GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 2, 2025

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

RE: License #:	AM250402509
Investigation #:	2025A1039011
	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.
- 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,

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 #:	AM250402509
Investigation #:	2025A1039011
Complaint Receipt Date:	11/18/2024
Investigation Initiation Date:	11/18/2024
Report Due Date:	01/17/2025
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Morgan Yarkosky
Licensee Designee:	Nicholas Burnett
Name of Facility:	Fenton South
Facility Address:	Suite 2 17600 Silver Parkway 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 DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was slapped across the face by Staff Brenity McQueen.	Yes

III. METHODOLOGY

11/18/2024	Special Investigation Intake 2025A1039011
11/18/2024	APS Referral Complaint denied by APS on 11/18/2024.
11/18/2024	Special Investigation Initiated - Letter email to administrator regarding resident living status.
11/20/2024	Contact - Document Received Email from ORR Elizabeth Kowalski concerning Resident A.
11/20/2024	Inspection Completed On-site Interviewed the Home Manager Shannon Kase, Direct Care Worker Fendi Garth and Resident A.
11/20/2024	Contact - Telephone call made Attempted phone call with Direct Care Worker Brenity McQueen. No Answer.
12/27/2024	Contact - Telephone call made Interviewed Northeast Michigan CMH ORR Worker Elizabeth Kowalski.
12/27/2024	Contact - Telephone call made Attempted phone call with Direct Care Worker Brenity McQueen. No Answer.
12/27/2024	Contact - Telephone call made Interviewed Direct Care Worker Shamacell Buggs.
12/30/2024	Contact - Telephone call made Attempted phone call with Direct Care Worker Rachel Keller. No answer left message.
01/02/2025	Contact - Telephone call made Interviewed Direct Care Worker Rachel Keller.

01/02/2025	Exit Conference Completed with Licensee Designee Nicholas Burnett.

ALLEGATION:

Resident A was slapped across the face by Staff Brenity McQueen.

INVESTIGATION:

On 11/18/2024, Adult Protective Services (APS) from the Department of Health and Human Services denied complaint and referred complaint to Bureau of Community and Health Systems (BCHS) online complaint system. On 11/18/2024, the Bureau of Community and Health Systems (BCHS) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A was slapped across the face by Staff Brenity McQueen.

On 11/20/2024, Northeast Michigan Community Mental Health Office of Recipient Rights (ORR) Worker Elizabeth Kowalski emailed me and informed me that she completed her investigation and substantiated the allegations against Direct Care Worker Brenity McQueen. ORR Kowalski stated that the DCW McQueen reportedly also slapped Resident A in the arm with a spatula and would provide me any additional information she received concerning the incident.

11/20/2024, I completed an unannounced investigation at Fenton South and interviewed the following people: Home Manager Shannon Kase, Direct Care Worker Fendi Garth and Resident A.

On 11/20/2024, I interviewed Home Manager (HM) Shannon Kase concerning the allegations. HM Kase stated that she believed that the allegations were true as she had staff witness Resident A get slapped by Direct Care Worker (DCW) Brenity McQueen. HM Kase stated that staff called in the incident when it occurred. HM Kase stated that she was not aware of all of the details of the incident off the top of her head and that she would get me the incident report to review. HM Kase stated that from what she understood Resident A did something to upset DCW McQueen and then DCW McQueen slapped Resident A on the face. HM Kase stated that DCW McQueen was removed from the schedule immediately and her employment was terminated. HM Kase stated that DCW McQueen was not a newer worker, so she was caught off guard that it happened. HM Kase stated that all of the staff were retrained on etiquette and recipient rights. HM Kase stated that Resident A is non-verbal, and no follow up questions could be asked to Resident A regarding the incident.

I reviewed an Incident Report (IR) dated 10/18/2024. The IR notes that DCW Shamacell Buggs and DCW Rachel Keller witnessed abuse of Resident A by DCW McQueen. DCW Buggs witnessed DCW McQueen hit Resident A in the arm with a

spatula. DCW Keller witnessed DCW McQueen slap Resident A across the face three times. Supervision and Office of Recipient rights were promptly called regarding the incident.

I reviewed the Assessment Plan for Resident A dated 06/21/2024. Resident A is diagnosed with the following: Autistic disorder, Unspecified mood disorder, Conduct disorder, Impulse disorder and Attention-deficit disorder. The plan notes that Resident A required one-on-one supervision at the time of the incident for health and safety reasons. Resident A displays emotional outbursts, which Resident A benefits from ongoing staff supervision to help with calming/redirecting. Resident A can communicate Resident A's needs in one-to-three-word phrases. Resident A can say bathroom, eat or other simple words. Resident A does not target people maliciously, but Resident A will swat at people and does not usually cause injury. Resident A has been known to break items such as pens and pencils. Staff working with Resident A will monitor for signs of anxiety/agitation and will provide verbal redirection and emotional support when necessary. Staff are trained in Crisis Prevention Institute (CPI) nonviolent crisis intervention foundational course including disengagement and holding skills.

On 11/20/2024, I interviewed Direct Care Worker (DCW) Fendi Garth concerning the allegations. DCW Garth stated that she was familiar with the allegations and that she is aware that the incident occurred. DCW Garth stated that she was not working at the time of the incident. DCW Garth stated that Resident A has been on one-on-one supervision and that Resident A can be on the aggressive side but that a staff member should not yell or hit a resident at any time. DCW Garth stated that Resident A is non-verbal. DCW Garth has witnessed Resident A throw things at staff and other residents. DCW Garth has not witnessed Resident A be physically aggress towards anyone. DCW Garth stated that Resident A can understand simple directions and can sometimes answer with one-word sentences. Resident A is severely limited with any communication other than simple directions.

On 11/20/2024, I interviewed Resident A in her bedroom. Resident A was on her bed at the time of the interview and appeared neat and clean. Resident A is non-verbal and could not answer any questions but was able to say hi and wave. Resident A did not appear to have any marks or bruises on her at the time of our interview.

On 11/20/2024, I attempted to contact Direct Car Worker (DCW) Brenity McQueen with no success. On 12/27/2024, I attempted to contact Direct Car Worker (DCW) Brenity McQueen with no success.

On 12/27/2024, I spoke with Northeast Michigan Community Mental Health CMH Office of Recipient Rights (ORR) Worker Elizabeth Kowalski. ORR Kowalski informed me that she had spoken to DCW McQueen and that DCW McQueen denied that she hit Resident A. ORR Kowalski stated that she spoke with Direct Care Worker (DCW) Shamacell Buggs about the additional allegation of Resident A being hit with a spatula. ORR Kowalski stated that DCW Buggs stated that she witnessed DCW McQueen hit Resident A with a spatula.

On 12/27/2024, I completed a phone interview with Direct Care Worker (DCW) Shamacell Buggs concerning the allegations. DCW Buggs stated that she was working at the time of the incident on 10/18/2024. DCW Buggs stated that Direct Care Worker (DCW) Rachel Keller was present when DCW McQueen slapped Resident A across the face three times. DCW Buggs stated that DCW Keller came and got her to ask her if she could see any visible marks on Resident A's face. DCW Buggs stated that when she walked into the room where Resident A was at that she witnessed DCW McQueen hitting Resident A in the arm with a spatula. DCW Buggs stated that DCW McQueen stopped hitting Resident A with the spatula when she walked in, but DCW Buggs went over and told DCW McQueen that DCW McQueen was not allowed to hit residents with anything. DCW Buggs stated that she stayed and watched Resident A while DCW Keller contacted management and informed them of what happened. DCW Buggs stated that management contacted DCW Buggs after the incident and spoke with DCW Buggs regarding the incident. DCW Buggs stated that the staff had to all take recipient rights training again after the incident. DCW Buggs stated that she has not witnessed any further incidents involving Resident A since then. DCW Buggs stated that DCW McQueen no longer works there and has no further information regarding DCW McQueen.

On 01/02/2025, I completed a phone interview with Direct Care Worker (DCW) Rachel Keller concerning the allegations. DCW Keller stated that she witnessed the incident on 10/18/2024. DCW Keller stated that at the time of the incident DCW McQueen was the one-on-one staff for Resident A. DCW Keller stated that she observed DCW McQueen make a bowl of noodles and while the noodles where in her hand Resident A slapped the bowl out of her hand and the noodles went everywhere. DCW McQueen then slapped Resident A across the face three times. DCW Keller stated that she intervened and told DCW McQueen to stop. DCW Keller stated that she then went and got a lead worker to come help her manage the situation. DCW Keller stated that she asked DCW Buggs to come over and look Resident A over for any marks. DCW Keller stated that when DCW Buggs went back over to view Resident A that DCW McQueen was hitting Resident A with a spatula. DCW Keller stated that she told supervision of the incident. Supervision handled the situation after that and that she has not seen DCW McQueen since then and believes that DCW McQueen was terminated. DCW Keller stated that an incident report was completed, and that management contacted the guardian and Office of Recipient Rights.

On 01/02/2025, I completed an exit conference with Licensee Designee (LD) Nicholas Burnett. I informed LD Burnett of the results of my investigation. LD Burnett stated that he did not have any questions concerning the investigation.

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 Resident A was slapped across the face by Staff Brenity McQueen. I interviewed the following people: Home Manager, Direct Care Workers, Northeast Michigan Community Mental Health ORR Worker and Resident A. I reviewed the assessment plan for Resident A and the Incident Report. Staff Keller observed Staff McQueen slap Resident A three time across the face. Staff Buggs witnessed Staff McQueen hit Resident A with a spatula. Upon completion of the investigation, it was determined that there was a preponderance of evidence to conclude that R 400.14305 was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

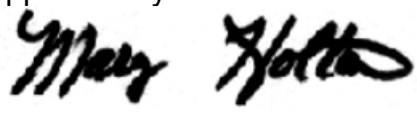
IV. RECOMMENDATION

Upon receipt of approved corrective action plan, I recommend no change in licensure status.

January 9, 2025

Martin Gonzales Licensing Consultant	Date

Approved By:



January 9, 2024

Mary E. Holton Area Manager	Date