



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 23, 2025

Nicholas Burnett  
Flatrock Manor, Inc.  
310 W. Oakley  
Flint, MI 48503

RE: License #: AS630419190  
Investigation #: 2026A0465002  
Whistle Stop

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Stephanie Gonzalez".

Stephanie Gonzalez, LCSW  
Adult Foster Care Licensing Consultant  
Bureau of Community and Health Systems  
Department of Licensing and Regulatory Affairs  
Cadillac Place, Ste 9-100  
Detroit, MI 48202  
Cell: 248-308-6012

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630419190
<b>Investigation #:</b>	2026A0465002
<b>Complaint Receipt Date:</b>	10/17/2025
<b>Investigation Initiation Date:</b>	10/20/2025
<b>Report Due Date:</b>	12/16/2025
<b>LicenseeName:</b>	Flatrock Manor, Inc.
<b>Licensee Address:</b>	7012 River Road Flushing, MI 48433
<b>Licensee Telephone #:</b>	(810) 964-1430
<b>Administrator:</b>	Carrie Aldrich
<b>Licensee Designee:</b>	Nicholas Burnett
<b>Name of Facility:</b>	Whistle Stop
<b>Facility Address:</b>	2400 Whistle Stop Ln Holly, MI 48442
<b>Facility Telephone #:</b>	(810) 877-6932
<b>Original Issuance Date:</b>	07/09/2025
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	07/09/2025
<b>Expiration Date:</b>	01/08/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A is being emotionally abused, physically abused, and threatened by direct care staff.	No
On an unknown date, direct care staff, Larrion Walker, punched Resident A in the arm twice while restraining her.	No
On 11/16/2025, Resident C eloped from the facility due to a lack of sufficient staff supervision.	Yes
Direct care staff are denying Resident A reasonable access to a telephone.	No

**III. METHODOLOGY**

10/17/2025	Special Investigation Intake 2026A0465002
11/17/2025	APS Referral Adult Protective Services (APS) Referral - denied
10/20/2025	Special Investigation Initiated - Telephone I spoke to Complainant via telephone
10/29/2025	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, observed residents, reviewed resident files and interviewed direct care staff, Shiloh Stacks
11/25/2025	Contact - Telephone call made I spoke to Guardian A1 via telephone
12/08/2025	Contact - Telephone call made I spoke to direct care staff, Iesha Love, via telephone
12/08/2025	Contact - Telephone call made I spoke to direct care staff, Malik McClure, via telephone
12/08/2025	Contact - Telephone call made I spoke to direct care staff, Kyle Ruffin, via telephone
12/09/2025	Contact - Telephone call made I spoke to licensee designee, Nicholas Burnett, regarding concerns that facility documents have not yet been received; Mr.

	Peel acknowledged the delay and agreed to send the documents immediately
12/09/2025	Contact - Telephone call made I spoke to direct care staff, Shaniya Edwards, via telephone
12/09/2025	Contact - Telephone call made I spoke to direct care staff, Karanja White, via telephone
12/09/2025	Contact - Telephone call made I spoke to direct care staff, Tashionna Smith, via telephone
12/09/2025	Contact - Telephone call made I spoke to licensee designee/administrator, Nicholas Burnett, via telephone
12/10/2025	Contact - Document Received Received facility documents via email
12/10/2025	Contact - Telephone call made I spoke to direct care staff, Tyrisha Brown, via telephone
12/10/2025	Contact - Telephone call made I spoke to direct care staff, Kaylee Eagles, via telephone
12/11/2025	Contact - Document Received Received facility documents via email
12/12/2025	Contact - Document Received Received additional facility documents via email
12/12/2025	Contact - Telephone call made I spoke to Lifeways Jackson County Case Manager, Madison Wetter; Case manager for Resident A
12/15/2025	Contact - Telephone call made I spoke to direct care staff, Larrion Walker, via telephone
12/15/2025	Contact - Telephone call made I spoke to Guardian B1 via telephone
12/15/2025	Contact - Telephone call made I spoke to Guardian C1 via telephone
12/15/2025	Contact - Telephone call made I spoke to Guardian D1 via telephone

12/16/2025	Contact - Document Received Received additional facility documents via email
12/16/2025	Contact - Telephone call made I spoke to Laurie Depillars (Flatrock Corporate Director) and Gabriel Rett (Flat Rock Medical Supervisor) via telephone
12/16/2025	Contact - Telephone call made I spoke to direct care staff, Tamarrious Brandon, via telephone
12/16/2025	Contact - Telephone call made I spoke to Katee Skinner, the case manager for Resident's B, D, E and F
12/16/2025	Contact - Telephone call made I spoke to Laurie DePillars, Flat Rock Corporate Program Director, via telephone regarding requested facility documents
12/17/2025	Contact - Telephone call made I spoke to Guardian E1 via telephone
12/17/2025	Exit Conference I conducted an Exit Conference with Nicholas Burnett and Carrie Aldrich via telephone

**ALLEGATION:**

**Resident A is being emotionally abused, physically abused and threatened by direct care staff.**

**INVESTIGATION:**

On 10/17/2025 and 11/19/2025, multiple complaints were received, alleging that Resident A is being teased and bullied by direct care staff, Iesha Love. The complaint stated that Ms. Love has told other residents to clap and laugh at Resident A. The complaint stated that direct care staff curse and yell at Resident A. The complaint stated that, on an unknown date, Resident A became physically aggressive and had to be restrained, during which time direct care staff, Larrion Walker, punched her in the arm twice. The complaint stated that on 11/16/2025, Resident A was arguing with staff and direct care staff, Kateronia Pugh, lunged at her to intimidate her. The complaint stated that on an unknown date, Resident A punched direct care staff, Deshawn Douglas, and he told her that if he got a black eye, he would come back and take care of her. The complaint stated that Resident A is being antagonized by others, resulting in her engaging in self-harm behavior.

On 10/29/2025, I conducted an onsite investigation at the facility. The home specializes in caring for the highly behavioral developmentally disabled and mentally ill populations. Due to the medical diagnoses and cognitive limitations of residents, I was unable to interview residents for this investigation. At the time of my onsite investigation, there were six residents residing at the home, with five residents requiring 1:1 staffing at all times. I completed a walk-through of the facility, observed residents, reviewed resident files and interviewed direct care staff, Shiloh Stacks. I observed the home to be well-maintained and the residents to be properly dressed and with adequate hygiene. I did not observe any concerns.

The *Face Sheet* stated that Resident A was admitted to the facility on 12/2/2022 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizoaffective Disorder, Borderline Personality Disorder, Anxiety Disorder and Borderline Intellectual Functioning. The *Assessment Plan for AFC Residents* stated that Resident A requires 1:1 supervision at all times, has a history of self-harm behavior, is verbally and physically aggressive towards others, requires Crisis Prevention Non-Violent Intervention (CPI) due to history of swallowing objects accompanied by suicidal ideation, completed self-care tasks with staff encouragement, and does not require use of assistive devices. The *Individual Behavioral Treatment Plan*, dated 1/28/2025, documented that Resident A has a history of behavioral challenges, self-injury, physical aggression and property destruction. The plan stated that Resident A requires 1:1 female staff supervision, delayed egress exit doors, locked kitchen, and supervised access to personal items that she is known to swallow.

I reviewed the *Incident/Accident Reports*, which documented the following:

10/27/2025 at 5:00pm; completed by Javonte Brown: On 10/27/2025 around 5:00pm, Resident A stated she wanted to go to Common Ground. Staff told Resident A that the medical coordinator would set up her an appointment. Resident A became agitated and stated that it would take too long and wanted to go today. Resident A started banging her head on wall. Staff used blocking techniques to prevent Resident A from head-banging. Staff were successful. Staff explained the importance of being patient. Resident A then used phone to call boyfriend. Resident A told boyfriend to call police because she was suicidal. Police arrived and EMS wanted to speak to Resident A. Resident A was transported to hospital. Staff followed and notified home manager.

10/27/2025 at 11:15pm; completed by Donovan Harris: At 10:27pm around 11:15pm, Resident A was upset and ripped her mirror off and removed it from her room. Staff began to pick up the little pieces from the floor but were unsuccessful with collecting them all. Resident A found a small piece that staff missed and swallowed it. Staff contacted on-call and medical coordinator. Resident A was transported to hospital and evaluated at medical.

10/30/2025 at 3:00am; completed by Tabatha Matthews: On 10/30/2025, approximately 3:00am, Resident A became upset with staff regarding the implementation of her plan.

Resident A exhibited verbal aggression towards staff. In response, staff reminded Resident A of her personal goals in an effort to de-escalate the situation. Resident A proceeded to her bedroom, retrieved a broom and walked down the hallway toward the staff member she was upset with. Appearing to intend to use the broom in an aggressive manner. Staff immediately utilized blocking techniques and verbally prompted Resident A five times to hand the broom over to staff. Resident A complied on the 5<sup>th</sup> prompt. After relinquishing the broom, Resident A continued to display verbal and physical aggression. Resident A struck a staff member in the face with an open hand. Staff attempted approved physical intervention, but the intervention was unsuccessful. Resident A then returned to her room and began engaging in self-injurious behavior by head banging. Staff quickly utilized a blocking technique to prevent self-harm and provided continuous verbal support. At 3:54 AM, Resident A had de-escalated and was calm, sitting in her room with staff present.

11/12/2025 at 7:15pm; completed by Ny'Asia Willingham: On 11/12/2025, around 7:15pm, resident a was heading home from community outing and stated to staff that she was agitated. Resident a stated she was going to elope upon arrival at the home. Resident A arrived home and headed towards driveway, attempting to elope. Staff tried implementing physical management and it was unsuccessful. Resident A ran to the ground and got into a fetal position. Staff prompted breathing techniques and Resident A walked back onto property. Resident expressed that she had suicidal thoughts due to a recent Med change period staff contacted home manager and medical on call.

11/15/2025 at 8:15pm; completed by Tashionna Smith: On 11/15/2025, at around 8:15pm, Resident A was talking with staff when she informed them that she took her vape apart and swallowed the battery. Staff did a search and seizure, collecting pieces of the vape but no battery. Staff notified medical on-call and support staff after trying to complete a medical assessment that was denied. Staff were directed by medical on-call to send resident aid to the hospital for further medical evaluation. Resident A was seen at the hospital and received emergency surgery to remove the object from her body.

11/16/2025 at 8:10pm; completed by Karanja White: On 11/16/2025, Resident A was upset and swallowed 2 staples. Staff called Code 3 and verbally redirected Resident A to utilize coping skills. Staff attempted to validate Resident A's feelings. Resident A spit on staff and went to talk to the police who were in the home for another reason. Police talked to Resident A, and she stated she was suicidal. Police took resident aid to the hospital and staff followed behind. And call staff were notified.

I spoke to direct care staff, Shiloh Stacks, who stated that she has worked at the facility for two years. Ms. Stacks stated that there were six residents residing at the facility at the time of my onsite investigation. Ms. Stacks stated, "This home provides care to highly behavioral individuals. All residents, except one, require 1:1 staffing. Resident A has a history of impulsive and aggressive behavior. She can become very emotional very easily. She's also verbally and physically aggressive towards other people, including staff. She has a history of self-injury behavior and swallowing objects. I have never observed anybody mistreating or causing harm to Resident A nor any other

resident that lives here. Most times, Resident A is the aggressor and will attack other people. I've never seen anyone punch Resident A or tease or bully her. I have observed times when staff have had to use restraining techniques to prevent Resident A from harming herself or others. Each time I've been involved in these incidents, I have never seen a staff intentionally hurt or cause harm to Resident A. I have observed Resident A punch staff when we are trying to prevent her from self-harm behavior." Ms. Stacks denied knowledge of this complaint being true.

On 11/25/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I have not had any concerns regarding Resident A's placement. I have not any issues or concerns with the care being provided by staff at the home. We are in the process of seeking a new placement for Resident A due to behavioral concerns." Guardian A1 denied any knowledge of concerns related to this complaint.

On 12/8/2025, I spoke to direct care staff, Iesha Love, via telephone. Ms. Love stated that she has worked at the facility for one year. Ms. Love stated that she is familiar with Resident A. Ms. Love stated, "I have provided care to Resident A, and I am also a lead manager at the facility. Resident A requires 1:1 staffing and has a long history of self-harm behavior as well as aggressive and verbal behavior towards others. Resident A becomes very upset when she does not get her way, and this usually results in aggressive or self-harm behavior. I have never bullied or mistreated Resident A. There was a time I was working when another resident clapped at Resident A while she was in the middle of a behavior. But I did not clap at Resident A, and I never asked any residents to clap at, or tease, Resident A. On this day, Resident A got mad at me because the other resident was clapping at her, and she blamed me because I didn't prevent it from happening. I have never emotionally or physically harmed Resident A. And I have never observed any other staff emotionally or physically mistreat a resident either." Ms. Love denied knowledge of this complaint being true.

On 12/8/2025, I spoke to direct care staff, Malik McClure, via telephone. Mr. McClure stated that he has worked at the facility for one year. Mr. McClure stated, "I am familiar with Resident A, however, I am not her staff. She is a 1:1 and only can have female staff with her, so I do not provide care to her directly. But when I am working, I see her and interact with her. Resident A has a history of swallowing and self-harm behavior. She can be verbally and physically aggressive to others. And there have been times when she's required to be restrained by staff because she tries to self-harm. I have never emotionally or physically harmed a resident. I have never observed any staff mistreat any resident nor harm a resident. I have never seen any concerns with how staff treat the residents and care for them." Mr. McClure denied knowledge of this complaint being true.

On 12/8/2025, I spoke to direct care staff, Kyle Ruffin, via telephone. Mr. Ruffin stated that he has worked at the facility for seven months. Mr. Ruffin stated, "I know Resident A. She is friendly but can manipulate others. She has behavioral issues and often bullies other people in the home. She has a history of self-harm behavior and swallowing objects. I have never emotionally or physically harmed a resident. I've never

observed any concerns regarding other staff and I've never seen staff mistreat or bully her. I have never seen any other resident bully Resident A either. She tends to be the dominating person in the home and, if anything, I've observed her bully other residents. I have no knowledge of any of these complaints. I've never seen any of these things happen in the facility. I think we do a good job of caring for all the residents in a supportive and respectful way." Mr. Ruffin denied knowledge of this complaint being true.

On 12/9/2025, I spoke to direct care staff, Shaniya Edwards, via telephone. Ms. Edwards stated that she has worked at the facility for one month. Ms. Edwards stated, "I enjoy working at the facility. I have not observed any concerns regarding staff's treatment of residents. I have not seen any staff be rude or bullying any residents. I've never observed staff yell or curse at any resident. Resident A does get upset and will retaliate against staff and the other residents. I have observed Resident A bully other residents in the home. I have not seen any staff cause physical or emotional harm to Resident A nor any other resident in the home." Ms. Edwards denied knowledge of this complaint being true.

On 12/9/2025, I spoke to direct care staff, Karanja White, via telephone. Mr. White stated that he has worked at the facility for five months. Mr. White stated, "I always treat every resident with respect and in a professional way. I have never punched or hit any resident. I do not directly work with Resident A, but I have assisted in behavioral management when needed. I have never seen a staff hit or punch Resident A or mistreat her. I have not seen any of these things happen in the home. I don't believe this is true." Mr. White denied knowledge of this complaint being true.

On 12/9/2025, I spoke to direct care staff, Tashionna Smith, via telephone. Ms. Smith stated that she has worked at the facility for eight months. Ms. Smith stated, "Resident A can be difficult at times, and has a tendency to manipulate the other residents. Resident A wants to always be right and sometimes will antagonize the other residents as well as staff in the home. Resident A has anger issues and does verbally and physically act out towards others when she is upset. Resident A will also self-harm and swallow objects when having a behavior. I have never observed any staff bully or threaten Resident A. Most times it is Resident A that is bullying or threatening other people in the home. I'm not aware of any time when a staff physically harmed or emotionally harmed Resident A." Ms. Smith denied knowledge of this complaint being true.

On 12/10/2025, I spoke to direct care staff, Tyrisha Brown, via telephone. Ms. Brown stated that she has worked at the facility for two months. Ms. Brown stated, "I am familiar with all the residents in the home. I have not observed any staff tease or bully Resident A. I have not heard staff laugh at Resident A or tell other residents to clap at her. I have not heard any staff curse or yell at any residents. And I have not witnessed any staff physically or emotionally harm a resident. I think we, as staff, do a good job at redirecting residents verbally. I don't believe any staff would physically or emotionally harm a resident. Resident A is friends with other residents in the home, but she also can

get easily upset and will retaliate. Resident A can be verbally and physically aggressive towards other people in the home, including staff. She also will self-harm and swallow objects. She is easily triggered by anything that other people are saying or doing, even if it has nothing to do with her. I don't believe this complaint is true." Ms. Brown denied knowledge of this complaint being true.

On 12/10/2025, I spoke to direct care staff, Kaylee Eagles, via telephone. Ms. Eagles stated that she has been working at the facility for six months. Ms. Eagles stated, "I have never mistreated or harmed a resident. I have never cursed or yelled at a resident. I have also not observed any concerns related to staff treating residents in a harmful way. Resident A has a history of aggressive behavior and behavioral issues. Resident A is easily triggered by other people and becomes upset easily. Resident A also has dated Resident B, off and on, and this causes issues in the home. Resident A will antagonize other residents in the home. She and Resident B will sometimes antagonize each other. I have not seen any concerns as it relates to the staff in the home." Ms. Eagles denied knowledge of this complaint being true.

On 12/12/2025, I spoke to Lifeways Jackson County Case Manager, Madison Wetter, assigned case manager for Resident A. Ms. Wetter stated, "Resident A has a history of self-harm behavior, verbal and physical aggression and swallowing objects. Resident A can be aggressive and requires 1:1 supervision at all times. I have been to the facility on a consistent basis and have never observed any concerns. The home always appears to be properly staffed, and her room organized, and objects secured. I am not aware of any issues pertaining to staff mistreatment of Resident A. And Resident A has not reported any concerns to me either." Ms. Wetter denied any concerns related to this complaint.

On 12/15/2025, I spoke to direct care staff, Larrion Walker, via telephone. Mr. Walker stated he has worked at the facility for a few months. Mr. Walker stated, "I am familiar with Resident A. I have never bullied or threatened her. I have also never physically hurt her, and I have never punched her. This complaint is not true. There was an incident when Resident A was trying to self-harm, and I was working that day. A Code 3 was called because Resident A was trying to swallow an object. She was also trying to bite staff. She was trying to take apart and break her tv covering to swallow them. I went to help and when I got there, Resident A spit on me. I continued to assist in verbal de-escalation and then I removed myself from the area after she spit on me. I did not yell or curse at her, and I did not punch her or touch her. We are all CPI trained in proper and safe restraint technique when necessary. I would never punch a resident or threaten them. I have never witnessed any other staff threaten or harm a resident." Mr. Walker denied knowledge of this complaint being true.

On 12/15/2025, I spoke to Guardian B1 via telephone. Guardian B1 stated, "Resident B has very difficult behaviors and needs a lot of support and supervision. She has required relocation from multiple prior facilities due to her high behavioral needs. Resident B is a habitual swallower and requires 1:1 at all times. Resident A intentionally will push people's buttons to upset them. I believe that she is doing well and making

progress at the facility. I have noticed very significant and good outcomes for her since living at the facility. The home provides good structure and care to Resident A. When I visit the facility, I always observe the staff to be helpful and caring. I speak to staff weekly for updates on Resident A, and they communicate very well with me. When I speak to Resident A on the phone, I hear her interactions with staff, and they are always polite and patient with her. I do not have any concerns.”

On 12/15/2025, I spoke to Guardian C1 via telephone. Guardian C1 stated, “I have no concerns related to the care being provided by staff to Resident C. I visit the facility at least once per week and I spend a decent amount of time in the home. I have always observed the staff to be great. I have not observed any concerns.”

On 12/15/2025, I spoke to Guardian D1 via telephone. Guardian D1 stated, “Resident D has been residing at the facility for two years and I have been her legal guardian for eight years. Resident D has a history of swallowing things and self-harm behavior. Since living at the facility, Resident D has been doing 1,000 times better and the 1:1 care has been extremely beneficial. Resident D has engaged in less self-harm behavior since living there. I go unannounced to the facility, and my family members also go to the facility every other week. We have not observed any concerns. Resident D calls me often to complain about things she is upset about, and she has never called to complain about staff.” Guardian D1 denied knowledge of this complaint being true.

On 12/16/2025, I spoke to Oakley Case Manager, Katee Skinner, via telephone. Ms. Skinner stated that she is the case manager for Resident's B, D, E and F. Ms. Skinner stated, “I have not observed any concerns related to staff mistreatment of Resident's B, D, E and F. All four residents require 1:1 staffing and I feel the home is well-staffed and they are providing quality care. The staff are always welcoming to me. When I am at the facility, I observe the staff to be very polite and attentive to all the residents. I speak to Resident B, Resident D, Resident E and Resident F consistently and they have not brought up any issues to me related to staff.”

On 12/17/2025, I spoke to Guardian E1 via telephone. Guardian E1 stated, “Resident E has a long history of self-harm and causing self-inflicted wounds. Overall, I have no concerns regarding staff interactions and treatment of Resident E. Resident E has been residing at the facility for three months. Resident E has not vocalized any concerns to me related to the staff.”

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk of physical or emotional harm, or the deliberate infliction of pain by any means.</b>

<b>ANALYSIS:</b>	<p>On 10/29/2025, I conducted an unannounced onsite investigation at the home. I observed all residents, including Resident A, to be properly dressed and with adequate hygiene. I did not observe any concerns.</p> <p>According to Ms. Stacks, Ms. Love, Mr. McClure, Ms. Ruffin, Ms. Edwards, Mr. White, Ms. Smith, Ms. Brown, Ms. Eagles, and Mr. Walker, they have never mistreated or caused emotional or physical harm to Resident A, nor any other resident.</p> <p>Based on the information above, there is not sufficient information to confirm that direct care staff are mistreating or causing emotional or physical harm to Resident A.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<p><b>(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following:</b></p> <p><b>(f) Subject a resident to any of the following:</b></p> <p><b>(iv) Threats.</b></p>
<b>ANALYSIS:</b>	<p>According to Ms. Stacks, Ms. Love, Mr. McClure, Ms. Ruffin, Ms. Edwards, Mr. White, Ms. Smith, Ms. Brown, Ms. Eagles, and Mr. Walker, they have never threatened Resident A, nor any other resident. Based on the information above, there is not sufficient information to confirm that direct care staff have made verbal threats to any resident, including Resident A.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**ALLEGATION:**

**On 11/16/2025, Resident C eloped from the facility due to a lack of sufficient staff supervision.**

**INVESTIGATION:**

On 11/19/2025, a complaint was received, alleging that on 11/16/2025, Resident C eloped from the facility due to lack of sufficient staff supervision. The complaint stated that, on 11/16/2025 at 8:00pm, Resident C eloped from the facility and tried to enter a

neighbor's home. The complaint stated this is not the first time someone has eloped from the facility.

On 10/29/2025, I conducted an onsite investigation at the facility. I reviewed Resident C's file. The *Face Sheet* stated that Resident A was admitted to the facility on 9/4/2025 and has a legal guardian, Guardian C1. The *Health Care Appraisal* listed Resident C's medical diagnosis as Autistic Disorder, Moderate Intellectual Disability, and Unspecified Affective Mood Disorder. The *Assessment Plan for AFC Residents* stated that Resident A requires 1:1 staff supervision at all times, including maintaining line of sight supervision at all times, history of elopement and eluding staff to engage in unsafe behavior (e.g. does not look when crossing roads, runs into traffic, tuns onto highway/freeway on foot, approaches police/strangers in abrupt manner/rushing toward them), history of physical aggression property destruction, and self-injurious behavior in the community, unable to communicate needs due to limited communication skills, independently completes self-care tasks with prompting and does not require use of assistive devices. I reviewed the *Incident/Accident Reports* for the last five months and only located one incident report that documented an elopement from the facility. I did not locate any additional documentation to confirm there have been additional elopements from the facility. The *Incident/Accident Report* dated, 11/16/2025, stated the following:

11/16/2025 at 7:30pm; Completed by Tamarrious Brandon and Karanja White: On 11/16/2025, Resident C went outside to help pickup leaves and smoke. Resident C asked staff {Mr. Brandon} to go for a walk. Staff {Mr. Brandon} walked with Resident C. After seeing the neighbor's house, Resident C ran to the back patio door and began trying to get into the house. Utilized blocking techniques and verbally redirected to return back to the home. Resident C complied when he saw a preferred staff {Mr. White}. {Mr. White} prompted Resident C, using his coping techniques, and walked home. The neighbor did call the police. Police showed up to home and asked to speak to Resident C. Police left and Resident C was calm and safe.

On 12/9/2025, I spoke to Mr. White, via telephone. Mr. White stated, "I am familiar with Resident C and have provided 1:1 staffing to him. I was working the day of the incident when Resident C eloped from the home. That day, staff, Tamarrious Brown, who doesn't normally work at our facility, was assigned to the home as Resident C's 1:1 staff. Mr. Brown had never worked at the home nor provided care to Resident C and was not aware of his behavioral plan. Resident C has a history of trying to elope from the home and is normally not allowed to go outside for walks due to this behavior. But on this day, Mr. Brown allowed Resident C to go outside and smoke a cigarette and to go for a walk off the property. This never should have been allowed, but Mr. Brown didn't know this wasn't allowed. This is the reason that Resident C was able to elope from the facility. Resident C should have been assigned to me or another staff that was more familiar with Resident C and his behaviors. As soon as Mr. Brown notified us that Resident C had eloped from the facility, I immediately went to the neighbor's home and was able to redirect Resident C back to the facility. This is the only time that I know of a resident eloping from the facility."

On 12/15/2025, I spoke to Guardian C1 via telephone. Guardian C1 stated, "I have no concerns related to the care being provided by staff to Resident C. I visit the facility at least once per week and I spend a decent amount of time in the home. Resident C has a history of trying to elope from the home and there was one time that he was able to leave the property, but staff were with him the entire time. I have always observed the staff to be great. I have not observed any concerns."

On 12/16/2025, I spoke to Mr. Brandon via telephone. Mr. Brandon stated, "I have been working for the corporation for eight months, but I primarily work at another licensed location in another county. On 11/16/2025, I was scheduled to work at the facility. This was the only day I ever worked there. When I arrived at the facility, I was told that I was assigned as Resident C's 1:1 staff. I was briefed on Resident C's behaviors, but I was not told that he had a history of elopement. And I did not know he was restricted from going on walks off the property due to a high elopement risk. At the start of my shift, about 30 minutes into the shift, Resident C began displaying a behavior. He kept asking me to go outside and smoke a cigarette. I allowed him to go outside and then he began walking around the property. And then, about two minutes later, he started walking towards the road and a neighboring home. He then began sprinting and I ran after him and also used my phone to notify the other staff in the home that there was a Code 3, which meant that Resident C had eloped from the home. Resident C went up to the neighbor's back door and tried to open it. Mr. Brown came and assisted me in redirecting Resident C back to the facility. I had my eyes on Resident C the entire time until we got to the trees/wooded area and then I lost line of sight for about 45 seconds until I made it past the trees and saw Resident C again. I was never told about Resident C's elopement history. I feel Resident C should have had a 1:1 staff assigned to him that was more familiar with him, his behaviors and redirection techniques."

On 12/17/2025, I spoke to licensee designee, Nicholas Burnett, via telephone. Mr. Burnett stated, "We have had issues with staffing and have been pulling staff from other homes to help cover shifts. We are aware there was an issue with a staff being assigned as Resident C's 1:1 staff, which should not have happened. There should have been a staff assigned that was more familiar with Resident C and his elopement history. We are aware of this issue and will ensure that newer staff will not be assigned as a 1:1 for residents until they have worked in the home for a longer period of time and have more training on the 1:1 staffing needs."

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>

<p><b>ANALYSIS:</b></p>	<p>According to the <i>Assessment Plan for AFC Residents</i>, Resident A requires 1:1 staff supervision at all times, including maintaining line of sight supervision at all times, due to a history of elopement and eluding staff to engage in unsafe behavior, history of physical aggression, property destruction, and self-injurious behavior in the community.</p> <p>According to the <i>Incident/Accident Report</i> dated, 11/16/2025, at 7:30pm, Mr. Brown allowed Resident C to go for a walk outside, which led to Resident C's elopement from the facility.</p> <p>According to Mr. White and Mr. Brown, Mr. Brown was assigned to provide 1:1 staffing to Resident C on his first day working at the facility and was not aware of Resident C's elopement history. Mr. Brown stated that during the time that Resident C eloped from the facility, he lost line-of-sight of Resident C for approximately 45 seconds. Mr. White and Mr. Brown both stated that Mr. Brown was not knowledgeable of Resident C personal care, supervision and protection needs specified in his assessment plan.</p> <p>According to Mr. Burnett, Mr. Brown should not have been assigned as Resident C's 1:1 staff without proper training and knowledge of his personal care, supervision and protection needs.</p> <p>Based on the information above, there is sufficient information to confirm that, on 11/16/2025, Mr. Brown did not provide adequate supervision, personal care and protection to Resident C, as specified in his assessment plan.</p>
<p><b>CONCLUSION:</b></p>	<p><b>VIOLATION ESTABLISHED</b></p>

**ALLEGATION:**

**Direct care staff are denying Resident A reasonable access to a telephone.**

**INVESTIGATION:**

On 11/19/2025, a complaint was received, alleging that direct care staff are denying Resident A reasonable access to a telephone. The complaint stated that Resident A has been denied access to a telephone during times that she is feeling suicidal. The complaint stated that direct care staff refuse to let Resident A use the phone when requested.

On 11/25/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I have not had any concerns regarding Resident A's placement. I have not any issues or concerns. We are in the process of seeking a new placement for Resident A due to behavioral concerns." Guardian A1 denied any knowledge of concerns related to this complaint.

On 12/8/2025, I spoke to Ms. Love, via telephone. Ms. Love stated, "All residents have access to the common telephone in the facility, and most residents also have their own personal cell phones. Resident A does have her own cell phone that she can use when she chooses to. I have never denied any resident access to a telephone when requested." Ms. Love denied knowledge of this complaint being true.

On 12/8/2025, I spoke to Mr. McClure, via telephone. Mr. McClure stated, "I am not aware of any telephone restriction issues with Resident A. We allow the residents access to the telephone within the facility, and they can also use their personal cell phones to make calls as well." Mr. McClure denied knowledge of this complaint being true.

On 12/8/2025, I spoke to Mr. Ruffin, via telephone. Mr. Ruffin stated, "We allow residents to use the telephone when requested. There are times we may withhold the phone when a resident is in the middle of a behavior because we have individuals here that will smash the telephone in order to cut themselves with the plastic or swallow it. I have never denied any resident access to a telephone when requested. I am not aware of this being an issue."

On 12/9/2025, I spoke to Ms. Edwards, via telephone. Ms. Edwards stated, "I am not aware of any issues with telephone access. Residents have access to the telephone when they want to use it." Ms. Edwards denied knowledge of this complaint being true.

On 12/9/2025, I spoke to Mr. White, via telephone. Mr. White stated, "We allow residents access to the phone at the facility, and they also have their personal cell phones that they can use as well. I have never denied Resident A, nor any other resident, access to a telephone." Mr. White denied knowledge of this complaint being true.

On 12/9/2025, I spoke to Ms. Smith, via telephone. Ms. Smith stated, "There is a phone in the home that residents can use any time. They also have access to their own personal cell phones. I have never denied a resident access to the telephone." Ms. Smith denied knowledge of this complaint being true.

On 12/10/2025, I spoke to Ms. Brown, via telephone. Ms. Brown stated, "This is not true. We never deny residents access to the telephone. The residents can use the house phone and their personal cell phone as well." Ms. Brown denied knowledge of this complaint being true.

On 12/10/2025, I spoke to Ms. Eagles, via telephone. Ms. Eagles stated, "I have never denied Resident A, or any other resident, access to the telephone. They can use the

phone in the facility, and they also use their cell phones.” Ms. Eagles denied knowledge of this complaint being true.

On 12/12/2025, I spoke to Ms. Wetter via telephone. Ms. Wetter stated, “I am not aware of any issues pertaining to staff mistreatment of Resident A. Resident A has not reported any concerns to me either.” Ms. Wetter denied any concerns related to this complaint.

On 12/15/2025, I spoke to Guardian B1 via telephone. Guardian B1 stated, “I do not believe there are any concerns related to telephone access for Resident B. Resident B calls me consistently and when we speak on the telephone, the calls are for long durations of time. I am not aware of any issues.”

On 12/15/2025, I spoke to Guardian C1 via telephone. Guardian C1 stated, “Resident C calls me, on average, 20 times per day. He is able to call me when he wants without restriction. I do not have any concerns related to his access to a telephone.” Guardian C1 denied concerns related to this complaint.

On 12/15/2025, I spoke to Guardian D1 via telephone. Guardian D1 stated, “I am not aware of any telephone restrictions. Resident D calls me twice per day on average. He uses the phone as needed.” Guardian D1 denied concerns related to this complaint.

On 12/16/2025, I spoke to Ms. Skinner, via telephone. Ms. Skinner stated, “I have not observed any concerns related to telephone restrictions or concerns. The home is well-staffed, and they provide good care for the residents. I speak to Resident B, Resident D, Resident E and Resident F consistently and they have not brought up any issues to me related to this complaint.”

On 12/17/2025, I spoke to Guardian E1 via telephone. Guardian E1 stated, “Overall, I have no concerns regarding the facility and care being provided. Resident E has been residing at the facility for three months and has not vocalized any concerns to me. I have no concerns.”

On 12/17/2025, I conducted an exit conference with Nicholas Burnett and Carrie Aldrich via telephone. Mr. Burnett is in agreement with the findings of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b> <b>(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.</b>

<b>ANALYSIS:</b>	<p>According to Ms. Love, Mr. McClure, Ms. Ruffin, Ms. Edwards, Mr. White, Ms. Smith, Ms. Brown, and Ms. Eagles, they have never denied Resident A, nor any other resident, reasonable access to a telephone for private communications.</p> <p>Based on the information above, there is not sufficient information to confirm that direct care staff are refusing to allow Resident A reasonable access to a telephone.</p>
<b>CONCLUSION:</b>	VIOLATION ESTABLISHED

**IV. RECOMMENDATION**

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

*Stephanie Gonzalez*

12/23/2025

Stephanie Gonzalez  
Licensing Consultant

Date

Approved By:

*Denise Y. Nunn*

12/23/2025

Denise Y. Nunn  
Area Manager

Date