



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

August 5, 2022

Nicholas Burnett  
Flatrock Manor, Inc.  
2360 Stonebridge Drive  
Flint, MI 48532

RE: License #: AM250402027  
Investigation #: 2022A0572040  
Goodrich South

Dear Mr. Burnett:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9700.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end.

Anthony Humphrey, Licensing Consultant  
Bureau of Community and Health Systems  
411 Genesee  
P.O. Box 5070  
Saginaw, MI 48605  
(810) 280-7718

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM250402027
<b>Investigation #:</b>	2022A0572040
<b>Complaint Receipt Date:</b>	06/17/2022
<b>Investigation Initiation Date:</b>	06/21/2022
<b>Report Due Date:</b>	08/16/2022
<b>Licensee Name:</b>	Flatrock Manor, Inc.
<b>Licensee Address:</b>	7012 River Road Flushing, MI 48433
<b>Licensee Telephone #:</b>	(810) 964-1430
<b>Administrator:</b>	Nicholas Burnett
<b>Licensee Designee:</b>	Morgan Yarkosky
<b>Name of Facility:</b>	Goodrich South
<b>Facility Address:</b>	7290 State Rd. Goodrich, MI 48438
<b>Facility Telephone #:</b>	(810) 877-6932
<b>Original Issuance Date:</b>	12/23/2019
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	06/23/2022
<b>Expiration Date:</b>	06/22/2024
<b>Capacity:</b>	12
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A hit staff Anteya Wilson with a shoe, and Anteya attempted to strike resident back, and said "I'm going to beat your (explicit)".	Yes

## III. METHODOLOGY

06/17/2022	Special Investigation Intake 2022A0572040
06/17/2022	APS Referral APS made referral.
06/21/2022	Special Investigation Initiated - On Site
06/21/2022	Contact - Face to Face Home Manager, Doug Keller, and Resident A.
07/07/2022	Contact - Face to Face Staff, Deonte Hopkins.
08/01/2022	Contact - Telephone call made Former employee, Anteya Wilson.
08/02/2022	Contact - Telephone call made Former employee, Anteya Wilson.
08/02/2022	Inspection Completed-BCAL Sub. Compliance
08/02/2022	Exit Conference Licensee Designee, Nicholas Burnett.

**ALLEGATION:**

Resident A hit staff Anteya Wilson with a shoe, and Anteya attempted to strike resident back, and said "I'm going to beat your (explicit)".

**INVESTIGATION:**

On 06/17/2022, the local licensing office received a complaint for investigation. Adult Protective Service (APS) referred to licensing for further investigation.

On 06/21/2022, an unannounced onsite was conducted at Goodrich South, located in Genesee County, Michigan. Interviewed were, Home Manager, Doug Keller, and Resident A.

On 06/21/2022, I conducted an interview with Home Manager, Doug Keller regarding the above allegation. Mr. Keller was a witness to the incident and informed that Ms. Wilson was terminated. He has not been able to speak to her since the incident. Recipient Rights were contacted, and they have been unable to get in touch with her for an interview. He is unaware if this is typical behavior by Ms. Wilson because he just returned to the company on 06/06/2022. The incident occurred because Resident A exposed himself to children during an outing. When they returned to the home, Ms. Wilson was describing what happened and Resident A became upset and began yelling at Ms. Wilson. When Resident A picked up a shoe to hit Ms. Wilson, she made a threat towards Resident A. When Resident A hit Ms. Wilson with the shoe, she charged at him, but staff were able to come in between her, and Resident A. Mr. Keller informed that Resident A was interviewed by Recipient Rights and told them that he did not remember what happened.

On 06/21/2022, I interviewed Resident A regarding the incident. He informed that he cannot remember exactly what happened, but he knows that something happened. He remembers fighting with Ms. Wilson but does not know what caused it. He believes they were arguing, and it led to them being physical. She may or may not have hit him.

On 06/21/2022, in speaking with Mr. Doug Keller again, he informed that Resident A should have been a pretty good interview because he does not have major memory loss. He thinks that Resident A may be afraid that he would get in trouble. Mr. Keller also informed that the other residents have cognitive delays so they would not be very good interviews.

On 07/07/2022, I conducted an interview with staff, Deonte Hopkins regarding the allegation. He informed that everything in the complaint was true, and he knows because he was one of the staff that grabbed Ms. Wilson so that she could not hit Resident A. He has known Ms. Wilson since grade school and was well aware of her attitude when she gets upset, which is why he grabbed her. Resident A was mad at Ms. Wilson for telling him that he was wrong for pulling his private part out at the beach in front of some kids. Ms. Wilson talked to Resident A when they got in the van in a nice and professional manner. When they got home and she was explaining

what happened to staff, and Resident A became upset. He then spit on her and hit her with a shoe. Resident A is a known spitter, and he will try to bite if he is upset.

On 07/15/2022, I reviewed the Incident Report, and it indicates that Resident A became upset when staff, Ms. Wilson informed that Resident A exposed himself at the beach in front of children. Resident A spit and threw a shoe at Ms. Wilson. Staff got in between them and made sure they were both safe.

On the morning of 08/01/2022, I left a voicemail message for Ms. Anteya Wilson to call me to be interviewed.

On the morning of 08/02/2022, I called Ms. Anteya Wilson for an interview. It appeared that someone answered the phone, held it momentarily and then hung up the phone. As of 08/05/2022, Ms. Wilson did not respond to my messages.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	In speaking with the Home Manager and the Staff member who witnessed the incident, there is enough evidence to substantiate against the facility. Resident A was interviewed as well. Although he denied remembering the specifics of the incident, he informed that he does remember a verbal incident between him and Ms. Wilson.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 08/02/2022, an Exit Conference was held with Licensee Designee, Nick Burnett regarding the special Investigation. He was informed that there was enough evidence to substantiate and that a corrective action plan would be required within 15 days of receipt of the report.

**IV. RECOMMENDATION**

I recommend that no changes be made to the licensing status of this medium sized adult foster care group home (Capacity 1-12).



08/05/2022

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Anthony Humphrey  
Licensing Consultant

Date

Approved By:



08/05/2022

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Mary E. Holton  
Area Manager

Date