STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR


March 25, 2025

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

RE: License #: AS250407224
Investigation #: 2025A0569022
Brookwood 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,

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 #:** | AS250407224 |
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| **Investigation #:** | 2025A0569022 |
| | |
| **Complaint Receipt Date:** | 02/04/2025 |
| | |
| **Investigation Initiation Date:** | 02/04/2025 |
| | |
| **Report Due Date:** | 04/05/2025 |
| | |
| **Licensee Name:** | Flatrock Manor, Inc. |
| | |
| **Licensee Address:** | 7012 River Road<br>Flushing, MI 48433 |
| | |
| **Licensee Telephone #:** | (810) 964-1430 |
| | |
| **Administrator:** | Morgan Yarkosky |
| | |
| **Licensee Designee:** | Nicholas Burnett |
| | |
| **Name of Facility:** | Brookwood South |
| | |
| **Facility Address:** | 5408 Brookwood Drive<br>Burton, MI 48509 |
| | |
| **Facility Telephone #:** | (810) 877-6932 |
| | |
| **Original Issuance Date:** | 04/22/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/22/2023 |
| | |
| **Expiration Date:** | 10/21/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| **Resident A was taken to the emergency room on 1/25/2025. Resident A was diagnosed with broken ribs and a collapsed lung. There is a concern Resident A was not adequately supervised.** | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 02/04/2025 | Special Investigation Intake<br>2025A0569022 |
| 02/04/2025 | APS Referral<br>Referral to APS. |
| 02/04/2025 | Special Investigation Initiated - Telephone<br>Contact with Ashton Byrne, RRO. |
| 02/04/2025 | Contact - Telephone call made<br>Contact with Guardian. |
| 02/04/2025 | Contact - Document Sent<br>Email to Michael Grant, APS worker. |
| 03/13/2025 | Contact - Telephone call made<br>Contact with Angela Gagney, nurse care manager. |
| 03/13/2025 | Contact - Document Sent<br>email to Michael Grant |
| 03/18/2025 | Inspection Completed On-site |
| 03/18/2025 | Contact - Telephone call made<br>Attempted contact with Richard Smith, staff person. Left voicemail requesting return phone call. |
| 03/18/2025 | Contact - Document Received<br>Email from Michael Grant, APS worker. |
| 03/19/2025 | Contact - Telephone call made<br>Contact with Caleb Hodge, staff person. |
| 03/19/2025 | Contact - Telephone call made<br>Contact with Shabaya Gurd, staff person. |

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| 03/19/2025 | Contact - Telephone call made<br>Contact with Lawrence Hudson, staff person. |
| 03/19/2025 | Contact - Telephone call made<br>Contact with Alana Wright, staff person. |
| 03/19/2025 | Contact - Telephone call made<br>Attempted contact with Destiny Hall, medical coordinator. Left voicemail requesting return phone call. |
| 03/19/2025 | Contact - Telephone call made<br>Contact with Richard Smith, staff person. |
| 03/20/2025 | Inspection Completed-BCAL Sub. Compliance |
| 03/20/2025 | Exit Conference<br>Exit conference with Nicholas Burnett, licensee designee. |
| 03/20/2025 | Corrective Action Plan Requested and Due on 04/15/2025 |

**ALLEGATION:**

**Resident A was taken to the emergency room on 1/25/2025. Resident A was diagnosed with broken ribs and a collapsed lung. There is a concern Resident A was not adequately supervised.**

**INVESTIGATION:**

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that Resident A was sent to the hospital on 1/25/2025 for treatment of a bruise on his leg. The complainant reported that while being treated at the hospital, Resident A was found to have two broken ribs and a collapsed lung. The complainant reported that the cause of the injury is unknown.

An unannounced inspection of this facility was conducted on 3/18/2025. Resident A has been discharged from this facility. Resident A’s file was reviewed. Resident A’s file contains an incident report (IR) dated 1/25/2025 and completed by Caleb Hodge, staff person. The IR documents that Resident A was observed to have a bruise on his right calf area. The IR documents that Resident A was then immediately taken to the emergency room for medical treatment due to Resident A’s diagnosis of hemophilia. The corrective measures documented in the IR were to continue to monitor Resident A and notify the medical coordinator of any changes in Resident A’s health.

Resident A's written assessment was reviewed. The assessment was completed on 11/25/2024. The assessment documents that Resident A is autistic and non-verbal. The assessment documents under 1a, that Resident A is currently under a 1:1 staffing ratio. The assessment documents that the 1:1 staff person assigned to Resident A "is to be at arm's reach" of Resident A when Resident A is in the community or in common areas of the facility. The assessment documents that the 1:1 staff person will "have eyes on" Resident A "at all times". The assessment documents that the 1:1 staff person will sit outside Resident A's bedroom door when Resident A is in his bedroom so that the staff person "is prepared to be arms reach away" when Resident A comes out of his bedroom. Resident A's file contains a behavioral treatment plan dated 10/24/2024. The treatment plan documents on page 4 that staff are to be within 10 feet or field of vision at all times. Resident A's file contains documentation confirming that he was admitted to the hospital at 7:30am on 1/25/2025 for treatment of a bruise on his leg due to hemophilia. Resident A's file contains additional documentation that Resident A was x-rayed and found to have two broken ribs and a punctured lung. All of the remaining Residents were observed during the inspection on 3/18/25. All Residents were observed to be appropriately dressed and groomed with no visible injuries.

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that staff observed Resident A to have a bruise on his leg on the morning of 1/25/2025 and immediately sent Resident A to the hospital. Resident B stated that he has never observed any staff person physically mistreat Resident A or any of the other residents in this facility. Resident B stated that he did not know how Resident A sustained his injuries. Resident B stated that Resident A was "acting normal" when he went to bed on 1/24/2025. Resident B stated that he slept through the night and did not observe anything happen to Resident A.

Resident A's guardian (Guardian) stated on 2/4/2025 that Resident A was taken to the hospital on 1/25/2025 due to a bruise Resident A had on his leg. Guardian stated that Resident A has hemophilia and must be taken for medical treatment anytime a bruise is observed on Resident A's body. Guardian stated that Resident A was then found to have two broken ribs and a collapsed lung. Guardian stated that Resident A then developed blood clots in his chest as a complication of having hemophilia. Guardian stated that Resident A is undergoing a third surgery for treatment of the blood clots. Guardian stated that staff are all saying that no one knows what happened to cause the injury. Guardian stated that she does not believe that Resident A has been properly supervised at this facility resulting in Resident A's injury. Guardian stated that Resident A will be moved to a different facility when Resident A is discharged from the hospital.

Caleb Hodge, staff person, stated on 3/19/2025 that he was the lead staff person on first shift of 1/25/2025. Staff Hodge stated that he arrived for his shift at 6:30am on 1/25/2025. Staff Hodge stated that Resident A had come to the dining room for Resident A's morning medications and was observed to have a slight limp. Staff Hodge stated a bruise was then observed on Resident A's leg. Staff Hodge stated that

Resident A was then sent to the hospital for treatment due to being diagnosed with hemophilia. Staff Hodge stated that Resident A was also “panting” slightly. Staff Hodge stated that he did not observe the cause of Resident A’s injury. Staff Hodge stated that Resident A requires a 1:1 staffing ratio. Staff Hodge stated that the 1:1 staff must be within “arm’s reach” of Resident A at all times. Staff Hodge stated that he does not know how Resident A was injured.

Shabaya Gurd, staff person, stated on 3/19/2025 that she worked the first shift on 1/25/2025. Staff Gurd stated that she has been assigned to be Resident A’s 1:1 staff person at times. Staff Gurd stated that Resident A’s 1:1 staff person is supposed to always “have eyes on” Resident A and be within arm’s reach of Resident A due to his aggressive behaviors with staff and peers. Staff Gurd stated that Resident A will hit and bite staff and other residents when Resident A is upset. Staff Gurd stated that she does not know how Resident A sustained his injuries. Staff Gurd stated that she has not observed any other staff mistreat Resident A in anyway. Staff Gurd stated that staff Hodge did observe a bruise on Resident A’s leg on 1/25/2025 and immediately sent Resident A to the hospital for treatment.

Alana Wright, staff person, stated on 3/19/2025 that she worked on 1/25/2025. Staff Wright stated that she did not observe anything happen to Resident A that would have caused his injuries. Staff Wright stated that she has been assigned to be Resident A’s 1:1 staff person, and that the 1:1 staff person must always be within reach of Resident A. Staff Wright stated that she does not know how Resident A was injured.

Lawrence Hudson, staff person, stated on 3/18/2025 that Resident A is a 1:1 staffing ratio. Staff Hudson stated that he did not observe how Resident A sustained his injuries. Staff Hudson stated that Resident A will frequently run up and down the hallway of this facility and has had falls in the past. Staff Hudson stated that Resident A will also “flop” onto his bed at times when Resident A gets into bed. Staff Hudson stated that Resident A’s 1:1 staff must always be within reaching distance of Resident A. Staff Hudson stated that he does not know how Resident A was injured.

Richard Smith, staff person, stated on 3/19/2025 that he worked the third shift on 1/24/2025-1/25/2025. Staff Smith stated that he worked alone for a period of about 2 hours from 11:30pm on 1/24/2025 to 1:30am on 1/25/2025. Staff Smith stated that a second staff had to take another resident to the hospital during this time leaving Staff Smith by himself. Staff Smith stated that staff typically complete “bed checks” every 15 minutes on each resident to make sure that they are ok. Staff Smith stated that he did not complete any bed checks for the two hours that he was the only staff person working. Staff Smith stated that he did not hear or observe anything happen to Resident A that would explain Resident A’s injuries. Staff Smith stated that Resident A “slept the whole night” which was unusual for Resident A. Staff Smith stated that Resident A will typically get up during the night and go to the bathroom and will then “pace the hallway” for a period of time. Staff Smith stated that when Resident A got up for his medications at about 6:30am on 1/25/2025, Resident A was limping. Staff Smith stated that Staff Hodge then observed a bruise on Resident A’s leg and sent Resident A to the hospital

for treatment. Staff Smith stated that he does not know how Resident A sustained his injuries.

Angela Gagney, nurse case manager, stated on 3/13/2025 that she is the case manager for Resident A while he is being treated at the hospital. Angela Gagney stated that Resident A was brought to the hospital due to staff observing a bruise on Resident A's leg. Angela Gagney stated that while being assessed, x-rays revealed that Resident A had two broken ribs and a punctured lung. Angela Gagney stated that the injuries could have been caused by a fall or some type of accident. Angela Gagney stated that the injuries were not necessarily consistent with being assaulted. Angela Gagney stated that, because Resident A has hemophilia, the trauma to his chest caused blood clots that required several surgeries to treat. Angela Gagney stated that it is unclear how Resident A sustained the injuries because Resident A is non-verbal, and no one observed an accident that would explain the injuries.

Michael Grant, APS worker, stated on 3/18/2025 that he has investigated this allegation. Michael Grant stated that he was unable to determine the cause of Resident A's injuries as none of the staff observed the cause. Michael Grant stated that he is substantiating neglect of Resident A due to a lack of supervision.

An exit conference was conducted with Nicholas Burnett, licensee designee, on 3/20/25. Nicholas Burnett stated that Flatrock Inc. did conduct an internal investigation regarding this incident. Nicholas Burnett stated that staff reported that they did not observe any incidents that would account for Resident A's injuries. Nicholas Burnett stated that Resident A was on a 1:1 staffing ratio for first and second shifts only, and not while Resident A is sleeping during the third shift. Nicholas Burnett stated that staff do 15-minute bed checks throughout the night while residents are sleeping, but it is not a licensing requirement or part of any of the residents' care plans. Nicholas Burnett stated that he believes that Resident A could have done something to harm himself during the night without staff observing what happened. Nicholas Burnett stated that he does not believe that staff did not properly supervise Resident A and disagrees with the findings in this report. Nicholas Burnett stated that he will submit a corrective action plan regarding this finding.

| **APPLICABLE RULE** | |
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| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Resident A was sent to the hospital on 1/25/2025 when staff observed Resident A to have a bruise on his leg in compliance with his written assessment and treatment plan. While being treated, Resident A was found to have two broken ribs causing |

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| | a puncture to his lung. All of the staff interviewed denied observing any incident that would explain Resident A’s injuries. Resident A’s written assessment documents that Resident A requires a 1:1 staffing ratio, and that staff are to be within arm’s reach with “eyes on” Resident A at all times. The assessment documents that when Resident A is in his bedroom, staff will remain at the door, ready to be within arm’s reach immediately. Resident A’s behavior plan also documents that Resident A is a 1:1 staff ratio and that staff will be within 10ft. of Resident A with “eyes on” Resident A at all times.<br><br>Nicholas Burnett and Richard Smith stated that the 1:1 staff ratio is not in effect for the third shift while Resident A is sleeping. The third shift exception is not documented in the written assessment or behavior plan. Richard Smith also stated that during the third shift on 1/24/2025-1/25/2025, he was the only staff present at the facility from 11:30pm- 1:30am, and that he did not complete any bed checks during that time frame. Resident B stated that Resident A was “acting normal” when Resident A went to bed on 1/24/2025 and was then taken to the hospital when he got up on 1/25/2025.<br><br>Based on the statements given and documentation reviewed, it is difficult to understand how Resident A could have sustained broken ribs causing a punctured lung from a significant trauma without a staff person observing what happened. The facility failed to provide the supervision indicated in Resident A’s assessment plan. It is determined that there has been a violation of this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

03/24/2025

Kent W Gieselman Date
Licensing Consultant

Approved By:

03/25/2025

Mary E. Holton Date
Area Manager