GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 19, 2024

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

RE: License #: AM250402509
Investigation #: 2025A0576004
Fenton South

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 #:	AM250402509
Investigation #:	2025A0576004
Complaint Receipt Date:	10/23/2024
Investigation Initiation Date:	10/25/2024
Report Due Date:	12/22/2024
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road, Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Nicholas Burnett
Licensee Designee:	Nicholas Burnett
Name of Facility:	Fenton South
Facility Address:	17600 Silver Parkway, Suite 2 Fenton, MI 48430
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/09/2021
License Status:	REGULAR
Effective Date:	09/09/2023
Expiration Date:	09/08/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff, Brittany McQueen slapped Resident A across the face three times.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/23/2024	Special Investigation Intake 2025A0576004
10/25/2024	Special Investigation Initiated - Letter Sent email to Elizabeth Kowalski, Office of Recipient Rights (ORR)
10/25/2024	Contact - Telephone call received Received email from Elizabeth Kowalski
11/04/2024	Contact - Telephone call made Interviewed Staff, Shamacell Buggs
11/05/2024	Contact - Telephone call made Interviewed Staff, Rachell Keller
11/08/2024	Inspection Completed On-site Interviewed Staff Lauren Sanders and viewed Resident A
11/12/2024	Contact - Telephone call made Interviewed Staff Brittany McQueen
11/12/2024	Contact - Telephone call made Interviewed Home Manager, Shannon Kase
11/14/2024	Contact - Document Received Reviewed Resident A's AFC Assessment Plan and Incident Report
11/14/2024	Exit Conference
11/15/2024	APS Referral

ALLEGATION:

Staff, Brittany McQueen slapped Resident A across the face three times.

INVESTIGATION:

On October 25, 2024, I sent an email to Elizabeth Kowalski, Recipient Rights Advisor from Northeast Michigan Community Mental Health regarding any updates she can provide. Advisor Kowalski stated that she had spoken to Fenton South Home Manager Shannon Kase who reported Staff Brittany McQueen was terminated the day the allegations were reported to Manager Kase.

On November 4, 2024, I interviewed Staff Shamacell Buggs who reported being employed at the facility for over one year. Regarding the allegations, Staff Buggs reported to witnessing Staff Brittany McQueen slap Resident A on the arm with a spatula. After witnessing this, Staff Buggs told Staff McQueen not to do that. Staff Buggs did not know why Staff McQueen hit Resident A. Staff Buggs has worked with Staff McQueen in the past and Staff Buggs has never witnessed Staff McQueen behave like this in the past. Staff Buggs has heard rumors that Staff McQueen has slapped other nonverbal residents. According to Staff Buggs, Staff Rachel Keller witnessed Staff McQueen slap Resident A three times in the face. Staff McQueen was upset because Resident A knocked a bowl of noodles out of Staff McQueen's hands. According to Staff Buggs, Staff McQueen is no longer working at the facility.

On November 5, 2024, I interviewed Staff Rachel Keller who reported that she has been transferred to another facility approximately two weeks ago. Staff Keller explained that Resident A likes to reach for things. Staff Keller reported that she witnessed Resident A hit noodles out of Staff Brittany McQueen's hands. This infuriated Staff McQueen who then slapped Resident A across the face three times very hard. Staff Keller told Staff McQueen to never do that again and got the other lead staff, Shamacell Buggs. Staff Buggs walked over, and she witnessed Staff McQueen slap Resident A.

On November 8, 2024, I conducted an unannounced on-site inspection at Fenton South and interviewed Staff Lauren Sanders. Staff Sanders had no knowledge of the allegations and stated that she may have been off work. Staff Sanders reported Resident A is doing well and is nonverbal. Resident A is mobile and presents some behaviors such as swatting. Resident A has lived at the home for over one year.

On November 8, 2024, I viewed Resident A. She was sitting at a table and appeared well. Resident A was dressed neatly, and her hair was combed neatly and was in braids. I waved to Resident A and said "hello". Resident A did not respond. Resident A was unable to be interviewed, and staff indicated Resident A is nonverbal.

On November 12, 2024, I interviewed Staff Brittany McQueen. Staff McQueen denied the allegations and stated she never put her hands on Resident A. Staff McQueen did not know why someone would say she hit Resident A. Staff McQueen denied slapping

Resident A in the face and denied hitting her with a spatula. Staff McQueen no longer works at Fenton South and was terminated. Staff McQueen is not sure why she was terminated and no one told her why she was fired.

On November 12, 2024, I interviewed Home Manager Shannon Kase. Manager Kase reported that Staff Rachel Keller reported witnessing Staff Brittany McQueen slap Resident A across the face. Staff Keller told Manager Kase about this at a weekly lead meeting. Staff Keller told Manager Kase that the incident happened a week prior. Manager Kase asked Staff Keller why it took a week for her to report that Resident A was abused and Staff Keller reported that she thought management was aware. Manager Kase was asked if she had any concerns regarding Staff Brittany McQueen and she reported that Staff McQueen "would get mouth" with management when being corrected. Staff McQueen also seemed to be impatient with the residents. Manager Kase never witnessed Staff McQueen hit any residents. Staff McQueen is no longer employed at the facility.

On November 14, 2024, I reviewed Resident A's Individual Plan of Service (IPOS). The plan documents that Resident A is 26 years old presents some challenging behaviors and mood instability.

On November 14, 2024, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated for October 24, 2024, and authored by Shannon Kase. The IR documented that on October 18, 2024, Staff S. Buggs and R. Keller reported witnessing abuse of Resident A by Staff B. McQueen. Staff Buggs reported witnessing Staff McQueen hit Resident A in the arm with a plastic spatula. Staff Keller reported witnessing Staff McQueen slap Resident A 3 times. Recipient Rights was contacted.

On November 14, 2024, I conducted an Exit Conference with Licensee Designee Nicholas Burnett. I advised Licensee Designee Burnett I would be requesting a corrective action plan for the cited rule violation. Licensee Designee Burnett confirmed that Staff Brittany McQueen was immediately terminated upon learning of the allegations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	It was alleged that Staff Brittany McQueen slapped Resident A. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A was unable to be interviewed as she is nonverbal. Staff Rachel Keller and Staff Shamacell Buggs were interviewed, and both reported witnessing Staff Brittany McQueen hit Resident A in the face and arm respectively. Staff McQueen was interviewed and denied hitting Resident A. Staff McQueen did not know why someone would say she hit Resident A. Staff McQueen advised that she was terminated from employment at Fenton South however she did not know why. There is a preponderance of evidence to conclude Resident A's safety and protection was not adhered to at all times given she was subjected to physical abuse by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 5, 2024, I interviewed Staff Rachel Keller who reported that she was transferred to another facility approximately 2 weeks ago which was the result of discipline she received for not immediately reporting the abuse of Resident A by Staff Brittany McQueen. Staff Keller reported she waited a couple weeks to report that Resident A had been abused and she is not sure why she waited.

On November 12, 2024, I interviewed Home Manager Shannon Kase. Manager Kase reported that Staff Rachel Keller reported witnessing Staff Brittany McQueen slap Resident A across the face. Staff Keller told Manager Kase about this at a weekly lead meeting. Staff Keller told Manager Kase that the incident happened a week prior. Manager Kase asked Staff Keller why it took a week for her to report that Resident A was abused and Staff Keller reported that she thought management was aware.

On November 14, 2024, I conducted an exit conference with Licensee Designee Nicholas Burnett. I advised Licensee Designee Burnett I would be requesting a corrective action plan for the cited rule violation. Licensee Designee Burnett reported that Staff Keller was transferred to a smaller facility that has more oversight. Licensee Designee Burnett stated that Staff Keller reported that she thought management was aware of the abuse of Resident A and that is why she did not report the incident sooner.

Licensee Designee Burnett did not believe Staff Keller's reasoning for not reporting was adequate.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.**
ANALYSIS:	At least 2 staff, Rachel Keller and Shamacell Buggs witnessed Resident A be abused by Staff Brittany McQueen. Neither staff immediately disclosed the abuse to anyone placing vulnerable residents at risk of additional abuse. There is a preponderance of evidence to conclude Staff Keller and Staff Buggs are not competent in reporting requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

C. Garza

11/19/2024

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Christina Garza Date
Licensing Consultant

Approved By:

Mary Holton

11/19/2024

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Mary E. Holton Date
Area Manager