



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2025

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

RE: License #: AM440388514
Investigation #: 2025A0779027
Lapeer 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,

A handwritten signature in dark ink, reading "Christopher A. Holvey". The signature is written in a cursive style with a large, stylized 'C' and 'H'.

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440388514
Investigation #:	2025A0779027
Complaint Receipt Date:	02/24/2025
Investigation Initiation Date:	02/24/2025
Report Due Date:	04/25/2025
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:	Lapeer South
Facility Address:	280 North Elba Road Lapeer, MI 48446
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	02/08/2018
License Status:	REGULAR
Effective Date:	08/08/2024
Expiration Date:	08/07/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On or about 1/23/2025, Law Enforcement (LE) was called to Wal-Mart for allegations of staff Deshon Marshall punching and choking Resident A.	Yes

III. METHODOLOGY

02/24/2025	Special Investigation Intake 2025A0779027
02/24/2025	APS Referral Complaint was received from APS.
02/24/2025	Special Investigation Initiated - Telephone Spoke to APS worker.
02/25/2025	Contact - Document Received Received email from APS worker.
02/27/2025	Inspection Completed On-site
02/27/2025	Contact - Telephone call made Interview conducted with staff person, Deshon Marshall.
02/27/2025	Contact - Telephone call made Interview conducted with staff person, Tiffany Harris.
02/27/2025	Contact - Telephone call made Interview conducted with staff person, Jameka Davis.
02/27/2025	Contact - Telephone call made Interview conducted with staff person, Latasha Edwards.
04/09/2025	Exit Conference Held with licensee designee, Nicholas Burnett.

ALLEGATION:

On or about 1/23/2025, Law Enforcement (LE) was called to Wal-Mart for allegations of staff Deshon Marshall punching and choking Resident A.

INVESTIGATION:

On 2/24/2025, a phone conversation took place with APS worker, Eric Janetsky, who confirmed that he was investigating the same allegations. APS Janetsky stated that he had already spoken to Resident A and that Resident A claimed that staff person, Deshon Marshall, grabbed him by the sweatshirt collar and choked him. APS Janetsky stated that Resident A did not sustain any marks or bruises from the incident. APS Janetsky reported that police were called and they pulled over the company van and spoke to Staff Marshall, did not press any charges and allowed them to leave. APS Janetsky stated that Resident A did not speak to the police at the scene.

On 2/25/2025, a copy of the police report was received via email from APS Janetsky. The police report stated that the Lapeer Police Department received a call on 1/23/2025 about a possible assault and battery occurring at Walmart. The caller of the complaint reported that it appeared to be a "group home" setting, where an employee took residents shopping and that the employee choked one of the residents, but had left Walmart in a white van. The report states that police officers pulled over the company van and interviewed staff person, Deshon Marshall, who claimed that no assault took place and that he just restrained a resident who was trying to elope. It stated that Resident A would not speak to the officers, but that the officers viewed Resident A to not have any visible injuries and concluded the traffic stop. The police report stated that an officer viewed security footage from Walmart and observed the van in the parking lot. The video showed that while walking out to the van, Resident A fell to the ground and Staff Marshall grabbed Resident A by the back of his jacket/hood and began pulling Resident A toward the van. Resident A started swinging his grocery bag toward Staff Marshall and that eventually Resident A had his back up against the side of the van. The officer stated that the video showed that Resident A was held against the van and that Staff Marshall had his hand around Resident A's upper chest/neck area. Resident A was eventually pushed into the van.

On 2/27/2025, an on-site inspection was conducted and Resident A was interviewed. Resident A stated that while at Walmart, he went to the van to smoke "in peace" and Staff Marshall told him to put the cigarette down. Resident A stated that he does not remember falling to the ground. Resident A reported that Staff Marshall grabbed him the collar of his shirt and admitted that he was trying to get away from Staff Marshall but denied that he was trying to run/elope. Resident A stated that Staff Marshall choked Resident A with his hand. As a way of describing the choking, Resident A put his hand up under his neck/chin area. Resident A admitted to being physical with Staff Marshall but denied swinging his grocery bag at Staff Marshall. Resident A was not able to provide any further information or details about the incident.

On 2/27/2025, Resident B stated that he was present during the Walmart trip and remembers witnessing Staff Marshall grab Resident A by the front of the jacket and slam Resident A against the side of the van. Resident B said that Staff Marshall held Resident A there for a minute or so, until he got Resident A into the van. Resident B stated that he felt the situation was inappropriately handled by Staff Marshall.

On 2/27/2025, Resident C stated that he was sitting in the van of the time of the incident between Resident A and Staff Marshall. Resident C stated that Staff Marshall seemed upset because Resident A had a behavior inside the store. Resident C reported that he witnessed Staff Marshall grab Resident A by the front of his shirt and hold Resident A up against the side of the van. Resident C could not say how long Staff Marshall held Resident A there before Resident A got into the van.

On 2/27/2025, a phone call was made to home manager, Tiffany Harris, who stated that she was the manager that was working on 1/23/2025 and at the time when the residents were on a run to Walmart with Staff Marshall and other staff. Manager Harris remembered the police calling her at the facility and asking her about their protocols regarding residents out in public. Manager Harris stated that the police did not mention anything about allegations of abuse by Staff Marshall, while at Walmart. Manager Harris reported that neither Staff Marshall or the other staff said anything to her that night about the alleged abuse/choking and that she did not learn of it until Resident A told her about it the next day. Manager Harris stated that Staff Marshall did not complete an incident report, but one was completed by management from the information provided by Resident A.

On 2/27/2025, a phone call was made to staff person, Jameka Davis, who confirmed that she was one of the staff present during the trip to Walmart on 1/23/2025. Staff Davis confirmed that Resident A had a behavior while inside Walmart, but that Staff Marshall was the one who walked out to the van with Resident A. Staff Davis stated that she was in the store still with other residents and that Resident A was in the van already when she came out of the store. Staff Davis claims that she did not witness any physical incident between Resident A and Staff Marshall and that there were no conflicts inside the van on the way home.

On 2/27/2025, a phone call made to staff person, Latasha Edwards, who confirmed that she was one of the staff present during the trip to Walmart on 1/23/2025. Staff Edwards stated that she was assigned as Resident D's 1-on-1 staff during that outing. Staff Edwards reported that Resident A started to have behaviors inside Walmart, so she took Resident D out to the van. Staff Edwards stated that when Resident A came out of the store, Staff Marshall was following behind Resident A. Staff Edwards stated that she could hear Staff Marshall redirecting Resident A to get into the van and that when Resident A got into the van, Resident A was upset and was punching the ceiling and windows and yelling. Staff Edwards claimed that she was busy focused on other residents inside the van and did not witness any physical interaction between Resident A and Staff Marshall.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan states that Resident A only requires verbal prompts from staff to complete all activities of daily living. The plan indicated that Resident A requires "field of vision supervision" by staff, while out in the community. It states that staff will monitor Resident A for increase in anxiety/agitation and provide verbal redirection and problem-solving skills when necessary.

Resident A's Behavioral Treatment Plan (BTP) only briefly touches on the topic of his community access/supervision. The BTP states that Resident A will be supervised at all times when leaving the home. Staff will be there to support and monitor safety, coach appropriate social and community interactions and redirect challenging behavior as needed. The BTP does mention that Resident A has a history of eloping when emotionally dysregulated but does not appear to provide guidance as to how to interact with Resident A when an elopement takes place.

On 4/9/2025, an exit conference was held with licensee designee, Nicholas Burnett. LD Burnett was informed of the outcome of this investigation and that a corrective action plan is required. LD Burnett stated that he will check and if Staff Marshall is still employed with them, he will probably terminate his employment.

APPLICABLE RULE	
R 400.14307	Resident behavior interventions generally.
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
ANALYSIS:	Resident A claims that staff person, Deshon Marshall, choked him during an outing to Walmart. Resident B and Resident C reported that they saw Staff Marshall grab Resident A by the front of his jacket/shirt and hold Resident A up against the side of the van. A report completed by the Lapeer Police Department states that a Walmart security video was viewed and showed that Staff Marshall grabbed Resident A by the back of his jacket/hood and began pulling Resident A toward the van. The video also showed that Staff Marshall had his hand on Resident A's upper chest/neck area and was holding Resident A against the van. There was sufficient evidence found to prove that the behavior intervention techniques that Staff Marshall used with Resident A were not positive in nature or relevant to Resident A's needs.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved written corrective plan, it is recommended that the status of this home's license remain unchanged.



4/10/2025

Christopher Holvey
Licensing Consultant

Date

Approved By:



4/10/2025

Mary E. Holton
Area Manager

Date