GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

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

RE: License #:	AS250392270
Investigation #:	2025A1039023
	Primrose

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,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250392270
Investigation #:	2025A1039023
Complaint Receipt Date:	04/29/2025
Investigation Initiation Date:	04/29/2025
Report Due Date:	06/28/2025
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:	Primrose
Facility Address:	476 Primrose Flushing, MI 48433
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	09/01/2024
Expiration Date:	08/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
It is alleged that Resident A was left unsupervised by his assigned 1:1 Staff Giorgio Hill.	Yes
It is alleged that Resident A inappropriately touched Resident B.	No
Resident C was taken to Hurley Hospital, and it was determined he had pink eye. There is concern that Resident C was not brought for medical treatment timely.	No
Staff Bobreannia Holloway is being abusive and hits Resident D.	No

III. METHODOLOGY

04/29/2025	Special Investigation Intake 2025A1039023
04/29/2025	Special Investigation Initiated - Letter Emailed GHS ORR Shepard concerning the complaint.
04/30/2025	APS Referral Called in via telephone.
05/12/2025	Contact - Document Received APS worker Brandi Morris informed me that she was not substantiating her investigation concerning physical abuse of the residents.
05/12/2025	Contact - Document Received APS worker Brandi Morris informed me that she would be substantiating against Resident A being left along without one-on-one supervision.
05/13/2025	Inspection Completed On-site Interviewed DCW Holloway, DCW Tiana Ferguson, DCW Tomika Bennett, Resident A, Resident B, Resident C and Resident D.
05/13/2025	Contact – Document Received ORR Shepard contacted me regarding the allegations.

05/20/2025	Contact - Document Received APS worker Kyle Whitman informed me that he is closing his investigation concerning Staff Holloway with no substantiation.
06/10/2025	Contact - Document Received Received email from GHS ORR Potts informing me that they did not substantiate the allegation regarding physical abuse.
06/16/2025	Contact - Telephone call made Phone interview with GHS case manager Alexis Standoakes.
06/16/2025	Contact - Telephone call made Phone interview with DCW Giorgio Hill.
06/16/2025	Contact - Telephone call made Phone interview with Guardian C1.
06/17/2025	Exit Conference Completed with the Licensee Designee.

ALLEGATION:

- **It is alleged that Resident A was left unsupervised by his assigned 1:1 Staff Giorgio Hill.**
- **It is alleged that Resident A inappropriately touched Resident B.**

INVESTIGATION:

On 04/29/2025, the Bureau of Community and Health Systems (BCSH) received the above allegations, via the BCHS online complaint system.

On 05/12/2025, Department of Human Services Adult Protective Services (APS) Worker Brandi Morris informed me that he completed an investigation concerning the allegations and did substantiate that staff left Resident A alone with Resident B without appropriate 1:1 supervision.

On 05/13/2025, I completed an unannounced investigation at Primrose AFC Home.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tiana Ferguson. DCW Ferguson stated that she was aware of the allegations but that she was not working at the time of the incident. DCW Ferguson stated that the incident happed on 2nd shift. DCW Ferguson stated that she believes that Resident A told his case manager that he was left alone and touched Resident B. The Office of Recipient

Rights and Adult Protective Services were then notified. DCW Ferguson stated that all of the staff are aware that Resident A has 1:1 supervision, and that her shift does a really good job of communicating and rotating to ensure that there is always appropriate 1:1 supervision for Resident A. DCW Ferguson stated that she believes that it was a new staff member who violated the 1:1 supervision for Resident A. DCW Ferguson stated that she was not sure if Resident A touched Resident B inappropriately because she was not present at the time that the incident occurred. DCW Ferguson stated that after the incident occurred that management reviewed the 1:1 supervision guidelines for Resident A with all staff members.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Bobreannia Holloway. DCW Holloway stated that she was aware of the allegations but that she was not working at the time of the incident. DCW Holloway stated that she works 1st shift and that have good coverage and communication for Resident A's 1:1 supervision to ensure that he is never left along unattended. DCW Holloway stated that anywhere outside of Resident A's room and bathroom that staff need to be within 3-6 feet of Resident A. DCW Holloway stated that staff had to go over the 1:1 supervision rules for Resident A after the incident occurred. DCW Holloway stated that she believes that the staff involved was reprimanded privately. DCW Holloway stated that she is unaware if Resident A touched Resident B inappropriately because she was not working at the time of the incident. DCW Holloway stated that Resident A will look for staff to not pay attention so that Resident A can tell on himself to his case manager. DCW Holloway believes that Resident A may do this for attention.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tomika Bennett. DCW Bennett stated that she was aware of the allegations but that she was not working at the time of the incident. DCW Bennett stated that the incident most likely occurred because Resident A will tell his case manager immediately if Resident A thinks that Resident A's 1:1 supervision staff is not paying attention properly. DCW Bennett stated that she is unaware if Resident A touched Resident B inappropriately but stated that Resident A usually tries to do something like that is no one is around. DCW Bennett stated that management usually does an internal investigation when something like this is reported. DCW Bennett stated that the staff involved is usually disciplined and if it happens again then they are terminated. DCW Bennett stated that she has not had any issues with Resident A's 1:1 supervision because the staff are able to use the radios to communicate with each other if a break is needed.

On 05/13/2025, I completed an interview with Resident A in Resident A's room. Resident A is diagnosed with Bipolar disorder, Autistic disorder, Mild intellectual disabilities and Cerebral palsy. Resident A was in his wheelchair at the time of the interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that Resident A was aware of the allegations because Resident A told his case manager about it. Resident A stated that Resident A was in the hallway and that staff was not paying attention and lost sight of him for a couple minutes. Resident A stated that Resident B was in the hallway and when staff was not looking, Resident A put Resident A's hand on Resident B's chest. Resident A then ran Resident

A's hand down Resident B's shirt and tried to touch Resident B's private parts. Resident A stated that his hand was on the outside of Resident B's clothes and that he did not put his hand on Resident B's private parts.

I reviewed Resident A's assessment plan dated for 12/30/2024. The plan notes that Resident A is not able to move independently in the community. Resident A has a history of inappropriate sexual behavior such as unwanted sexual advances; sexual behavior directed toward children and unwanted sexual behavior toward vulnerable adults. Resident A is provided with field of vision supervision of staff at all times while in the community and it will be increased to line-of-sight supervision when minors/children and vulnerable adults are present. Resident A is able to communicate his wants and needs without limitation or barriers. Resident A is able to follow instructions without difficulties. Resident A requires 1:1 supervision in the home on a 24-hour per day basis due to his behaviors. Resident A will be provided by his group home in accordance with policies and procedures of Flatrock Manor. This includes minimally safety checks/bed checks at 15-minute intervals when Resident A is in private areas of his bedroom or bathroom alone. When Resident A is not in Resident A's bedroom, he should receive 1:1 supervision. Resident A is expected to follow all local, State and Federal laws/criminal statues as they apply to sexual behavior.

On 05/13/2025, I viewed Resident B in Resident B's room. Resident B is diagnosed with Bipolar disorder, Intermittent explosive disorder, Mixed receptive language disorder and severe intellectual disabilities. Resident B appeared neat and clean but is nonverbal and is unable to communicate. Resident B was sitting on his bed when I viewed him.

I reviewed Resident B's assessment plan dated for 02/18/2025. Resident B requires supervision and assistance from staff at all times in the community. Staff will maintain field of vision supervision at all times. Flatrock staff will provide the supervision except during coordinated leave of absences. Resident B presents as nearly nonverbal, speaking very few words. Resident B will utilize sign language on a very limited basis. Resident B will point and take staff to things that he wants. Resident B's history reflects that his verbal and language skills are that of a two-year-old. Resident B is alert to Resident B's surroundings but does not interpret risks and dangers in a reasonable manner. Resident B does not act out in a sexually inappropriate manner. Resident B is not engaged in intimate sexual activity or relationships.

On 05/13/2025, Genesee Health Systems Office of Recipient Rights (ORR) Patricia Shepard informed me that she was aware that Resident A was left unsupervised and still investigating other portions of the allegation and would inform me of the results of the rest of her investigation.

On 06/16/2025, I completed a phone interview with Resident B's GHS Case Manager (CM) Alexis Standoakes. CM Standoakes stated that she was aware of the allegations. CM Standoakes stated that she does not believe that Resident A touched Resident B inappropriately. CM Standoakes stated Resident A has history of trying to touch

residents inappropriately but that it does not appear that he was able to touch Resident B besides trying to swipe at his clothes and torso. CM Standoakes stated that she has spoken to the Resident B's guardian, and they are satisfied that Resident B is cared for properly and that they have no issues with the staff not watching Resident B appropriately. CM Standoakes stated that when she visits Resident B, she sees the staff communicating a lot when it comes to ensuring that Resident A always has his 1:1 supervision with him.

On 06/16/2025, I completed a phone interview with Direct Care Worker (DCW) Giorgio Hill. DCW Hill stated that he is aware of the allegations. DCW Hill stated that does not believe that Resident A touched Resident B inappropriately. DCW Hill stated that he was working at the time of the allegations and that what happened is different than what was reported. DCW Hill stated that he had 1:1 supervision of Resident A and was in the laundry room and Resident A was in the doorway of the laundry room. DCW Hill stated that he turned his head and observed Resident B walking down the hallway towards him and Resident A. DCW Hill stated that he turned his head and when he turned back around Resident B was standing behind Resident A and then Resident B kept moving past Resident A. DCW Hill stated that the next day he was made aware that there were allegations that Resident A touched Resident B inappropriately. DCW Hill stated that there was no time for Resident A to do that and that Resident B was behind Resident A and Resident A was in his wheelchair facing the other direction. DCW Hill stated that management talked to him about the expectations of 1:1 supervision after the incident. DCW Hill stated that was his first time being assigned to Resident A as 1:1 supervision. DCW Hill stated that he now understands the expectations better and is able to communicate better with other staff if he needs a break or help with something while he is on 1:1 supervision with Resident A.

I viewed the Incident Report (IR) dated 04/29/2025. The IR notes that the case manager for Resident A notified the Home Manger that Resident A stated that he touched Resident B over his clothes swiping at Resident B's torso. The Home Manger then notified the GHS Office of Recipient Rights of the allegations. The IR notes that staff will remind Resident A to be appropriate with other residents.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that Resident A was left unsupervised by his assigned 1:1 Staff Giorgio Hill. It was alleged that Resident A inappropriately touched Resident B.

	I interviewed DCW Ferguson, DCW Bennett, DCW Hill, DCW Holloway, Resident A, Resident D, APS Worker Morris, GHS Case Manager Standoakes, and GHS ORR Shepard. I reviewed Resident A's assessment plan, Resident B's assessment plan and the Incident Report. DCW Hill stated that he turned his head and lost line of sight on his 1:1 supervision of Resident A but stated that he does not believe that Resident A touched Resident B inappropriately. DCW Hill stated that he was corrected by management and that he had to review the rules for 1:1 supervision. Resident A stated that he was left unsupervised for a short period of time, and he touched Resident B on the outside of his clothes but not on Resident B's private parts. CM Standoakes stated that she believes that staff lost line of sight of Resident A but does not believe that he was able to touch Resident B inappropriately. APS Worker Morris confirmed that she did substantiate her investigation. Upon completion of my investigation, it was determined that there was enough evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C was taken to Hurley Hospital, and it was determined Resident C had pink eye. There is concern that Resident C was not brought for medical treatment timely.

INVESTIGATION:

On 05/07/2025, the Bureau of Community and Health Systems (BCSH) received the above allegations, via the BCHS online complaint system.

On 05/07/2025, Michigan Department of Health and Human Services Centralized Intake denied this allegation and did not assign it for investigation.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tiana Ferguson. DCW Ferguson stated that she was not aware of the allegations, but she did not believe they were true. DCW Ferguson stated that Resident C had gone home with Guardian C1 for the weekend and when Guardian C1 brought Resident C back home she dropped off some over the counter eye medicine for him to use as it looked like his

eye was irritated. DCW Ferguson showed me the empty bottle of medication. The medication was “Natural Eyes pink eye relief”. DCW Ferguson stated that the staff gave Resident C the medication that was provided and his eye appeared to clear up. DCW Ferguson stated that Resident C appeared to have another eye issue, and they used the remaining medication, and it did not help, and he was taken to Hurley Medical Center to be examined. DCW Ferguson stated that Resident C was given Amoxicillin and Bactrim to use two times a day. DCW Ferguson showed me the Medication Administration Record (MARs) and I was able to review the medication and confirm that it was administered as prescribed. DCW Ferguson stated that Resident C’s eye is still red, and the infection might not be all the way clear. DCW Ferguson stated that Resident C is nonverbal, and he has issues putting his hands in and around his butt and then will scratch hey eyes and face. DCW Ferguson stated that the staff do the best job they can to ensure that Resident C’s hands are clean. Resident C does not rub his eyes so that Resident C’s eye issues can heal.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tomika Bennett. DCW Bennett stated that she was not aware of the allegations, but she did not believe they were true. DCW Bennett stated that Resident C had antibiotics and over the counter medication that his Guardian dropped off for him and his eyes are still red and not all the way clear. DCW Bennett stated that Resident C plays with his feces and the staff are always cleaning his hands because he is always touching his face and eyes. DCW Bennett stated that Resident C’s pink eye will go away and come back even with the medication.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Bobreannia Holloway. DCW Holloway stated that she was not aware of the allegations, but that she did not believe they were true. DCW Holloway stated that she does not work that many hours, but over the last month when she has come in, she has observed staff give Resident C his eye medication on a daily basis. DCW Holloway stated that Resident C’s eye issues come and go on a regular basis.

On 05/13/2025, I viewed Resident C in the day room as Resident C was watching TV. Resident C is diagnosed with Bipolar disorder, Autistic disorder, Speech and language development delay due to hearing loss and Unspecified intellectual disabilities. Resident C’s eye appeared red and irritated at the time of my investigation. Resident C is nonverbal, but Resident C appeared happy as he was smiling and interacting with the staff members. Other than Resident C’s eye issue, he appeared neat and clean.

I viewed Resident C’s assessment plan dated 07/24/2024. Resident C does not evidence possession of adequate adaptive behaviors skills, coping skills and judgment at this time to move about the community independently. Resident C’s current emotional and behavioral functioning place him and other at rick of potential harm, injury and death in the event of unsupervised movement in the community. Resident C communicates wants and needs on a limited basis. He has very limited vocabulary and articulation is por. Resident C’s speech is difficult to understand and speak in very short, very simple sentences. He cannot routinely communicate thoughts, desires,

needs, or what is bothering him. Staff should combine verbal communication and gestures to increase likelihood of accurate comprehension. Staff should utilize as much as possible a simple vocabulary, using straightforward language. Resident C is able to follow instructions stated in uncomplicated language but is at times oppositional when presented with reasonable requests. Resident C can utilize toilet for urinating and defecating, he does need physical assistance of staff in wiping after defecating. Resident C can assist in washing himself some but needs physical assistance of staff for bathing to perform the activity thoroughly/adequately. Resident C is dependent for physical assistance in all grooming and hygiene related activities.

I viewed Resident C's discharge paperwork from Hurley Medical Center dated 05/04/2025. The paperwork notes that Resident C was seen for facial swelling and diagnosed with Preseptal cellulitis of the left eye. Resident C was prescribed Amoxicillin and Sulfamethoxazole-trimethoprim.

On 06/16/2025, I completed a phone interview with Resident C's guardian, Guardian C1. Guardian C1 stated that she was familiar with the allegations but was unsure if they were true. Guardian C1 stated that she did have concern initially that Resident C was not getting proper treatment for his eye. Guardian C1 stated that she did speak with staff concerning Resident C's care and wanted to ensure that he was getting his eye treatment properly and that staff were monitoring his eye. Guardian C1 stated that she did provide the home with over-the-counter medication for Resident C's eye and is aware that the eye infection can come and go because Resident C has a history of touches his butt and feces and then touching his face and eyes. Guardian C1 stated that she is aware that staff have been giving Resident C appropriate medication to treat his eye infection. Guardian C1 stated that she has no other concerns about Resident C's overall care in the home and that staff do a pretty good job of making sure Resident C is taken care of. Guardian C1 stated that she interacts with staff regularly, takes Resident C on weekends and checks Resident C over then as well. Guardian C1 stated that no one can take care of a resident like their family can but stated that the staff do the best they can with the number of residents they have.

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:	It was alleged that Resident C was taken to Hurley Hospital, and it was determined he had pink eye. There is concern that Resident C was not brought for medical treatment timely.

	I interviewed DCW Ferguson, DCW Bennett, DCW Holloway and Guardian C1 I viewed Resident C in Resident C's bedroom. Resident C is severely limited and was unable to be interviewed. I reviewed Resident C's MARs, assessment plan and Hurley Medical Center discharge paperwork. APS denied the complaint. The DCWs denied that Resident C was not cared for properly. They stated that Resident C received his medication daily and as prescribed. I reviewed the MARs, and it showed that medication was given to Resident C as prescribed. Guardian C1 stated that she wanted to ensure that Resident C was cared for properly and has no other concerns regarding Resident C's care at the home. Upon completion of my investigation, it was determined that there was not enough evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff Bobreannia Holloway is being abusive and hits Resident D.

INVESTIGATION:

On 05/12/2025, the Bureau of Community and Health Systems (BCSH) received the above allegations, via the BCHS online complaint system.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tiana Ferguson. DCW Ferguson stated that she was aware of the allegations but that they were not true. DCW Ferguson stated that she has never witnessed DCW Holloway verbally or physically abuse anyone in the home. DCW Ferguson stated that Resident D has had issues with DCW Holloway as she holds Resident D accountable and redirects Resident D when Resident D needs it. DCW Ferguson stated that Resident D will become upset with the staff if Resident D does not get Resident D's way around the house. DCW Ferguson stated that she overheard Resident D ask another resident if they wanted to get DCW Holloway in trouble. DCW Ferguson stated that she notified the home manager immediately. DCW Ferguson stated that Resident D is moving out of the home soon and just wanted to get DCW Holloway in trouble or fired before Resident D left.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Tomika Bennett. DCW Bennett stated that she was aware of the allegations but that they were not true. DCW Bennett stated that DCW Holloway does not abuse anyone and that she is one of the most experienced and respected workers in the home. DCW Bennett stated that Resident D was mad at DCW Holloway and accused her of hitting Resident D so she would get in trouble. Resident D threatened to have her fired because she was on 1:1 supervision with another resident and could not leave that resident to go get Resident D a snack from the kitchen. DCW Bennett stated that on 05/09/2025, Resident D spoke to her about the incident. Resident D was sorry that he lied about DCW Holloway and that Resident D was just upset because Resident D was going through some family stuff. DCW Bennett stated that Resident D talked to DCW Holloway and apologized to her for lying. Resident D was going to tell management that he lied.

On 05/13/2025, I completed an interview with Direct Care Worker (DCW) Bobreannia Holloway. DCW Holloway stated that she was aware of the allegations, and they were not true at all. DCW Holloway stated that she has never hit or yelled at any resident in the home and that Resident D was just mad at her because she didn't go get Resident D snacks. DCW Holloway stated that Resident D becomes upset with her a lot because she makes Resident D follow the rules and doesn't let Resident D get away with stuff. DCW Holloway stated that she will just redirect Resident D when Resident D is doing something that Resident D is not supposed to do, and Resident D will get upset with her. DCW Holloway stated that Resident D apologized to her last weekend on 05/09/2025, when she was working and stated that he was sorry for lying about her and he didn't want her to get fired. DCW Holloway stated that she has not had any issues with Resident D since Resident D apologized. DCW Holloway stated that she does not take things personal as she knows the residents can get worked up sometimes.

On 05/13/2025, I completed an interview with Resident A in his room. Resident A was in his wheelchair at the time of the interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that the allegations were not true. Resident A stated that DCW Holloway has never hit him, and she is very nice to him. Resident A stated that he has never witnessed DCW Holloway hit or yell at any resident. Resident A stated that he has never witnessed Resident D and DCW Holloway have any issues in the home. Resident A stated that he heard Resident D ask another resident to lie about DCW Holloway. Resident A stated that he doesn't know if the other resident lied about DCW Holloway.

On 05/13/2025, I completed an interview with Resident D in his room. Resident D is diagnosed with Mood disorder, Attention deficit hyperactivity disorder and Oppositional defiant disorder. Resident D was sitting on his bed at the time of the interview. Resident D appeared neat and clean and was able to communicate. Resident D stated that DCW Holloway did not hit him, and she has never yelled at Resident D or abused Resident D. Resident D stated that he was mad and was going through a lot and apologized to DCW Holloway last week about lying on her. Resident D stated that sometimes Resident D gets mad because DCW Holloway makes Resident D follow the

rules and Resident D just gets upset about it. Resident D stated that he was supposed to be moving to a new home soon and wanted to make sure that DCW Holloway didn't get in trouble for Resident D lying about her.

On 05/20/2025, Department of Health and Human Services Adult Protective Services (APS) worker Kyle Whitman informed he that he completed his investigation and did not substantiate.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Staff Bobreannia Holloway is being abusive and hits Resident D. I interviewed DCW Ferguson, DCW Bennett, DCW Hill, DCW Holloway, APS worker Whitman, Resident A and Resident D. The DCWs denied this allegation and stated that Resident D was upset and lied about DCW Holloway. DCW Holloway stated that Resident D apologized to her and said he was sorry for lying about the situation and that he was going through some family issues. Resident D stated that he lied and that he apologized to DCW Holloway and that he did not want her to get in trouble. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 06/16/2025, I completed an exit conference with Licensee Designee (LD) Nicholas Burnett. I informed LD Burnett of the results of my investigation.

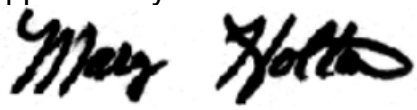
IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change to the status of this license.

06/17/2025

Martin Gonzales Licensing Consultant	Date

Approved By:



06/17/2025

Mary E. Holton Area Manager	Date