GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 6, 2026

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

RE: License #: AS250406894
Investigation #: 2026A0576036
Lippincott

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.
- Be signed and dated.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250406894
Investigation #:	2026A0576036
Complaint Receipt Date:	05/11/2026
Investigation Initiation Date:	05/14/2026
Report Due Date:	07/10/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	310 W. Oakley St., Flint, MI 48503
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Lippincott
Facility Address:	4408 Lippincott Blvd., Burton, MI 48519
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/21/2021
License Status:	REGULAR
Effective Date:	10/21/2025
Expiration Date:	10/20/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/4/2026 around 1pm, Resident A walked to the store and purchased a bottle of sleeping pills. Resident A continuously took the pills taking all of them. Resident A told third shift staff what she had done. Resident A was told staff were not going to do anything resulting in a delay in Resident A getting needed medical care.	Yes

III. METHODOLOGY

05/11/2026	Special Investigation Intake 2026A0576036
05/11/2026	APS Referral
05/14/2026	Special Investigation Initiated - Letter Sent email to Samantha Belanger, Genesee County Adult Protective Services (APS)
05/14/2026	Contact - Document Received Received email from Samantha Bellenger
05/29/2026	Inspection Completed On-site Interviewed Staff Ariana Wright
06/16/2026	Contact - Document Received Received email from Samantha Bellenger
06/18/2026	Contact - Document Received Reviewed AFC Assessment Plan and Incident Report (IR)
07/01/2026	Contact - Telephone call made Interviewed Alivia Paetz, Case Manager
07/02/2026	Contact - Telephone call made Unsuccessful contact with Staff Kiara Munson
07/02/2026	Contact - Telephone call made Interviewed Liz Herring Case Manager from Guardian A1 Office
07/02/2026	Contact - Telephone call made Interviewed Ebony Walker-Smith Case Manager from Guardian A1 Office

07/02/2026	Contact - Telephone call made Left message for Staff Kenyatta Campbell to return call
07/02/2026	Contact - Telephone call made Left message for Staff Jessiana Arron to return call
07/02/2026	Contact - Telephone call made Interviewed Staff Deziryah Grubbs
07/02/2026	Contact - Telephone call made Interviewed Staff Nyla Givens
07/02/2026	Contact - Telephone call made Interviewed Medical Coordinator Tracy Casey
07/02/2026	Exit Conference

ALLEGATION:

On 3/4/2026 around 1pm, Resident A walked to the store and purchased a bottle of sleeping pills. Resident A continuously took the pills taking all of them. Resident A told third shift staff what she had done. Resident A was told that staff were not going to do anything resulting in a delay in Resident A getting needed medical care.

INVESTIGATION:

On May 14, 2026, I sent an email to Samantha Bellanger Genesee County Adult Protective Services (APS) Investigator regarding her investigation involving Resident A. On May 14, 2026, Investigator Bellanger reported that Resident A moved from Lippincott home and the pills Resident A had were caffeine pills and not sleeping pills. On June 16, 2026, Investigator Bellanger reported she closed her case and did not substantiate abuse or neglect.

On May 29, 2026, I conducted an unannounced on-site inspection at Lippincott and interviewed Staff Ariana Wright. Staff Wright reported Resident A may have obtained pills on an outing and staff took the pills from the resident. Resident A did not require any enhanced staffing while she lived at Lippincott and had full community access. The pills were in a bottle, and Staff Wright is not sure Resident A took any pills. Resident A was taken to the hospital and Resident A “has done this before”. Staff Wright reported Resident A has made the same allegation in the past and it was not true. Resident A was transported to the hospital and had lab work completed. Resident A was cleared and not admitted to the hospital.

On June 18, 2026, I reviewed Resident A's AFC Assessment Plan which revealed Resident A "has the opportunity to move about the outdoor premises of the group home and within the community without direct supervision of staff dependent on the phase of titration for her community supervision restriction she is on that is outlined in her behavior treatment plan."

On June 18, 2026, I reviewed an AFC Licensing Division Accident / Incident Report (IR) dated March 4, 2026, and was authored by Staff Kiara Munson. The IR documented that on March 4, 2026, at 5:40am, Resident A was pacing in the hallway crying and breathing very hard. Resident A reported she swallowed some pills on her outing and was scared. The pills were identified as caffeine pills by upper management on second shift. Staff assisted with breathing exercises, Resident A was provided a PRN medication per her request, and staff increased wellness checks. Corrective measures include staff will continue to monitor Resident A.

On June 18, 2026, I reviewed a second AFC (IR) dated March 4, 2026, and was authored by Staff Jessiana Arron. The IR documented that on March 4, 2026, at 10am Resident A's case manager arrived for a scheduled visit. It was reported that Resident A took some pills she purchased from the store the day prior. Due to observed abnormal behavior the case manager requested Resident A be medically evaluated. Staff called the medical coordinator and home manager for further direction. Resident A was transported to urgent care and then to Hurley Hospital.

On July 1, 2026, I interviewed Alivia Paetz Case Manager from Central Michigan Community Mental Health Authority (CMH). Case Manager Paetz reported Resident A currently resides in Midland. Regarding the allegations, Case Manager Paetz reported she arrived at the facility around 10am on March 4, 2026, and Resident A had not been taken for medical care. Staff and Resident A told Case Manager Paetz that Resident A reported to third shift staff she took pills. Third shift staff told first shift staff, and first shift staff called the medical coordinator for direction. The home manager arrived at the home and Resident A was transported to the hospital. Resident A was not admitted and there is no indication that Resident A took any pills. Case Manager Paetz had concern that Resident A was not immediately taken for medical care when she initially told staff she took the pills. When Case Manager Paetz arrived at the home, she advised staff that she wanted Resident A to be taken in for medical care. According to Case Manager Paetz, the Office of Recipient Rights (ORR) cited neglect of Resident A given she did not receive medical attention in a timely manner.

On July 2, 2026, I interviewed Liz Herring, Office Case Manager from Guardian A1's office. Case Manage Herring reported Resident A had community access without staff and this can be difficult. Guardian A1 received a call from Hurley Hospital requesting consent to treat Resident A which was provided. Case Manager Herrin reported Resident A is a difficult client and she is often in and out of the hospital due to self-injurious behavior (i.e. swallows items, cuts). Case Manager Herring reported that Office Case Manager Ebony Walker-Smith saw Resident A at Lippincott in March 2026.

On July 2, 2026, I interviewed Ebony Walker-Smith, Office Case Manager from Guardian A1's office. Case Manage Walker-Smith reported she is aware of the allegations and her concern was why wasn't Resident A's vitals taken and why wasn't Resident A taken to the hospital right away for possibly taking the pills. Resident A does have community access, and Resident A displays extreme behaviors like swallowing rocks.

On July 2, 2026, I attempted to call Staff Kiara Munson. There was a recording that indicated the phone was not in service.

On July 2, 2026, I left a message for Staff Kenyatta Campbell and Staff Jessiana Arron to return my call. I interviewed Staff Deziryah Grubbs who reported she was working on first shift 7am-3pm on March 4, 2026. Resident A told third shift staff she took pills and third shift staff told Lead Staff Jessiana Arron when she arrived at work at 7am. Staff Arron called the medical coordinator. Resident A's case manager arrived at the home around 9am and Resident A told the case manager she took the pills. The case manager directed staff to take Resident A to the hospital. Eventually, the home manager arrived at the home and took Resident A to the hospital. Staff Grubbs did not know why there was a delay in getting Resident A needed medical attention.

On July 2, 2026, I interviewed Staff Nyla Givens who reported she was working on first shift 7am-3pm on March 4, 2026. Staff Givens reported Resident A may have taken pills on third shift. Third shift staff knew and told first shift staff when they arrived. There is a process to reach out to the medical coordinator, and the medical coordinator reaches out to someone else to decide if a resident is to be taken for medical treatment.

On July 2, 2026, I interviewed Medical Coordinator Tracey Casey regarding the allegations. Coordinator Casey reported she was notified by first shift Staff Jessiana Arron at about 7:30am on March 4, 2026, that Resident A took pills. Resident A told third shift staff that she took pills, and third staff was supposed to call either the home manager or the medical coordinator, however this did not happen. Coordinator Casey is not sure why staff did not immediately contact anyone when Resident A first disclosed that she took the pills. Resident A's case manager called Coordinator Casey to report the incident, and Coordinator Casey told her boss who said Resident A was to be sent out for medical care. The home manager went to the home and Resident A was transported to the hospital.

On July 2, 2026, I conducted an exit conference with Licensee Designee Nicholas Burnett and Administrator Carrie Aldrich. The findings of my investigation were discussed, and I advised I would be citing a rule violation. Licensee Designee Burnett and Administrator Aldrich stated third shift did not do anything when Resident A disclosed that she took pills and the staff should have called someone for direction. The ORR cited the facility for neglect of Resident A. Licensee Designee advised he will provide a corrective action plan for the cited rule violation which will include staff re-training.

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:	It was alleged that Resident A reported to staff that she took pills and staff did not obtain needed health care immediately. Upon conclusion of investigative interviews and a review of documentation there is a preponderance of evidence to conclude a rule violation. Incident Reports documented on March 4, 2026, at 5:40am Resident A was pacing, crying, and breathing very hard. Resident A reported to third shift staff that she took pills on her outing and was scared. Staff did not contact anyone or ensure Resident A obtained needed medical care immediately. Several hours later Resident A was transported for medical treatment at the behest of her case manager. There is a preponderance of evidence to conclude that the facility did not obtain needed health care immediately upon Resident A reporting to staff that she took pills and exhibited a change in her health condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

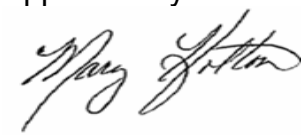
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

7/2/2026

Christina Garza Date
Licensing Consultant

Approved By:



7/06/2026

Mary E. Holton Date
Area Manager