs of agitation. Resident D went to his bedroom and when he came out of his room, he told a staff member he inserted razors in his rectum. Mr. Hunter does not remember which staff member Resident D told this information to. Mr. Hunter stated when something like this occurs the staff are required to follow protocol which involves contacting the medical coordinator or the on-call supervisor depending on what time it is. The next step is for staff to contact 911. Mr. Hunter stated Resident D was hospitalized overnight.

Mr. Hunter is not aware of any of Resident D’s medications missing after he was released from the hospital. Mr. Hunter does not know how Resident D obtained the razors and he never told staff how he got the razors. Mr. Hunter stated the razors have always been locked up with the hygiene products. Mr. Hunter stated the staff are continuing to ensure the razors are kept locked up.

On 02/07/25, Mr. Russey does not know how Resident D got ahold of razors. Resident D's target behaviors is to find objects and insert and/or swallow them. Mr. Russey stated he does not think Resident D swallowed any razors as there was no evidence but, he did insert more than one razor in his anus. Resident D was transported to the hospital to have the razors removed which resulted in him getting a colostomy bag. Mr. Russey stated the damage may be reversible. Mr. Russey stated the razors are kept locked up in the staff closet. The staff are expected to collect the razors after a resident is finished shaving and properly disposed of it in a sharp container. Mr. Russey stated it is possible that a staff member did not collect the razors which is how this incident happened. Mr. Russey does not believe any of the staff that were working during this incident was reprimanded.

According to the discharge paperwork for Resident D's hospitalization at McLaren Oakland hospital, his discharge diagnosis was 1: foreign body in anus and rectum, initial encounter; 2: suicide attempt; 3: status post cecostomy; 4: acute post-operative pain; 5: suicidal ideation; 6: depression; 7: schizophrenia; 8: hydronephrosis; 9: hypothyroidism; 10: dyslipidemia; 11: history of traumatic brain injury; 12: tobacco use; 13: obesity. An admission date was not found on the discharge paperwork however; the paperwork was dated for 01/02/25. Resident D was prescribed the following new medications:

- Baclofen 10mg
- Buspirone 10mg
- DME
- Docusate 100mg
- Gabapentin 300mg
- Oxycodone 10mg

On 02/12/25, Mr. Burnett stated he is not aware of the incident regarding Resident D inserting razors in his rectum. Mr. Burnett knows Jessica Fryer and he does not believe she was investigated regarding stealing medication.

On 02/12/25, I received a copy of the incident report dated 12/30/24. According to the incident report, staff member Jessica Fryer was assigned to Resident D and Skyler Wright is documented as other person involved/witness. Ms. Fryer is documented as the person who completed the incident report. The incident report indicates that Resident D was smoking outside and when staff went outside to check on him, he stated he did something "bad". Resident D told staff that he self-harmed and inserted shaving utensils into his rectum right before asking to go outside to smoke. Resident D was transported to McLaren Oakland Hospital. A CT scan was completed and the doctor could see two shaving utensils inserted inside Resident D's rectum. Resident D received a procedure to remove the shaving utensils.

On 02/12/25, I received a copy of Resident D's assessment plan. The assessment plan was last updated on 09/12/24. According to the assessment plan, Resident D requires supervision by staff while in the community for health and safety. Resident D has an

extensive history of physical aggression, self-harm, property destruction, crisis generating behavior, and negative interactions with community members which could result in harm to self and others due to his impulsiveness and inability to regulate his emotions. Resident D will require supervision at all times when in the community.

Resident D has an extensive history of self-injurious behaviors, starting around the age of 9 years old. His self-injurious behavior history includes cutting himself, putting objects into his cuts, swallowing inedible objects, and inserting objects into his rectum requiring surgery for removal. He should be considered high risk for self-injurious behaviors. Resident D's current self-injurious behaviors include inserting objects into his rectum. The severity of his self-harm has resulted in 1:1 supervision in the past, however, Resident D has recently shown improvement with his reduction of self-harm and titrated off 1:1 supervision last year. Since titrating off enhanced staffing, Resident D has engaged in self-harm approximately 1-2 times per month, typically requiring surgery to remove foreign objects from his rectum. Staff will verbally redirect, engage in problem-solving strategies with him, encourage and teach relaxation skills/encourage use/practice, and promote learning of other positive coping strategies.

Moreover, Resident D needs physical assistance with shaving and keeping his nails trimmed. Staff will assist Resident D as needed with the minimum amount of intervention, allowing for maximum independence. Resident D may benefit from verbal prompting and encouragement to complete grooming tasks on a routine basis.

On 02/12/25, I interviewed Resident D. Resident D has resided at the AFC group home for six months. Resident D stated he has some good days and some bad days at the AFC group home. Resident D stated that he likes some of the staff members. Resident D stated his needs are met at the AFC group home. Regarding the allegations, Resident D stated he did go to the hospital for swallowing six razor blades. Resident D was in the hospital for a week. Resident D stated the razors were sitting in the bathroom. Resident D admitted that the razors are supposed to be locked up because it can be used as a weapon. However, the razors were not locked up and when Resident D went to go use the bathroom, he saw the razors sitting in the bathroom. Resident D stated he did not use a razor to shave that day and he does not know who had used the razor before he came into the bathroom. Resident D stated when he saw the razors he took them because he was tired of life. Resident D stated since the incident he has not seen a razor lying around the home as the day in question scared everyone in the home including himself.

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 the information gathered, there is sufficient evidence to support the allegation regarding Resident D. Resident D confirmed that the razors were not locked up as they were unsecured in the bathroom. Resident D admitted that the razors are supposed to be locked up by staff because it can be used as a weapon. Ms. Wright admitted that staff are supposed to retrieve the razors once a resident finishes shaving but, the staff failed to do so. Mr. Russey stated it is possible that a staff member did not collect the razors which is how this incident happened. Resident D has a history of self-harming and it is well known that his target behaviors is to find objects and insert and/or swallow them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The staff were recording that they were passing medications to a dead person. Staff member Jessica Fryer was stealing Resident D's medication.

INVESTIGATION:

On 02/04/25, Ms. Wright stated the allegation regarding staff member Jessica Fryer stealing Resident D's medication is false. Ms. Wright stated there was a staff member by the name of Shayla who worked the midnight shift. Shayla was known for making up lies against other staff members as she wanted to become a lead staff member. When Resident D was discharged from the hospital, he was prescribed Oxycodone for three days for pain. Ms. Wright stated the staff complete a medication count at the beginning of their shift and at the end of their shift to ensure they have the correct number of medications for each resident. Ms. Wright stated Shayla did not know that Resident D was only prescribed Oxycodone for three days therefore; when she saw it was gone, she told Resident D that Ms. Fryer stole his medication. Ms. Wright stated an internal investigation was completed against Ms. Fryer and the findings were unsubstantiated.

On 02/06/25, Mr. Hunter denied there being any issue with staff lying about administering medications. Mr. Hunter stated the allegation about staff member Jessica Fryer stealing Resident D's medication is not true. Ms. Fryer was investigated and based on the fact that she is still employed, Mr. Hunter assumes she did not do anything wrong. The staff count the medications at the beginning of each shift and at the end of each shift. Mr. Hunter stated if any medication was to go missing it would be immediately looked into.

On 02/07/25, Mr. Russey denied any staff member recording that they were passing medication to a resident who was deceased. Mr. Russey stated the allegations against staff member Jessica Fryer is not true. Mr. Russey does not know why anyone would accuse Ms. Fryer of stealing medication.

On 02/07/25, I received a copy of Resident M and Resident D MAR for the month of January and a copy of Resident D discharge paperwork from his hospitalization According to the MAR for Resident M, it appears that his medication is being administered as prescribed including his eye drops. According to the MAR for Resident D, it appears that his medication is being administered as prescribed.

On 02/12/25, Mr. Burnett stated he is not aware of any staff member recording that they were passing medication to a deceased resident.

On 02/13/25, I completed an exit conference with the licensee designee Nicholas Burnett. Mr. Burnett was informed which allegations not substantiated and which allegation will be substantiated. Mr. Burnett was informed that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is no evidence to support the allegation against staff member Jessica Fryer stealing Resident D medication. The home manager Tyler Hunter confirmed that an internal investigation was completed and; it appears that Ms. Fryer did not do anything wrong. I reviewed Resident D's MAR for the month of January and it appears that he received all of his medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	There is no evidence to support this allegation that staff are recording they are passing medication to a deceased resident. It has been confirmed by the licensee designee Nicholas Burnett and the staff interviewed that no residents have passed away at Brandon West in 2024 or 2025.
CONCLUSION:	VIOLATION NOT ESTABLISHED

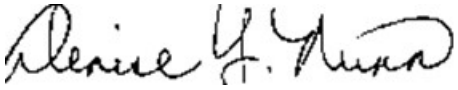
IV. RECOMMENDATION

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

02/13/25

Sheena Worthy
Licensing Consultant
Date

Approved By:



02/13/2025

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Denise Y. Nunn
Area Manager
Date