GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 13, 2022

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

RE: License #: AM440388517
Investigation #: 2022A0580039
Elba North

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.
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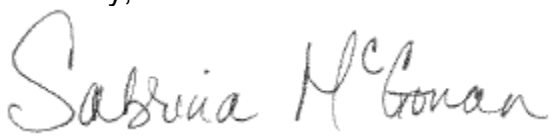
If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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,



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 #:	2022A0580039
Complaint Receipt Date:	05/18/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	07/17/2022
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:	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?
Staff admitted to running out of Resident A's medications.	Yes

III. METHODOLOGY

05/18/2022	Special Investigation Intake 2022A0580039
05/18/2022	APS Referral- A complaint conducted by APS was received for investigation.
05/20/2022	Special Investigation Initiated – Telephone call was made to Ms. Rose Koss, APS Investigator in Lapeer County.
05/20/2022	Inspection Completed On-site- Onsite inspection was conducted at Elba North.
07/05/2022	Contact – Email received from Md. Rose Koss of APS.
07/08/2022	Contact – A Telephone call was made to Ms. Shayna Moore, Med Coordinator for Elba North.
07/11/2022	Contact – Telephone call was made to Relative Guardian A1, assigned guardian for Resident A.
07/12/2022	Contact – Document Received.
07/13/2022	Exit conference was held with the licensee designee, Mr. Nick Burnett.

ALLEGATION:

Staff admitted to running out of Resident A's medications.

INVESTIGATION:

On 05/19/2022, I received a complaint via BCAL Online complaints. This complaint was opened by APS for investigation.

On 05/20/2022, I spoke with Ms. Rose Koss of APS in Lapeer County. She shared her investigation thus far has revealed the facility did in fact run out of Resident A's medication. Ms. Shanya Moore, the Medication Coordinator at Elba North indicated she contacted Genesee County Health Systems (GHS) on 05/12/2022 and 5/13/2022 and left a voice mail indicating that Resident A needed a prescription refill. Resident A ran out of the medication on 05/15/2022 and was without one dose of his Ativan on 05/16/2022. The facility's personal care physician (PCP), Ms. Lisa Lindsay wrote a 9-day prescription for Resident A until GHS refilled his medication. She also shared that Resident A was autistic and non-verbal. Subsequently, he was unable to participate in an interview.

On 05/20/2020, I conducted an onsite inspection at Elba North. Resident A was observed while in the kitchen area eating a snack. Resident A was well groomed and dressed appropriately. Resident A appeared to be receiving appropriate care. I confirmed Resident A is non-verbal, diagnosed with autism, and was unable to participate in an interview.

On 07/05/2022, I received an email from Ms. Rose Koss of APS. She indicated that due to Resident A being without his medication for at least one day, she did substantiate against the facility for neglect.

On 07/08/2022, I made a call to Ms. Moore, who confirmed Resident A did run out of his medication for 2 dosages. He is scheduled to take the medication 3 x's a day. Ms. Moore also confirmed an emergency script was written by the facility's PCP.

On 07/11/2022, I spoke with Relative Guardian A1, assigned guardian for Resident A, who stated he was informed of the allegation from a staff member at Resident A's school. According to Relative Guardian A1, upon receiving this information, he immediately followed up with Ms. Moore. To his knowledge, an emergency prescription was then written and filled. Relative Guardian A1 indicated that he tries to give Elba North some consideration. He understands that it is a tough business. However, things continuously fall through the cracks and no one seems to know how things occurred. Relative Guardian A1 stated Resident A has never run out of his medication, to his knowledge, while at the facility.

On 07/12/2022, I received an emailed copy of the May 2022 Medication Log for Resident A. The log indicates Resident A is prescribed 2mg of Lorazepam, 3 times a

day, at 8am, 2pm and 8pm. Resident A did not receive his 2pm or 8pm medication on 05/17/2022, due to waiting for the prescription to be filled.

On 07/13/2022, I conducted an exit conference with ~~the~~ licensee designee Nick Burnett and shared with him the findings of this investigation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken or applied pursuant to label instructions
ANALYSIS:	Based upon my investigation, which included interviews with Lapeer County APS Specialist Rose Koss, Medication Coordinator Shanya Moore, and Relative Guardian A1, as well as a review of pertinent documentation relative to this investigation, there is enough evidence to substantiate the allegation Resident A did not receive his 2pm or 8pm Lorazepam on 05/17/2022, due to waiting for the prescription to be filled.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

Sabrina McGowan July 13, 2022

Sabrina McGowan Date
Licensing Consultant

Approved By:

Michele Streeter July 13, 2022

Michelle Streeter Date
Section Manager