GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 7, 2024

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

RE: License #: AM250415869
Investigation #: 2025A0569002
Curtis

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250415869
Investigation #:	2025A0569002
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Morag Yarkosky
Licensee Designee:	Nicholas Burnett
Name of Facility:	Curtis
Facility Address:	3138 Curtis Drive Flint, MI 48507
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	06/04/2024
License Status:	TEMPORARY
Effective Date:	06/04/2024
Expiration Date:	12/03/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Shytaryia Mitchell, staff person, physically mistreated Resident A on 10/10/24.**	Yes
• **Keenen Coleman, staff person, physically mistreated Resident B on 10/16/24.**	No

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0569002
10/15/2024	APS Referral Referral to APS.
10/15/2024	Special Investigation Initiated - Letter Email to Genesee County ORR.
10/31/2024	Contact - Telephone call made Attempted contact with Shytaryia Mitchell, staff person. Left voicemail requesting return phone call.
11/04/2024	Contact - Telephone call made Contact with Dearea Holmes, staff person.
11/06/2024	Inspection Completed On-site
11/06/2024	Contact - Telephone call made Attempted contact with Shytaryia Mitchell. Left voicemail requesting return phone call.
11/06/2024	Inspection Completed-BCAL Sub. Compliance
11/06/2024	Exit Conference Exit conference with Nick Burnett, licensee designee.
11/06/2024	Corrective Action Plan Requested and Due on 11/30/2024

ALLEGATION:

- **Shytaryia Mitchell, staff person, physically mistreated Resident A on 10/10/2024.**
- **Keenen Coleman, staff person, physically mistreated Resident B on 10/16/2024.**

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A became physically aggressive on 10/10/24 and started hitting Shytaryia Mitchell, staff person. The complainant reported that Staff Mitchell then sprayed pepper spray at Resident A.

A second complaint was received via the on-line complaint portal on 10/17/2024. The complainant reported that Resident B stated that Keenen Coleman, staff person, choked Resident B on 10/16/2024 while restraining Resident B. The complainant reported that Resident B stated that Staff Coleman choked Resident B with his “fingers pushing on pressure points” on Resident B’s neck. The complainant reported that Resident B stated that no one observed this incident but then stated that Terryonna Suggs, staff person, did observe this incident.

An inspection of this facility was conducted on 11/6/2024. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that on 10/10/2024 he was drawing on a paper pad and Staff Mitchell walked by the table and threw his paper on the floor. Resident A stated that this made him upset. Resident A stated that staff Mitchell also was listening to songs that he does not like and kept playing the same songs over and over. Resident A stated that he asked Staff Mitchell to stop playing the music, but she refused. Resident A stated that he became more upset and started trying to hit staff Mitchell. Resident A stated that Staff Mitchell then pulled pepper spray out and sprayed him in his eyes and face. Resident A stated that the pepper spray caused his eyes and skin to burn. Resident A stated that Staff Mitchell then left the facility and staff helped Resident A take a shower and wash the pepper spray off. Resident A stated that he is fine now and did not sustain any further injuries. Resident A stated that Staff Mitchell no longer works at this facility, and he feels safe with the staff that are working at this facility.

Multiple attempts to contact Staff Mitchell were made to obtain a statement. Staff Mitchell has not returned messages left for her.

Dearea Holmes, staff person, stated on 11/4/2024 that she was working the third shift on 10/10/2024 with Staff Mitchell. Staff Holmes stated that she observed Resident A getting upset at Staff Mitchell and Resident A began hitting and kicking Staff Mitchell. Staff Holmes stated that she observed Staff Mitchell spray Resident A with pepper

spray twice into Resident A's eyes and face. Staff Holmes stated that she immediately intervened and told Staff Mitchell to put the pepper spray down and leave the facility. Staff Holmes stated that Resident A was then placed into the shower to wash the pepper spray off of Resident A. Staff Holmes stated that Staff Mitchell was terminated from employment and a police report was made.

Morgan Yarkosky, administrator, stated on 11/6/2024 that Staff Mitchell was terminated from employment on 10/10/2024 for physical assault. Morgan Yarkosky submitted documentation confirming that Staff Mitchell was terminated.

Resident B was alert and oriented to person, place, and time on 11/06/2024. Resident B was appropriately dressed and groomed with no visible injuries on his neck or body. Resident B stated that he did not remember an incident on 10/16/2024 involving Staff Coleman choking Resident B. Resident B then stated that he thinks that he had physically assaulted a staff person, and that the staff person then "put [Resident B] in a choke hold" for a few seconds while restraining Resident B. Resident B stated that he was not injured during this incident. Resident B could not recall any additional information regarding this incident.

Resident B's file contains an incident report (IR) dated 10/16/2024 documenting that an incident occurred with Staff Coleman. The IR documents that Resident B became verbally and physically aggressive with staff. The IR documents that Resident A started trying to hit staff and threw a bowl at staff. The IR documents that staff used blocking techniques and verbal redirection to deescalate Resident B. The IR documents that Resident B then went to his room and staff continued to monitor Resident B throughout the remaining shift (first shift). The corrective measures document that staff will continue to remind Resident B of appropriate coping skills.

Staff Coleman stated on 11/06/2024 that he has never physically managed Resident B. Staff Coleman stated that Resident A does become physically aggressive with staff at times, but Staff Coleman has always been able to verbally redirect Resident B. Staff Coleman stated that he has never choked Resident B or any other residents.

Staff Suggs stated on 11/06/2024 that she is the first shift "lead staff" person. Staff Suggs stated that Staff Coleman did not physically manage or choke Resident B on 10/16/24. Staff Suggs stated that she has never observed Staff Coleman physically or verbally mistreat Resident B or any of the other residents in this facility.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(a) Use any form of punishment. **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident A and Staff Holmes both stated that Staff Mitchell used pepper spray on Resident A on 10/10/2024. Morgan Yarkosky submitted documentation confirming that Staff Mitchell has been terminated from employment due to physical assault of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident B could not recall any specific details regarding Staff Colemen choking Resident B. Resident B originally reported that Staff Coleman used his fingers to press on “pressure points” on Resident B’s neck. When interviewed, Resident B stated that Staff Coleman put Resident B in a “choke hold” using Staff Coleman’s arm. Resident B did not have any injuries on his neck when interviewed on 11/6/2024. Staff Suggs stated that Staff Coleman did not physically manager Resident B on 10/16/2024 as documented in the IR contained in Resident B’s file. Based on the statements given and documentation reviewed, it is determined there is insufficient evidence to substantiate a violation of this rule concerning the incident with Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

An exit conference was conducted with Nicholas Burnett, licensee designee, on 11/6/2024. The findings in this report were reviewed. Nicholas Burnett agreed to submit a corrective action plan.

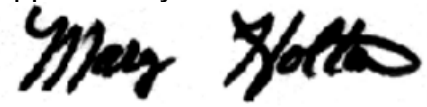
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

11/06/2024

Kent W Gieselman Date
Licensing Consultant

Approved By:



11/07/2024

Mary E. Holton Date
Area Manager