GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 28, 2023

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

RE: License #: AM250402027
Investigation #: 2023A0871056
Goodrich South

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 (517) 643-7960.

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 #:	AM250402027
Investigation #:	2023A0871056
Complaint Receipt Date:	07/03/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	09/01/2023
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:	Goodrich South
Facility Address:	7290 State Rd. Goodrich, MI 48438
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	12/23/2019
License **Status:**	REGULAR
Effective Date:	06/23/2022
Expiration Date:	06/22/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given 200 mg of Seroquel at the AFC and he is allergic to the medication. The meds caused him to react violently and began to bang his head on the floor. Second shift gave him this medication and it is unknow why. Resident A was taken to the hospital.	Yes

III. METHODOLOGY

07/03/2023	Special Investigation Intake 2023A0871056
07/03/2023	APS Referral From Genesee County MDHHS
07/03/2023	Special Investigation Initiated - Telephone Telephone call to APS Worker Dan Spalthoff by Licensing Consultant Sabrina McGowan
07/19/2023	Contact - Document Received Received notes from Adult Protective Service Worker Daniel Spalthoff
07/28/2023	Contact - Document Received Received information from Adult Protective Service Worker Danial Spalthoff
08/23/2023	Inspection Completed On-site Interviewed Home Manager Doug Keller and Med Coordinator Naajiyahn Randall
08/25/2023	Contact - Telephone call made Telephone call to Shamir Chappell
08/25/2023	Contact - Telephone call made Telephone call to Guardian A1
08/28/2023	Exit Conference Telephone exit conference with Nicholas Burnett
08/28/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
Resident A was given 200 mg of Seroquel at the AFC and he is allergic to the medication. The meds caused him to react violently and began to bang his head on the floor. Second shift gave him this medication and it is unknow why. Resident A was taken to the hospital.

INVESTIGATION:
On July 28, 2023, Adult Protective Service Worker Daniel Spalthoff emailed me Resident A's emergency room notes written by Dr. Monique Ice on July 2, 2023. At admittance, Dr. Ice wrote "Per caregiver pt received 200 mg of Seroquel at 1930 tonight. Pt has an allergy to Seroquel. Per pt chart reaction is violent behavior. Pt in no signs of distress at this time." Resident A arrived at Hurley Hospital on 07/02/2023 @ 8:27 pm, admitted on 07/02/2023 @ 10:10 and discharged on 07/03/2023 @ 3:40 am.

On August 23, 2023, I conducted an unannounced onsite investigation and interviewed Home Manager Doug Keller. Manager Keller indicated that he was not working at the time of the incident. Manager Keller stated Resident A "bangs his head a lot" and his head banging had nothing to do with him taking the Seroquel. Manager Keller said the staff member that Resident A grabbed the meds from is out of the country.

Manager Keller provided me with a copy of an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Administrator Morgan Yarkosky dated on July 3, 2023. Date of incident indicates 07/02/2023 @ 7:30 pm. What happened indicates "Around 7:32 pm meds were being passed by Staff and doing a shadowing under med log for Staff #1 training Staff #2. While doing the training Staff #2 was walking side by side with Staff #1 going to the proper resident's room for med pass. Just as staff walked into living room, Staff #1 answered (redirected) a resident's question, but [Resident A], who is usually one of the first residents to get nighttime meds excitedly jumped up and grabbed meds from Staff #2 and consumed them before either of staff could stop him. Immediately after lead on shift contacted medical coordinator to talk with her in taking the appropriate steps for the situation at hand. [Resident A] was sent to hospital with a staff member for medical treatment and observation at Hurley. Staff will continue to stay with [Resident A] until given further instructions."'

Action taken indicates "Contacted house manager, contacted medical coordinator, Sent Resident to hospital promptly with staff."

Corrective measures indicates "Be more cautious with Medication." An addendum indicates "[Resident A] got vital signs at ER and were within normal limits. [Resident A was then released back to the care home with no new orders."

On August 23, 2023, at the onsite investigation, I interviewed Med Coordinator Naajihan Randall. Med Coordinator Randall indicated that a phone call was

received from Staff Shamir Chappell, and it was reported that [Resident A] grabbed meds out of the hand of the new staff and ingested them. Med Coordinator advised Staff Chappell to send Resident A to the hospital. Med Coordinator said Resident A's blood levels were checked, they were within the normal limits, and Resident A was sent home.

On August 25, 2023, I attempted to interview Resident A, but he is severely cognitively impaired and unable to be interviewed. Resident A appeared clean, and no marks or bruising was noted on him.

On August 25, 2023, I telephoned Staff Shamir Chappell. Staff Chappell advised he was told "several different versions of how to train someone to pass meds." Staff Chappell indicted he "had a misunderstanding of shadowing." Staff Chappell indicated he was getting the meds ready, and they were handed to Staff #2, Jasmine McKay. Staff Chappell stated they walked through the living room and a resident needed his attention, and the resident was to his left. When Staff Chappell turned back and as soon as they reached the hallway, Resident A "grabbed the meds out of her hand and took them."

On August 26, I telephoned Guardian A1. Guardian A1 indicated Resident A has a history of head banging and goes to the emergency room a lot. Guardian A1 stated Resident A has been in Goodrich South since 2020 and has been doing very well. Guardian A1 has no concerns about the care Resident A receives in the facility.

On August 28, 2023, I conducted a telephone exit conference with Licensee Nicholas Burnett. Resident A did ingest another resident's medications and had to go to the emergency room. Therefore, a rule violation was cited, and I advised Licensee Burnett about the citation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Staff Shamir Chappell said Resident A grabbed the medications out of Staff Jasmine McKay's hand and ingested them. Staff McKay is out of the country and unable to be interviewed. Resident A was taken to the emergency room because he ingested another resident's medications. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

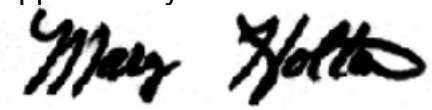
IV. RECOMMENDATION

Upon receipt of an acceptable correction plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

08/28/2023

Kathryn A. Huber Date
Licensing Consultant

Approved By:



08/28/2023

Mary E. Holton Date
Area Manager