GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

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

RE: License #: AS630391550
Investigation #: 2026A0991005
Brandon East

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 (248) 972-9136.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630391550
Investigation #:	2026A0991005
Complaint Receipt Date:	12/04/2025
Investigation Initiation Date:	12/05/2025
Report Due Date:	02/02/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Brandon East
Facility Address:	301 Sleepy Hollow Brandon, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/24/2018
License Status:	REGULAR
Effective Date:	10/24/2024
Expiration Date:	10/23/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/30/25, Resident A charged at staff. He and staff, Nicholas Scott were out of view in the laundry room. Resident A later alleged that staff, Nicholas Scott, hit him. Resident A was diagnosed with a left eye contusion.	Yes
On 12/09/25, Resident B drank toilet bowl cleaner that was left out by staff. Staff did not obtain medical care for Resident B until three hours later.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/04/2025	Special Investigation Intake 2026A0991005
12/04/2025	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
12/05/2025	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR), Sarah Rupkus
12/05/2025	APS Referral Received from Adult Protective Services (APS)
12/05/2025	Contact - Telephone call made To assigned APS worker, Heather Stickel
12/05/2025	Contact - Document Received Incident report
12/09/2025	Contact - Document Received Photographs of injuries
12/09/2025	Contact - Document Received Discharge paperwork
12/10/2025	Contact - Document Received Additional allegations regarding Resident B

12/11/2025	Contact - Document Received Resident B's discharge paperwork
12/12/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
12/12/2025	Contact - Telephone call received From program director, Laurie Depelliers
12/12/2025	Contact - Document Received Video of repaired door
01/14/2026	Contact - Document Received Copy of sheriff's department report
01/21/2026	Contact - Telephone call made To APS worker, Heather Stickel- substantiating allegations
01/21/2026	Contact - Telephone call made Left message for manager, Keo Riouse-Russey
01/21/2026	Contact - Telephone call made To direct care worker, Colton Morin
01/21/2026	Contact - Telephone call made To staff, Lydia Brooks- no voicemail
01/21/2026	Contact - Telephone call made To staff, Laniyah Kincaid- left message
01/21/2026	Contact - Telephone call made To staff, Dresean Holden- no voicemail
01/22/2026	Contact - Telephone call made Interviewed second shift manager, Keo Riouse-Russey
01/22/2026	Contact - Document Received Email from ORR worker, Sarah Rupkus- substantiating allegations
01/22/2026	Exit Conference Via telephone with compliance officer, Chelsay Hamburg

ALLEGATION:

On 11/30/25, Resident A charged at staff. He and staff, Nicholas Scott were out of view in the laundry room. Resident A later alleged that staff, Nicholas Scott, hit him. Resident A was diagnosed with a left eye contusion.
INVESTIGATION:

On 12/04/25, I received a complaint alleging that on 11/30/25, Resident A became escalated and began charging at staff. Staff, Nicholas Scott, ran into the laundry room area to avoid Resident A. Resident A followed Mr. Scott into the laundry room, where they were out of sight of the other staff. Resident A later reported that Mr. Scott struck him in the face. Staff observed swelling under Resident A's eye. He was taken to urgent care and diagnosed with a contusion to the left eye. I initiated my investigation on 12/05/25 by contacting the assigned Office of Recipient Rights (ORR) worker, Sarah Rupkus, and the assigned Adult Protective Services (APS) worker, Heather Stickel. Ms. Stickel stated that she observed Resident A at the home on 12/04/25. He has a contusion on his cheekbone, and his left eye is bright red as though a blood vessel burst. Resident A stated that he hit Mr. Scott with a lighter, and Mr. Scott came after him and punched and slapped him. Ms. Stickel stated that Mr. Scott is still working in the home and was not removed from the schedule. The other staff on shift was outside with another resident at the time of the incident. Staff could not provide any explanation for Resident A's injuries.

On 12/12/25, I conducted an unannounced onsite inspection at Brandon East with the assigned APS worker, Heather Stickel, and the assigned ORR worker, Sarah Rupkus. I interviewed the home manager, Tyler Hunter. Mr. Hunter stated that he was not working at the time of the incident. He was told that the incident started when Resident A took staff's sweatshirt. Resident A has a history of stealing. Staff were trying to verbally redirect Resident A. Resident A started throwing stuff at direct care worker, Nicholas Scott. Resident A was chasing Mr. Scott around the house and Mr. Scott was trying to dodge him. Resident A later reported that Mr. Scott hit him in the face. Mr. Scott denied hitting or punching Resident A when asked by Mr. Hunter. Mr. Hunter stated that staff could not provide an explanation for the injury to Resident A's face and eye. Staff reported that Resident A's eye was swollen. During second shift, the busted blood vessel in Resident A's eye appeared. Mr. Hunter stated that the incident occurred around 2:45pm, which is right before shift change. The other staff on shift, Alex, was outside with another resident. The third staff on shift, Doug, was outside because his car was stuck in the snow. Kyla, a staff from Brandon West, which is located next door, came to assist. Mr. Hunter stated that Mr. Scott was taken off of the schedule on 12/4/25, after APS came to the home.

On 12/12/25, I interviewed direct care worker, Douglas Walker. Mr. Walker stated that he has worked in the home for four or five months. He stated that he was scheduled to work on 11/30/25. He left the home shortly before his shift ended around 2:45-2:50pm, because his car was stuck in the snow in a ditch and he was trying to get it out. He stated that when he left, Resident A was outside smoking. He could not recall where staff, Nicholas Scott, was when he left. He stated that staff, Kyla, Alex, and Nick were at the home when he left. When he came to work the following day, he saw Resident A's eye was red and swollen. He asked Resident A what happened. Resident A just asked to go outside and did not tell him what happened. He stated that Resident A told him that he "beat Nick's ass." He asked Resident A what he was talking about, but Resident A did not elaborate. Mr. Walker did not have any knowledge of what happened or how Resident A's eye got injured. He stated that Resident A was mad about a sweatshirt earlier that day. He was talking about it and seemed annoyed. Mr. Walker stated that he has not seen Mr. Scott since the day that the incident happened. Mr. Walker stated that he typically works the same shift as Mr. Scott. He never saw Mr. Scott being aggressive. He stated that Mr. Scott is a good worker and makes the residents laugh.

On 12/12/25, I interviewed staff, Kyla Cummings. Ms. Cummings stated that she is the shift lead on the weekends and has worked in the home for six years. Ms. Cummings stated that on 11/30/25, she was scheduled to work at the other building, Brandon West. She left at the end of her shift to use the bathroom at Brandon East, because the bathroom was broken at the other home. She stated that when she came to the home, Resident A was wearing her sweatshirt that she had left there. She told Resident A, "sweet sweatshirt." Resident A became verbally aggressive and started yelling, "It's not your mother fucking sweatshirt." Ms. Scott stated that Nick Scott was working in the home, and he told Resident A that it was no big deal and tried to calm him down. Resident A threw a lighter at Mr. Scott's head. The lighter hit Mr. Scott in the face or forehead. Ms. Cummings did not see Resident A throw anything else. Ms. Cummings stated that she went into the bathroom. She could hear running back and forth. Ms. Cummings stated that when she came out of the bathroom, Resident A and Mr. Scott were leaving the kitchen area and moving to the back of the home near the laundry area. Resident A cornered Mr. Scott by the garage door. The other staff on shift, Alex, was outside. Alex opened the door and came in. Alex used body positioning to get in between Mr. Scott and Resident A. Mr. Scott left and went outside. Resident A was saying, "I beat Nick's ass." He seemed proud of himself. Ms. Cummings stated that Alex validated Resident A's feelings and they used verbal redirection. Ms. Cummings stated that Mr. Scott stayed calm throughout the incident. She did not observe him raising his voice or yelling. She stated that she did not see Mr. Scott hit Resident A. She has no clue how he got injured. She stated that she has worked with Mr. Scott for a long time and she never observed him being physically aggressive. She stated that she has not worked with Mr. Scott since the incident and she did not talk to him about what

happened. She stated that she has no clue how Resident A's eye was injured and she did not want to speculate. Resident A does not have a history of self-injurious behaviors.

On 12/12/25, I interviewed direct care worker, Nick Scott. Mr. Scott stated that he has worked in the home for three years. He typically works first shift from 7:00am-3:00pm. Mr. Scott stated that on 11/30/25 around the end of his shift, Resident A was acting agitated. Staff tried to redirect him, and Alex Thompson took Resident A outside to smoke. He came back inside and was still agitated. Resident A said, "Hey Nick. You're a bitch." He threw a lighter at Mr. Scott. Mr. Scott stated that he told Resident A he was going to write that down. Resident A then charged at him. Mr. Scott stated that he used body positioning to get away from Resident A. He used his radio to call for a "Code 3", which is the code they use to call all staff for resident behaviors. Mr. Scott stated that he had been sitting down, but he got up and moved behind the chairs in the dining room. Resident A charged at him again, and they were "in a tussle." Resident A was clawing and biting him. Mr. Scott stated that he had his coat on, so he did not sustain any injuries. Mr. Scott stated that Alezandra (Alex) Thompson came inside and got in between them. He stated that he thought Resident A was calmed down, so he went back to charting. He stated that Resident A escalated again and got ahold of him. Resident A grabbed his coat and threw objects at him. Resident A tried to go out the front door, but he did not put the code in. Mr. Scott used body positioning to try to get away from Resident A. Mr. Scott stated that Kyla came into the home around that time. Resident A threw a bottle at him and kept charging at him. Mr. Scott stated that the second shift staff was coming into the home, so he left the home through the front door as they were coming in. The other staff told him to get out of the home. He stated that he did not punch Resident A. Resident A kept jumping on him and attacking him. He stated that at one point they were in the living room and they both fell. Resident A tripped over his foot and fell against the wall. Mr. Scott stated that he saw injuries on Resident A's face that same day. He noticed that Resident A's eye was swollen before he left the home. He stated that he did not remember anything hitting Resident A. He stated that he was fully aware and calm throughout the incident. He stated that his elbow might have hit Resident A during the altercation. Mr. Scott stated that he is trained in CPI (Crisis Prevention Institute nonviolent crisis intervention). He stated that he tried to use a child control hold where you put your arms around someone to hold their arms down, but it did not work because Resident A was moving around too much. He stated that they used body positioning, and nobody physically managed Resident A. He stated that he never hit Resident A. Mr. Scott stated that he came into work the following day and made amends with Resident A. Resident A told him that he did not want to have behaviors again. Mr. Scott stated that he was informed by the weekend manager, John, that Resident A said he hit him.

On 12/12/25, I interviewed direct care worker, Alezandra (Alex) Thompson. Ms. Thompson stated that she is a lead worker, and she has worked in the home for a little over a year. Ms. Thompson stated that she was working on 11/30/25. Resident A was upset about something and was antsy all day. She tried to get Resident A to go outside and smoke, but after a minute he stated that he was going to his room to listen to music. Ms. Thompson stayed outside with another resident who was smoking. She stated that she could hear running and a commotion coming from inside, so she immediately went inside. She stated that she did not receive a “Code 3” call on her radio. When she went inside, she saw Resident A chasing Mr. Scott around the house. Mr. Scott was dodging Resident A and trying to get away from him. She stated that she did body positioning to get between Resident A and Mr. Scott. They were near the kitchen, coming out from the laundry room. She stated that it was around 2:45pm, near the end of Mr. Scott’s shift, so she told him to leave. Mr. Scott made his way to the front door and left. She stated that she did not see Mr. Scott hit Resident A or physically restrain him. He was just trying to get away from Resident A. She did not see Resident A fall or run into anything. She stated that Resident A was throwing boards around, but he did not throw them at Mr. Scott. She stated that she was not sure what Resident A was upset about. Ms. Thompson stated that she left her shift at 3:17pm that day. She did not see any marks or bruises on Resident A at that time. She observed some swelling of Resident A’s eye the next day. She stated that Resident A never told her that Mr. Scott punched him. She stated that she did not physically manage Resident A, and she did not see Mr. Scott physically manage Resident A. She did not see Resident A put his hands on Mr. Scott. She stated that Resident A was swearing at Mr. Scott saying, “Fuck you. Get out of my house.” Mr. Scott remained calm. She stated that Resident A is a good resident. He will sometimes cuss you out, but he does not usually get physically aggressive. She stated that staff can typically talk to Resident A and get him to calm down. Ms. Thompson stated that this was the first time she worked on shift with Mr. Scott.

On 12/12/25, I interviewed Resident A. Resident A stated that staff, Nick (Nicholas Scott), picked a fight with him. He stated that Nick jumped up like he was about to punch him. Nick told Resident A to “shut the fuck up.” Resident A stated that he told Nick, “No, you shut the fuck up or you are about to get your ass beat.” He stated that he jumped up and hit Nick, and then Nick jumped up and hit him too. Resident A stated that he took a lighter and hit Nick in the face with it. He stated that he took a bottle and threw it at Nick. Resident A stated that he fell, because Nick made him fall. He stated that Nick punched him in the face with a fist. Kyla was there, but nobody else was there. Resident A stated that he was outside smoking, but he came back inside and cussed Nick out. He stated this happened last week and that Nick punched him in the eye. He punched him ten times. Resident A said that this is the only time Nick hit him. He stated that he does not care for Nick, and that he is disrespectful. He wants him fired. Resident A stated that he chased Nick that day, but he did not bite him or his jacket.

During the onsite inspection, I observed that Resident A's left eye was still red from a broken blood vessel. I observed pictures of Resident A's eye and cheekbone that were taken by staff on 11/30/25, which show swelling and bruising on the cheekbone under Resident A's left eye, as well as redness in his eye.

I reviewed an incident report dated 11/30/25. It notes that on 11/30/25, upon arrival to second shift, the second shift staff noticed swelling underneath Resident A's left eye. Staff asked Resident A what the cause of the swelling was, and he accused a first shift staff of hitting him. Staff immediately called on-call, while another staff provided Resident A with an ice pack and administered Tylenol. Staff were advised to take Resident A to urgent care. The urgent care staff assessed Resident A's injury and conducted an x-ray. He was diagnosed with a "contusion of the left eye." Resident A was given instructions to continue icing the area. Staff will continue to closely monitor Resident A for any worsening symptoms. Staff contacted recipient rights to report Resident A's allegation.

I reviewed the patient care summary from Springfield Urgent Care. It notes that the reason for the visit is that Resident A got into a fight with a staff member at his group home. He stated that staff punched him in the left eye. He denies LOC (loss of consciousness). Resident A stated that he has swelling and bruising underneath his left eye. He also reported a headache and some blurry vision in the left eye. The diagnosis listed is a contusion of the left eye, initial encounter. The notes state that Resident A has an injury to his left orbital bone. The x-ray is normal, but staff are aware that they cannot completely rule out a fracture with an x-ray. They will continue to treat it with ice packs. Resident A has no signs of concussion and may go back to the facility that he lives at. The summary notes that it is difficult to tell exactly what happened since Resident A stated that he "swung on Nick" first.

I received and reviewed the case report from the Oakland County Sheriff Office. It notes that on 01/14/26, a warrant was denied for this case by the prosecutor's office. During Nicholas Scott's interview with the sheriff's department, he stated that Resident A was agitated and had behavior issues throughout the day. Mr. Scott verbally directed Resident A to go outside for a smoke to calm down. When Resident A returned, he approached Mr. Scott, called him a "bitch" and said he didn't like him. Mr. Scott told Resident A that this behavior could result in him losing community access, which triggered Resident A. Resident A charged at him. Mr. Scott used body-positioning techniques to separate Resident A and create distance, while also giving verbal commands to try to calm him down. Resident A continued to go after Mr. Scott and grabbed his jacket. Mr. Scott called a "Code 3" over the radio to request emergency help from other staff. Staff member, Alezandra responded and used body-positioning techniques, including a CPI child hold, to separate Resident A and Mr. Scott. Resident A broke away from Alezandra and continued to go after Mr. Scott. Mr. Scott tried to

leave the house, but Resident A chased him and jumped on his back. Mr. Scott stated that he turned around and told Resident A to stop, but Resident A was biting and scratching him. Resident A then began throwing a water bottle, plastic plates and utensils, a binder, boards, and a pitcher of juice at him. Mr. Scott stated that he bear-hugged Resident A in an attempt to use body-positioning techniques again. During this, Resident A tripped and fell to the floor in the living area, which caused the injury to his eye. Second shift staff arrived, and Mr. Scott was able to safely remove himself from the home. Mr. Scott stated that he saw a knot on Resident A's eye and informed staff about it prior to leaving the home. He also stated that staff, Alezandra, may have seen Resident A fall. Mr. Scott did not have any significant injuries from the altercation- no bite marks, only a scratch under his right eye. He denied punching Resident A and explained that he is trained only in body positioning and open-hand control techniques, which are used for separation. Mr. Scott stated, "He is not trained to punch or deliver strikes to residents."

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff used physical force, other than physical restraint for crisis intervention, against Resident A. On 11/30/25, Resident A charged at staff, Nicholas Scott. Resident A chased Mr. Scott around the house and Mr. Scott stated that they "tussled." Resident A reported that Mr. Scott hit him in the face. While Mr. Scott denied the allegations, Resident A sustained injuries to his face and was diagnosed with a left eye contusion after going to urgent care. His eye was red and his cheekbone was swollen and bruised. Mr. Scott provided conflicting information regarding Resident A's injuries and the account of the incident. He stated that Resident A might have been hit by his elbow during the incident, but also told the sheriff's department that the injury occurred when Resident A fell.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 12/09/25, Resident B drank toilet bowl cleaner that was left out by staff. Staff did not obtain medical care for Resident B until three hours later.

INVESTIGATION:

On 12/10/25, I received additional allegations that on 12/09/2025, Resident B ingested diluted toilet bowl cleaner. Resident B spit it out at workers but did swallow some of the cleaner. The staff diluted the cleaner with one ounce toilet cleaner and water. The staff had a staff meeting and they found Resident B with it. The staff believe that day shift left it out. The cleaner is usually locked in a cabinet. This was not reported for three hours to the police dispatch. Resident B was taken to the hospital.

On 12/12/25, I interviewed Resident B. Resident B stated that he drank cleaner. Staff had it out, and he drank some of it. He stated that it was in the laundry room. He did not know who left it out. Resident B stated that it was bleach, “the blue stuff.” He stated that he felt sick and started throwing up. Staff took him to the hospital.

On 12/12/25, I interviewed the home manager, Tyler Hunter. Mr. Hunter stated that he was not working when Resident B drank the cleaner. He stated that Keo Riouse-Russey is the second shift home manager who was on call at the time. Mr. Hunter stated that Resident B drank toilet bowl cleaner that was left out by staff. Mr. Hunter stated that poison control was contacted at 7:14pm. Staff called 911 at 9:40pm. He could not provide an explanation as to the delay in calling 911 but stated that Resident B was likely refusing to go to the hospital. They typically prompt the residents three times with 15 minutes in between prompts when they are refusing to do something.

I viewed a bottle of Clorox toilet bowl cleaner with bleach, which was in a locked closet. The bottle notes that the active ingredient is 2.4% sodium hypochlorite. The bottle states, “KEEP OUT OF REACH OF CHILDREN. DANGER: CORROSIVE.” The label on the back of the bottle notes that it causes irreversible eye damage and skin irritation. It notes that if swallowed you should call a poison control center or doctor immediately for treatment advice. Have the person sip a glass of water if able to swallow. Do not induce vomiting unless told to do so by the poison control center or doctor.

On 01/21/26, I interviewed Colton Morin, the lead worker who was on shift on 12/09/25. Mr. Morin stated that he did not see Resident B drink the bleach. He stated that he went over to the other home, Brandon West, to assist with a behavior. When he returned to Brandon East, he went to the bathroom. He stated that he was in the bathroom when Resident B drank the bleach. He stated that he did not know how staff missed the cleaner being left out. At the beginning of each shift, staff typically walk through the

home to check for any dangerous items. He stated that Resident B has self-harming behaviors, so they always check to make sure any hazardous items are removed. He stated that they must have missed doing their checks that day, and he believed the cleaner was left out by the first shift staff. He stated that another staff reported to him that Resident B drank the cleaner, but he spit it right back out. He stated that staff said Resident B did not swallow the cleaner, but they could not be sure if that was true. Mr. Morin stated that they called Keo, the second shift manager. Keo contacted the director's on-call number and came to the home a short while later. Mr. Morin stated that he believed Keo contacted poison control. He stated that it was a couple of hours before Resident B went to the hospital. He was not sure why there was a delay in calling 911, as the on-call managers were handling the situation at that point.

On 01/22/26, I interviewed the second shift manager, Keo Riouse-Russey, via telephone. Mr. Riouse-Russey stated that he was on shift when Resident B drank the cleaner; however, he was at the main office picking up supplies and was not at the home. Staff contacted him to let him know that they saw Resident B coming out of the laundry room with a bottle in his hand. He spit something out and based on the smell, they determined that it was toilet bowl cleaner. Mr. Riouse-Russey stated that the cleaner was not in its original bottle. Staff put the toilet bowl cleaner in another bottle, possibly to dilute it. He stated that this is not standard procedure, and the cleaner should remain in its original bottle. Mr. Riouse-Russey stated that staff did not see Resident B swallow any of the cleaner, but they did observe him spitting it out. Mr. Riouse-Russey contacted the Flatrock medical on-call person and medical on-call contacted poison control. Poison control advised that Resident B should be sent out to the hospital as a precaution, as it was unknown if he ingested any of the cleaner. Mr. Riouse-Russey stated that he received the initial call about Resident B around 7:00pm. He called 911 after he arrived at the home, which was after 9:00pm. He stated that they typically transport residents to the hospital in a company vehicle, but there were issues as Resident B initially agreed to go to the hospital, but then he began refusing to go. He stated that Resident B can have behaviors during transport, so staff were trying to calm him down before taking him to the hospital. Mr. Riouse-Russey stated that when he arrived to the home, he made the decision to call 911 and have Resident B transported by ambulance. He stated that he was not sure why staff did not call 911 earlier, but he thought they were trying to follow his initial instructions to transport him themselves. Mr. Riouse-Russey stated that Resident B was not showing any physical symptoms. He was not pale and his vitals were stable. He stated that he did not know how the cleaner was left out or why checks for hazardous items were not completed. He stated that staff were retrained following this incident.

I reviewed the emergency department notes from Trinity Oakland Emergency Department dated 12/09/25 at 10:43pm. The notes indicate that Resident B presented

to the emergency department after he drank bleach at his group home. Staff stated that Resident B drank bleach and then spit it out and gagged himself to vomit. It was an intentional ingestion. The emergency department notes indicate that Resident A was alert and was not in any acute distress. An examination of his ears, nose, mouth, and throat showed that his oral mucosa was moist. His ears and nose were normal. There were no burns in his intraoral cavity. Resident B's lungs were clear to auscultation. No wheezes or rhonchi were noted. The emergency department notes indicate that Resident B was uncooperative and aggressive with staff members. He threw urine at staff members and was being very aggressive. Resident B was sedated and placed in restraints. The case was discussed with poison control, and they recommended obtaining x-rays and lab work, which was already ordered. The notes indicate that a chest x-ray was reviewed and found to be negative for any acute cardiopulmonary pathology. All lab work was within normal limits. Resident B was found to be stable and medically cleared. He was placed in the emergency department for observation.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(7) Poisons, caustics, and other dangerous materials must be stored and safeguarded in nonresident, non-food preparation areas, and storage areas.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that toilet bowl cleaner containing bleach was not stored and safeguarded in a non-resident area. On 12/09/25, Resident B ingested toilet bowl cleaner that was left out in an unlocked area by staff. Resident B was transported to the hospital as a result of drinking the cleaner.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that needed health care was not obtained immediately when Resident B ingested toilet bowl cleaner containing bleach. Poison control was initially contacted at 7:14pm, but 911 was not called until over two hours later. Staff could not provide an explanation for the delay in calling 911.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 12/12/25, I interviewed Resident A in his bedroom with the assigned APS and ORR workers. We closed the bedroom door for privacy during the interview process. When we went to leave the bedroom, the door would not open. Staff could be heard from the other side of the door saying, “Oh, no. They closed the bedroom door.” Several attempts were made to open the door from both inside and outside of the bedroom, but the attempts were unsuccessful. Another resident in the home came to the door and told us to stand back. The resident proceeded to body slam the door and rammed it open.

The staff on shift, Michael Pickett, stated that the door got kicked about a month ago, and has been broken since that time. He stated that staff were aware that the door was broken, and it is usually propped open. He stated that management was aware that the door was broken.

On 12/12/25, I spoke with the manager, Tyler Hunter. Mr. Hunter stated that he did not know that the door was broken.

On 12/12/25, I spoke with the program director, Laurie Depelliers. She stated that maintenance would be out to the home to address the door immediately. She provided a video of the repaired door a few hours later.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home was not maintained to provide for the safety and well-being of the occupants. On 12/12/25, Resident A's bedroom door would not open from the inside or outside after it was closed, preventing safe egress from the room. Another resident had to body slam the door in order to gain entry into the room. Staff stated that the door had been broken for at least a month without being repaired.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**
ANALYSIS:	Based on the information gathered through my investigation, Resident A's right to privacy was not safeguarded when his bedroom door was broken for at least one month. Resident A's bedroom door was unable to be closed and was propped open during this time, preventing him from having privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the findings of the initial investigation as well as additional findings identified during the investigation process, there is sufficient information to conclude that the residents in the home were not protected and safe. Resident A's safety was not ensured when he sustained injuries following an interaction with staff, Nicholas Scott, in which he suffered a contusion to his left eye. His safety was further ignored when the facility failed to repair his broken bedroom door, which allowed him to get locked inside the bedroom, preventing safe egress from the

	home. The staff also failed to complete a thorough safety check of the home to ensure that cleaning supplies were properly stored and locked up, resulting in Resident B's hospitalization after ingesting toilet bowl cleaner with bleach.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 12/12/25, I observed that one of the smoke detectors in the home was chirping, indicating that the battery needed to be replaced. The assigned APS worker, Heather Stickel, stated that the smoke detector was also chirping during her onsite inspection on 12/04/25. On 12/12/25, I spoke with the manager, Tyler Hunter. Mr. Hunter stated that the maintenance team was notified that the smoke detector was chirping, but they had not been out to fix it yet. On 12/12/25, I spoke with the program director, Laurie Depelliers. She stated that maintenance would be out to the home to address the smoke detector immediately.

APPLICABLE RULE	
R 400.727	**Smoke detection equipment for family home and small group home with 6 or less residents after March 27, 1980.**
	(3) If batteries are used as a source of energy, the batteries must be replaced in accordance with the recommendations of the alarm equipment manufacturer.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the smoke detector batteries were not replaced in accordance with the recommendations of the manufacturer. The smoke detector was chirping on 12/12/25, indicating that the battery needed to be replaced. The APS worker stated that the smoke detector was also chirping on 12/04/25, indicating that the issue had not been addressed for over a week.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

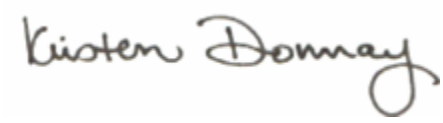
During the onsite inspection on 12/12/25, I observed that the walkway to the front of the home had not been adequately shoveled and cleared of snow. Some snow was shoveled from the grass, leaving an icy and slippery path to the door. The cement walkway was not cleared. On 12/12/25, the program director, Laurie Depelliers, provided a video showing that the front walkway had been cleared.

On 01/22/26, I conducted an exit conference via telephone with the compliance officer, Chelsay Hamburg. Ms. Hamburg did not have any additional information to share regarding the investigation. She stated that she would review the report and submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.737	**Means of egress.**
	(1) A means of egress must be considered the entire way and method of passage through a facility and out an exit door to free and safe ground outside the facility. Means of egress must be maintained in unobstructed travel condition.
ANALYSIS:	On 12/12/25, the means of egress from the front of the home was not maintained in unobstructed travel condition. The walkway to the front of the home had not been adequately cleared of snow to allow for safe passage from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

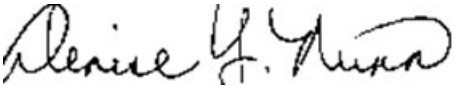
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



01/22/2026

Kristen Donnay Date
Licensing Consultant

Approved By:



01/29/2026

Denise Y. Nunn Date
Area Manager