



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 17, 2026

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

RE: License #: AS250388491
Investigation #: 2026A0623015
Ortonville

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,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250388491
Investigation #:	2026A0623015
Complaint Receipt Date:	01/28/2026
Investigation Initiation Date:	01/29/2026
Report Due Date:	03/29/2026
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, Designee
Name of Facility:	Ortonville
Facility Address:	12399 Ray Road Ortonville, MI 48462
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	08/29/2017
License Status:	REGULAR
Effective Date:	02/28/2026
Expiration Date:	02/28/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 2/3/2026, Resident A eloped and was found alone at 1:15am miles away from the AFC home.	Yes
On 1/26/2026, Resident A was slapped in the back of the head by a staff person named Barry.	No

III. METHODOLOGY

01/28/2026	Special Investigation Intake 2026A0623015
01/29/2026	APS Referral I completed an APS referral.
01/29/2026	Special Investigation Initiated - Telephone Voicemail was left for Recipient Rights Keegan Sarkar.
02/04/2026	Contact - Telephone call made Spoke to APS worker.
02/04/2026	Inspection Completed On-site
02/04/2026	Contact - Face to Face Spoke to Resident A's guardian.
02/04/2026	Contact - Telephone call made Spoke to staff person, Jameaka Thomas-wells.
02/09/2026	Contact - Telephone call made Spoke to staff person, Ja'Quavis Sanders.
02/09/2026	Contact - Telephone call made Spoke to staff person, D'Jeneba Coulibaly.
02/09/2026	Contact - Telephone call made Spoke ORR investigator.
02/09/2026	Contact - Telephone call made Spoke to staff person, Quenten Holliday.

02/17/2026	Contact - Telephone call received Received voicemail from APS worker.
02/19/2026	Contact - Telephone call made Spoke to staff person, Hezekiah Patton.
02/19/2026	Contact - Telephone call made Spoke to home manager.
02/20/2026	Inspection Completed On-site
03/06/2026	Exit Conference Held with licensee designee, Nicholas Burnett.

ALLEGATION:

On 2/3/2026, Resident A eloped and was found alone at 1:15am miles away from the AFC home.

INVESTIGATION:

On 2/4/2026, a phone conversation took place with APS worker, Dan Spalthoff, who confirmed that he was investigating the same allegations. APS Spalthoff stated that he has confirmed that Resident A was found by the Michigan State Police at 1:15am, but that they are not investigating the situation. APS Spalthoff stated that MSP took Resident A to the hospital, but Resident A was not admitted and returned home. APS Spalthoff reported that he visited Resident A at this home on 2/3/2026 and that Resident A told him that he snuck out through the laundry room and then garage door. APS Spalthoff stated that Resident B told him that Resident A had barricaded himself in the laundry room earlier that night and that he kicked open the door in the laundry room that leads into the garage, so staff could get to Resident A. APS Spalthoff stated that he had spoken to Resident A's guardian, who has some concerns about Resident A not getting enough supervision at this home.

On 2/4/2026, an on-site inspection was conducted and Resident A was interviewed. Resident A provided a walk-through of how he got out of the home on 2/3/2026. Resident A showed how he went into the laundry room and how there is another door inside that leads into the garage and from there he got outside. Resident A confirmed that he had locked himself in the laundry room earlier that night and while in there, he removed the battery from the locking keypad on the laundry room door. Resident A confirmed that Resident B kicked open the door leading to the garage, so it was broken and easy to get out of later that night. When asked where staff were when he left the home, Resident A stated that the staff he calls "Chewey" (Hezekiah Patton), was in the living room, but that he snuck past him. Resident A stated that once he got outside, he just started walking, but he does not know how far he walked or how long he was gone.

On 2/4/2026, Resident B confirmed that when Resident A barricaded himself in the laundry room, he kicked open the door from the garage to the laundry room, so staff could get to Resident A. Resident B stated that staff did not ask him to do this and that he did it himself. Resident B stated that later that night, staff came to his room looking for Resident A and woke him up. Resident B stated that staff said that they could not find Resident A anywhere and that he helped them look for Resident A. Resident B reported that police eventually came to the home and said that they had Resident A.

On 2/4/2026, home manager, Tyler Hunter, stated that Resident A has a history of elopement, but had not eloped from this home for several months. HM Hunter stated that, because of his elopement history, Resident A is supposed to have line-of-sight supervision, except when he is in his room or the bathroom. HM Hunter stated that the laundry room door has a locked entry pad on it and that he is not sure how Resident A got into the laundry room. HM Hunter reported that other residents have access to the laundry room and know the code for entry and they may have left the door unlocked. HM Hunter stated that the door from the laundry room leading to inside the garage does not have an alarm on it, like all the other exit doors do.

During the on-site inspection on 2/4/2026, Resident A's guardian visited the home. Guardian A1 stated that CMH had reduced Resident A's supervision from 1-on-1 staffing to line-of-sight. Guardian A1 stated that things like this will keep happening until 1-on-1 supervision is reinstated. Guardian A1 stated that someone needs to keep eyes on Resident A all the time.

On 2/4/2026, a phone call was made to staff person, Jameaka Thomas-Wells, who confirmed that she worked 3rd shift on 2/2/2026, into the morning hours of 2/3/2026. Staff Thomas-Wells claims that she was not aware that Resident A required line-of-sight supervision. Staff Thomas-Wells confirmed that she was aware that both laundry room doors were broken during that shift. Staff Thomas-Wells reported that when she started her shift, Resident A was already upset about things that happened earlier that night, but that he eventually went to his room and went to sleep. Staff Thomas-Wells claimed that she checked on Resident A at 1:04am and that Resident A was in his bed. Staff Thomas-Wells reported that she then went upstairs to talk to Resident C, who was upset about something and that Staff Patton was downstairs with other residents, who were still awake. Staff Thomas-Wells stated that while she was talking to Resident C, Staff Patton called her on the radio and said that Resident A was gone and that he could find him. Staff Thomas-Wells stated that while they were looking for Resident A, police came to the home and said they had found him and were taking Resident A to the hospital. Staff Thomas-Wells reported that she went to the hospital with Resident A, tests were run and Resident A was fine, so Resident A came back home without being admitted.

The home provided a copy of an *AFC Division Incident/Accident Report (IR)*, regarding Resident A's elopement from the home on 2/3/2026. The IR was completed by Staff Thomas-Wells. It states that when staff completed a wellness check for Resident A at

around 1:40am, Resident A was not in his room, so staff searched the entire home and the outside perimeter of the home and could not locate Resident A. The IR states that police came to the home to say that Resident A eloped and that they were taking him to the hospital. Staff notified Resident A's guardian and went with Resident A to the hospital. Corrective measures listed on IR were for staff to continue to closely monitor all residents in the home and ensure their health and safety.

On 2/9/2026, a phone conversation took place with Office of Recipient Rights (ORR) investigator, Angela Wend, who confirmed that she was investigating the same allegations. ORR Wend confirmed that Resident A has had multiple elopements from this home and that Resident A requires line-of-sight supervision, when outside of his bedroom and bathroom. ORR Wend stated that there are no required bed checks in Resident A's Behavior Treatment Plan (BTP) or that Resident A has to be checked any specific amount of times during sleeping hours. ORR Wend reported that it is part of Resident A's BTP that all exit doors of the home must have alarms. Later on 2/9/2026, an email from ORR Wend was received that stated that she had conferred with the psychologist, who wrote Resident A's BTP, and confirmed that the laundry room door leading out to the garage should have been equipped with an alarm, per his BTP.

Resident A's record was reviewed. Resident A's *Assessment Plan For AFC Residents* states that Resident A has a history of elopement, aggression, inappropriate sexual behavior and self-injurious behavior. The assessment states that Resident A requires line-of-sight supervision while out in the community and only needs verbal prompting to complete all his activities of daily living.

Resident A's BTP states that Resident A is required to have line-of-sight (within 4-6 feet) supervision, except during 3rd shift when he is in his bedroom. The BTP (Behavior Treatment Plan) states Resident A is to be within arm's reach of staff while out in the community.

On 2/17/2026, a voicemail was received from APS worker, Dan Spalthoff, who stated that he had received information regarding Resident A eloping from this home again on 2/16/2026. APS Spalthoff stated that Resident A was outside the home unsupervised for about 20 minutes, before staff could find him somewhere on the property.

On 2/19/2026, a phone call was received from staff person, Hezekiah Patton, who confirmed that he worked 2nd and 3rd shift on the night Resident A eloped from the home on 2/3/2026. Staff Patton confirmed that he was aware that both laundry room doors were broken, leaving access to the garage. Staff Patton stated that this was his first time working at this home and that he was not aware that Resident A required line-of-sight supervision. Staff Patton stated that at the start of 3rd shift, Resident A was in his bedroom. Staff Patton stated that Staff Thomas-Wells was in the upstairs of the home talking to Resident C and that he was sitting at the dining room table with 2-3 other residents. Staff Patton reported that when he did a wellness check on Resident A at approximately 1:40am, Resident A was not in his bedroom. Staff Patton stated that they searched the entire home and property before the police arrived to say they had

Resident A and were taking him to the hospital. Staff Patton stated that he did not see Resident A leave the home and that he was not sure what the last time was that he saw Resident A that night.

On 2/19/2026, a phone call was made to 2nd shift home manager, Keo Riouse-Russey, who confirmed that Resident A was able to leave the home unsupervised on 2/16/2026. HM Riouse-Russey stated that staff person, D'Jeneba Coulibly, called him around 11:00pm on 2/16/2026 to say that they could not find Resident A. HM Riouse-Russey reported that Staff Coulibly claims that she last checked on Resident A at 10:50pm and that he was in his room, but that when she checked on him again before leaving her shift at 11:00pm, he was gone. HM Riouse-Russey reported that staff were able to find Resident A on the property approximately 20 minutes later. HM Riouse-Russey stated that Staff Coulibly has quit and is no longer employed at this home.

This home provided a copy of the IR regarding Resident A's second elopement that took place on 2/16/2026. The IR was completed by Staff Coulibly and was brief. The IR stated that Resident A was found missing during a routine wellness check and that management and police were contacted, before Resident A was found on the property. The corrective measure listed on the IR was for staff to review elopement and supervision prevention procedures to ensure Resident A's safety.

On 2/20/26, an on-site inspection was conducted and Resident A was interviewed. Resident A confirmed that he eloped again on 2/16/2026. Resident A stated that he followed Resident D out the front door, when Resident D went to smoke, and then he hid in the maintenance shed on the property. Resident A reported that he does not know where staff were at that time and he does not know how long he was gone before being found.

On 2/20/2026, Resident D stated that he is allowed to go outside to smoke unsupervised and that he has the code to exit the home. Resident D confirmed that Resident A followed him out the door without him knowing at first and that when Resident A left the porch, he went back inside and told staff. Resident D stated that staff found Resident D a few minutes later.

On 3/6/2026, an exit conference was conducted with licensee designee, Nicholas Burnett. LD Burnett stated that they typically do not like the standard of line-of-sight supervision. LD Burnett stated that Resident A's BTP has changed to reflect that he now requires full 1-on-1 staffing and that Resident A has been moved to a different home. LD Burnett stated that he agrees with the outcome of this investigation and will provide a written corrective action plan.

APPLICABLE RULE	
R 400.671	Resident care.
	(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.
ANALYSIS:	Review of Resident A's records has confirmed that Resident A required line-of-sight in the home, except while in his room during 3 rd shift. Resident A is also required to be within arm's reach of staff and not be unsupervised while out in the community. On 2/3/2026, Resident A was able to elope from the home during the night and was found several miles away. On 2/16/2026, Resident A was able to elope from the home a second time and was found approximately 20 minutes later, still on the property. On two separate occasions, staff failed to adequately supervise and protect Resident A, by failing to provide him with his required line-of-sight supervision.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

On 1/26/26, Resident A was slapped in the back of the head by a staff person named Barry.

INVESTIGATION:

On 2/4/2026, Resident A claimed that the staff he calls "Barry" hit him in the head. Resident A stated that the staff slapped him in the back of his head, with an open hand, but that he was not hurt. Resident A stated that he does not know why the staff slapped him, that it was a 1-time thing and that there were no other staff or residents around to witness the incident.

On 2/4/2026, home manager, Tyler Hunter, stated that the staff Resident A refers to as "Barry" is Ja'Quavis Sanders. HM Hunter stated that he is not aware of any witnesses to Resident A's alleged incident with Staff Sanders. HM Hunter stated that Resident A has a history of making allegations, but because of Resident A's allegations, Staff Sanders has been moved to work at a different AFC home.

On 2/9/2026, a phone call was made to staff person, Ja'Quavis Sanders, who denied ever hitting or being physical with Resident A. Staff Sanders stated that on 1/26/2026, Resident A was upset because he was prompting Resident A to not call 911, which is in Resident A's BTP to do. Staff Sanders stated that Resident A has a long history of making false allegations against staff when he gets upset.

On 2/9/2026, a phone call was made to staff person, D'Jeneba Coulibly, who confirmed that she worked with Staff Sanders on 1/26/2026. Staff Coulibly stated that Staff Sanders and Staff Holliday rode to work with her and that her car slid off the road into a ditch on the way to work. Staff Coulibly stated that 1st shift staff had to stay late until they could get there and Resident A was upset about them being late and wanted to call 911. Staff Coulibly stated that she did not witness Staff Sanders hit Resident A and that Resident A never mentioned that happening to her. Staff Coulibly reported that she witnessed Staff Sanders prompting Resident A to go to his room and calm down and Resident A went and took a nap and was fine when he woke up. Staff Coulibly confirmed that Resident A has a history of making up stories like this as a way of getting attention.

On 2/9/2026, a phone call was made to staff person, Quinten Holliday, who stated that he remembers Resident A being upset when they arrived at work on 1/26/2026, but that he does not know why he was upset. Staff Holliday stated that he witnessed Staff Sanders to a good job of talking Resident A down and nothing physical happened. Staff Holliday stated that he did not witness Staff Sanders even touch Resident A. Staff Holliday reported that nothing out of the ordinary happened with Resident A during that shift.

On 2/9/2026, a phone call was made to ORR Keegan Sarker, who confirmed that she was investigating these same allegations. ORR Sarker stated that her office has conducted multiple unfounded investigations, due to Resident A's history of making false allegations against staff. ORR Sarker stated that she spoke to Resident A about the alleged incident on 1/26/2026 and that Resident A told her that Staff Sanders hitting him was an accident. ORR Sarker reported that Resident A said that Staff Sanders was playing around and hit him on the top of his head by accident.

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:	Resident A has provided two different stories as to the alleged incident of staff person, Ja'Quavis Sanders hitting him on the head. It was confirmed that Resident A has a history of making false allegations against staff. Resident A confirmed that there were no other staff or residents present to witness the incident. Staff Sanders denies ever hitting or being physical with Resident A. The other two staff that worked with Staff Sanders on 1/26/2026, stated that they did not witness Staff Sanders hit or

	slap Resident A. There was insufficient evidence found to prove that Resident A was slapped and/or not treated with dignity and respect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 3/6/2026, an exit conference was conducted with licensee designee, Nicholas Burnett. LD Burnett stated that he agrees with the outcome of this investigation and will provide a written corrective action plan.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remains unchanged.

Christopher A. Holvey

3/16/2026

Christopher Holvey
Licensing Consultant

Date

Approved By:

Mary Holton

03/17/2026

Mary E. Holton
Area Manager

Date