GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 13, 2023

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

RE: License #: AM440388517
Investigation #: 2023A0580058
Elba North

Dear Nicholas Burnett:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388517
Investigation #:	2023A0580058
Complaint Receipt Date:	08/14/2023
Investigation Initiation Date:	08/16/2023
Report Due Date:	10/13/2023
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Morgan Yarkosky
Licensee Designee:	Nicholas Burnett
Name of Facility:	Elba North
Facility Address:	300 N. Elba Rd. Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	09/05/2017
License Status:	REGULAR
Effective Date:	03/05/2022
Expiration Date:	03/04/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has some abrasions on his face and back. There is no explanation on how it occurred.	Yes

III. METHODOLOGY

08/14/2023	Special Investigation Intake 2023A0580058
08/14/2023	APS Referral Complaint received. Opened by APS for investigation.
08/16/2023	Special Investigation Initiated - Telephone Call to Rose Koss, Lapeer Co. APS.
08/21/2023	Inspection Completed On-site An onsite was conducted. Contact with staff, David Mcree.
08/21/2023	Contact - Telephone call made Call to Ericka Hilliker, Home Mgr.
08/21/2023	Inspection Completed On-site Observation of Resident A.
08/21/2023	Contact - Document Received Spoke with the home manager, Ericka Hilliker.
09/25/2023	Contact - Telephone call made Spoke with Relative Guardian A.
09/25/2023	Contact - Telephone call made Spoke with staff, Jacquetta Darrough.
09/26/2023	Contact - Document Received Photos and documents received.
09/26/2023	Contact - Telephone call made Call to Rose Koss of APS.

09/29/2023	Contact - Telephone call made Spoke with Ericka Hilliker.
10/04/2023	Contact - Document Received Additional documents requested were received.
10/09/2023	Exit Conference Call to Morgan Yarkosky, License Admin.
10/10/2023	Exit Conference Call to Nick Burnette, Licensee.

ALLEGATION:

Resident A has some abrasions on his face and back. There is no explanation on how it occurred.

INVESTIGATION:

On 08/14/2023, I received a complaint via BCAL Online Complaints. This complaint was opened by Adult Protective Services (APS) for investigation.

On 08/16/2023, I spoke placed a call to Rose Koss, APS Investigator in Lapeer County, requesting a return call.

On 08/17/2023, I spoke with APS Investigator, Rose Koss. She shared that a courtesy observation with Resident A was conducted by APS in Royal Oak, MI, due to Relative/ Guardian A taking Resident A to his home when he left the facility. Relative Guardian A did not want Resident A to return to the facility because no one knew what happened to cause the scratches on Resident A. To her knowledge, Relative Guardian A ended up retuning Resident A to the AFC on 08/13/2023. She adds that she spoke with the home manager, Ericka Hilliker who stated that while no one saw what occurred, she denied the scratches were caused by staff. It is assumed that another resident, identified as Resident B, was the perpetrator due to the fact that he has scratched and attacked other residents before. She shared a copy of the Incident Report (IR) that was provided to her by the facility.

The incident report indicates that on 08/05/2023 Resident A was in the TV room while staff went to complete 15-minute checks on the other residents. When staff returned to the room, she noticed Resident A had scratches on the right side of his face, about 4 inches long, scratches on the bridge of his nose and forehead. Staff validated his feelings and contacted the home manager and medical coordinator, who directed staff

to apply basic first aid and to continue to monitor Resident A for health and safety the remainder of the shift. Staff listed are Jaquetta Darrough and Jalissa Blue.

On 08/21/2023, I conducted an onsite inspection at Elba North. Contact was made with staff, David McCree, who escorted me to observe Resident A. Resident A is non-verbal and unable to participate in an interview. Resident A was observed in what was identified as the playroom for the residents. He was shirtless; however, he was wearing jean pants. While his shirt was off, I was able to observe a scratch on his back which appears to be in the pink stages of healing. The scratch appears to have been deep in nature as it is very visible, even its healing stages. This also applies to the scratches observed across the bridge of his nose as well as on the right side of his face.

On 08/21/2023, I spoke with the home manager, Ericka Hilliker, informing her of the documents needed for this investigation.

On 09/25/2023, I spoke with Relative Guardian A. He stated that when he visited Resident A in August of this year and observed the scratches, he initially took him to his primary physician in Royal Oak, MI., who recommended that he been seen at the hospital to ensure that his nose was not broken. While at the hospital, X-rays determined that his nose was not broken. He was given a tetanus shot. Photos were taken.

Relative Guardian A stated that initially he was told by the home manager, Ericka Hilliker, that Resident A caused the scratches to himself. However, he has since heard that there is another resident in the home that is attacking Resident A. He adds that Resident A has had at least 3 other incidents. They continue to allow the other resident to attack Resident A and are not doing anything to prevent the attacks. He fears that the other resident is trying to gouge Resident A's eyes out.

On 09/25/2023, I spoke with staff, Jacquetta Darrough. She recalled that on the day in question, she was working 3rd shift. When she began doing 15-minute room checks on the residents, Resident A was in the living room alone. Resident A does not require 1:1 supervision. When she returned to the living room, Resident B was in the living room with Resident A and Resident A was all scratched up. She does not know what occurred because she did not see anything happen, however, she adds that it is assumed that the scratches were caused by Resident B, who has scratched other residents in the past.

On 09/26/2023, I received an emailed copy of the photos taken of Resident A's injuries from Relative Guardian A and a copy of his medical discharge paperwork from his hospital visit.

Photos reportedly taken on 07/26/2023 depict:
Scratch on the right side of his face near right eye and eyebrow.
Scratch behind his right ear.
Scratches under both his left and right eyes, extending to his cheek.

Scratches on his neck at the end of his hairline, on his left-side, on his neck near his back/shoulder and directly on his back.

Photos reportedly taken on 08/09/2023 depict:
2 scratches in their healing stages with scabbing.
Fresh scratches w/blood on his nose and forehead, as well as a deep gash which took off the top layer of skin, across the bridge of Resident A's nose. Residents A's old scratches under both his left and right eyes, extending to his cheek can be seen.
Photo of scabbed healing scratches on his back.
A photo of a fresh scratch w/blood on his right temple, extending from his temple (near his hairline) to the corner of his mouth, near his lip.

Medical discharge paperwork obtained for Resident A indicates that Resident A was seen at Beaumont Hospital on 08/09/2023, with a chief complaint of Nasal Injury. The report states that there is a linear abrasion over the nasal bridge, no ecchymosis, deviation, or septal hematoma. It also states that there are small linear lacerations noted on the back and chest of various stages. These do not appear to be in the pattern of a scratch from right hand. The lacerations were not bleeding but do have dry blood present. Bacitracin was applied to the nasal wound. Multiple superficial injuries with no clear cause. No evidence of fracture on exam or other acute emergent process.

On 09/26/2023, I placed a follow-up call to Rose Koss of APS. She shared that she closed her case with a substantiation of abuse against the facility.

On 09/29/2023, I spoke with Ericka Hilliker for follow-up information. She stated that there were 3 additional incident reports in which Resident A was scratched and attacked by the other resident. In an effort to prevent the attacks from occurring, she stated that staff attempt to keep them separated from one another if they are in the same room or staff division is used to separate them if passing one another in the hall, however, they do share a home and are bound to interact. She adds that the other resident's attacks are random, and have preceding behaviors, therefore they don't know when he will attack. Copies of the additional incident reports were requested.

On 10/04/2023, I received an emailed copy of the additional incident reports requested. It states that on 07/14/2023, at 7:10am, upon arrival to work, while completing 15-minute checks, staff noticed multiple scratch marks on both Resident A's left and right shoulder, the right side of his face and the top left side of his back. Staff validated his feelings while analyzing the scratch wounds. Staff contacted medical coordinator and home manager. Staff instructed to apply basic first aid to his wounds. Staff will continue to monitor Resident A for health and safety for remainder of shift. Staff listed on this incident report are Tiffany Harris and David McCree.

The next incident report states that on 07/24/2023 at 1:02am, Resident A was walking the halls when staff noticed Resident A had some new scratches on his face and some scabs reopened. Staff validated his feelings, contacted the home manager and medical coordinator, who then directed staff to apply basic first aid to the scratches. Staff will

continue to monitor Resident A for health and safety the remainder of the shift. Staff listed on this incident report are Wesley Wilson and SuQuondra Martin.

The next incident report states that on 09/17/2023, at 12:10pm, Resident A was in the hallway with staff engaging, when he began to grab at staff's belongings. A peer turned around agitated and scratched Resident A on his back near his left shoulder, leaving superficial scratches, about 4 inches long. Staff quickly intervened using blocking techniques to separate Resident A from the peer to a safe area and validated his feelings. Staff contacted the home manager and medical coordinator, who instructed staff to apply basic first aid, and to monitor Resident A and peer. Staff validated Resident A's feelings and verbally prompted him to the TV room to do a preferred activity of Legos. Staff will continue to monitor Resident A for the remainder of the shift for his health and safety. Staff listed on this incident report are Tanya Jeffries and Alexis Williams.

The next incident report states that on 09/25/2023, at 11:50am, a peer was walking past Resident A in the hall when the peer quickly became agitated and grabbed Resident A's face causing a small superficial scratch on Resident A's right inner eye. Staff quickly used verbal redirection, validated Resident A's feelings, and redirected Resident A to a safe area. Staff contacted home manager and medical coordinator, who directed staff to apply basic first aid and to monitor Resident A for health and safety for the rest of the shift. Staff, Isiah Turner is listed on this incident report.

On 10/052023, I received a copy of the Behavior Treatment Pans for both Residents A and B. The Behavior Treatment Plan for Resident A indicates that he engages in several behaviors, not limited to physical aggression, food aggression, elopement, and property destruction. He requires supervision while in the community, delayed egress exit doors, locked kitchen, and laundry room. Any time Resident A begins to engage in aggression, verbally redirect him to transition to his room. If he refuses to transition, if necessary, call for assistance to prevent escalation of behaviors. Staff should document the behaviors, contact the medical coordinator to assess how to proceed. Staff should try to block and redirect Resident A to another activity to divert his attention. The AFC assessment plan states that he does not engage in any self-injurious behavior.

The Behavior Treatment Plan for Resident B states that per the reports, Resident B will become aggressive towards others when transitioning from one space to another and changes to his routine. Because of the frequency of and severity of Resident B's challenging behaviors, he requires supervision while in the community, delayed egress exit doors, locked kitchen, and laundry room. Staff should be in line-of-sight of Resident B for 16 hours a day and staff should remain 4-6 feet from Resident B during those 16 hours to intervene when needed. Staff will change to arms reach of Resident B during times of agitation. The only time he does not need 1:1 staff is when Resident B is using the restroom, or when he is in his personal bedroom. During these times staff will still complete 15-minute checks. Resident B requires 1:1 staffing in order to keep himself and others safe. Due to the high frequency of physical aggression towards peers and staff that puts him at risk as well as others. Anytime Resident B begins to engage in

aggression, staff should document these behaviors, contact the medical coordinator to assess how to proceed. Staff should try to block and redirect Resident B to another activity to divert his attention. Should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

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:	It was alleged that Resident A has some abrasions on his face and back. Rose Koss, APS Investigator, Lapeer County, shared that the home manager, Ericka Hilliker, stated that while no one saw what occurred, she denied the scratches were caused by staff. It is assumed that another resident, identified as Resident B, was the perpetrator due to the fact that he has scratched and attacked other residents before. She concluded with a substantiation of abuse against the facility. 08/09/2023 Beaumont Hospital documentation indicates that Resident A was seen with a chief complaint of Nasal Injury. The report states that there is a linear abrasion over the nasal bridge, no ecchymosis, deviation, or septal hematoma. It also states that there are small linear lacerations noted on the back and chest of various stages. These do not appear to be in the pattern of a scratch from right hand. Photos of the scratches in various stages were obtained. I observed scratches on Resident A's back, pink in color, within the stages of healing. The scratches appear to have been deep in nature as it is very visible, even its healing stages. This also applies to the scratches observed across the bridge of his nose as well as on the right side of his face. Relative Guardian A stated that the facility continues to allow the other resident to attack Resident A and are not doing anything to prevent the attacks. He fears that the other resident is trying to gouge Resident A's eyes out.

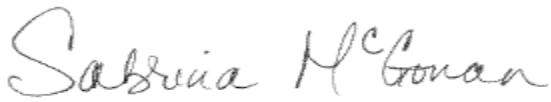
	Staff, Jacquetta Darrough stated that Resident A was in the living room alone when she began doing 15-minute room checks on the residents. When she returned to the living room, Resident B was in the living room with Resident A and Resident A was all scratched up. She does not know what occurred because she did not see anything happen, however, she adds that it is assumed that the scratches were caused by Resident B, who has scratched other residents in the past. Manager, Ericka Hilliker stated to prevent the attacks from occurring, staff attempt to keep the 2 residents separated from one another if they are in the same room or staff division is used to separate them if passing one another in the hall, however, they do share a home and are bound to interact. She adds that the other resident's attacks are random, and have preceding behaviors, therefore they don't know when he will attack. Incident reports dated 7/14, 7/24, 8/5, 9/17, and 9/25/2023 indicate that there were 5 separate incidents in which Resident A was found with multiple scratch marks. Based on the interviews conducted with Rose Koss of APS, Home manager, Ericka Hilliker, Staff, Jacquetta Darrough, Relative Guardian A, an observation and photos of Resident A's scratches, medical and incident reports reviewed, there is sufficient evidence to support the rule violation that Resident A has been attacked and is not being safeguarded.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/09/2023, I placed a call to Margan Yarkosky, License Administrator, for an exit conference. A voice mail message was left requesting a return call.

On 10/10/2023, I placed a call to Nick Burnette, Licensee, for an exit conference. A voice mail message was left requesting a return call. An exit interview was attempted.

IV. RECOMMENDATION

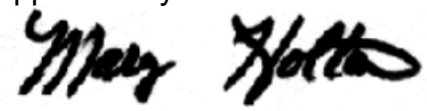
Upon the receipt of an approved corrective action plan. No changes to the status of the license are recommended.



October 13, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



October 13, 2023

Mary E. Holton — Date
Area Manager