



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2026

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

RE: License #:	AS250409449
Investigation #:	2026A1039047
	Westwood

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) 335-5985.

Sincerely,

A handwritten signature in cursive script, appearing to read "Martin Gonzales".

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250409449
Investigation #:	2026A1039047
Complaint Receipt Date:	08/10/2026
Investigation Initiation Date:	08/11/2026
Report Due Date:	10/09/2026
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:	Westwood
Facility Address:	2811 Westwood Parkway Dr Flint, MI 48503
Facility Telephone #:	(810) 407-6332
Original Issuance Date:	12/30/2025
License Status:	TEMPORARY
Effective Date:	12/30/2025
Expiration Date:	06/29/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is on 1:1 supervision and staff took Resident A to his Physical Therapy appointment and left him by himself at the doctor's office to go get his sensory bag.	Yes
Resident A was emergency discharged from Westwood inappropriately and was not given proper 24 hour notice.	No
On 08/06/2026, Westwood home was understaffed at the time Resident A was arrested.	No
Staff gave another resident's medication to Resident A's guardian when Resident A was discharged from Westwood Home.	Yes

III. METHODOLOGY

08/10/2026	Special Investigation Intake 2026A1039047
08/11/2026	Special Investigation Initiated - Letter APS completed via online referral.
08/11/2026	APS Referral Completed online.
08/11/2026	Contact - Telephone call made Phone interview with Case Manager Alivia Paetz concerning complaint.
08/13/2026	Contact - Document Received Received additional complaint regarding Westwood from BCHS online complaints.
08/26/2026	Contact - Telephone call received Phone interview with Guardian A1.
08/26/2026	Contact - Telephone call made Phone interview with Case Manager Alivia Paetz concerning complaint.
09/02/2026	Inspection Completed On-site Interviewed DCW Imani Callaway, Medical Coordinator Mela Allen, Resident B and Resident C.

09/10/2026	Contact - Document Received Received email from Guardian A1 concerning complaint information.
09/16/2026	Contact - Document Received Received email from Guardian A1 concerning complaint information.
09/23/2026	Contact - Document Received Received email from Guardian A1 concerning additional complaint information.
09/24/2026	Contact - Document Received Received email from Guardian A1 concerning additional complaint information.
09/25/2026	Contact - Document Sent Emailed Guardian A1 requesting current location of Resident A.
09/25/2026	Contact - Document Received Received email from Guardian A1 concerning additional complaint information.
09/25/2026	Contact - Document Received Received email from APS Harrison concerning the allegations.
09/25/2026	Contact - Document Received Received email from Flatrock with documents concerning Resident A.
09/25/2026	Contact - Telephone call made Phone interview with Home Manager Tiara Pouncil.
09/25/2026	Contact - Telephone call received Phone interview with Resident A concerning the allegations.
09/25/2026	Contact - Telephone call made Phone interview with Guardian A1.
09/25/2026	Contact - Telephone call made Phone call with Flatrock Manger Jeff Selle.
09/25/2026	Contact - Document Received Documents received from Quality Control Administrative Assistant Marriah Kimball.

09/25/2026	Contact - Telephone call made Phone call with Quality Control Administrative Assistant Marriah Kimball.
09/25/2026	Contact - Telephone call made Phone interview with Resident A.
09/26/2026	Contact - Document Received Received email from Guardian A1 concerning complaint.
09/28/2026	Contact - Telephone call made Phone interview with DCW Dupree.
09/30/2026	Contact - Telephone call made Phone interview completed with Case Manager Annie McGibbon.
09/30/2026	Contact - Telephone call made Phone call with Genesee County Sheriff's Records Department.
10/01/2026	Exit Conference Completed with Administrator Aldrich and LD Burnett.
10/01/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A is on 1:1 supervision and staff took Resident A to his Physical Therapy appointment and left him by himself at the doctor's office.

INVESTIGATION:

On 08/10/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A is on 1:1 supervision and staff took Resident A to his Physical Therapy appointment and left him by himself at the doctor's office to go get his sensory bag.

On 08/12/2026, The Department of Health and Human Services Centralized Intake received the complaint. Centralized Intake denied the complaint and referred to BCHS.

On 08/26/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations, and she believed they were true. Guardian A1 stated that on 07/29/2026, Resident A was at a physical therapy appointment for his knee and staff left him alone while he was getting treatment to go get Resident A's sensory bag. Guardian A1 stated

that she is unsure of how long Resident A was left alone, but his treatment plan states that he needs 1:1 supervision 24 hours a day and can't be left alone due to his behaviors.

On 09/02/2026, I completed an unannounced investigation at Westwood concerning the allegations. I interviewed the following people: Direct Care Worker Imani Callaway, Medical Coordinator Mela Allen, Resident B and Resident C.

On 09/02/2026, I completed an interview with Direct Care Worker (DCW) Imani Callaway concerning the allegations. DCW Callaway stated that she was not aware of the allegations and that she had not witnessed any staff leaving Resident A while they were providing 1:1 supervision. DCW Callaway stated that all the staff are aware of Resident A's 1:1 supervision guidelines and that they are not allowed to leave him unless they are relieved by another staff member. DCW Callaway stated that they always have enough staff on duty to provide relief for the 1:1 staff if needed. DCW Callaway stated that they currently have 4 total residents and they have at least 3 direct staff and a 1:1 staff if needed. DCW Callaway stated that she has provided 1:1 supervision for Resident A on multiple occasions and that never left him alone for any reason. DCW Callaway stated that Resident A keeps his sensory bag by his bedroom door and staff usually grab it on the way out of the home. DCW Callaway was not present when the alleged incident occurred, so she was unable to say if the incident occurred or not.

On 09/02/2026, I completed an interview with Medical Coordinator (MC) Mela Allen concerning the allegations. MC Allen stated that she was not aware of the allegations, but she has not seen staff leave Resident A while they are providing 1:1 supervision. MC Allen stated that she works between multiple homes, so she is in and out of the home on a daily basis. MC Allen stated that she has seen staff be redirected to make sure they are properly providing 1:1 supervision to Resident A, but she has not witnessed any staff leave Resident A unattended. MC Allen stated that there are always 4 staff working during 1st and 2nd shift so if the 1:1 staff needs a break they can ask for relief. MC Allen stated that all of the staff are aware of the rules for providing 1:1 supervision for Resident A.

On 09/02/2026, I completed an interview with Resident B. Resident B was sitting at the dining room table at the time of our interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that he was not aware of the allegations, but she has not witnessed staff leave Resident A alone while providing 1:1 supervision. Resident B stated that staff are always with Resident A and that he was not with Resident A when he went to his doctor's appointment, so he doesn't know if staff left him alone or not. Resident B stated that Resident A is in his room a lot, so staff is always in there with him and when he leaves the house that staff go with him and take the sensory bag with them.

On 09/02/2026, I completed an interview with Resident C. Resident C was sitting in the dining room table at the time of our interview. Resident C appeared neat and clean and

was able to communicate. Resident C stated that she was not aware of the allegations, but she has not seen staff leave Resident A alone while providing 1:1 supervision. Resident C stated that staff are always with Resident A, even when he leaves the home.

On 09/25/2026, I completed a phone interview with Home Manager (HM) Tiara Pouncil concerning the allegations. HM Pouncil stated that she was aware of the incident, but she was not present when it occurred. HM Pouncil stated that staff are aware of the guidelines when providing 1:1 supervision to Resident A or any other resident. HM Pouncil stated that staff can ask for relief at any time if they need a break. HM Pouncil stated that when Resident A goes into the community staff are to ensure that Resident A has his sensory bag with them when they leave the home. HM Pouncil stated that she has not witnessed any of Resident A's 1:1 staff leave him alone. HM Pouncil stated that she has redirected staff on occasion in the home to ensure that staff are providing appropriate care for Resident A.

I reviewed Resident A's assessment plan dated 12/11/2025. The plan notes that Resident A is diagnosed with the following: Moderate intellectual disabilities, Autistic disorder, Bipolar disorder, Post-traumatic stress disorder, obsessive-compulsive disorder, Oppositional defiant disorder and Attention-deficit hyperactivity disorder. The plan notes that due to symptoms associated with Resident A's diagnoses of PTSD and Intellectual Disability (mild), Resident A has a history of engaging in impulsive and aggressive behaviors that endanger himself and others including verbal and physical aggression, self-injury, public disrobing, intentional incontinence and elopement. Resident A receives 1:1 supervision that is 6-10 feet away due to Resident A exhibiting maladaptive behaviors in the community such as stripping, eloping, physical aggression, and self-injurious behaviors. Resident A will always be accompanied and supervised by a staff person in the community to ensure safety. The above community supervision will be provided by Flatrock staff unless on a coordinated leave of absence, titration trials, or in the event of elopement.

On 09/25/2026, I completed a phone interview with Resident A. Resident A is currently at St. Mary's Hospital in Livonia, MI. Resident A stated that he is aware of the allegations and they were true. Resident A stated that staff left him while he was at the doctor's appointment and did not tell him. Resident A stated that staff forgot his sensory bag and had to go get it. Resident A did not have much other information concerning this incident as he had other information concerning other complaints that he wanted to talk about.

On 09/25/2026, Quality Control Administrative Assistant (QCAA) Marriah Kimball emailed me concerning the allegations. QCAA Kimball stated that management was aware of the allegations and it does appear that the staff member left Resident A alone while they were providing 1:1 supervision. QCAA Kimball stated that there was no incident report completed and that the staff member involved was Direct Care Worker (DCW) Sumiyah Dupree. QCAA Kimball stated that DCW Dupree received disciplinary action and that it was placed in her staff file.

On 09/29/2026, I completed a phone interview with Direct Care Worker (DCW) Sumiyah Dupree concerning the allegations. DCW Dupree stated that she was aware of the allegations and that they were true. DCW Dupree stated that she took Resident A to a physical therapy appointment and that when they got to the office, they realized that the sensory bag was not with them. DCW Dupree stated that Resident A started getting irritated that they did not have the sensory bag, so when Resident A began his physical therapy session, she asked the staff at the doctor's office if it was ok for her to leave Resident A at the office and she left to go get his sensory bag. DCW Dupree stated that the staff at the office said that it was ok for her to leave. DCW Dupree stated that she went back to Westwood home and could not find the sensory bag and went back to the doctor's office to pick up Resident A. DCW Dupree stated that she thought she could leave Resident A while he was at the office in physical therapy. DCW Dupree stated that management spoke to her about the situation and she was written up.

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:	It was alleged that Resident A was on 1:1 supervision and staff took Resident A to his Physical Therapy appointment and left him by himself at the doctor's office. I interviewed Flatrock Quality Control Administrative Assistant (QCAA) Marriah Kimball concerning the allegation. QCAA Kimball confirmed that the allegation was true and that the staff involved received disciplinary action and it was placed in her file. I interviewed Direct Care Worker (DCW) Sumiyah Dupree concerning the allegations. DCW Dupree confirmed that the allegations were true and that she was talked to by management and received disciplinary action. I interviewed Resident A concerning the allegations. Resident A confirmed that Resident A left him at his physical therapy appointment and did not tell him he was leaving to get his sensory bag.

	Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A was emergency discharged from Westwood inappropriately and was not given proper 24 hour notice.

INVESTIGATION:

On 08/12/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A was emergency discharged from Westwood inappropriately and was not given proper 24 hour notice.

On 08/12/2026, The Department of Health and Human Services Centralized Intake received the complaint. Centralized Intake denied the complaint and referred to BCHS.

On 08/25/2026, I completed a phone interview with Community Mental Health of Central Michigan Case Manager (CM) Alivia Paetz. CM Paetz stated that she was unaware of the allegations, but she was there at the time of the incident that led to Resident A being discharged from the home. CM Paetz stated that while she was in the home to see a resident that she was the case manager for that Resident A became extremely upset at something or someone and started yelling and escalating his behaviors. CM Paetz stated that she spoke to the staff to see if Resident A might need a PRN (as needed) medication to help with his behaviors. CM Paetz stated that staff was unable to de-escalate Resident A's behaviors and Resident A then came after her and punched her in the back of the head. CM Paetz stated that she then called the police to file a complaint. CM Paetz stated that the police came and arrested Resident A for 2 counts of domestic violence and 1 count of assault. CM Paetz was not available for any follow up questions as she is on leave until 01/04/2027.

On 08/26/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations, and she believed they were true. Guardian A1 stated that on 08/06/2026, Resident A had an incident with another resident's case manager, and the police were called and Resident A was arrested and taken to jail. Guardian A1 stated that the night prior to Resident A going to jail that staff kept Resident A up all night because they were on their phone. Guardian A1 stated that Resident A was triggered when another resident in the home was humming and would not stop. Guardian A1 stated that

another resident's case manager became involved and asked if Resident A needed a PRN (as needed) medication to help him calm down. Guardian A1 stated that allegedly Resident A hit the case manager in the back of the head. Guardian A1 stated that the police were then called and Resident A was arrested and taken to Genesee County Jail. Guardian A1 stated that less than an hour after Resident A was taken to jail that she received a phone call from Flatrock ownership informing her that they were giving Resident A a 24 hour emergency discharge notice. Guardian stated that Flatrock left Resident A homeless as they did not secure an alternate placement and left her at severe risk. Guardian A1 stated that the case manager should not have gotten involved and that the case manager was pregnant and this is also a trigger for Resident A. Guardian A1 stated that it's in Resident A's behavioral treatment plan that pregnant women can be a trigger for Resident A to act out. Guardian A1 stated that she does not believe that Resident A hit the case manager and that the incident report that was completed is full of false information. Guardian A1 stated that she did not receive a written notice prior to Resident A's emergency discharge and this is against the rules. Guardian A1 stated that Flatrock submitted written discharge notice the next day by email.

On 09/02/2026, I completed an unannounced investigation at Westwood home concerning the allegations. I interviewed Direct Care Worker (DCW) Imani Callaway. DCW Callaway stated that she was not aware of the allegations but had no information on the discharge process and the Home Manager Tiara Pouncil was not working but would be able to provide me with her contact information.

On 09/25/2026, I completed a phone interview with Home Manager (HM) Tiara Pouncil concerning the allegations. HM Pouncil stated that she was not aware of the allegations and that she did not know if they were true or not as she does not deal with the discharge paperwork. HM Pouncil stated that upper management deals with discharges and that she manages the day to day operations at the home. HM Pouncil stated that she was not present when the incident occurred between Resident A and Case Manager Paetz, but she is aware that the police came and took Resident A to Genesee County Jail and he has not been back to the Westwood home since.

On 09/25/2026, I completed a phone interview with Program Director (PD) Jeff Selle concerning the allegations. PD Selle stated that he was aware of the allegations but did not believe they were true. PD Selle stated that Resident A has a history of verbal and physical aggression towards residents and staff. PD Selle stated that the incident where Resident A assaulted a case manager on 08/06/2026, prompted Flatrock to complete an emergency discharge for Resident A. PD Selle stated that Resident A was taken to Genesee County Jail on 08/06/2026 and Flatrock gave Guardian A1 a verbal notice that they would be completing an emergency discharge due to the imminent threat to the health and safety of the other residents, staff and guests within the home. PD Selle stated that on 08/07/2026, Flatrock completed a written 24 hour discharge notice and sent it to Guardian A1, Resident A's Anne McGibbon and Licensing Consultant Martin Gonzales. PD Selle stated that Resident A was in Genesee County Jail and was then transferred to St. Mary's Hospital in Livonia, MI, on 08/09/2026. PD

Selle stated that he does not believe that Flatrock violated any rules regarding the emergency discharge of Resident A due to Resident A being incarcerated for multiple days after Flatrock issued their 24 hour written emergency discharge notice to Guardian A1.

On 09/25/2026, I completed a phone interview with Quality Control Administrative Assistant (QCAA) Marriah Kimball emailed me concerning the allegations. QCAA Kimball stated that she was aware of the allegations but does not believe they are true. QCAA Kimball stated that all parties were notified in a timely manner and written notice was given 24 hours prior to emergency discharge as Resident A was in Genesee County Jail for multiple days after the 24 hour discharge notice was provided to his guardian. QCAA Kimball sent me a copy of the incident report regarding Resident A and the incident that led to emergency discharge.

On 09/30/2026, I completed a phone interview with Community Living Services Case Manager (CM) Annie McGibbon concerning the allegations. CM McGibbon is the case manager for Resident A. CM McGibbon stated that she was aware of the allegations but was unsure if any rules were violated. CM McGibbon stated that she did receive a notice from Flatrock on 08/06/2026 that an emergency discharge was being completed for Resident A. CM McGibbon stated that she received a written emergency discharge notice via email on 08/07/2026 from Flatrock. CM McGibbon stated that Flatrock informed her that Resident A was being discharged due to the incident that occurred where she assaulted another resident's case manager and was arrested by the police. CM McGibbon stated that she felt that Westwood staff did the bare minimum as far as treatment with Resident A. CM McGibbon stated that she believes that staff not preparing items such as tablet or phone, that Resident A used daily as de-escalation tools contributed to some of his behaviors. CM McGibbon stated that she was present the day that Resident A was arrested, but she left Westwood before the incident occurred. CM McGibbon stated that home was fully staffed while she was present and that Resident A's 1:1 staff was with him while she visited Resident A. CM McGibbon stated that Resident A appeared agitated that day as she stated that she did not sleep well and another resident would not stop humming. CM McGibbon stated that she just recently visited Resident A at the psychiatric hospital, and he stated that he did not throw anything at another resident and that he did not hit anyone. CM McGibbon stated that although she believes staff did the bare minimum for Resident A, she does not believe that he was neglected in his care.

I received a copy of the emergency discharge notice on 08/07/2026. The notice is addressed to Guardian A1, Case Manager McGibbon and myself and states "that Resident A's actions of physical assault directed at other clients, staff, and external parties constitute a direct and imminent threat to the health and safety of residents, staff and guest within the care home".

I reviewed an Incident Report (IR) dated 08/06/2026. The report notes that at approximately 1:30 pm Resident A seemed agitated. Staff tried to validate his feeling but were unsuccessful. Resident A became triggered after another resident would not

stop humming. Resident A then became more agitated and was redirected by his 1:1 staff and refused and began yelling at staff and peers. Staff attempted to validate Resident A's feelings again and was unsuccessful. Resident A then reached over and smacked the back of his peer's neck. Staff immediately got in between the two residents. Resident A then attempted to punch staff. Staff was able to use blocking techniques, and this was successful. Resident A then got out of the chair and ran towards the stairs taking her clothes off until he was naked. Staff used a sheet to cover him from peers and visitors. Resident A then ran back into the dining room without his clothes and punched a case manager in the back of the head. Staff immediately used child control and were unsuccessful. Resident A grabbed a shoe and threw it at one of his peers. Staff attempted to use child control again and were unsuccessful. Resident A then ran to his bedroom and slammed the door. Staff validated his feelings and were successful. Resident A put a shirt on and went back into the dining room. As Resident A was getting the phone to make a call the police pulled up to the home to speak to Resident A about attacking the case manager. Resident A became combative. Staff attempted to validate his feelings and were unsuccessful. The police detained Resident A and walked him to their vehicle. The police took Resident A to jail and staff followed behind to ensure safety.

On 09/30/2026, I completed a phone call with Genesee County Sheriff's Records Department concerning the allegations. Genesee County Sheriff's Records Department confirmed that Resident A was lodged on 08/06/2026. Genesee County Sheriff's Records Department stated that they were unable to provide me with a police report, but they could confirm that Resident A was incarcerated until 08/09/2026.

APPLICABLE RULE	
R 400.687	Resident admission and discharge policy; house rules; change of residency; provision of resident records.
	(6) A licensee shall take all of the following steps before discharging a resident under subrule (5) of this rule: (a) A licensee shall notify the resident, resident's designated representative, responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge in writing and include all of the following: (i) Reason for discharge including the specific nature of the risk. (ii) Alternatives to discharge that have been attempted by the facility. (iii) Location where the resident will be discharged, if known.

ANALYSIS:	It was alleged that Resident A was emergency discharged from Westwood inappropriately and was not given proper 24 hour notice. I interviewed the Flatrock Program Director and Quality Control Administrative Assistant. They informed me that they completed a verbal and written emergency discharge notice and notified the case manager, guardian and licensing consultant no less than 24 hours before discharging Resident A. Resident A was arrested and lodged at Genesee County Jail on 08/06/2026. Flatrock verbally informed Guardian A1 on 08/06/2026 that Resident A was being discharged from Westwood home due to the imminent threat to the health and safety of the other residents, staff and guest within the home. Flatrock provided a written notice via email to the case manager, guardian and licensing consultant on 08/07/2026. Resident A remained lodged at Genesee County Jail until 08/09/2026 and was then released and moved to St. Mary's Hospital in Livonia, MI. I interviewed Guardian A1 concerning the allegations and she believes that Resident A's discharge was illegal and is a violation of AFC rules. Genesee County Sheriff's Records Department verified that Resident A was lodged on 08/06/2026 to 08/09/2026 but was unable to provide a police report. Upon completion of my investigation, it has been determined that there is no preponderance of evidence to conclude that a rule has been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 08/06/2026, Westwood home was understaffed at the time Resident A was arrested.

INVESTIGATION:

On 08/12/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that on 08/06/2026, Westwood home was understaffed at the time Resident A was arrested.

On 08/12/2026, The Department of Health and Human Services Centralized Intake received the complaint. Centralized Intake denied the complaint and referred to BCHS.

On 08/25/2026, Community Mental Health of Central Michigan Case Manager (CM) Alivia Paetz called me concerning the allegations. CM Paetz stated that she was not aware of the allegations, but she did not believe they were true as she was present at the home and there were multiple staff in addition to Resident A's 1:1 supervision staff working. CM Paetz stated that Resident A was having behavioral issues and becoming verbally and physically aggressive with residents and staff. CM Paetz stated that Resident A hit her in the back of the head and she called the police to press charges for assault. CM Paetz stated that after the police were called additional staff came to assist at the home.

On 08/26/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations, and she believed that the allegations were true. Guardian A1 stated that she was not present when the incident occurred but that she was on the phone with Resident A trying to give support and staff took the phone away from Resident A. Guardian A1 stated that she was not alerted right away that the police became involved and that she was notified several hours after the incident. Guardian A1 stated that staff did not let Resident A use the phone during that time to call her. Guardian A1 stated that she believes that there were not enough staff in the home to help de-escalate the situation and that the incident would not have occurred if there was appropriate staff at Westwood.

On 09/02/2026, I completed an unannounced investigation at Westwood home concerning the allegations. I interviewed the following people: Direct Care Worker Imani Callaway, Medical Coordinator Mela Allen, Resident B and Resident C.

On 09/02/2026, I completed an interview with Direct Care Worker (DCW) Imani Callaway concerning the allegations. DCW Callaway stated that she was not aware of the allegations, but she does not believe they are true as they usually have at least 3 direct care workers and 1:1 staff also if necessary. DCW Callaway stated that sometimes workers do not show up timely to get relieved, but that does not mean that workers leave their shift uncovered. DCW Callaway stated that if a staff member is late, then the person they are supposed to relieve will stay on duty until that staff person comes in or until management can find another staff to replace them. DCW Callaway stated that since she has worked at Westwood there has not been a day where the home has been understaffed. DCW Callaway stated the only issue they have is getting workers to come in timely so that other workers can leave on time.

On 09/02/2026, I completed an interview with Medical Coordinator (MC) Mela Allen concerning the allegations. MC Allen stated that she was not aware of the allegations, but she does not believe the allegations are true. MC Allen stated that as a medical coordinator she goes to multiple homes during the day to assist them with medical issues. MC Allen stated that she did work at Westwood the day this incident occurred,

but she was not at the home when the actual incident occurred. MC Allen stated that when the incident occurred, she was at another home and was asked to go to Westwood to assist. MC Allen stated that when she arrived there were multiple staff working in addition to Resident A's 1:1 staff. MC Allen stated that there are always at least 3 direct care workers and 1:1 staff during 1st and 2nd shift. MC Allen stated that there is 1 less staff member during 3rd shift. MC Allen was able to show me the staff schedule for the month, and I was able to confirm the staffing schedule, and it appeared appropriate for the amount of residents in the home. MC Allen stated that she has worked in the home since April of 2026 and she has never witnessed the home be understaffed.

On 09/02/2026, I completed an interview with Resident B. Resident B was sitting at the dining room table at the time of our interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that he was not aware of the allegations but does not believe they are true. Resident B stated that he was home when the incident occurred, but he was in his room upstairs and did not see what happened. Resident B stated that the home had their normal staff that day and does not remember them missing any staff members. Resident B stated that they always have a lot of staff in the home and they are never short on staff. Resident B stated that Resident A always has his 1:1 staff with him and he does not remember seeing his staff ever leave him alone and unsupervised.

On 09/02/2026, I completed an interview with Resident C. Resident C was sitting at the dining room table at the time of our interview. Resident C stated that she was not aware of the allegations but does not believe they are true. Resident C stated that she was home when the incident happened, but she does not remember much of what happened. Resident C stated that there were staff in the home and Resident A had his 1:1 staff with him too. Resident C stated that more staff came to help after the incident happened. Resident C stated that there are always staff in the home. Resident C stated that she went back to her room when the police came, and she doesn't remember anything that happened after that.

On 09/25/2026, I completed a phone interview with Home Manager (HM) Tiara Pouncil concerning the allegations. HM Pouncil stated that she was not aware of the allegations but does not believe they are true. HM Pouncil stated that she remembers the incident that occurred and that they were not short staffed. HM Pouncil stated that additional staff were called to help de-escalate the situation and residents. HM Pouncil stated that the police came to the home and took Resident A away with them and he has not been back to the home since. HM Pouncil stated that they always have at least 3 direct care workers on site not counting the 1:1 staff if needed. HM Pouncil stated that she could send me the staff schedule if needed. I informed HM Pouncil that I reviewed the schedule while I completed my onsite investigation.

On 09/30/2026, I completed a phone interview with Community Living Services Case Manager (CM) Annie McGibbon concerning the allegations. CM McGibbon is the case manager for Resident A. CM McGibbon stated that she was not aware of the

allegations, but she did not believe they were true. CM McGibbon stated that she was at Westwood home the day the incident occurred. CM McGibbon stated that she was at the home visiting Resident A prior to the incident and that there was no shortage of staff or 1:1 staff. CM McGibbon stated that there was a time she was at the home that relief did not come timely for staff but the staff member that was working did not leave until someone relieved her. CM McGibbon stated that every time she has been at the home, there has been a full staffing team working.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.
ANALYSIS:	It was alleged that on 08/06/2026, Westwood home was understaffed at the time Resident A was arrested. I completed an onsite investigation at Westwood and interviewed Medical Coordinator (MC) Mela Allen concerning the allegations. MC Allen informed me that she worked on the day of the incident and that Westwood was fully staffed and was also able to provide me with the staff schedule for the month of June, July and August 2026. I was able to verify that the appropriate number of staff were scheduled to include Resident A's 1:1 staff supervision. I interviewed Community Living Services Case Manager (CM) Annie McGibbon and Community Mental Health of Central Michigan Case Manager (CM) Alivia Paetz concerning the allegations. They both confirmed that they were at Westwood home the day that Resident A was arrested and there were an appropriate number of staff working in addition to Resident A's 1:1 staff supervision.

	Upon completion of my investigation, it has been determined that there is no preponderance of evidence to conclude that rule has been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff gave another resident's medication to Resident A's guardian when Resident A was discharged from Westwood Home.

INVESTIGATION:

On 08/13/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Staff gave another resident's medication to Resident A's guardian when Resident A was discharged from Westwood Home.

On 08/20/2026, The Department of Health and Human Services Centralized Intake Department emailed me concerning the complaint. Centralized Intake informed me that the complaint had been assigned to an adult protective services worker for review.

On 08/26/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations, and she stated the allegations are true. Guardian A1 stated that she picked up Resident A's medication and belongings after he was illegally kicked out of Westwood home. Guardian A1 stated that she was going the medication bag and noticed that there was a brand new bubble pack of medication for another resident. Guardian A1 stated that she contacted Flatrock supervision to inform them that they had given her the wrong medication and a meeting time and date was arranged to drop the medication off.

On 09/02/2026, I completed an unannounced investigation at Westwood home concerning the allegations. I interviewed the Medical Coordinator (MC) Mela Allen concerning the allegations. MC Allen stated that she was aware of the allegations and that Guardian A1 was given the wrong medication when staff packed up Resident A's medication and other items. MC Allen stated that staff were able to get the medication back from Guardian A1. MC Allen stated that the medication bubble pack was new and it was unopened when they got it back from Guardian A1. MC Allen stated that the resident who was missing the medication did not miss getting any medication as the medication was extra and they still had to finish off medication from the bubble pack that was already being used. MC Allen stated that she is not sure how this happened, but there is no history of this happening since she has worked at Westwood home. MC Allen took me to the basement where the medication room is located. The medication room was locked and MC Allen opened it and was able to show me the resident

medication and Medication Administration Reports (MARs). The medication and MARs were up to date, and the medication was securely locked and neatly organized by resident name with their pictures on the wall.

On 09/25/2026, I completed a phone interview with Quality Control Administrative Assistant (QCAA) Marriah Kimball emailed me concerning the allegations. QCAA Kimball stated that she was aware of the allegations and is aware that Guardian A1 did in fact get another resident's medication on accident. QCAA Kimball stated that she could not find an incident report for the medication incident and had no further information concerning the incident.

On 09/30/2026, I completed a phone interview with Community Living Services Case Manager (CM) Annie McGibbon concerning the allegations. CM McGibbon is the case manager for Resident A. CM McGibbon stated that she was aware of the allegations and Flatrock did give Guardian A1 another resident's medication. CM McGibbon stated that she has not had any issues in the past regarding this type of incident. CM McGibbon stated that Guardian A1 returned the medication, but she doesn't have any further details about how or when the medication was returned.

APPLICABLE RULE	
R 400.675	Resident medications.
	(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and instructions when the resident is out of the facility but still requires medication during that period.
ANALYSIS:	It was alleged that Staff gave another resident's medication to Resident A's guardian when Resident A was discharged from Westwood Home. I interviewed Flatrock Quality Control Administrative Assistant (QCAA) Marriah Kimball concerning the allegation. QCAA did confirm that Guardian A1 did receive medication that belonged to a resident other than Resident A. I interviewed Medical Coordinator (MC) Mela Allen concerning the allegations. MC Allen confirmed that staff packed up Resident A's medication and personal items after he was discharged and gave them to Guardian A1. The staff accidentally included another resident's medication. MC Allen stated that Guardian A1 returned the medication and that the resident did not miss receiving any of their medication as prescribed.

	I interviewed Guardian A1 concerning the allegations. Guardian A1 stated that the allegations are true. Guardian A1 stated that Flatrock packed up another resident's medication along with Resident A's medication and personal items and gave them to her. Guardian A1 stated that she coordinated with Flatrock staff to return the medication to Westwood staff. Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.
CONCLUSION:	VIOLATION ESTABLISHED

On 10/01/2026, an exit conference was completed with Administrator Carrie Aldrich and Licensee Designee (LD) Nicholas Burnett. I informed them of the results of my investigation. Administrator Aldrich stated that she would get the corrective action plans completed as soon as possible.

IV. RECOMMENDATION

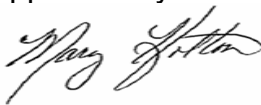
Upon receipt of approved correction plan, I recommend no change in the status of the license.



10/02/2026

Martin Gonzales Licensing Consultant	Date
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Approved By:



10/02/2026

Mary E. Holton Area Manager	Date
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