GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

July 31, 2023

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

RE: License #:	AS250392270
Investigation #:	2023A0572044
	Primrose

Dear Mr. Burnett:

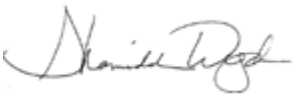
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250392270
Investigation #:	2023A0572044
Complaint Receipt Date:	06/05/2023
Investigation Initiation Date:	06/09/2023
Report Due Date:	08/04/2023
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:	Primrose
Facility Address:	476 Primrose Flushing, MI 48433
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	09/01/2022
Expiration Date:	08/31/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B have not been taken to their medication review appointments. Resident A has not been taken to five medication appointments. Resident B has not been taken to two medication appointments.	Yes

III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A0572044
06/09/2023	Special Investigation Initiated - On Site An initial on-site inspection was conducted by AFC consultant Anthony Humphrey.
07/11/2023	Inspection Completed On-site An unannounced follow-up on-site was conducted.
07/17/2023	APS Referral APS referral completed.
07/17/2023	Contact - Document Sent An email was sent requesting documentation.
07/20/2023	Contact - Document Received Requested documentation received.
07/24/2023	Contact- Telephone call made I left a voicemail for former medical coordinator Trenae Burnette requesting a return call.
07/27/2023	Contact- Telephone call made I attempted to contact Trenae Burnette via phone.
07/27/2023	Exit Conference I spoke with licensee designee Nicholas Burnette via phone.
07/27/2023	Contact- Telephone call received I spoke with staff Trenae Burnette via phone.
07/27/2023	Contact- Telephone call made I made a follow-up call to case manager Crystal Perkins.

07/27/2023	Contact- Document Received I received an email from licensee designee Nicholas Burnette.

ALLEGATION: Resident A and Resident B have not been taken to their medication review appointments. Resident A has not been taken to five medication appointments. Resident B has not been taken to two medication appointments.

INVESTIGATION: On 06/09/2023, AFC Licensing Consultant Anthony Humphrey spoke Lead Worker, Tiana Ferguson regarding the allegation. Staff Ferguson reported the following:

They had some difficulties with appointments due to the recent turnaround with med coordinators. After their long-time med coordinator left the company, they had gotten a new med coordinator, but she was demoted after only a few months due to lack of performance. The appointments would be made for the residents, but she would not let the staff know until the last minute that they had an appointment. The med coordinator would then have to reschedule appointments, but there was no follow through. They used to tell her that the appointments have to be written down so they can see it in advance, instead of telling them 20 minutes prior to the appointment because by that time, they would be already late and have to scramble to change their day around. The previous long time med coordinator would have every resident's appointment written down on the wall calendar for everyone to see, so they knew in advance when those appointments were to take place so that they can plan accordingly. The current med coordinator started about two weeks ago and she has the entire wall calendar filled out with appointments and the appointment sheets are pre-filled for them for the month. Staff Ferguson reported being aware that Resident A missed some appointments but was not sure if Resident B had missed any appointments.

On 06/09/2023, AFC Licensing Consultant Anthony Humphrey spoke with Lead Worker, Tomika Bennett regarding the allegation. Staff Bennett reported the following:

Staff Bennett reported that the recent med coordinator was not doing her job. She either was not scheduling the appointments or was not informing them of when those appointments until it was too late. Staff Bennett believes that the med coordinator was terminated. The current Med Coordinator is awesome. The current med coordinator had to play catch up from what all the previous med coordinator left her with, and she is doing a great job. Staff Bennett is not aware of how many appointments were missed but wouldn't be surprised at how many missed appointments there may be.

On 06/09/2023, AFC Licensing Consultant Anthony Humphrey spoke with staff Bobreannia Holloway regarding the allegation. Staff Holloway reported the following:

The previous med coordinator did not know how to stay organized. Staff looks at the wall calendar for appointments every day to look for scheduled appointments. If it's not on the calendar, then there's no appointments as far as the staff are concerned. The staff do not schedule appointments, they only provide the transports to the appointments. The previous med coordinator never really communicated to the staff about appointments. She worked as a Med Coordinator for approximately 2 or 3 months and now she is either demoted or terminated. They are now on their third med coordinator within a period of six months. The current med coordinator has been working for two weeks and she is entering all appointments on the wall calendar.

On 06/09/2023, AFC Licensing Consultant Anthony Humphrey observed Resident B sitting in the living room, eating grapes, and watching tv. It appeared that Resident B needs are being met and that Resident B is being providing an adequate amount of care and supervision. Resident B is non-verbal.

On 06/09/2023, AFC Licensing Consultant Anthony Humphrey spoke with Resident A. Resident A was in bed sleep but was willing to speak briefly. Resident A does not have any current issues or concerns. Resident A is currently being taken to all appointments, an but Resident A indicated that there have been some missed appointments in the past but Resident A does not know why.

On 06/09/2023, AFC Licensing Consultant Anthony Humphrey observed the calendar, and it had pre-written appointments entered on specific dates.

On 07/11/2023, I conducted an unannounced on-site at the facility. I interviewed medication coordinator Shawndrekia Cooper, as well as Resident A and Resident B's Genesee Health System case manager Crystal Perkins. Resident A and Resident B were not present. They both were reportedly on outings per their case manager, Crystal Perkins.

Staff Shawndrekia Cooper reported the following:

Upon starting the position Staff Cooper did not receive any old paperwork regarding past appointments and is not aware of any past appointment information but stated that there have been no missed appointments since Staff Cooper started the position. Staff Cooper stated that the following is implemented to stay on top of appointments:

1. Reminders are sent to staff the day before and morning of the appointment.
2. A calendar in the medication room is utilized.
3. Appointment records are kept.

Case manager Crystal Perkins reported the following:

Resident A missed appointments for a medication injection on 04/13/2023, 05/17/2023, and per an email dated 05/26/2023 Resident A missed two lab appointments. The injections are for Invega Sustenna 234 mg once every three weeks. Resident A also missed five other appointments on 12/21/2022, 02/07/2023, 02/07/2023, 03/22/2023, 05/09/2023, and 05/17/2023. It was reported to Case Manager Perkins that Resident A was leaving on outings but was not going to appointments. Resident B usually has behaviors that hinders Resident B from getting to appointments. Resident B has to receive medication just for staff to be able to get Resident B to leave the home. Resident B's behaviors are the main cause of missed appointments. Resident B had one or two missed appointments. Resident A had a significant number of missed appointments that drew attention. Resident A's physician Dr. Ashigh Rungta sent Case Manager Perkins an email stating Resident A had not been seen and inquired about closing out Resident A's file. Resident A's last visit to his doctor was about a year prior, but medication reviews are supposed to be completed quarterly, or more if necessary for psych meds. Resident A's last appointment with Dr. Rungta was 10/05/2022.

On 07/20/2023, I received requested documentation via email for Resident A and Resident B.

Resident A's *Resident Care Agreement* dated for 03/17/2023 states that the basic fees include the following transportation services "*Routine medical, dental, vision appointments and community outings.*"

Resident B's *Resident Care Agreement* dated for 10/27/2022, states that the basic fee includes the following transportation services "*routine medical, dental, vision appointments and community outings.*"

On the signature page of both Resident A and Resident B's *Resident Care Agreement* the box for *"I agree to provide personal care, supervision, and protection, in addition to room and board, and to assure the availability of transportation services as indicated in this agreement, the resident's written assessment plan, and the resident's health care appraisal, as defined in this ac*t" are checked. Both assessment plans are electronically signed by the facility's administrator Morgan Yarkosky.

Resident A's Genesee Health System's (GHS) *Individual Plan of Service* (IPOS) with an effective date of 04/30/2023 was obtained. It was electronically signed by GHS case manager Crystal Perkins on 04/10/2023. Under *Goal #2: Objective A*, it states:

"5. AFC Home staff to schedule all health, medical, psychiatric and dental appointments for [Resident A] as needed. [Resident A's] physical exam is due annually."

“7. Medication manager/Assistant is responsible for setting up the initial appointment and establishing regular contact with the doctor to ensure that [Resident A] has access to medical services.”

“9. AFC home staff to provide transportation to and from all medical and health appointments and provide appropriate supervision throughout the appointments.”

Resident B’s Genesee Health System’s (GHS) *Individual Plan of Service* (IPOS) with an effective date of 10/15/2022 was reviewed. It was electronically signed by GHS case manager Crystal Perkins on 09/13/2022. Under *Goal #1: Objective A*, it states:

“8. AFC Home Staff to schedule all annual health, medical, psychiatric and dental appointments for [Resident B] as needed.”

“7. Medication Manager/Assistant is responsible for setting up the initial appointment and establishing regular contact with the doctor to ensure that [Resident B] has access to medical services.”

“9. AFC Home staff to provide transportation to and from all medical and health appointments and provide appropriate supervision throughout the appointments.”

On 07/27/2023, I received a return call from former staff person Trenae Burnette. Staff Burnette stated the following:

Staff Burnette’s first day as a medication coordinator at the facility was on or around March 13, 2023, and the last day as a medication coordinator was on or around May 20, 2023. Staff Burnette stated that she kept letting management know that she still needed things (to do her job effectively) and was not done with training. Staff Burnette stated that she was never fully trained, felt overwhelmed, and no one was providing her with assistance. The residents’ physicians still had the previous medication coordinator’s (staff Angelene Hardy) phone number, so Staff Burnette was not getting the notices of appointments. Home manager Doron White would screenshot information from Staff Hardy and sent it to Staff Burnette because the doctors’ offices were still contacting Staff Hardy. Staff Burnette stated that she recalls that Resident A missed at least one injection appointment during her time as medication coordinator, and it was rescheduled. Staff Burnette stated that she did not know how to check Resident A’s appointments because she did not know how to use the computer system. Staff Burnette stated that both Resident A and Resident B missed therapy appointments. Resident B did miss a medication review, that she was working on the day she had her job title taken from her. She stated that she no longer works for the company. Staff Burnette stated that she was instructed to reschedule some appointments, and she stated to personally take the residents to their appointments, and every appointment she made, the residents attended. She stated that some appointments were missed due to lack of communication.

On 07/27/2023, I spoke with recipient rights investigator Pat Shephard to get clarification on which appointments were missed. Pat Shephard reported the following:

There were two different medication coordinators that dropped the ball during the timeframe of the missed appointments. It was only after this investigation started, that there were some mix ups with trying to get appointments rescheduled. She stated that she spoke with the highest ranked medication coordinator for the facility who told her that it is staff's responsibility to call and find out when new appointments are set, even if they were not informed of a rescheduled appointment. Staff Burnette reported that she was not trained properly and had excuses. There were notes in the file where a doctor noted that appointments were missed, but that the resident had an ample supply of current medications.

Pat Shepard called me back later on this day and reported the following per the Genesee Health System records:

Resident A was a no-show for medications reviews on:

- 12/21/2022
- 02/07/2023
- 03/22/2023
- 05/09/2023
- 05/17/2023

Resident A had missed injection appointments on:

- 03/01/2023 (no show, but showed up two days later)
- 03/22/2023 (no show, came next day)

Pat Shepard reported that the medication reviews that were missed were not made up on a later date, and this was not resolved until June 2023. Resident A is supposed to have med reviews quarterly. Resident A had a med review in October 2022, and the one Resident A was supposed to attend in December 2022, was not done until June 2023. Resident A was six months late for a quarterly review. The notes indicate that Resident A's doctor wrote "*no show*" but there were no notes on Resident A's medications.

Pat Shepard reported the following regarding Resident B:

Resident B had an appointment on 12/12/2022 that Resident B attended. A follow-up was scheduled for 03/07/2023 but was rescheduled to 03/10/2023. On 03/10/2023 it was rescheduled to 03/16/2023. The appointments were rescheduled, not no-shows. But on 03/16/2023, Resident B was a no-show and on 04/13/2023 he was a no-show again. It was not until June 2023 that Resident B got his appointment three months later.

On 07/27/2023, I spoke with Resident A and Resident B's case manager Crystal Perkins for a follow-up call. She stated that the new medication coordinator Shawndrekia Cooper calls her with any issues. She stated that the med clinic does have issues as well, but these issue with the clinic are recent issues. The appointments in the past were missed. She stated that the facility has had multiple medication coordinators, at least four to five that she is aware of.

On 07/27/2023, I received an email from licensee designee Nicholas Burnette including a list of notes regarding appointments for Resident A and Resident B. In summary, regarding the dates in question the email states the following for Resident A:

- *"Med review 12/21/22- No record of this appointment being scheduled- DR has note in CHIP* (Clinical Health Information Program) *about missed med review stated she tried to leave a voicemail, but it was full, did not state who they called. No voicemail received by Flatrock."*
- *"Med review 02/07/23- No record of this appointment being scheduled- Dr has note in CHIP about missed med review left a message but did not document who it was with. No voicemail received by Flatrock."*
- *"Injection 03/01/23- No record of this appointment being scheduled."*
- *"Med review 03/22/23- No record of this appointment being scheduled. Dr has note in CHIP about missed med review left a message but did not document who it was with. No voicemail received by Flatrock."*
- No summary included in email for 05/07/2023.
- *"Med review 05/09/23- No record of the appointment being scheduled. Dr has note in CHIP about missed med review left a message but did not document who it was with. No voicemail received by Flatrock."*

For Resident B the email states:

- *"Med review 12/12/22 -Attended, GHS notes state to follow up in 4 weeks, No appt listed in January on their schedule. GHS was closed 12/23-26, then 12/30-1/2/23. No record of appointment with Flatrock or on CHIP."*
- *"Med review 03/07/23- No record of this appointment, no voicemail received by Flatrock. GHS states rescheduled by staff to 03/10, no record of this appointment, no voicemail received by Flatrock. Rescheduled by staff to 03/16/23, no record of this appointment, no voicemail received by Flatrock. GHS closed on 3/10 due to weather."*
- No summary included in email for 03/10/2023.
- No summary included in email for 03/16/2023.
- *"Med review 04/13/23- No record of this appointment. Dr noted in CHIP that they left a message. No voicemail received by Flatrock. Her notes also stated that he had refills on all medications."*

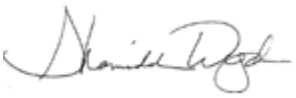
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.**
ANALYSIS:	On 06/09/2023, AFC Licensing Consultant Anthony Humphrey conducted an on-site visit at the facility and interviewed staff Tiana Ferguson, staff Tomika Bennett, and staff Bobreannia Holloway, who all reported that the facility's previous medication coordinator was unorganized, and appointments were either missed, rescheduled and/or not scheduled and staff were notified last minute regarding appointments. On 06/09/2023, AFC Licensing Consultant Anthony Humphrey interviewed Resident A who reported missing some appointments. Resident B could not be interviewed due to being non-verbal. On 07/11/2023, I interviewed GHS case manager Crystal Perkins at the facility. Crystal Perkins provided multiple dates that Resident A missed appointments. She stated that Resident B only missed two appointments, and that Resident B mainly misses appointments due to behavioral issues. On 07/20/2023, I obtained both Resident A and Resident B's Resident Care Agreements which include an agreement to provide transportation services for routine medical appointments. Both Resident A and Resident B's Individual Plans of Service notes that the facility is responsible for scheduling appointments and providing transportation. On 07/27/2023, I spoke with recipient rights investigator Pat Shephard who also reported details record regarding dates Resident A and Resident B missed appointments.

	There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/27/2023, I conducted an exit conference with licensee designee Nicholas Burnette via phone. I informed him of the findings and conclusions.

IV. RECOMMENDATION

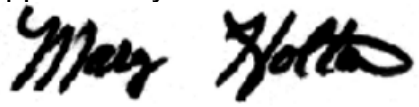
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



07/31/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



07/31/2023

Mary E. Holton Date
Area Manager