GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2025

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

RE: License #: AL250388516
Investigation #: 2025A0569033
Burton West

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 #:	AL250388516
Investigation #:	2025A0569033
Complaint Receipt Date:	04/09/2025
Investigation Initiation Date:	04/09/2025
Report Due Date:	06/08/2025
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:	Burton West
Facility Address:	1345 Connell St. Burton, MI 48529
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	06/28/2018
License Status:	REGULAR
Effective Date:	12/24/2024
Expiration Date:	12/23/2026
Capacity:	15
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Torren Thomas, staff person, physically mistreated Resident A on 4/7/2025.**	Yes

III. METHODOLOGY

04/09/2025	Special Investigation Intake 2025A0569033
04/09/2025	APS Referral referral to APS.
04/09/2025	Special Investigation Initiated - Letter Email to Pat Shepard, RRO.
05/06/2025	Inspection completed On-site Resident A was not available.
05/14/2025	Contact - Document Received Email from Samantha Belanger, APS worker.
05/22/2025	Contact - Telephone call made Contact with Fendi Garth, staff person.
05/22/2025	Contact - Telephone call made Contact with Torren Thomas, staff person.
05/27/2025	Contact - Telephone call received Contact with Pat Shepard.
06/02/2025	Inspection Completed On-site
06/02/2025	Inspection Completed-BCAL Sub. Compliance
06/02/2025	Exit Conference
06/02/2025	Corrective Action Plan Requested and Due on 06/17/2025

ALLEGATION:

Torren Thomas, staff person, physically mistreated Resident A on 4/7/2025.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that on 4/7/2025, Torren Thomas, staff person, grabbed Resident A's neck and pushed Resident A down into a chair. The complainant reported that another staff person, Fendi Garth, then intervened and separated Torren Garth and Resident A.

Samantha Belanger, APS worker, stated on 5/15/2025 that she investigated this complaint. Samantha Belanger stated that Torren Thomas admitted to grabbing Resident A by his neck and pushing Resident A down. Samantha Belanger stated that she did substantiate physical abuse in her investigation.

Pat Shepard, recipient rights officer, stated on 4/9/2025 that she investigated this complaint. Pat Shepard stated that Resident A stated that Fendi Garth, staff person, witnessed this incident and reported that Torren Thomas did physically mistreat Resident A and that she had to intervene. Pat Shepard stated that she substantiated physical mistreatment.

An unannounced inspection of this facility was conducted on 5/6/2025 and 6/2/2025. On 6/2/2025 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 he did not remember the exact date, but that Torren Thomas did grab Resident A's neck and pushed Resident A down. Resident A stated that he ended up on the floor and that Fendi Garth, staff person, immediately got between Resident A and Torren Thomas to separate them. Resident A stated that he was using his phone and Torren Thomas grabbed the phone from Resident A, then pushed Resident A. Resident A stated that Torren Thomas then left the facility and no longer works at this facility. Resident A stated that he has not been mistreated by any other staff person and that he feels safe residing at this facility.

Resident A's file was reviewed. Resident A's file contains an incident report (IR) dated 4/7/2025. The IR documents that on 4/7/2025 at 8:30pm Resident A was in the dining room of the facility playing cards when another resident "attacked" Resident A. The IR documents that Resident A was redirected verbally by Torren Thomas. The IR documents that Resident A then began yelling at Torren Thomas. The IR documents that Resident A then grabbed a phone and started walking away from Torren Thomas and Torren Thomas the grabbed the phone from Resident A. The IR documents that Resident A then physically attacked Torren Thomas and Torren Thomas then pushed Resident A down by placing his hands around Resident A's neck. The IR documents that Fendi Garth them got between Resident A and Torren Thomas to separate them.

The IR documents that police were then contacted, and the police came to the facility to take a statement from Resident A. The IR documents that Resident A was then taken to the emergency room for a medical evaluation. The IR documents that Resident A was prescribed acetaminophen for any pain and returned to the facility. The corrective measures documented in the IR were that staff will verbally redirect Resident A when he becomes upset and offer Resident A “preferred activities” to deescalate Resident A.

Fendi Garth, staff person, stated on 5/2220/25 that she worked the second shift on 4/7/2025 and was the shift manager. Fendi Garth stated that Resident A was in the dining room when he got into an altercation with another resident. Fendi Garth stated that Torren Thomas attempted to intervene by verbally redirecting Resident A and Resident A went into the kitchen area. Fendi Garth stated that Resident A then had a phone and Torren Thomas asked Resident A who he was calling. Fendi Garth stated that Resident A became upset at Torren Thomas and refused to tell Torren Thomas who he was calling. Fendi Garth stated that Torren Thomas then grabbed the phone and pushed Resident A down into a chair by putting his hands on Resident A’s neck and pushing Resident A down. Fendi Garth stated that she immediately separated Resident A and Torren Thomas. Fendi Garth stated that Torren Thomas no longer works at this facility.

Torren Thomas was contacted via telephone on 5/22/2025. Torren Thomas stated that he did not wish to answer any questions regarding this incident.

APPLICABLE RULE	
R 400.15308	**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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident A stated that Torren Thomas grabbed Resident A’s neck on 4/7/2025 and pushed Resident A down. Fendi Garth stated that she observed this incident. Torren Thomas stated that he did not wish to answer any questions regarding this incident. Samantha Belanger and Pat Shepard stated that they investigated this allegation and substantiated mistreatment of Resident A. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Nicholas Burnett, licensee designee, on 06/02/2025. The findings in this report were reviewed and a corrective action plan was requested.

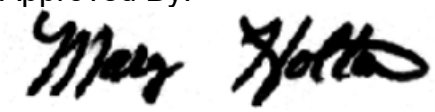
IV. RECOMMENDATION

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

06/02/2025

Kent W Gieselman — Date
Licensing Consultant

Approved By:



06/03/2025

Mary E. Holton — Date
Area Manager