GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 30, 2022

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

RE: License #: AS250398408
Investigation #: **Amended** 2022A0871040
Heatherwoode

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.

This report was amended to provide additional methodology and information from the management and staff that were obtained on September 1, 2022.

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) 284-9700.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250398408
Investigation #:	2022A0871040
Complaint Receipt Date:	06/16/2022
Investigation Initiation Date:	06/16/2022
Report Due Date:	08/15/2022
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:	Heatherwoode
Facility Address:	1115 Heatherwoode Rd Flint, MI 48532
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/29/2019
License **Status:**	REGULAR
Effective Date:	09/29/2021
Expiration Date:	09/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A overdosed on Aspirin and was admitted to the ICU.	Yes

III. METHODOLOGY

06/16/2022	Special Investigation Intake 2022A0871040
06/16/2022	APS Referral From Genesee County MDHHS
06/16/2022	Special Investigation Initiated – Letter Received information from Adult Protective Service Worker Jacqueline Williams
06/21/2022	Inspection Completed On-site Interviewed Staff Sheri Williams along with Adult Protective Service Worker Jacqueline Williams
07/19/2022	Inspection Completed On-site Interviewed Home Manager Natalie Skinner, Received copies of Resident A's Behavioral Treatment Plan, Observed Resident A
07/27/20022	Inspection Completed On-site Interviewed Med Coordinator Donell Fisher
07/29/2022	Contact – Telephone call made Telephone Call to Resident A's Guardian A1
07/29/2022	Exit Conference Telephone exit conference with Nicholas Burnett
07/29/2022	Inspection Completed-BCAL Sub. Compliance
07/27/2022	Inspection Completed On-site Interviewed Med Coordinator Donell Fisher

09/01/2022	Contact-Document received Received email from Chief Operating Officer Carrie Aldrich
09/01/2022	Inspection Completed On-site Interviewed Staff Members Sheree Williams, Shianna Jenkins, Monique Anthony, Residents B-E

ALLEGATION:

Resident A overdosed on Aspirin and was admitted to the ICU.

INVESTIGATION:

On June 21, 2022, I conducted an onsite investigation along with Adult Protective Service Worker Jacqueline Williams. I introduced myself to Resident A and she replied, "I don't want to talk to you." Resident A appeared clean with no bruising noted.

I then interviewed Staff Sheri Williams. Ms. Williams indicated Resident A did overdose on Aspirin and believes Resident A stole them from a store. Ms. Williams said, "staff was unaware that she stole them, and she was in the ICU." Ms. Williams said she was working that day and did not know anything about Resident A taking pills until the Med Coordinator Donell Fisher told her. Ms. Williams said Resident A "is not a 1:1 staffing."

On June 21, 2022, Ms. Jacqueline Williams told me she interviewed Resident A at the hospital. Resident A told her that when they went to the store, the residents are allowed to go into the store without staff. Resident A told Ms. Williams that is how she obtained the aspirin.

On July 19, 2022, I conducted an onsite investigation and interviewed Staff Sheri Williams. Ms. Williams indicated Resident A's plan states she is "to be within eyesight" of staff when out in the community.

Resident A was also interviewed, and she said, "staff had nothing to do with it" and that the staff are great.

Staff Sheri Williams gave me a copy of the *AFC Licensing Division – Incident/Accident Report* that was signed and dated on 06/07/2021 by Administrator Morgan Yarkosky. The report indicates what happened, action taken by staff, and corrective measures "See Attachment." The attachment indicates "[Resident A] was in bedroom when staff were doing 15-minute safety checks. Staff found an empty bottle of aspirin. Staff asked [Resident A] where the pills went and [Resident A] told staff she took all the pills to harm herself. Staff quickly reached out to medical coordinator. He instructed them to transport [Resident A] to Hurley Hospital. Staff

transported [Resident A] to Hurley where they evaluated [Resident A] and admitted [Resident A] for more observation. Staff contacted management."

It also indicates "Validated feelings, transported to Hurley, contacted management. Staff will continue to monitor [Resident A] throughout shift."

On July 25, 2022, I conducted an onsite investigation and interviewed Home Manager Natalie Skinner. Manager Skinner stated that Resident A's stories changed many times about when she got the Aspirin. Manager Skinner said staff had no idea that she had them or when she got them.

On July 25, 2022, I telephoned Staff Jenya Griffith. Ms. Griffith indicated that on June 6, 2022, she worked second shift. Ms. Griffith stated that she was the one who took Resident A to the hospital that day. Resident A told Ms. Griffith that she "bought the Aspirin months back and was planning to take them." Ms. Griffith said she had no idea that she had the Aspirin.

On July 27, 2022, I conducted an onsite investigation and interviewed Med Coordinator Donell Fisher. Mr. Fisher said on June 6, 2022, Resident A came to him and told him she swallowed the Aspirin. She told Mr. Fisher she "had gotten it by stealing it a while ago." Resident A told Mr. Fisher that she talked to her mother and her mother told her that her father had passed away. This distressed Resident A but then found out her dad had not passed away. Mr. Fisher said the facility cannot limit the contact Resident A has with her mother and has not talked to her since. Mr. Fisher said Resident A talked to her psychiatrist and is doing great now.

I received a copy of Resident A's 'Behavioral Treatment Plan' that was signed Jeffrey Walker, BCBA, LBA on May 26, 2022. It indicates "She (Resident A) will be supervised in the community by care staff and will receive 'Field of Vision' supervision when in the community. Field of vision means that at any time, [Resident A's] staff should be able to immediately make visual contact, speak with her, and provide assistance as needed."

On July 29, 2022, I interviewed Resident A's Guardian A1 via telephone. Guardian A1 stated Resident A told her she was out shopping with staff and other residents. Resident A said that the residents went into the store without staff and that is how she stole the Aspirin. Guardian A1 indicated Resident A was supposed to be in "field of vision but was not." Guardian A1 sated she feels that the staff at the facility are not trained to deal with Resident A's behaviors, but Heatherwoode was the only place that would take her when she left Kalamazoo Psychiatric Hospital.

On July 29, 2022, I conducted a telephone exit conference with Licensee Nicholas Burnett. Licensee Burnett was advised this is a rule violation as staff did not keep Resident A within 'field of vision' when she was on an outing.

On September 1, 2022, Chief Operating Officer Carrie Aldrich emailed me that she spoke with Home Manager Natalie Skinner. Ms. Aldrich reported "Natalie Skinner, the home manager, had spoken to the staff and inquired whether they have ever allowed residents to enter in a store unsupervised or were under the impression that was acceptable. All staff denied ever allowing this to happen or hearing that it had." She also reported that Resident A's Behavior Plan has been updated to reflect that she has 1:1 at all times when taken into the community by Flatrock. In addition, her belongings are searched each time she returned to the care home and any packages delivered to the home for her are search prior to being given to her.

On September 1, 2022, I conducted an unannounced onsite investigation and interviewed Staff Sheree Williams. Ms. Williams reported that she has transported residents and she "has to go in the store with them and has to be eyes on them, field of vision." Ms. Williams said she is about four feet away from them and she can still see them. She also said she helps them count their money. Ms. Williams said Resident A "has never been on an outing with her family or anyone else."

I also interviewed Staff Shianna Jenkins. Ms. Jenkins reported she has taken the residents on outings and has never dropped them off. She also reported that she is in 'field of vision' with the residents when on an outing.

I them interviewed Monique Anthony. Ms. Anthony reported that she has transported residents and has never "just dropped them off." Ms. Anthony said the residents are in field of vision, which is about 3-4 feet away. Ms. Anthony reported that there is always two staff and 5-6 residents that go on the outing.

On September 1, 2022, I attempted to interview Resident A and when I introduced myself, she replied "I don't want to talk to you." I then interviewed Residents B-E. Resident B indicated staff go into the store and they can always see what they are doing. Resident C stated she has never gone into a store by herself, and staff go with them. Resident D said she has never gone into a store by herself. Resident E indicated when she goes on outings, staff are always with her in the store.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A told Adult Protective Service Worker that when they went to the store, the residents went in by themselves. Resident A's 'Behavioral Treatment Plan' indicates she needs to be in 'field of vision' of staff while out in the community. Resident A stole Aspirin and consumed them while living in the facility. Residents B-E reported staff go in the store with them. Staff interviewed reported that 2 staff supervise 4 or 5 residents at a time, when taking them to the store. Staff Williams reported Resident A has never been on an outing with family members or anyone else. Resident A was able to obtain a bottle of aspirin while on an outing with staff. We confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

09/30/2022

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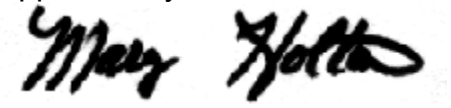
Kathryn A. Huber Date
Licensing Consultant

Approved By:



09/30/2022

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Mary E. Holton Date
Area Manager