STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 21, 2022

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

RE: License #: AM440388517
Investigation #: 2022A0582039
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.
- 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388517
Investigation #:	2022A0582039
Complaint Receipt Date:	06/15/2022
Investigation Initiation Date:	06/15/2022
Report Due Date:	08/14/2022
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

	Violation Established?
From 04/11/2022 through 06/06/2022, Resident A was being administered Diazepam twice in the morning, at 7 AM at the facility and 9 AM at his school, Lapeer ISD. Diazepam was prescribed to be administered once in the morning.	Yes

III. METHODOLOGY

06/15/2022	Special Investigation Intake 2022A0582039
06/15/2022	Special Investigation Initiated - Letter With Jody Marsh, Livingston County ORR
06/30/2022	Inspection Completed On-site Interview with Erika Hilliker, Home Manager, and observation of Resident A
07/06/2022	Contact - Telephone call made With Tiffany Ellis, Flatrock Healthcare Manager
07/07/2022	Inspection Completed On-site Interview with Shiana Moore, Medical Coordinator
07/11/2022	Contact - Telephone call made With Madison Roush, Livingston County CMH Case Manager
07/11/2022	Contact - Document Sent Email to Jody Marsh, ORR Livingston County CMH
07/18/2022	Contact - Telephone call made With Case Rich, Program Administrator, Lapeer ISD
07/18/2022	Contact - Telephone call made With Guardian A
07/20/2022	Exit Conference With Nicholas Burnett, Licensee Designee
07/20/2022	Inspection Completed-BCAL Sub. Compliance

07/20/2022	Corrective Action Plan Requested and Due on 08/05/2022

ALLEGATION:

From 04/11/2022 through 06/06/2022, Resident A was being administered Diazepam twice in the morning, at 7 AM at the facility and 9 AM at his school, Lapeer ISD. Diazepam was prescribed to be administered once in the morning.

INVESTIGATION:

I received this complaint on 06/15/2022, and contacted Jody Marsh, ORR Livingston County CMHA on the same day. Ms. Marsh stated that she was waiting to speak with Flatrock Manor's Healthcare Manager Tiffany Ellis. Ms. Marsh stated that she was provided the 4/11/2022 physician order. Ms. Marsh clarified that the medication in question was Diazepam, not Ativan as originally reported. Ms. Marsh stated that she was provided with Lapeer ISD's medication log, which did not match up with the facility's medication log.

On 06/30/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Erika Hilliker, Home Manager. Ms. Hilliker stated that she was recently assigned as manager and was not aware of the issue with Resident A's medication at the time. Ms. Hilliker stated that Shiana Moore, the Medical Coordinator at the facility, could provide further details about the complaint.

I attempted to interview Resident A, who could not be interviewed due to his diagnoses. Resident A appeared to be receiving proper care and supervision. Ms. Hilliker stated that she was not aware of any medication side effects that Resident A may have experienced.

On 7/06/2022, I contacted Tiffany Ellis, Healthcare Manager for Flatrock. Ms. Ellis stated that she would fax Resident A's Medication Administration Records (MAR) from April 2022 through June 2022. I reviewed the MARs, which documented that Resident A was prescribed Diazepam Tab 5MG beginning 04/11/2022, with instructions to "take 1 tablet by mouth three times daily." The MARs documented that Resident A was being administered Diazepam at 7 AM, 3 PM, and 8 PM.

On 07/07/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Shiana Moore, Medical Coordinator. Ms. Moore stated that there was a discrepancy between what they were administering Resident A at the facility and what the school was administering. Ms. Moore stated that the school was administering medications from a March 2022 medication list, and the school did not receive an updated medication order/list for April 2022 through the beginning of June 2022. Ms. Moore stated that the previous order in March 2022 had Resident A taking Diazepam at 8 AM, 2 PM, and 8 PM, then the order changed in April 2022 to be

administered at 7 PM, 2 PM and 8 PM. Ms. Moore stated that she was a new Medical Coordinator and assumed that the school was working from the same medication orders as the facility, so she did not send a medication order/list for April 2022. Ms. Moore stated that Resident A was being administered Diazepam at the facility in the morning and at the school that same morning. Ms. Moore stated that there were no side effects from Resident A being administered the Diazepam more times than required. Ms. Moore stated that the discrepancy has since been corrected, and she ensures that the school and facility are working from the same medication order. I reviewed the March 2022 MAR, which documented that Resident A was prescribed Diazepam at 8 AM, 2 PM, and 8 PM.

On 07/11/2022, I interviewed Madison Roush, Livingston County CMH Health Support Coordinator/Case Manager. Ms. Roush stated that the school was not informed of a change in Resident A's Diazepam medication time after he had a medication review in April 2022. Ms. Roush stated that the school continued to administer Resident A'a Diazepam from a previous order in March 2022, under the assumption that there were no changes to his medication. Resident A was receiving the same medication twice in the mornings.

On 07/11/2022, I emailed Jody Marsh, ORR Livingston County CMHA. Ms. Marsh stated that she would provide the medication log that Lapeer ISD was using before the discrepancy was discovered. Ms. Marsh stated that she would be substantiating in this matter. Ms. Marsh stated that although she had not received Resident A's March 2022 medication order, she was verbally told by Tiffany Ellis, Flatrock Healthcare Manager, that the order was different from the April 2022 order. Ms. Marsh stated that she was informed that Shaina Moore was the medical coordinator at the time of the medication discrepancy, although Ms. Moore denied that she was the medical coordinator at the time.

I reviewed the Medication Log from Resident A's school, which documented a start date of March 22, 2022, for Diazepam 5MG crushed in applesauce at 8:30 AM.

On 07/18/2022, I interviewed Casey Rich, Program Administrator at Lapeer ISD Ed Tech. Ms. Rich stated that she became aware that they were incorrectly administering Diazepam after receiving a call from Shaina Moore, Medical Coordinator, in early June. Ms. Rich stated that Ms. Moore informed her that there was a change that was not communicated to them. Ms. Rich stated that in the past, the facility would fax over any changes in medications, but this did not occur. Ms. Rich stated that currently they request the medication orders at the beginning of each month regardless of if there was no change. Ms. Rich stated that she was no aware of any side effects for Resident A being administered the same medication twice in the morning.

On 07/18/2022, I contacted Guardian A, who stated that she was made aware of the medication discrepancy from Casey Rich at Resident A's school. Guardian A stated that someone should be held accountable for this mistake.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on interviews with Ms. Marsh, Ms. Ellis, Ms. Moore, Ms. Roush, Ms. Rich, and Resident A's medical documentation, there is sufficient evidence to suggest that Resident A was mistakenly receiving her prescribed Diazepam twice in the mornings at the facility and at school from 04/11/2022 through 06/06/2022. Medical Coordinator Shiana Moore admitted that the facility did not communicate an updated medication order to Resident A's school. The licensee did not ensure that Resident A's school had an updated prescription for administering Resident A's Diazepam. The investigation supports that this rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/20/2022, I conducted an Exit Conference with Nicholas Burnett, Licensee Designee. I informed Mr. Burnett of the findings of the investigation and the need for a Corrective Action Plan.

IV. RECOMMENDATION

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

07/20/2022

Derrick Britton — Date
Licensing Consultant

Approved By:

07/21/2022

Mary E. Holton — Date
Area Manager