GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 9, 2023

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

RE: License #:	AM440388514
Investigation #:	2023A0871070
	Elba South

Dear Nicholas 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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388514
Investigation #:	2023A0871070
Complaint Receipt Date:	09/20/2023
Investigation Initiation Date:	09/25/2023
Report Due Date:	11/19/2023
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:	Elba South
Facility Address:	280 North Elba Road Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	02/08/2018
License Status:	REGULAR
Effective Date:	08/08/2022
Expiration Date:	08/07/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 09/19/23, Resident A ingested the medication of another resident.	Yes

III. METHODOLOGY

09/20/2023	Special Investigation Intake 2023A0871070
09/20/2023	APS Referral Denied to Lapeer County MDHHS
09/25/2023	Special Investigation Initiated - Telephone Telephone call to Home Manager T'ierra Pauncil
09/27/2023	Inspection Completed On-site Interviewed Home Manager T'ierra Pauncil, observed Resident A
11/07/2023	Contact - Telephone call made Several phone calls were made to Guardian A1 but as of this date, he has not returned the call
11/07/2023	Exit Conference I conducted an exit conference with the licensee designee, Nicholas Burnett
11/07/2023	Inspection Completed-BCAL Sub. Compliance
11/09/2023	Contact – Document received I received and reviewed the Incident Report regarding this complaint

ALLEGATION: On 09/19/23, Resident A ingested the medication of another resident.

INVESTIGATION: On 09/27/23, Adult Foster Care Licensing Consultant, Kathryn Huber conducted an unannounced onsite inspection of Elba South Adult Foster Care facility. She interviewed the home manager (HM), Tiara Pouncil and observed Resident A who is nonverbal. HM Pouncil stated that on 09/19/23, staff Breanna Selph had another client's medications in her hand when Resident A reached out and took them from her,

ingesting them. HM Pouncil said that according to Staff Selph, Resident A was upset about something when he did this. Resident A is nonverbal, and AFC Huber was unable to interview him. However, she did observe him to be appropriately supervised by staff. As a result of the incident, Resident A was transported to Hurley Medical Center. He did not suffer any side effects from ingesting the wrong medication.

On 10/02/23, AFC Consultant Huber telephoned staff Breanna Selph. According to Staff Selph, on 09/19/23 she was in the back hallway trying to give another resident their medications. Resident A came out of his room and was acting aggressively so she tried to redirect him. Resident A grabbed the medications out of her hand and ingested them. Staff Selph said that she had Resident A go to a safe space and she contacted the facility medication coordinator. Staff Selph checked Resident A's vitals and took his blood pressure, all which were within normal limits. Resident A was then transported to the hospital.

According to Staff Selph, Resident A is "strong and quick." She said that she felt very bad about this incident and said that nothing like this has ever happened to her before. She said that Resident A was mad about something which caused his behavior.

On 10/02/23, AFC Consultant Huber left a voicemail message for Guardian A1. As of 10/18/23, she had not heard back from him.

AFC Consultant, Susan Hutchinson left several voicemail messages for Guardian A1 requesting a return phone call. As of 11/09/23, Guardian A1 has not returned the call.

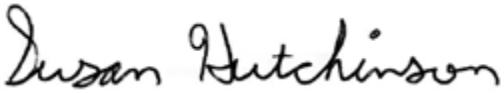
On 11/09/23, I (Susan Hutchinson) received and reviewed an Incident/Accident Report (IR) dated 09/19/23 regarding Resident A. According to the IR, on 09/19/23, Staff Breanna Selph was passing medications to another resident. Resident A came out of his room, and he was agitated about something. Resident A started walking aggressively toward Staff Selph. Staff Selph tried to verbally redirect him and tried to use body positioning, but she was unsuccessful. Resident A grabbed the medications out of Staff Selph's hands and ingested them. Staff Selph immediately contacted the medical coordinator and was directed to take Resident A to Hurley Medical Center for observation. The corrective measures taken by staff were verbal redirection, body positioning, contacted medical coordinator, and transported Resident A to Hurley Medical Center.

On 11/07/23, I (Susan Hutchinson) conducted an exit conference with the licensee designee, Nicholas Burnett. I discussed the results of my investigation and explained which rule violation I am substantiating. Mr. Burnett agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
ANALYSIS:	**(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.**
	On 09/19/23, Resident A ingested the medications of another resident. According to Staff Breanna Selph, Resident A came out of his room and was upset about something. She had another resident's medications in her hand. Resident A grabbed the medications out of Staff Selph's hand and ingested them. Resident A was transported to the hospital where he was examined and released. He did not suffer any side effects from ingesting the medications. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

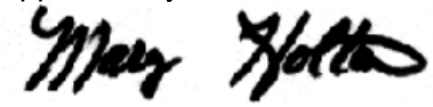
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



November 9, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



November 9, 2023

Mary E. Holton Area Manager	Date