GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 30, 2021

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

RE: License #: AS630391550
Investigation #: 2021A0991024
Brandon East

Dear Mr. Burnett:

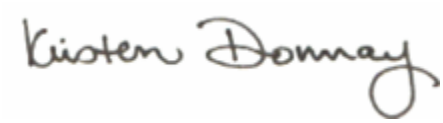
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630391550
Investigation #:	2021A0991024
Complaint Receipt Date:	06/04/2021
Investigation Initiation Date:	06/07/2021
Report Due Date:	08/03/2021
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Licensee Designee:	Nicholas Burnett
Name of Facility:	Brandon East
Facility Address:	301 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 964-1430
Original Issuance Date:	04/24/2018
License Status:	REGULAR
Effective Date:	10/24/2020
Expiration Date:	10/23/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has not been receiving his medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/04/2021	Special Investigation Intake 2021A0991024
06/07/2021	Special Investigation Initiated - Telephone Call to Resident A's mother
06/07/2021	Contact - Telephone call made To Office of Recipient Rights (ORR) worker, Johnna Cade
06/07/2021	Referral - Recipient Rights Referred to ORR
06/10/2021	Contact - Telephone call made Left message for medication coordinator
06/10/2021	Contact - Telephone call made Left message for administrator
06/30/2021	Contact - Telephone call made Call to Flatrock Manor- left message
07/13/2021	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident A and case manager
07/13/2021	Contact - Document Received Copy of individual plan of service
07/20/2021	Contact - Telephone call made To Flatrock Manor- left message
07/20/2021	Contact - Telephone call received From clinical director, Patty Lee - requested medication records

07/20/2021	Contact - Telephone call made To medical coordinator, Kayla Elrich
07/20/2021	Contact - Telephone call made To home manager, Amanda Hall
07/22/2021	Contact - Telephone call made To clinical director, Patty Lee
07/22/2021	Contact - Telephone call made Left message for previous medication coordinator, Nakia Loafer
07/23/2021	Contact - Document Received Medication records
07/28/2021	Contact - Telephone call made Left message for medication coordinator
07/29/2021	Contact - Telephone call made To medication coordinator, Kayla Elrich
07/29/2021	Contact - Telephone call made To case manager, Nicole Szarek
07/29/2021	Contact - Telephone call made To Resident A's mother
07/29/2021	Contact - Document Received Discharge paperwork/prescriptions
07/30/2021	Exit Conference Via telephone with licensee designee, Nick Burnett

ALLEGATION:

Resident A has not been receiving his medications as prescribed.

INVESTIGATION:

On 06/07/21, I initiated my investigation by interviewing Resident A's mother via telephone. She indicated that Resident A moved to Flatrock Manor's Brandon East home in February of 2021 from an inpatient facility in Grand Rapids, MI. She expressed concern that there have been frequent changes with staff and management since Resident A moved into the home. The facility does not currently have a home manager and the communication regarding Resident A's care has been very limited. On

05/21/21, Resident A went back to Grand Rapids for hernia surgery. Resident A was prescribed a narcotic, Oxycodone, for pain as well as a stool softener following the surgery. He returned to the home on 05/23/21. Resident A's mother indicated that she was not sure if Resident A ever received these medications, because the medication coordinator, Nakia Loafer, did not communicate well with her. Resident A was only supposed to take the narcotic for pain for a few days after his operation. When Resident A came for a home visit on 06/04/21, he still had the Oxycodone with his medications. Resident A's mother indicated that she was not sure why staff included this medication, as Resident A did not need it for more than two days after surgery. Resident A's mother indicated that she disposed of the medication. Resident A was also prescribed an antibiotic for a rash. When Resident A came for a home visit, Resident A's mother noticed he had more pills remaining than he should have. He was supposed to be getting the medication twice a day, but during a follow up visit with the dermatologist, Resident A stated that he was only getting the medication once a day in the evenings.

On 07/13/21, I conducted an unannounced onsite inspection at Brandon East and interviewed Resident A. Resident A indicated that he gets all of his medications like he is supposed to. Staff give him his medications every day. He was previously prescribed an antibiotic medication for a rash. Staff did not know that he was supposed to be getting the medication twice a day, so he was only receiving it at night. Resident A's mother reminded him that he was supposed to take it in the morning too, so staff began giving it to him twice a day. The rash is gone now, and he no longer takes this medication. Resident A indicated that he had hernia surgery in May. After the surgery, he was prescribed a pill to help him go to the bathroom and a pain pill. He took the stool softener, but he never took the pain medication because he did not feel like he needed it. There was never a time when he asked for pain medication and staff refused to give it to him. It was his choice not to take it, because he was not experiencing pain.

On 07/13/21, I interviewed Resident A's case manager, Nicole Szarek. Ms. Szarek indicated that she was not aware of any issues with Resident A's medications. She stated that the previous medication coordinator, Nakia Loafer, is no longer with the agency. The new medication coordinator is Kayla Elrich.

On 07/20/21, I interviewed the medication coordinator, Kayla Elrich via telephone. Ms. Elrich indicated that she was not aware of any issues with regards to Resident A not receiving his medications as prescribed. She stated that she took over as the medication coordinator a few weeks ago. Ms. Elrich reviewed Resident A's medication logs and indicated that she did not see an antibiotic prescribed to Resident A in May or June 2021. It was not listed on his discontinued medication orders either. She stated that they use an electronic system, Quick MAR, for passing medications. The pharmacy enters the new orders into the system, and they appear on the electronic medication administration record (E-MAR). The medication coordinator is responsible for reviewing the medications and E-MAR to ensure that they are correct.

On 07/20/21, I interviewed the home manager, Amanda Hall, via telephone. Ms. Hall indicated that she has been the home manager since June 2021. She was not aware of Resident A not receiving his medications as prescribed. She stated that Resident A has not been taking an antibiotic for a rash since she has been working in the home. Ms. Hall indicated that prescriptions are sent to the pharmacy, then the pharmacy enters the prescriptions into the Quick MAR system. The home has an assigned medication coordinator, who is supposed to double check the medication records and prescriptions for accuracy. Ms. Hall indicated that Nakia Loafer was the previous medication coordinator assigned to the home, but she left the company. Ms. Hall never had any conversations with Resident A or his mother about his prescriptions being incorrect. She stated that she was not working in the home when Resident A had his hernia surgery.

I reviewed a copy of Resident A's medication administration record (MAR) from May 2021 and June 2021. The MARs did not list an antibiotic and did not show a stool softener or Oxycodone as being prescribed to Resident A following his surgery on 05/21/21. I followed up with the medication coordinator, Kayla Elrich, via telephone on 07/29/21. Ms. Elrich indicated that Resident A's mother took him to his appointment when he had his hernia surgery. He stayed with his mother for a few days following the surgery. When asked if there were any new prescriptions or documents provided after his surgery, Resident A's mother told staff no. Ms. Elrich indicated that if Resident A returned to the facility with medications, then they should be listed on the MAR. She stated that when residents go to medical appointments with family members, they are sent with a face sheet with their information, a medication list, and an appointment record form for the doctor to fill out. Ms. Elrich indicated that this paperwork was not received following Resident A's surgery. She stated that there is a process to follow up to obtain this documentation if it is not received. She was not the medication coordinator at the time and was not sure why the documentation was not obtained. Ms. Elrich indicated that there was no documentation on file showing that Resident A had an appointment with a dermatologist. She stated that his mother also took him to this appointment. Ms. Elrich stated that when a resident goes on a home visit, the guardian or family member signs off on the medications that are given to them. She stated that she would check to see if this was completed for Resident A's home visits in May and June. To date, I did not receive any additional documentation from Ms. Elrich.

On 07/29/21, I followed up with Resident A's mother via telephone. She indicated that she had the prescriptions filled in Grand Rapids following Resident A's dermatologist appointment and hernia surgery. She stated that she provided the medications to staff who transported Resident A back to the facility following his home visit. She did not recall the staff person's name. Resident A's mother indicated that she did not receive any paperwork from the facility to have completed following his medical appointments. She stated that Resident A was not complaining about any pain when he returned to the facility on 05/23/21, but she sent the Oxycodone to the facility since it was so soon after his surgery. She was concerned when Resident A came for a home visit two weeks later and the pain medication and stool softener were still included with his medications. Resident A should not have been taking these medications at this point. Resident A's

mother indicated that she disposed of the Oxycodone because it was no longer needed. Staff at the facility did not follow up or ask any questions when Resident A returned to the facility without the medication. Resident A's mother indicated that she does not typically sign off on the medications that she receives when she picks up Resident A for a home visit. Last weekend was the first time staff asked her to sign off on the medications.

Resident A's mother provided a copy of Resident A's after visit summary from his surgery on 05/21/21 for a right inguinal hernia. It indicates that his medications changed, and he is to start taking Oxycodone (Roxicodone) and Senna-Docusate (Pericolace). The instructions for the Senna-Docusate 8.6-50mg indicate to take one tablet by mouth nightly. The instructions for Oxycodone 5mg immediate release tablets indicate to take one tablet by mouth every two hours as needed for pain for up to 12 days. Resident A's mother stated that Resident A was also prescribed Minocycline 100mg on 05/19/21 - take one tablet twice daily and Ketoconazole shampoo on 06/04/21 by the dermatologist at the West Michigan Dermatology. None of these medications were listed on Resident A's MAR for May or June 2021.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A did not receive his medications as prescribed. Resident A and his mother reported that Resident A was only receiving his Minocycline antibiotic once per day, but the prescription indicated to take one tablet twice daily. This medication was not listed on Resident A's medication administration record, so it cannot be determined that staff were giving it pursuant to label instructions. The prescriptions for Oxycodone and Senna-Docusate, which Resident A was prescribed following his hernia surgery on 05/21/21, were also not list on the medication administration record. The Oxycodone was prescribed on an as needed basis for 12 days following surgery, but the medication was given to his mother when she picked him up for a home visit more than 12 days after his surgery on 06/04/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed a copy of Resident A's after visit summary from his surgery on 05/21/21 for a right inguinal hernia. It indicates that his medications changed, and he is to start taking Oxycodone (Roxicodone) and Senna-Docusate (Pericolace). The instructions for the Senna-Docusate 8.6-50mg indicate to take one tablet by mouth nightly. The instructions for Oxycodone 5mg immediate release tablets indicate to take one tablet by mouth every two hours as needed for pain for up to 12 days. Resident A's mother indicated that Resident A was also prescribed Minocycline 100mg on 05/19/21- take one tablet twice daily and Ketoconazole shampoo on 06/04/21 by the dermatologist at the West Michigan Dermatology.

I reviewed a copy of Resident A's medication administration records (MAR) for May and June 2021. None of these medications were listed on Resident A's MAR for May or June 2021. The medication coordinator, Kayla Elrich, indicated that she was not the medication coordinator at the time these medications were prescribed. She stated that if the medications were filled when Resident A was on a home visit, then the medication coordinator at the time, Nakia Loafer, should have entered them into the Quick MAR system when Resident A returned to the facility. Ms. Elrich indicated that when residents go to medical appointments with family members, they are sent with a face sheet with their information, a medication list, and an appointment record form for the doctor to fill out. Ms. Elrich was unable to locate any appointment records or medication instructions regarding Resident A's hernia surgery or dermatologist appointment. She stated that there is a process to follow up to obtain this documentation if it is not received, but she did not know why this was not completed by the previous medication coordinator.

On 07/30/21, I conducted an exit conference via telephone with the licensee designee, Nick Burnett, and the chief operating officer, Carrie Aldrich. Mr. Burnett indicated that the prescriptions would not be listed on the MAR if they did not receive a copy of the prescription or if it was not filled by their pharmacy. Ms. Aldrich indicated that she was familiar with the situation but was not directly involved. She stated that she was informed that Resident A's mother did not provide any documentation or medications to the facility following his hernia surgery. Ms. Aldrich indicated that their residents do not typically go to medical appointments while they are on home visits, so there may be some improvements that need to be made regarding this process, including improved communication and following the documentation protocols that are already in place.

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: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	Based on the information gathered through my investigation and a review of the documentation, there is sufficient information to conclude that Resident A's May and June 2021 medication logs did not include the prescription information for his Oxycodone, Senna-Docusate, Minocycline, and Ketoconazole shampoo. These medications were prescribed and filled while Resident A was on a home visit and the information was not transcribed onto his medication administration records upon his return to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's record did not include instructions for his prescription medications or a record of physician contacts. The facility did not obtain an appointment information record, discharge paperwork, or prescription instructions following the appointments that Resident A attended while on home visits, including his hernia surgery and dermatologist appointment.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

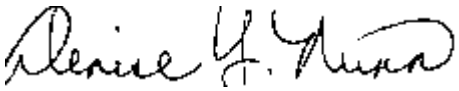
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

07/30/2021

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



07/30/2021

_____

Denise Y. Nunn Date
Area Manager