



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 4, 2024

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

RE: License #: AS250392270
Investigation #: 2024A0871002
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.
- 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 (989) 732-8062.

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 #:	AS250392270
Investigation #:	2024A0871002
Complaint Receipt Date:	01/16/2024
Investigation Initiation Date:	01/17/2024
Report Due Date:	03/16/2024
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 had a liver transplant and the facility failed to ensure that Resident A attends his annual appointment or get his quarterly lab work with U of M as required.	Yes

III. METHODOLOGY

01/16/2024	Special Investigation Intake 2024A0871002
01/16/2024	APS Referral Denied to Genesee County MDHHS
01/26/2024	Inspection Completed On-site Interviewed Home Manager Casey Wong, observed Resident A
02/12/2024	Contact - Document Received Received Physician's Orders and Physician's Contacts
02/14/2024	Contact - Document Received Received information from Recipient Rights Officer Pat Shepard
02/22/2024	Inspection Completed On-site Observed Resident A
02/23/2024	Contact - Telephone call made Telephone call to Guardian A1
02/29/2024	Inspection Completed-BCAL Sub. Compliance
02/29/2024	Exit Conference Telephone exit conference with Licensee Nicholas Burnett

ALLEGATION:

Resident A had a liver transplant and the facility failed to ensure that Resident A attends his annual appointment or get his quarterly lab work with U of M as required.

INVESTIGATION:

On January 26, 2024, I conducted an unannounced onsite investigation and interviewed Home Manager Casey Wong. Manager Wong indicated Resident had labs in August 2023. Manager Wong stated there was a meeting last week on January 15, 2024, with Resident A's Guardian A1 and the med coordinator. Manager Wong did not know what transpired at this meeting.

Manager Wong provided me with a copy of Resident A's Individual Plan of Service that was written completed and signed on March 24, 2023, by Case Manager Crystal Perkins and Guardian A1. It indicates '[Resident A] had a liver transplant in 2009. U of M manages his follow up annually. Labs drawn at Hurley every 2 months and sent to U of M. Dentist is at U of M. No medications to be ordered without clearance from U of M-Ann Arbor.'

On January 26, 2024, I observed Resident A. Resident A is nonverbal and unable to be interviewed. He appeared healthy and happy and was smiling.

On February 12, 2024, I received 'Physician Contacts' from Executive Assistant Stevie Walton, dating back to May 31, 2023. On May 31, 2023, Staff Danielle Thompson's summary of contact indicates 'Checked with office to see if they wanted to see [Resident A] sooner than October, receptionist stated would ask the doctor if she wants to see him or not. She did mention that she knew about the med change and that he was recently at Hurley. She has my number and will give me a call back.' On June 13, 2023, summary of contact written by Staff Shawndrekia Cooper indicates 'Called to reschedule [Resident A's] med review due to him being in the hospital. His new appt. date will be 06/22/23 @ 12:30 with Rebecca.' Again, on June 13, 2023, Staff Cooper's summary of contact indicated 'I had to call back to get a different time. I have an appointment that day at the time, so his appointment is still 06/22 but at 4:00 pm.' Other contacts were made in regard to Resident A's medications, but no record of medical appointments.

On February 14, 2024, Recipient Rights Officer Pat Shepard emailed me information that she received from U of M regarding Resident A's appointments. The information received from U of M indicated "[Resident A] was seen in person on 12/13/22. He was scheduled for a video appointment on 08/22/23 – he was a no show. He completed a phone visit on 10/14/23 – which satisfied the annual requirement.' U of M also provided Recipient Rights Officer Shepard information that indicated '[Resident A] had labs drawn at the 12/13/22 appointment. He did not have any labs completed in 2023 (supposed to be done every 3 months.) He had 2024 labs done in January and February so far.'

On February 23, 2024, I telephoned Guardian A1. Guardian A1 indicated there was a meeting with the Med Coordinator and things are a lot better now. Guardian A1 said Resident A “is getting wonderful care” and that staff are going above and beyond to meet his needs. I asked Guardian A1 if she was aware that Resident A missed some appointments and she state that she was aware that he missed some appointments. Guardian A1 stated the facility “had some hiccups” but things are going much better now.

On February 29, 2024, I conducted a telephone exit conference with Licensee Nicholas Burnett. Licensee Burnett was advised this is a rule violation, even though it appears the issue has been resolved.

APPLICABLE RULE	
R 400.14310	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (a) Medications.
ANALYSIS:	Per Resident A’s Individual Plan of Service, Resident A is ordered to have labs drawn every two months. Recipient Rights Officer Pat Shepard received information from U of M that Resident A did not have any labs drawn in 2023. Guardian A1 was aware that Resident A missed appointments. I confirm violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this small group home remain unchanged (capacity 1-6).

Kathryn Huber

02/29/2023

Kathryn A. Huber
Licensing Consultant

Date

Approved By:

Mary Holton

03/04/2023

Mary E. Holton
Area Manager

Date