GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 5, 2025

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

RE: License #: AS250407224
Investigation #: 2025A0569013
Brookwood 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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250407224
Investigation #:	2025A0569013
Complaint Receipt Date:	12/17/2024
Investigation Initiation Date:	12/17/2024
Report Due Date:	02/15/2025
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:	Brookwood South
Facility Address:	5408 Brookwood Drive Burton, MI 48509
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/22/2021
License Status:	REGULAR
Effective Date:	10/22/2023
Expiration Date:	10/21/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with bruising on 12/3/2024 but was not medically treated until 12/9/2024.	Yes

III. METHODOLOGY

12/17/2024	Special Investigation Intake 2025A0569013
12/17/2024	APS Referral complaint received from PS.
12/17/2024	Special Investigation Initiated - Telephone Contact with Ashton Byrne, RRO.
01/29/2025	Inspection Completed On-site
02/03/2025	Contact - Document Sent Email to Michael Grant, APS worker.
02/03/2025	Contact - Telephone call made Contact with Ashton Byrne, RRO.
02/03/2025	Contact- Telephone call made Attempted contact with Nicholas Burnett. Left voicemail requesting return phone call.
02/04/2025	Contact- Telephone call made Contact with Guardian.
02/04/2025	Exit conference Exit conference with Nicholas Burnett, licensee designee.

ALLEGATION:

Resident A was observed with bruising on 12/3/2024 but was not medically treated until 12/9/2024.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A has been diagnosed with hemophilia and autisim. The complainant reported that Resident A was observed with bruising on his back and base of his skull on 12/3/2024 by staff. The complainant reported that the bruising was “hot and swollen, dark purple bruise on his shoulder and at the base of his skull”. The complainant reported that Resident A’s face and jaw are also swollen. The complainant reported that because of Resident A’s hemophilia he must be taken to a physician immediately when bruising is observed but Resident A was not taken to the emergency room until 12/9/2024.

An unannounced inspection of this facility was conducted on 01/29/2025. Resident A was receiving treatment at the hospital during this inspection and was not observed. Resident A’s file was reviewed. Resident A’s file documents that he has been diagnosed with severe intellectual disabilities, autistic disorder, mood disorder and hemophilia. Resident A’s file contains a document titled "hemophilia care instructions”. The care instructions are dated 3/22/2024 and state that Resident A must be taken to the emergency room if, 1) there is any concern or suspicion of bleeding, 2) there is any muscle or joint swelling or soft tissue swelling, 3) there is prolonged bleeding from any wound that does not stop with general first aid measures, 4) any larger bruise that is swollen, red, warm, or firm (this may be hematoma), 5) any trauma to the head, chest, neck, or abdomen.

Resident A’s file contains an incident report (IR) dated12/3/2024 and completed by Lawrence Hudson, staff person. The IR documents that Resident A was observed with “a mark” on his back left shoulder. The IR documents that staff “notified support” then prompted Resident A to take a shower to prepare for the day. The corrective measures for the IR were to “continue 15-minute checks to ensure Resident’s safety”.

Lawrence Hudson, staff person, stated on 1/29/2025 that he did complete the IR dated 12/3/2025. Staff Hudson stated that he was getting Resident up for the day when he noticed “a bruise” covering Resident A’s back right shoulder. Staff Hudson stated that he notified management of the bruise, then took a picture to document the bruise. Staff Hudson stated that he did not know how Resident A sustained the bruise. Staff Hudson stated that he then assisted Resident A with showering for the day. Staff Hudson stated that Resident A was not taken for medical attention on 12/3/2025. Staff Hudson stated that staff are aware that Resident A has hemophilia, and any bruise is supposed to be “taken seriously”. Staff Hudson stated that Resident A also slipped on a wet floor “a couple of days” after observing the bruise. Staff Hudson stated that Stanley Steamer

was cleaning the floors in the facility, and Resident A came out of his bedroom and slipped on the wet floor. Staff Hudson stated that he did not know if Resident a was injured from this incident.

Resident A's file contains an IR dated 12/09/2024 and completed by Caleb Hodge, staff person. The IR documents that Resident A was observed with "a mark" on the back of his right shoulder. The IR documents that "staff the notified support" and were instructed to take Resident A to the emergency room. The IR documents that Resident A was then taken to the emergency room for treatment. The corrective measures in the IR were that staff will continue to monitor Resident A and notify the medical coordinator of any changes.

Caleb Hodge, staff person, stated on 1/29/25 that staff are supposed to check Resident A's body daily for any injuries. Staff Hodge stated that on 12/9/2025 he was checking Resident A when he observed a bruise on the back of Resident A's right shoulder. Staff Hodge stated that he documented the injury, then notified management and was instructed to take Resident A to the emergency room. Staff Hodge stated that staff are aware that Resident A has hemophilia, and any bruising is to be addressed immediately. Staff Hodge stated that he did not know how Resident A sustained the bruise.

Ashton Byrne, Network 180 recipient rights officer, stated on 02/03/2025 that she investigated this allegation. Ashton Byrne stated that Resident A was observed with a bruise on 12/3/2024 and that staff are supposed to immediately seek medical attention for Resident A when he is observed with any bruising due to his diagnosis of hemophilia. Ashton Byrne stated that Resident A also fell on 12/5/2024 because the floor was wet while being cleaned, but no IR was completed, and it is unknown if Resident A sustained any further injuries from this fall. Ashton Byrne stated that Resident A was not taken to the emergency room per his care plan and physician orders immediately when bruising was observed on 12/3/2024 and did not receive medical attention until 12/9/2024. Ashton Byrne stated that she has substantiated neglect in this investigation and Resident A will not be returned to this facility following his discharge from the hospital. Ashton Byrne stated that she does not believe that Resident A was receiving proper care in this facility.

Resident A's guardian (Guardian) stated on 02/04/2025 that Resident A has not received proper care at this facility. Guardian stated that Resident A does have hemophilia and must be treated by a physician if bruising is observed. Guardian stated that she has photos of Resident A's injuries observed on 12/03/2024 and the photos document that Resident A had a large bruise on his right shoulder that was "hot and swollen". Guardian stated that Resident A also had a "knot" on the back of his neck at the base of his head and Resident A's face was "red and swollen". Guardian stated that Resident A should have been taken to the emergency room immediately but was not taken until 12/9/2025. Guardian stated that Resident A has had other injuries for unknown reasons. Guardian stated that Resident A is currently in the hospital and will not be returning to this facility.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A's file contains documentation confirming that Resident A has been diagnosed with hemophilia, and as a result, must be taken to the emergency room immediately if any bruising or injuries are observed. IRs dated 12/03/24 and 12/09/24 document that staff observed the injuries on 12/03/24 but that Resident A was not taken to the emergency room until 12/09/24. Staff statements corroborated the information in the IRs. Guardian also confirmed that Resident A was observed with "hot and swollen" bruising on his shoulder, a knot on the back of his neck at the base of his head, and a red and swollen face on 12/3/24, but was not taken to the emergency room until 12/09/24. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Nicholas Burnett, licensee designee, on 02/04/2025. The findings in this report were reviewed and a corrective action plan was requested.

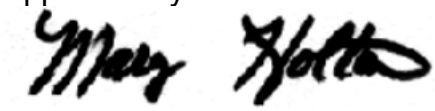
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

02/04/2025

Kent W Gieselman Date
Licensing Consultant

Approved By:



02/05/2025

Mary E. Holton Date
Area Manager