GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

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

RE: License #: AS250415868
Investigation #: 2025A0576035
Coldwater

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250415868
Investigation #:	2025A0576035
Complaint Receipt Date:	04/18/2025
Investigation Initiation Date:	04/18/2025
Report Due Date:	06/17/2025
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:	Coldwater
Facility Address:	8163 Coldwater Rd., Flushing, MI 48433
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	08/28/2024
License Status:	REGULAR
Effective Date:	02/28/2025
Expiration Date:	02/27/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A arrived at the hospital due to groin pain. Resident A has pelvic bruising and swelling. Resident A also has abrasions to his tail bone. It is unknown how these injuries were caused. There are concerns Resident A is being neglected or physically abused by staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/18/2025	Special Investigation Intake 2025A0576035
04/18/2025	APS Referral
04/18/2025	Special Investigation Initiated - Telephone Interviewed Kyle Whitman, Genesee County Adult Protective Services (APS)
04/28/2025	Inspection Completed On-site Interviewed Staff Marquita Johnson, Jai'air Roberts, Chrisjhn McElwee, Devaun Marsh, Resident B, and viewed Resident A
04/29/2025	Contact - Document Received Received photo of Resident A
05/05/2025	Contact - Document Received Interviewed Kyle Whitman
05/05/2025	Contact - Telephone call made Interviewed Licensee Designee, Nicholas Burnett
05/20/2025	Contact - Telephone call received Interviewed Kyle Whitman
05/21/2025	Contact - Document Received Reviewed police reports
05/28/2025	Contact - Telephone call made Interviewed Staff, Ishanti Skipper

05/29/2025	Contact - Telephone call made Interviewed Staff Derek Beelby
06/02/2025	Contact - Document Received Received and reviewed facility and resident documents
06/02/2025	Contact - Telephone call made Interviewed Detective Daren Hawley, Flushing Township Police
06/03/2025	Contact - Telephone call made Interviewed Joy Dempsy, Genesee County Medical Examiner's Office
06/03/2025	Contact - Telephone call made Interviewed Kyle Whitman, APS
06/03/2025	Contact - Telephone call made Interviewed Staff Makayla Schmock
06/04/2025	Contact - Telephone call made Interviewed Staff Johns Jones
06/04/2025	Contact - Telephone call made Left message for Guardian A1 to return call
06/04/2025	Contact - Telephone call made Interviewed Amy Johnson, Livingston County Community Mental Health (CMH)
06/05/2025	Contact - Telephone call made Interviewed Staff Nikita Smith
06/05/2025	Contact - Telephone call made Interviewed Derek Scroi, Livingston County Case Manager
06/05/2025	Contact - Telephone call made Interviewed Staff Braylon Daniel
06/06/2025	Contact - Telephone call made Interviewed Staff Malik McClure
06/06/2025	Contact - Telephone call made Interviewed Haley Urah, Genesee County Case Manager
06/06/2025	Contact - Telephone call made Interviewed Andrew Mahler, Berrien County Case Manager

06/06/2025	Contact - Telephone call made Interviewed Guardian B1
06/06/2025	Contact - Telephone call made Interviewed Medical Coordinator Eric Tobias
06/09/2025	Contact - Telephone call made Interviewed Staff Jazmyne Jimmerson
06/09/2025	Contact - Telephone call made Interviewed Staff Stephanie Borieo
06/11/2025	Contact - Telephone call received Message received from Guardian A1
06/11/2025	Contact - Telephone call made Interviewed Guardian A1
06/17/2025	Exit Conference Exit Conference conducted with Licensee Designee, Nicholas Burnett

ALLEGATION:

Resident A arrived at the hospital due to groin pain. He has pelvic bruising and swelling. He also has abrasions to his tail bone. It is unknown how these injuries were caused. There are concerns Resident A is being neglected or physically abused by staff.

INVESTIGATION:

On April 18, 2025, I interviewed Kyle Whitman, Genesee County Adult Protective Services (APS) Investigator. Investigator Whitman reported Resident A is 38 years old and nonverbal. Resident A has bruising on his lower back and groin area. The bruises have not been explained, and it is unknown how Resident A obtained the injuries. Resident A has a guardian, and his case manager is Derrick Scroi from Livingston County.

On April 28, 2025, I conducted an unannounced on-site inspection at Coldwater and upon entry to the facility, I observed a resident walking around in a T-shirt. The resident, who staff later confirmed to be Resident A had a black eye. Resident A's right eye was bruised below and above the eye and was dark purple in color. Resident A took my hand twice and walked me around the facility. Resident A was docile and walked around the home during the time I was there. I asked staff if I was able to see

the bruise on Resident A's back and they lifted his t-shirt. Resident A had a small, light red, circular mark in the middle of his lower back. The mark was the size of a quarter. Resident A was not interviewed as he is nonverbal.

On April 28, 2025, I interviewed Staff Marquita Johnson at the facility. Staff Johnson has been employed at the facility since September 2024. Regarding the allegations, Staff Johnson reported that she did not see the bruises to Resident A's groin or back. Third shift staff said maybe he fell or got pushed. Regarding Resident A's black eye, Staff Johnson has not been to work in 4 days and she first saw the back eye yesterday. Staff Johnson does not know how Resident A obtained a black eye. Staff Johnson did not know how Resident A obtained any of the injuries. No one reported to Staff Johnson that staff mistreated Resident A.

On April 28, 2025, I interviewed Staff, Jai'air Roberts who has been employed at the facility since December 2024. Staff Roberts had no knowledge of how Resident A obtained injuries to his groin. Staff Roberts did not know what happened to Resident A's eye. Staff Roberts denied concerns that staff caused Resident A's injuries. Staff Roberts heard that Resident E tries to push Resident A, and Resident B can become aggressive. Resident B tries to hit other residents and staff. According to Staff Roberts, Resident B said that Resident E pushed Resident A and caused the eye injury.

On April 28, 2025, I interviewed Staff Chrisjhn (CJ) McElwee regarding the allegations. Staff McElwee said he worked on April 14, 2025, and he does not know what happened to cause Resident A's groin injuries. Staff McElwee stated another resident may have hit Resident A, but he does not know. Regarding Resident A's eye, he noticed Resident A's eye on April 25, 2025. Staff McElwee worked on April 23, 2025, and it was a good shift. Staff McElwee was off the following day, April 24, 2025. Staff McElwee stated Resident A's eye injury started out as a knot and then it shut. The medical coordinator came to look at Resident A and on April 26, 2025, Resident A was taken to the hospital. According to Staff McElwee, Resident A will bang his head however he does not hit his eye. Resident A is not a difficult resident, he does not hit others and is not aggressive with staff or his peers. Regarding Resident B, he is verbal and gets aggressive with staff and residents. There was an occasion when Resident B was massaging the shoulders of a resident, and the next moment Resident B had the resident in a headlock.

On April 28, 2025, I interviewed Staff Devaun Marsh who denied any knowledge of how Resident A obtained the injuries to his groin and back. Staff Marsh asked others about this, and no one ever gave him an answer as to how Resident A obtained the injuries. Staff Marsh did not know how Resident A obtained the black eye. Staff Marsh found out about the eye injury on April 25, 2025, as he received a message on his phone. Staff Marsh was asked how he thinks Resident A obtained the injuries and he stated Resident A sometimes hits his head on the door and he falls. Staff Marsh explained that Resident E has pushed Resident A before. Resident E can become aggressive if it is too loud in the home or if he wants to watch a television show and they cannot find the remote control.

On April 28, 2025, Resident B was interviewed at his home. Resident B appeared nervous as he walked slowly into the room and held his head down. Staff came into the room and assured Resident B he was not in trouble. Resident B was not sure how long he lived at Coldwater. Resident B does not like his home much and staff treat him well. Resident B is familiar with Resident A and Resident B does not know what happened to Resident A's eye. Resident B has not seen anyone hit or push Resident A. No staff have hit or pushed any residents at the home. Resident B denied he pushed or hit Resident A. Resident B denied any concerns.

On April 29, 2025, I received a picture from Kyle Whitman, Genesee County APS Investigator. The picture was of Resident A's black eye.

On May 5, 2025, I received a call from Kyle Whitman Genesee County APS Investigator who reported Resident A was attacked by Resident B on May 4, 2025. Resident B jumped on Resident A's head resulting in a 3mm brain bleed, fractured skull, and fractured jaw. Staff jumped in and the police responded to the home. Investigator Whitman provided a picture of Resident A. Resident A had a shoe imprint on the right side of his face and there was blood coming from Resident A's right ear. Resident A's black eye was still visible.

On May 5, 2025, I called Licensee Designee, Nicholas Burnett. I inquired as to what occurred over the weekend and what was being done to keep Resident A safe. Licensee Designee Burnett reported they are looking to move Resident B today or tomorrow and Resident A will have 1 on 1 supervision. Licensee Designee Burnett called back later to report Resident B would be moving to another facility the next day.

On May 20, 2025, I received a call from Kyle Whitman Genesee County APS Investigator who reported that on May 17, 2025, staff discovered Resident A in the bathroom with his legs crossed. Resident A was found unconscious in the bathroom. Resident A is at the hospital and had surgery. Resident A had an 8 mm brain bleed and there was a "brain shift" over the weekend. An MRI was conducted, and it was concluded that "the brain bleed was not healing" and it was 1cm. On May 27, 2025, Investigator Whitman called and stated he went to facility to see Resident A. Investigator Whitman learned that Resident A died today at the hospital.

On May 21, 2025, I reviewed Flushing Township Police Department reports. Case number 2540100281 documented that on April 18, 2025, Officer Greninger was assisted to investigate an Adult Protective Services (APS) Law Enforcement Notification (LEN). Information provided was that Resident A arrived at the hospital with groin pain, pelvic bruising, swelling, and abrasions to his tailbone. Resident A is noted to be a nonverbal autistic resident living at an assisted living facility and there are concerns he is being neglected and or abused by staff. Ashanti Skipper was interviewed and reported that she and her coworker located bruising on Resident A's right shoulder, left arm, and the front and back of Resident A's pelvic area. The bruising was described as black, purple, fresh. Photos were taken of Resident A's injuries, and he was sent to the

hospital. Skipper advised that she was told by management that they had spoken to third shift staff who stated Resident A had slipped and fallen as they were mopping the floor, which is how the injuries were sustained however there was no incident report written. Skipper stated she was suspicious of the events told to her however she did not have any firsthand knowledge. Officer Greninger interviewed second shift supervisor Makayla Schmock on April 24, 2025, via telephone. Supervisor Schmock was notified that Resident A had bruising on his pelvic region and was taken to the hospital for treatment. Supervisor Schmock was aware of bruising which was caused by another resident when Resident A was shoved. As for the new bruising, no one was able to provide any insight as to what happened. Officer Greninger asked about Resident A's fall, and Supervisor Schmock stated that she spoke to a Staff Braylon Daniel. Staff Daniel reported Resident A slipped when Staff Daniel was mopping the floor and he fell to the floor on his knees. Supervisor Schmock advised there was no report regarding this fall which is against protocol. Officer Greninger interviewed Staff Daniel, and he stated he was mopping and heard a noise behind him. Staff Daniel turned around and seen Resident A standing up from his knees after he had slipped. Staff Daniel did not see any marks or injuries and Resident A eventually returned to his room to go to sleep. The case was closed as there was no witnesses to any assault that may have taken place, and Resident A is unable to provide a statement.

Case number 2540100333 documented that on May 4, 2025, 12:25am there was an aggravated/felonious assault. The victim was Resident A, and his height was 4'10" and weight was 100 pounds. Suspect was listed as Resident B, and his height was 5'8" and weight was 170 pounds. The report documented that Officer Zach Palmreuter was dispatched to the home for an assault that just occurred. Upon the officer's arrival, Resident A was lying on the floor face up. Resident A was bleeding from his right ear and had a shoe print on the right side of his face. Resident B was locked in his bedroom. Resident A was transported to the hospital and Resident B spoke with Staff Eric Tobias. Resident B stated that he was upset that another resident was trying to leave. Resident B said he kicked Resident A when he got in his way. On May 5, 2025, Sergeant Hough contacted Resident A's guardian, Guardian A1 who reported Resident A was released back home from the hospital and Resident A suffered a skull fracture, brain bleed, and fractured mandible because of the assault. Guardian A1 will be having a meeting later today with Flatrock and Resident B will be moving from the home today. The police report documented that on May 21, 2025, Detective Daren Hawley contacted Resident B's guardian, Guardian B1. Guardian B1 reported Resident B had a history of violent tendencies and there was no other assisted living in the state of Michigan that would permit Resident B to live with them. Guardian B1 was aware of Resident B's violent past and stated Resident B was arrested several times for violent crimes. Detective Hawley was given consent to interview Resident B and Detective Hawley went to Resident B's new home for the interview. Detective Hawley noted that during the interview of Resident B he showed indications of deceit, appeared to intentionally slow his speech down, and act confused. Resident B stated he remembered when Resident A got hurt and stated "yeah, I stomped his head in." Detective Hawley asked why he did it and Resident B said he was done talking. The interview was concluded.

Case number 2540100372 documented that on May 17, 2025, at 3:34pm police responded to Coldwater for EMS assist. Officer Greninger was dispatched to the home for a medical complaint. The patient, Resident A, was unconscious. Officer documented that upon arrival he met with Resident A and staff members. Officer Greninger was advised that Resident A was taking a shower and was found by staff limp and unconscious but breathing. The staff brought him back to his room and called 911. Officer Greninger observed Resident A to be having some type of medical incident however because he is nonverbal no statement was obtained. Resident A was transported to the hospital via ambulance. Follow up was made with Resident A's guardian, Guardian A1 on May 20, 2025, by Detective Daren Hawley and Guardian A1 reported when Resident A was found he was seated in the shower with his legs appearing to be to have been in a crossed position. Resident A was slouched forward and unconscious but still breathing. It appeared he had guided himself down rather than fell into that position. As of that date, Guardian A1 reported that Resident A had 2 brain surgeries and had an 8mm brain bleed. Resident A had been unconscious since May 17, 2025, and there was concern that this injury was more severe than it was previously believed to be. The case status was listed at closed.

On May 28, 2025, I interviewed Staff Ishanti Skipper. Staff Skipper has been employed at the facility for 1 year. Staff Skipper reported she worked second shift on April 15, 2025, when her coworker, Derek Beelby discovered the bruises to Resident A's groin area. Staff Skipper stated that Resident A was just getting out of the shower when she was arriving for duty. First shift staff may have gotten Resident A in the shower, or Resident A may have gotten himself in the shower, but she was not sure. Staff Beelby was assisting Resident A with getting dressed in Resident A's bedroom. Staff Beelby came to Staff Skipper and said to come view Resident A. Staff Skipper saw bruising on Resident A's groin area, tailbone, and on the back of his left arm. Resident A's pelvic area looked the worst, by Resident A's penis area. There was a "black ring" on Resident A's groin and penis. The bruise was "horrifying", and it was large. The bruise was dark red, purple, and black and was throughout the entire groin area and penis. The bruise on Resident A's arm was red "almost like it was just starting". Staff Beelby reported the injuries to the medical coordinator and Resident A was taken to the hospital. Staff Skipper did not think Resident A was admitted to the hospital and believed he came back to the home on the same shift. Staff Skipper reported that the first shift staff on April 15, 2025, did not report anything about Resident A or the injuries. Staff Skipper does not know how Resident A sustained the injuries and no one has said what happened to him to cause the injuries. Staff Skipper stated that she thinks staff should have noticed the injuries to Resident A and staff were neglectful. Staff are to complete a body chart every day on every shift for Resident A and first shift staff did not do the body chart on April 15, 2025. Staff Skipper remembers this because she had to go get the form so 2nd shift could chart.

Regarding Resident A's black eye, Staff Skipper saw the injury, but she could not recall when. Staff Skipper asked her coworkers about Resident A's eye, and no one knew why it was swollen.

Staff Skipper further reported she was working on May 3, 2025, from 3pm-11pm. When Staff Skipper left the facility Resident A was sleeping, and Resident B and Resident C were awake. Third shift staff lead, Stephanie Borieo arrived for duty and Staff Skipper left the facility at approximately 11:10pm. According to Staff Skipper, Resident A displayed no behaviors, and he liked to grab you and walk with you. Resident A would hold staff's hand to take staff where he needed them to go. Resident A displayed no combative or aggressive behaviors. Regarding Resident B, Staff Skipper reported he was very combative and angry. Resident B was combative with staff and one time with a resident. Resident B tried to punch and kick others.

On May 29, 2025, I interviewed Staff Derek Beelby. Staff Beelby confirmed he was working on April 15, 2025, and he walked on duty at 3pm. Resident A was walking out of the shower, was naked, and Staff Beelby took him to Resident A's room to dry off. Staff Beelby observed bruises on Resident A's groin, back, and arm. There were bruises around Resident A's groin and pelvic area and Resident A's penis was also bruised. The bruising was black, purple, and yellow in color and the whole area was bruised. The groin area "looked really bad". On Resident A's backside, in the middle of his lower back was a yellow bruise almost a circle shape. It was bigger than a half dollar and it was clear that it was a bruise. On Resident A's elbow there was another bruise that was yellow, and it covered the entire elbow. Staff Beelby contacted the Medical Coordinator (MC) Eric Tobias, and second shift manager, Mikayla Schmock, and Staff Beelby was directed to take pictures of the areas and forward to MC Tobias and Manager Schmock. Staff Beelby was directed to take Resident A to the hospital, which was done, and he was at the hospital for the remainder of the shift. Resident A was not admitted, and Staff Beelby thinks Resident A returned to the home the following day between 3am-6am. The hospital doctor did not say much about what the problem was. Staff Beelby reported it looked like Resident A may have gotten kicked in the groin and "it looked bad, and it looked like it hurt." Staff Beelby asked first shift staff that worked on April 15, 2025, about Resident A's injuries, and no one said they saw them however the injuries were noticeable.

Staff Beelby was asked about Resident A's black eye, and he stated he came into work on April 24, 2025, and Resident A's eye looked fine. Around 4pm-5pm Staff Beelby noticed the right eye was "puffy" and as the shift went on the eye kept getting worse. By 7pm Staff Beelby noticed some bruising to Resident A's eye, so the medical coordinator and home manager were contacted. MC Tobias came to the home to look at Resident A's eye and instructed staff to watch it. Staff Beelby was not sure if Resident A was sent to the hospital, and he completed an incident report. No one could tell Staff Beelby what happened to Resident A's eye. Staff Beelby asked Resident B about Resident A's eye, and he said he did not see what happened. Staff Beelby stated that he does not know how Resident A obtained the eye injury. Staff Beelby explained on that day there were lots of staff from other homes working first shift at the Coldwater facility. Staff Beelby thought maybe staff harmed Resident A as he sets the alarms off and likes to get in the shower with his clothes on. Staff Beelby explained that Resident A would set off the door timer causing it to beep. Resident A would not go outside, and he just

wanted staff to come. Staff Beelby thought maybe staff got fed up with Resident A however he now believes Resident B harmed Resident A causing the injuries.

Regarding Resident A's injuries sustained on May 4, 2025, Staff Beelby was not working that weekend. Staff Beelby understood that one of the residents was eloping and Resident B stomped on Resident A. There were 2 staff on duty and the incident happened at approximately 12am. No residents required enhanced staffing at that time.

Staff Beelby was asked what extra precautions were put in place after Resident A began displaying unexplained injuries. Staff Beelby made the decision to increase supervision on his shift. Staff Beelby would watch Resident A around other residents in the home and when he was on the floor. This increased supervision of Resident A was something Staff Beelby did on his own accord, and he was not given this directive from anyone.

Staff Beelby reported that Resident A liked attention and "he was a great client". Resident A did not present lots of behaviors and was never aggressive. Resident A never hit staff or other residents. Resident A never grabbed other residents and kept to himself. Resident A did not bother other residents.

Staff Beelby stated that Resident B was his client for 2 months. Resident B was sweet at times and other times sour. Resident B displayed verbal aggression, physical aggression with staff, and property destruction. According to Staff Beelby, Resident A did not fit with the other clients at the home. Resident B was higher functioning and would have done better with other residents like him. The other 5 Coldwater residents do not interact and keep to themselves. Resident A was a good fit with the other residents (apart from Resident B) and there were never any issues with Resident A prior to Resident B moving into the home.

On June 2, 2025, I reviewed the Resident Register for Coldwater. Resident A moved into the facility on October 2, 2024; Resident B moved into the facility on February 6, 2025; Resident C moved into the facility on September 4, 2024; Resident D moved into the facility on September 11, 2024; Resident E moved into the facility on May 16, 2023; Resident F moved into the facility on June 23, 2023.

On June 2, 2025, I reviewed Resident A's *Individual Plan of Service* (IPOS). The plan revealed Resident A is 38 years old and severely cognitively impaired. Resident A is diagnosed with autism and is nonverbal. The IPOS documented that "staff will monitor Resident A's movement in shared spaces" and provide redirection when he attempts to enter other resident rooms or personal areas. I reviewed Resident A's *Assessment Plan for AFC Residents* which revealed Resident A is not always alert to his surroundings. The plan stated that Resident A "has great difficulty in identifying possible risks and dangers." Resident A is noted to typically get along with others "however, interactions are minimal due to minimal ability to communicate with others." Resident A "shows minimal interest in interacting with peers." I reviewed Resident A

Behavioral Treatment Plan which indicated Resident A "is unaware of how to assess and respond to dangerous situations to keep himself safe."

On June 2, 2025, I reviewed Resident B's *Assessment Plan for AFC Residents*. The plan indicated that Resident B is 21 years old and diagnosed with intermittent explosive disorder, post-traumatic stress disorder, severe intellectual disabilities. Resident B "is able to communicate his needs and wants verbally." Resident B "is able to understand when others are communicating with him." Resident B is noted to be alert to his surroundings. Resident A engages in behaviors that are harmful to himself and others. Resident B displays property destruction, physically aggressive behaviors, elopement, self-injurious behaviors, and impulsive behavior that places him and others at risk of harm. These behaviors have led to police contact and legal involvement. Resident B's legal history includes property destruction in January 2024, resisting/assaulting an officer in April 2024 resulting in jail time for one month, home invasion in August 2024 resulting in jail time for 5 days, assaulting a McDonalds employee in September 2024 resulting in jail time for 5 days. Resident B was discharged from Van Buren County jail on a PR bond, contingent upon him being placed outside the county.

On June 2, 2025, I reviewed Resident C's *Assessment Plan for AFC Residents*. The plan indicated that Resident C is 26 years old and diagnosed with autistic disorder and moderate intellectual disabilities. Resident C "is not able to communicate wants and needs fully. He has limited vocabulary and typically communicates with 1-4-word phrases. When he does speak, Resident C is hard to understand due to articulation challenges." Resident C "is alert to his surroundings but does not interpret risks and dangers in a reasonable manner. Resident C requires supervision and support of staff consequently. Resident C's safety skills especially in the community are very poor. Staff will provide supervision and assist him in remaining safe from dangers/risks."

On June 2, 2025, I reviewed Resident D's *Assessment Plan for AFC Residents*. The plan indicated that Resident D is 25 years old and diagnosed with autistic disorder and impulse disorder. Resident D "is vocal, but not verbal…" Resident D "is not able to remain safe and alert to his surroundings. Resident D requires total assistance to remain safe. Staff should be there to assist Resident D and redirecting him to another room/environment or safe place if danger is present."

On June 2, 2025, I reviewed Resident E's *Assessment Plan for AFC Residents* which revealed Resident E is 23 years old. The plan indicated that Resident E is diagnosed with autistic disorder, moderate intellectual disabilities, and attention-deficit hyperactivity disorder, predominantly inattentive type. It is noted that "due to cognitive limitations…Resident E has great difficulty in identifying possible risks and dangers." Resident E's "interactions are minimal due to minimal ability to communicate with others." Resident E "shows minimal interest in interacting with peers." I reviewed Resident E's *Behavioral Treatment Plan*. Resident E is nonverbal and unable to communicate his wants and needs. Resident E "is not aware of his surroundings; he is not cognizant of others in his environment or potential dangers that may arise."

On June 2, 2025, I reviewed Resident F's *Assessment Plan for AFC Residents* which revealed Resident F is 20 years old. The plan indicated that Resident F is diagnosed with autistic disorder, cerebral palsy, and moderate intellectual disabilities. Resident F "can verbally communicate using 1-syllable words." It is noted that Resident F "…can sometimes be aware of his surroundings, but other times is not. Staff should be there to assist Resident F and redirect him to another room/environment or safe place if danger is present."

On June 2, 2025, I reviewed Resident A's *AFC Licensing Division – Incident / Accident Report* (IR) from the time he began residing at Coldwater on October 2, 2024:

On December 16, 2024, at 3:05pm staff noticed 3 superficial scratches Resident A's left arm near his elbow. Staff administered first aid. Corrective measures included staff to maintain increased supervision of Resident A for the duration of shift.

On February 7, 2025, at 11am staff noticed a scratch at the crown of Resident A's head. Staff provided first aid. Corrective measures included staff continuing to observe and monitor Resident A to ensure his safety and document findings if necessary.

On March 19, 2025, at 8pm staff were administering Resident A his medication. Resident A was asked to sit up in bed. Staff noticed dried blood on his pillow where he rested his head. Staff checked Resident A's ear, and it was bleeding. Staff cleaned the area and applied wound care. Corrective measures were staff will continue to monitor Resident A for health and safety.

On April 13, 2025, at 4pm staff noticed a mark on Resident A's back above his tailbone. Resident A was transported to urgent care and it was reported Resident A had an abrasion. Corrective measures were that staff will continue to provide supervision for health and safety.

On April 15, 2025, at 4:30pm staff was helping Resident A get dressed and noticed swelling and bruising to his groin. Staff checked Resident A for further injury and noticed a bruise on Resident A's elbow and back. Resident A was transported to urgent care and then to the hospital emergency room. While at the hospital Resident A was given a Ct scan of pelvis and labs was taken. Corrective measures were that staff will continue to provide supervision for health and safety.

On April 24, 2025, at 7:40pm staff noticed Resident A's eyebrow area was swollen. The medical coordinator came to the home and inspected Resident A's eye. Staff were directed to provide Resident A allergy relief medication and closely monitor the area for changes. At 10:15pm staff noticed bruising under the eyebrow and the medical coordinator was notified. Corrective measures were that staff will continue to provide supervision for health and safety.
On April 26, 2025, at 8:20am, staff arrived on shift and was instructed to transport Resident A to get eye examined. Resident A was transported to urgent care, and they advised staff to put an ice pack on the eye and recommended a scan completed to

ensure nothing was fractured or broken. Mobile X-ray came to the home and completed a scan with no findings. Corrective measures were that staff will continue to provide supervision to ensure health and safety.

On May 4, 2025, at 12:25am staff walked into the building at observed peer attacking Resident A. Staff immediately ran to incident and used blocking technique to separate peer. Staff was on the phone with on-call support and was directed to call 911. EMS and the police arrived, and Resident A was transported to the hospital. Test findings included stable 3 mm thick left parietal subdural hemorrhage with no underlying mass effect, small subdural hematoma located along the left parietal convexity, small area of hypodensity located about the right parietal lobe deep white matter, moderate right preseptal soft tissue swelling superiorly which propagates in the frontal scalp. Corrective measures were that staff will continue to provide supervision for Resident A's safety.

On May 17, 2025, at 3pm Resident A was in his bedroom laying in his bed. Upon staff going into his room to do a welfare check staff found Resident A to be unresponsive. Resident A was breathing but his body was limp and not responding to sound. Resident A's vitals were taken, and the medical coordinator was contacted. Staff were instructed to call 911 and at 3:47pm Resident A was transported to the hospital. Corrective measures were that staff will continue to monitor Resident A for health and safety.

On May 27, 2025, at 10:27am staff were informed Resident A passed away.

On June 2, 2025, I reviewed Resident B's *AFC Licensing Division – Incident / Accident Report* (IR) from the time he began residing at Coldwater on February 6, 2025:

On February 11, 2025, at 4pm Resident B expressed to staff his need to go on an outing. Staff told him he needed to wait for lead to return from a meeting. Resident B became upset leading to verbal aggression. Resident B was redirected but that did not work, and Resident B began kicking and hitting the wall with staff utilizing blocking techniques and body positioning. Resident B pushed staff and charged staff. Staff called for assistance and continued to validate Resident B. Lead staff returned from the meeting and Resident B walked out of his room. Resident B began lightly punching the glass door expressing his desire to go on an outing. Staff used body positioning techniques which were successful and Resident B calmed down and went to his bedroom. Resident B became verbally aggressive again and threatened to beat up and choke male staff. Resident B spat at the male staff and got up to hit him. Resident B attempted to bite staff and staff utilized outside/inside technique. Staff prompted Resident B to complete deep breathing and listen to music which was successful. Around 6pm Resident B told staff his finger and wrist hurt from punching the wall. Resident B was transported to the hospital for examination and diagnosed with left wrist sprain. Corrective measures include staff will closely monitor Resident B to ensure health and safety.

On February 14, 2025, Resident B became aggressive towards a male staff member displaying verbal and physical aggression including yelling, punching, and kicking. Another resident hit Resident B triggering an aggressive episode. Resident B went to his room and began damaging a vent and expressed self-harm intentions. Resident B calmed down for a short period and attempted to hit and bite staff. Corrective measures include staff will continue to monitor Resident B and follow up with BCBA for better coping skills strategies.

On February 16, 2025, at 4:40pm Resident B was listening to music then got up and was walking toward his room. Resident B kicked a laundry basket and pushed his chair into the wall causing a hole. Resident B pushed staff, began hitting staff, and tried to bite staff. Physical intervention was utilized until Resident B calmed down. Staff would closely monitor Resident B for the remainder of the shift to ensure health and safety.

On March 6, 2025, at 2pm Resident B asked staff to leave his room as he was going to do property damage. Resident B was upset that he could not be left alone by himself. Staff reminded Resident B of his goals and that he is a 1 on 1 for a reason. Resident B kicked his window, and the outside glass shattered. Staff attempted to redirect Resident B and use blocking techniques. Corrective measures include reminding Resident B of his goals, prompting Resident B to use coping skills, and closely monitoring of Resident B for his health and safety.

On March 15, 2025, at 3:45pm Resident B began to threaten staff. A second staff came to Resident B's bedroom and Resident B began to curse at staff and hit staff. Resident B punched staff in the face and tried to bite staff. Physical intervention was utilized until Resident B was calm. Corrective measures were that staff would continue to provide 15-minute welfare checks for remaining of shift to ensure health and safety of Resident B.

On April 6, 2025, at 3:15pm Resident B began hitting and kicking doors and walls. Resident B flipped over a couch and walked into another room. Staff followed Resident B and Resident B threatened staff telling them to leave him alone or he would hit them. Another resident followed staff and Resident B started to go after the resident. Staff used blocking techniques to prevent Resident B from hitting his peer and Resident B punched staff in the back. Resident B broke a window saying he would jump out. When staff tried to intervene, Resident B tried to attack his peer. Staff put themselves in between Resident B and his peer. Resident B pulled a 4-foot-long piece of metal off the radiator and swung it at staff's face to keep them away. Resident B eloped from the facility and walked down the side of the road with staff following behind. After 10 minutes, Resident B began walking back to the home. Resident B ran ahead to the facility and when staff caught up to him, he reported he had broken out the back window of staff's car. Resident B told staff to leave him alone or he would throw a rock at their head, choke them out, and hit them. Resident B picked up a rock and threw it at staff's windshield, cracking it. Resident B picked up another rock and threw it at staff's head then at the front door trying to break the glass. Another staff arrived at the facility and Resident B started to move towards that staff's car saying he would break out their

windows too and then the facility van. Staff called the police and Resident B wanted to go back inside the facility. Staff told Resident B he needed to be safe and stop attacking peers and staff to which Resident B agreed. Once in the home, Resident B went to his bedroom for one minute and came back out and went after another resident in the living room. Staff attempted physical management which was unsuccessful and Resident B went after another peer who was sitting at the dining room table. Resident B hit his peer in the back. Another resident became triggered that Resident B was attacking people, and the resident began to attack Resident B. Physical management was utilized for both peers and Resident B shook free and started threatening staff more. Resident B punched staff and staff attempted physical intervention and was unsuccessful. Resident B attempted to hit a peer again and staff physically intervened. Police arrived and Resident B stopped fighting. Resident B spoke with the police and promised not to attack staff or peers anymore. Resident B was calm the remainder of the shift. Corrective measures include reminded Resident B of his goals, continue to closely monitor resident for health and safety. Staff will work with BCBA to strategize better coping skills techniques.

On April 19, 2025, at 1:45pm, Resident B was upset with a peer as he thought the peer was going into his room. Resident B stood on his bed and pulled the ceiling light fixture out. Resident B threw the fixture outside his window. Corrective measures were that staff would continue to provide supervision to ensure health and safety.

On April 19, 2025, at 2:45pm, Resident B was standing on his bed attempting to rip down the ceiling tiles due to being agitated that another peer entered his room. Staff stated he was going to hurt himself and staff and was trying to peel light covers off causing an injury to his fingers. Resident B was transported to the hospital. Corrective measures were that staff will continue to provide supervision for Resident B to ensure health and safety.

On April 19, 2025, Resident B started becoming verbally aggressive towards peer and staff. Resident B began to jump on bed and pulled down ceiling tile. Resident B started being physically aggressive towards staff and staff physically managed Resident B. Resident B continued to be aggressive, and he found a loose screw in his room. Resident B tried to attack staff while saying “I am going to shank you”. Corrective measures were that staff will continue to provide supervision for Resident B and work with BCBA to strategize other coping skills.

On April 21, 2025, at 9:30am Resident B was informed he had an appointment and stated he did not want to go. Staff prompted Resident B 10 minutes later that he should get ready for his dental appointment and Resident B stated he was not going. Staff attempted to explain to Resident B the importance of dental appointments and Resident B stated he would assault the dentist if he attended appointment. The medical coordinator advised staff not to take Resident B to the appointment due to the threat he made. Corrective measure was that dental appointment would be rescheduled.

On April 28, 2025, at 7:30pm Resident B began to threaten peer with physical violence while in the van. The other peer hit Resident B, and staff redirected the resident out of the van. The 2 residents were separated and staff attempted to speak with Resident B. Resident B said he wanted to hurt his peer. Staff took Resident B on a 5-minute walk and after the walk Resident B said he was fine and wanted to go inside. Once inside Resident B started to threaten his peer again and went after the resident trying to hit him. Resident B said he was going to kill the peer. Staff physically managed Resident B and Resident B went to his room to listen to music. After 5 minutes Resident B came out and broke a handle off a laundry basket and tried to go after the peer again. Staff physically managed Resident B and he complied with handing staff the handle when they asked. Corrective measures were that Resident B was reminded of goals and to continue to closely monitor for health and safety.

On May 4, 2025, at 12:25am staff was outside the door dealing with another resident's elopement. Resident B became agitated with peer setting off alarms. Resident B began to kick and bang on exit door trying to get out. Staff held the door shut so Resident B could not get outside. Resident B said if he could not get out, he was going to hurt a peer. Staff immediately went inside and saw Resident B attacking peers face causing bleeding and bruising to the peer's ear and face respectively. Staff used blocking technique to get in front of peer. Resident B ran through the exit door and staff informed on-call of Resident B's elopement. Corrective measures were that staff will continue to provide supervision and work with BCBA to strategize better coping skill techniques.

On May 4, 2025, at 3am, Resident B came into the kitchen with a smashed pop can with a sharp edge in his hand. Staff asked Resident B if they could discard the can, and he said no. Resident B started to scratch his wrist and said if staff came close, he would stab staff. Staff called on-call support and followed Resident B back to his room. Support staff arrived and provided staff with the can. Corrective measures were that staff will continue to monitor and provide supervision for health and safety.

On June 2, 2025, I interviewed Detective Daren Hawley from Flushing Township Police Department. Detective Hawley reported he is conducting a homicide investigation, and he can confirm an assault took place. The aggressor is in custody and being housed at the Genesee County Jail. Detective Hawley has been in contact with the medical examiner and there is no update as to cause and manner of Resident A's death. Detective Hawley advised he could not release any other information at this time.

On June 3, 2025, I interviewed Joy Dempsey, Autopsy Assistant from the Genesee County Medical Examiner's Office. Assistant Dempsey confirmed Resident A's date of death as May 27, 2025, and an autopsy was completed. Dr. Brian Hunter conducted the autopsy, and it is "pending" for cause and manner of death. Resident A died while a patient at Hurley Hospital. Dr. Hunter is awaiting additional information and the timeframe for the autopsy to be complete is 4-6 months. I asked Assistant Dempsey to leave a message for Dr. Hunter to return my call.

On June 3, 2025, I interviewed Kyle Whitman, Genesee County APS Investigator regarding his investigation involving Resident A. Investigator Whitman reported he substantiated neglect on the facility and physical abuse against Resident B. Resident B is in jail with an upcoming court date on June 12, 2025, and bond was revoked.

On June 3, 2025, I interviewed Makayla Schmock who reported she is the first shift home manager at Coldwater. Manager Schmock reported she manages 3 different homes and rotates each day. Each day she goes to each facility. Manager Schmock has been employed at the facility since November 2024. Regarding the injuries to Resident A's pelvic area, second shift staff told her about the injuries and Staff, Derrick Beelby called to report the bruises to her. Manager Schmock arrived at the home within 30 minutes, and she viewed the injuries. Manager Schmock did not recall looking at Resident A's back. Resident A's pelvic area was dark blue and purple, and the bruising was about 6-7 inches across the pelvic area. The bruises "looked bad" and she said, "that's not normal." The medical coordinator may have come to the home and the medical team decides to send Resident A to the hospital. Manager Schmock does not recall who made the decision to send Resident A to the hospital however he was sent. Manager Schmock does not know what Resident A was diagnosed with at the hospital.

Manager Schmock conducted an inquiry of staff to determine what happened to Resident A and she reported second shift staff noticed the pelvic injuries. Manager Schmock called first shift staff, and they did not know what happened to Resident A. Third shift staff said Resident A fell on his knees and got right back up. The staff person did not report this fall to anyone and did not document the fall on an incident report (IR). Manager Schmock did not think the pelvic injuries were the result of Resident A falling on his knees. Manager Schmock had no explanation for the injuries to Resident A's back or pelvic area. Manager Schmock did not know happened to Resident A and did not think staff caused the injuries to Resident A. According to Manager Schmock, staff are very caring, and she does not believe staff would injure Resident A. Manager Schmock reported Resident B could have caused the injuries given what occurred on May 4, 2025.

Manager Schmock was asked about Resident A's black eye. Manager Schmock reported she was not working at the time however she was told Resident A had a black eye. Initially, no one knew how Resident A obtained the black eye. Resident B admitted to the police he hit Resident A in the eye. Manager Schmock talked with Resident B, and she asked him why he hit Resident A in the eye, and he said he was mad. To Manager Schmock's knowledge, no one witnessed Resident B assault Resident A causing the black eye.

Regarding the events that took place on May 4, 2025, Manager Schmock was not working at that time. The medical coordinator "got the call and informed the team". Manager Schmock stated that Resident C was trying to elope on third shift. Resident B was awake and pushed Resident A to the ground. Resident B had his shoes on and started kicking Resident A in the head. Resident A was sent to the hospital and

diagnosed with a “minor brain bleed.” The hospital did not admit Resident A according to Manager Schmock.

Manager Schmock reported that couple days after Resident A being injured on May 4, 2025, Flatrock Clinical Director Patty Lee gave the order for Resident A to have “emergency 1 on 1”. This consisted of 1 on 1 supervision 16 hours per day during waking hours and 15-minute checks during sleeping hours. Staff were to see Resident A breathing and check for breathing. The 1 on 1 staffing was not discontinued.

Manager Schmock was asked about events that occurred on May 17, 2025. Manager Schmock stated Resident A was in his bedroom lying in bed and his emergency staff was with him. Resident A was breathing but not responding. Staff called the medical coordinator, and the medical coordinator directed staff to call 911. Manager Schmock did not know anything about Resident A being in the shower area when found unresponsive. During showers, Resident A would stand under the water and staff would assist with washing him.

Manager Schmock reported she knew Resident A since 2018, when Resident A lived at a different facility. Resident A was nonverbal, liked puzzles, and watching his tablet. Resident A did not interact with other clients and kept to himself. Resident A was not aggressive and there were times when Resident A would hit himself with his fist however it was just a tap of the head. Resident A did not bang his head at Coldwater. Resident A would put his forehead on the door and look at staff for their attention. Resident A would ball his fists and tap his forehead and not actually bang his head. Resident A would set off the door alarms for attention and not to elope from the facility. When the alarm would sound, Resident A would turn and walk away. Resident A may have liked the sound of the alarm.

Manager Schmock reported Resident B moved into Coldwater within the last 2 months. Resident B was verbal and could communicate well. Resident B had a “sensory need” and liked deep squeezes to his arms. Resident B started to display aggression toward staff and sometimes he would verbalize it. Resident B would try to hit staff, and staff would block Resident B’s attacks and try to talk to him. Resident B would say “I’m going to punch you” or “I’m going to beat you up” and then try to punch staff. Sometimes Resident B could explain what was upsetting him or say, “I’m angry”. Other times Resident B did not verbalize things and there were certain staff Resident B preferred. According to Manager Schmock, Resident B did not match the other residents in the home. Coldwater was a low functioning home and Resident B was not low functioning. Manager Schmock told management that Resident B was not a good fit for the home and Resident B said he wanted to move to another home where there were residents he could talk to. Coldwater residents liked to be in their bedrooms or on a tablet. Manager Schmock reported she told the “clinical team” which consisted of the occupational therapist and behavior analyst, about a month and a half after Resident B moved to the facility that the home was not a good fit for Resident B. Manager Schmock noticed that Resident B would associate more with staff than residents. Manager Schmock thought another Flatrock facility in Flushing would be a better fit for Resident B however they

needed approval. Resident B discussed the issue of wanting to move with his case manager also.

On June 4, 2025, I interviewed Staff John Jones who used to be lead staff on first shift. Staff Jones no longer works at the Coldwater facility and now does maintenance/lawn care for the company. Staff Jones was interviewed about the allegations and Staff Jones remembered Resident A's initial injuries. One day Resident A had no injuries and the next day he was told Resident A had injuries. Staff Jones often showered Resident A and he never seen Resident A with bruises. Staff Jones seen pictures of Resident A's back and there was a red mark near his waist. Staff Jones was told about Resident A's pelvic area and he seen the injuries the next time he showered Resident A. Staff Jones does not know how Resident A obtained the injuries to his back or pelvic area, and no one told him how Resident A was injured. Everyone was confused as to how Resident A was injured. Staff Jones was asked what he thinks happened to Resident A and he said maybe Resident A was laying on his back causing the mark on his backside. As for the groin injury, Staff Jones did not have any explanation. Staff Jones did not think staff on his shift mistreated Resident A causing the injuries. Staff Jones reported that another resident could have caused the injuries to Resident A however not on his shift. Resident B was a new resident that recently moved to the home, and Resident B would say what Resident B was going to do. Resident B knew what staff will do their job and the ones that did not. Resident B was the only high functioning resident who resided at the home and the remaining residents were nonverbal. Resident B targeted weaker clients and Resident B would not behave that way when Staff Jones was working. Staff Jones explained that there was an occasion when things were fine at the home when he worked first shift. Staff Jones left work at 3pm and then at 3:15pm he received a message that Resident B was having a behavior. According to Staff Jones, Resident B knew what he could get away with. Staff Jones stated Resident B was not a good fit for the home and "he liked to be active and doing stuff". Resident B would get bored and did not understand why he was placed at Coldwater. Resident B could not talk to anyone or have a full conversation with any of the other residents. Staff Jones stated him and other first shift staff agreed with this assessment of Resident B. Staff Jones told managers and other lead staff at meetings, and everyone knew Resident B was having difficulties at the home. All staff, managers, and leads talked about it and upper management said it was not their decision. They could not control the placement and would "tell the higher ups".

Staff Jones reported Resident B destroyed property, broke windows, and kicked the walls. Resident B targeted residents and he hit Resident A prior to Resident A's first unexplained injury. Resident B would get mad and "go after the weaker" clients. Staff Jones stated Resident B targeted lower functioning residents, those not capable of defending themselves. Staff Jones stated he believed everyone knew Resident A was Resident B's main target. Staff Jones stated when Resident A obtained the black eye he had already been transferred from the facility. Staff Jones saw a picture of the black eye as he was still in a staff group chat, and he did not know how Resident A obtained the injury. Staff Jones believed some staff were afraid of Resident B and they may have not intervened. Staff may have not done what they were trained to do. Staff

Jones would tell Resident B “You’re not going to do that” when he engaged in problematic behaviors. Resident B wanted attention and Resident B said he wanted to go to the other house so he could talk to people. Staff Jones denied there were safety measures enacted when Resident A had unexplained injuries.

On June 5, 2025, I interviewed Nikita Smith, first shift lead staff. Staff Smith reported she no longer worked at Coldwater and stopped working at the home about 1 month ago. Regarding Resident A’s initial injuries to his back and groin area, she worked first shift on April 16, 2025, after second shift staff had already discovered the injuries the day prior. Staff Smith saw Resident A’s pelvic/groin area and it was swollen, purple and blue. Resident A’s entire groin was discolored and “it looked awful.” Staff Smith could tell the area was swollen as she was helping Resident A with a shower. Resident A also had a bruise/scratch that was oval. The mark was reddish in color on his back near his buttocks. No one told Staff Smith how Resident A obtained the injuries, and she still does not know what happened to Resident A. Staff Smith was asked if any safety measures were put in place after Resident A had these unexplained injuries and she stated staff were to do more checks of Resident A and he was given pain medication. Staff Smith reported she was not working when Resident A obtained his black eye. Staff Smith came back to work and observed Resident A had a black eye and there were bruises on Resident A’s face. Staff Smith found out Resident A was attacked by Resident B on a chat message. Resident A was put on 1 on 1 staffing until they moved Resident B from the home. Resident A continued the 1 on 1 when Resident B was moved from the home and Staff Smith stopped working at the facility.

Regarding Resident A, Staff Smith reported Resident A was clingy and wanted a mom-figure. Resident A wanted someone to be around, and he was not aggressive at all.

Staff Smith stated that Resident B was “totally out of place” at Coldwater and she informed supports staff including the manager, administration, and the medical coordinator. The response she received was “that’s where they put him”. Staff Smith was never provided an answer as to why Resident B was placed at Coldwater, and she was not sure if another placement was being sought for Resident B. According to Staff Smith, the other residents distanced themselves from Resident B. Resident B was out of place, and he was different from the other residents. Resident B liked listening to music and wanted attention. Resident B said he did not want to live at the home. Resident B was easily triggered and when bored he would exhibit a behavior. Resident B would become aggressive with staff and would punch, kick, and pull staff’s hair. Resident B would “nit-pick” at other residents and would motion like he was going to hit clients. Resident B would do things he knew other residents did not like and cause them to have a behavior, which would trigger Resident B more.

On June 5, 2025, I interviewed Derek Scroi, Resident A’s Case Manager from Livingston County. Case Manager Scroi had been Resident A’s case manager for one year. Case Manager Scroi reported that he saw Resident A’s bruise on his back, and it looked like it was healing. It was about the size of a half dollar. Staff said maybe Resident A fell and staff did not have a clear answer as to what happened to Resident

A. There was a meeting to discuss Resident A and Clinical Director from Flatrock, Patty Lee said Resident A bruises easily and the bruises may be self-inflicted. Manager Scroi was asked if any safety measures were put in place after Resident A's unexplained injuries and he stated the home was doing skin checks. 1 on 1 supervision was discussed at the meeting however 1 on 1 supervision was turned down. Case Manager Scroi went to the home again when Resident A had a black eye. Resident A did not appear to be doing well, and staff had no answer as to how Resident A obtained the black eye. The black eye was big, and it appeared as if Resident A got hit in the face or he was in a fight. There was another meeting and Director Lee said Resident A has a history of taking certain medications that cause bruising. Case Manager Scroi did not think Resident A caused the injury to his eye. Case Manager was asked what safety precautions were put in place after Resident A's black eye and he stated more staff monitoring however no 1 on 1 supervision.

Case Manager Scroi reported that after Resident A was stomped by Resident B on May 4, 2025, Resident A was not in the hospital long for the head injury and Resident A was put on a 1 on 1 until Resident B was moved from the home. Resident A returned to the hospital on May 17, 2025, and it was discovered that Resident A had an 8mm brain bleed and he required surgery. A CT scan was completed, and things were not healing correctly. Resident A had many seizures and needed another surgery however he is unsure if Resident A made it to the second surgery.

Case Manager Scroi reported that when Resident A moved into the Coldwater home in October or November 2024, things were going well. After Resident B moved into the home, Case Manager Scroi heard from staff and other case managers that he was aggressive and making threats. When Resident A started having unexplained bruising there should have been better monitoring of Resident A. Case Manager Scroi stated he wished he would have done more at the meetings and Patty Lee did not want to put Resident A on enhanced staffing citing his history or bruising.

Case Manager Scroi reported he has worked with Resident B in the past and is aware of his history. He talked with his supervisor about Resident B being in the same home as Resident A and he thought it was odd. Resident B is verbal and Resident A and Resident B were not on the same level. Resident B was "pretty aware", and Case Manager Scroi did not feel like the home was a good fit for Resident B. Resident B is higher functioning and had different abilities than Resident A. Resident B was able to express his needs and wants and can play sports. Case Manager Scroi was not sure why Resident B was allowed to live in the home given his history.

Case Manager Scroi described Resident A as high energy and liked Disney. Resident A loved to watch Disney movies on his I-Pad. The interview was concluded as Case Manager Scroi became upset and was unable to continue. I told him he could call me back the following day.

On June 5, 2025, I interviewed Staff Braylon Daniel. Staff Daniel works 3rd shift at Coldwater and has been employed at the facility since September 2024. Staff Daniel

was asked about the injuries to Resident A's groin area, and he stated he never knew what happened. A coworker brought the injuries to his attention, and he received a call from Mikayla Schmock on April 15, 2025, around 5pm. Staff Daniel stated that Resident A often took his clothes off and he did not see any injury to Resident A. When Staff Daniel eventually saw the injury after being told about it "it was so bad". Resident A's groin area was purple and swollen. Staff Daniel explained that when he working the midnight shift on April 14, 2025, he heard something behind him. Staff Daniel turned around and saw Resident A getting up from the ground. Staff Daniel was not sure if Resident A put himself down however Staff Daniel thought Resident A fell. Resident A was getting up from his knees and Resident A did not appear hurt. Resident A had on a t-shirt and underwear and Staff Daniel did not see his groin area. Staff Daniel did not think Resident A's groin injury was the result of Resident A falling on his shift. Staff Daniel thought something else happened to Resident A and he thought it happened on first shift. Staff Daniel did not complete an IR for this incident as he did not know he was supposed to, and he did not see Resident A fall. Staff Daniel did not believe staff harmed Resident A. Staff Daniel explained Resident A is not aggressive and is the opposite of confrontational. Staff Daniel thought Resident B may have harmed Resident A. Staff Daniel stated that when Resident B first moved into the home he started to act out and have behaviors. Resident B would attack staff, and he put Resident D in a head lock. Resident B tore down his ceiling because he was bored. Resident B would target certain residents, and he targeted Resident A and Resident D the two least confrontational residents. Staff Daniel reported Resident B should have stayed a 1 on 1 and Staff Daniel was not sure why he was taken off the enhanced staffing.

Regarding Resident A's black eye, Staff Daniel reported he walked on shift and second shift staff showed him Resident A's black eye. Resident A's eye was closed and purple. No one knew how Resident A received the black eye. Staff Daniel did not believe staff caused Resident A's black eye and he does not know how Resident A obtained this injury. Staff Daniel explained he never saw such a serious injury like that. Staff Daniel was asked if there were any safety precautions taken upon Resident A obtaining a black eye and he stated staff were to do body charts, which they had already been doing, and staff were to take pictures of bruises. It was routine for Resident A to have body charting done however it was being enforced, and they wanted to stay on top of it. Staff Daniel did not know who gave this directive.

Staff Daniel was asked about the incident that occurred on May 4, 2025, when Resident A was assaulted by Resident B. Staff Daniel denied any knowledge of the incident. Staff Daniel did have to meet with staff at the hospital.

Staff Daniel was asked about time Resident A was found unresponsive on May 17, 2025. Staff Daniel stated a female staff person whose name he could not recall found Resident A in the shower. Resident A was found by a second shift employee, and he had to go relieve her at the hospital. Resident A was admitted so Staff Daniel did not have to stay at the hospital. The female employee explained she found Resident A unresponsive in the shower. The female staff came in early and was checking on the

residents. She found Resident A on the ground, and she did not say if anyone moved Resident A from the shower area or not.

Staff Daniel stated Resident A liked to set off the alarms however not to elope. Resident A just walked around and tried to get in the kitchen for snacks. Resident A was not irritating, and he did not do anything to anyone. Resident A never hit anyone, and he was “in his own world”.

Staff Daniel stated Resident B was social and was the only resident in the home who could talk. On bad days, Resident B was overwhelming and would threaten staff. Resident B did not always tell the truth and would not tell everything that happened. Resident B never hit Staff Daniel however Staff Daniel heard Resident B would try to hit staff and do things to the residents. Resident B put Resident D in a headlock and Resident A was Resident B’s “main target”. Resident B pushed Resident A down before and Staff Daniel kept hearing Resident B was aggressive. Staff Daniel denied he was afraid of Resident B, but he believed other staff were afraid of Resident B. Staff were not used to being threatened by a resident and the residents who lived at the home did not have many behaviors. Resident B was aggressive, and no other residents were aggressive. The home was calm prior to Resident B moving into the facility and according to Staff Daniel, Resident B was not a good fit for the home given the other residents that resided there. Staff Daniel thought after 2 weeks of Resident B’s arrival that maybe he needed to go to another home. Staff Daniel reported Resident B said he had no one to talk to because none of the other residents could talk to him. Resident B reported to Staff Daniel he was bored and had nothing to do. The other residents do not interact with each other and are low functioning. Resident B was not low functioning. Staff Daniel believed Resident B to be lonely and bored.

On June 6, 2025, I interviewed Malik McClure, Coldwater 3rd shift staff. Staff McClure has worked at Coldwater since January 2025 and works from 11pm-7am. Staff McClure reported that there are 2 staff that work on 3rd shift. Staff McClure reported he worked 3rd shift on April 11, 2025, and April 12, 2025. Staff McClure did not work any other days in April 2025. Regarding the injuries to Resident A’s back and groin, Staff McClure reported that the home manager, Casey Young called him on April 15, 2025, and informed him of the bruises and asked if he knew how Resident A obtained them. Staff McClure advised he did not know anything about the injuries to Resident A or how he obtained them.

Regarding the incident that occurred on May 4, 2025, Staff McClure was working and walked in at 10:55pm. Second shift staff was still there and then left. Staff McClure was working with one other Staff Stephanie Borieo. According to Staff McClure, residents started coming out of their bedrooms. Resident C started destroying his bedroom and Staff McClure tried to calm him down. Resident A woke up and set off the door alarm. Resident B was up and said he was trying to go to sleep. Resident B pushed Resident A and Staff McClure told Resident B not to push Resident A. Staff McClure told Resident B Resident A “does not understand like you”. Resident C got agitated again and was trying to get out the back door. Staff Borieo went to block the

door however Resident C got the door open and ran out of the home. Staff McCure was also trying to keep Resident C in the home, but he got out and Staff McCure went after Resident C. Resident C went into a neighbor's yard and tore down a bird house and started crying. Staff McClure believed Staff Borieo was in the home and Staff McClure heard a noise. Staff McCure then seen Resident B walking around outside. Staff McClure had Resident B and Resident C outside walking with them and trying to keep them calm. Staff McClure was talking with Resident B and tried to get him to go back in the home. Resident B said he did not want to go back in the home and at that time the medical coordinator, Eric Tobias pulled into the driveway. When Staff McCure re-entered the home, Resident A was on the ground bleeding from both ears. Staff Borieo said that Resident B said "I'm gonna hurt someone if you don't let me out this door." Staff McClure stated everything happened so fast. Staff McClure stated 911 was called and police and the ambulance came. Resident A was transported to the hospital and Staff McClure followed Resident A to the hospital. Resident A had to be restrained at the hospital, and Staff McClure told hospital personnel Resident A was "like a child". At 8:30am, Staff McClure left the hospital, and another staff person relieved him. Resident A returned home 2 days later and still had a footprint on his face. Resident A and Resident B did not have any enhanced staffing prior to this incident but after this injury, Resident A required 1 on 1 staffing including when he was sleeping. Staff McClure reported Resident B had 1 on 1 staffing when he first moved into the home. Staff McClure confirmed 2 staff work on 3rd shift at Coldwater.

Staff McClure described Resident A as wanting attention. Resident A "wants to hold your hand". Resident A liked Beauty and the Beast and was "like a toddler".

Staff McClure was asked if Resident B was aggressive, and Staff McClure stated it depended "on who it is." According to Staff McClure, Resident B would pick on weaker or smaller people, staff and residents. Resident B would "pick on" smaller people and threaten them. Resident B was "a talker" and would say "I'm going to break your face" and other violent things. According to Staff McClure, Resident B was not a good fit with the other residents who resided at Coldwater. Resident B "was too advanced" and he could talk and none of the other residents could not talk. Resident B could lie, and the other residents could not. Resident B was smart and "too advanced to be in the home."

On June 6, 2025, I interviewed Haley Urah, Resident B's Case Manager from Genesee County Community Mental Health Authority. Case Manager Urah explained that she has been Resident B's Case Manager since March 26, 2025. Resident B had been living at Coldwater since that time and Resident B is from Berrien County. Berrien County is paying for services for Resident B. Resident B also had a case manager from Berrien County, Andrew Mahler. Case Manager Urah reported Resident B is currently in jail and she cannot provide services to Resident B while he is in jail. Case Manager Urah is aware that an assault happened, and Resident B's guardian told her Resident B was arrested in connection with the assault. Case Manager Urah has no other clients at Coldwater, and she met with Resident B one time at the facility. Case Manage Urah stated she was very new to Resident B, and he never showed any aggression toward her. Case Manager Urah did not push Resident B "too hard", and they had "surface

level conversation." Resident B seemed lonely and the other residents that lived in the home were nonverbal. Resident B seemed to want attention and others to talk to. The medical coordinator said they wanted to move Resident B to a home with more verbal residents. Case Manager Urah was aware of Resident B's history including his history of aggression. Case Manager Urah reported she was debriefed on Resident B's behaviors.

On June 6, 2025, I interviewed Andrew Mahler, Berrien County Program Services Manager and Resident B's acting Case Manager. Manager Mahler reported that he has known Resident B since November 2021. Resident B came through child services in his early teens as he was in foster care. Resident B was removed from his parental home due to sexual abuse by family members. When Resident B was aging out of foster care, the Michigan Department of Health and Human Services (MDHHS) came to Berrien County as they struggled to find placement for Resident B due to the behaviors he presented. Resident B was placed at an AFC home in Kalamazoo and even though Resident B had wrap around services in place, Resident B displayed "scary" behaviors including aggression and property destruction. The placement did not last, and Resident B had a 2–3-month inpatient stay as they could not find placement. Resident B moved to another AFC home and was there for 2-3 years. During this placement, Resident B eloped, destroyed property, displayed aggression, and fought and attacked the police. Resident B would run in the roads and there was concern for Resident B's safety and the safety of others. Resident B spent time in jail and the forensic center and was deemed incompetent 2-3 times for crimes he committed. Resident B's behaviors were escalating and nothing was helping. The county was paying for 1 on 1 staffing and Resident B continued to display maladaptive behaviors in his AFC home. Resident B was out of the AFC placement by September 2024, and Berrien County contracted services with a non-licensed setting. Resident B was the only resident in a Semi-Independent Living (SIL) program and resided there for 4 months. Resident B then required out of state inpatient hospitalization due to breaking out windows and threatening to murder staff. Resident B was in a psychiatric unit in Indiana and had serious aggressive episodes in the hospital. While in the hospital, Resident B broke into the nurse's station and attacked nurses. Resident B was moved to a different inpatient facility in Indiana and Berrien County applied for Resident B to go to the state hospital as there was concern for the safety of the general public. MDHHS denied the request for state hospitalization for Resident B. In February 2025, they were referred to Flatrock/Coldwater and there was a provisional approval process. It was decided that Resident B would have 1 on 1 staffing upon arrival to Coldwater and titrate down. By May 2025, Resident B was to have no 1 on 1 staffing regardless of his behaviors in the home and this was direct guidance from the PIHP and MDHHS. There was "hyper focus" on removing the 1 on 1 once Resident B was to arrive at Coldwater. Manager Mahler did not agree with the 1 on 1 titration schedule and Flatrock "did not like it" either however they had to follow the guidelines. Coldwater was aware they had to follow the titration plan prior to accepting placement of Resident B. There was a huge meeting with Flatrock clinical management prior to Resident B's placement and they were provided Resident B's history and lots of documentation. Flatrock "was the only one to come to the table" in addition to the state hospital application, which was denied, for

placement of Resident B. There was an initial meeting on January 21, 2025, with Flatrock, clinical staff, MDHHS, Coldwater Staff, case managers, psychiatric staff and there were 40 people on the call. The hospital in Indiana wanted to discharge Resident B and they called many providers however no one would take him. Once it was decided that Flatrock/ Coldwater would place Resident B there was a delay due to a call with MDHHS, PIHP, and federal compliance. Coldwater was advised they had 60 days to titrate 1 on 1 staffing to none for Resident B. Genesee Health System was contracted for supports as they wanted an "objective group" involved. Manager Mahler met with Flatrock staff every month and his initial meeting was on February 10, 2025. Manager Mahler drove to Coldwater on February 24, 2025, to meet with Resident B's case manager and home manager and no one attended the meeting. Manager Mahler did meet with Resident B on this date. Manager Mahler got the impression that Coldwater did not care to collaborate. There was a meeting on March 14, 2025, via telephone and there was a meeting in April 2025, also. Manager Mahler stated Coldwater knew all Resident B's behaviors and "what he was bringing to the table". Manager Mahler wanted Resident B in the hospital and did not think he should have been living in the community. Manager Mahler was very concerned about Resident B and the placement however he was told he "had to do this."

Case Manager Mahler reported he was aware that on May 4, 2025, there was an incident with a roommate. One resident was trying to elope and Resident B wanted to go. Resident B said, "I'm going to hurt someone if you don't let us go". Resident B caused serious injuries to another resident. Case Manager Mahler received a call from Flatrock management stating they did not want to discharge Resident B however they would if they were not allowed to move him into another Flatrock facility, Wesley. Berrien County had to agree as they were worried about everyone's safety.

On June 6, 2025, I interviewed Resident B's guardian, Guardian B1 who reported she has been Resident B's guardian since November 2022. Resident B is currently in jail according to his guardian. Guardian B1 reported Resident B has a long history of behaviors and assaulting others. Resident B has been in and out of jail a lot and some charges were dropped because it was determined he was unable to stand trial due to his mental illness. Recently in December 2024, Resident B had 3 charges of assault and battery and attempted home invasion. There was a past incident in Berrien County where Resident B strangled a staff member, and a staff member had to sit on him. Guardian B1 stated that Resident B knows what he is doing is wrong and he will go back and do the same thing. Resident B has assaulted police officers, thrown bricks through windows, and puts holes in walls. Resident B always said he would hurt himself or someone else. Resident B "did not respond to anything and remained violent." Guardian B1 explained that Resident B was in a behavior hospital in Indiana beginning December 12, 2024, right after he received the assault and attempted home invasion charges. On February 6, 2025, Resident B moved to Coldwater. Guardian B1 confirmed she was involved in Resident B's move to Coldwater. Coldwater personnel were provided with Resident B's information to decide to place him. There were lots of meetings prior to Resident B moving into Coldwater and after the move. Guardian B1 believed Coldwater personnel had all the information on Resident B to make an

informed decision about placing him at the facility. Coldwater was in communication with Guardian B1 biweekly and when there were any issues regarding Resident B.

On June 6, 2025, I interviewed Coldwater Medical Coordinator (MC) Eric Tobias. MC Tobias confirmed he saw Resident A's injuries to his groin and back area and staff brought these injuries to his attention. MC Tobias stated that Lead Staff Derek Beelby sent him a picture of Resident A when he was doing his checks. MC Tobias went to the home the same day to view Resident A. The injury to Resident A's back was known about a couple days prior and there was a scratch and bruise near Resident A's tailbone. MC Tobias thought maybe Resident A scratched himself. Resident A's groin was deep purple, and it looked bad. There was bruising on Resident A's right inner thigh. MC Tobias reached out to his superiors (Tiffany and Gabby) and he was instructed to send Resident A to the hospital. Resident A was diagnosed with abdominal pain. MC Tobias did not know what happened to Resident A and no staff was able to explain how Resident A obtained the injuries or when. MC Tobias was asked about safety measures put in place given Resident A's unexplained injuries. MC Tobias was told to monitor Resident A more closely and do more welfare checks on Resident A.

Regarding Resident A's black eye, MC Tobias stated staff brought this to his attention. Staff Beelby sent him a picture and MC Tobias went to the home. Resident A's eye was puffy, and Resident A was given Benadryl as MC Tobias believed it was allergy related. The following day MC Tobias went back to the home and Resident A's eye lid was purple and Resident A's doctor was contacted. The doctor instructed them to monitor the eye. The eye was the same color 6 hours later and Resident A was taken to the doctor and an X-ray was completed. MC Tobias did not know how Resident A obtained the black eye. MC Tobias asked staff what happened to Resident A, and they did not know. MC Tobias was asked if any additional safety measures were put in place upon Resident A having a black eye. MC Tobias stated he was to increase supervision, and he would call the home more often to inquire about Resident A. MC Tobias would increase his welfare checks of Resident A, which consisted of going to the home and viewing Resident A. MC Tobias would do body checks of Resident A during home visits. MC Tobias explained he visited the home once per day and he had always done that. After Resident A's unexplained groin injury, he was a little more thorough on the body checks of Resident A.

Regarding Resident A being assaulted by Resident B on May 4, 2025, MC Tobias was not there however he was "on-call support staff". Staff Stephanie Borieo called him, and he was trying to calm her down as "she was freaking out". There were multiple behaviors going on at the home and 2 residents were trying to elope. Staff Borieo was trying to block the door so Resident B could not elope. Staff Borieo said Resident B "is over there stomping Resident A's face, what do I do?" MC Tobias told Staff Borieo to go stop the assault and Staff Borieo said she was afraid of Resident B. Staff Borieo said Resident B stopped stomping Resident A and Resident A was just lying there. Staff Borieo reported to MC Tobias that Resident A was bleeding from his ear. Staff Borieo was crying on the phone, and told MC Tobias that Resident A was not moving.

MC Tobias instructed Staff Borieo to get off the phone and call 911. While this was occurring, MC Tobias was enroute to the facility. Once at the facility, MC Tobias observed Resident A lying on the floor trying to get up. Resident A's ear was bleeding. Emergency Medical Services (EMS) arrived and took Resident A's vitals. Resident A was transported to the hospital, and he was admitted and discharged within 48 hours of the assault. MC Tobias was asked if any safety precautions were put in place after the assault and he reported Resident A was placed on an emergency 1 on 1 and Resident B was moved from the home. When Resident B was moved from the home, Resident A's 1 on 1 staffing was only required in common areas of the home. If Resident A was in his bedroom, he did not require the 1 on 1. MC Tobias was not sure when this change was made however, he believed it to be when Resident B moved from the home.

Regarding Resident A being found unresponsive on May 17, 2025, MC Tobias said staff were doing their 15-minute checks and Resident A was in his bedroom relaxing. Staff noticed Resident A was limp and unresponsive. Staff called him immediately and he instructed them to take Resident A's vitals. MC Tobias dropped everything and left for the home. When MC Tobias arrived at the home, Resident A was awake but not responsive. MC Tobias did not think Resident A could hear staff. MC Tobias said Resident A was laying in his bed with his eyes open. MC Tobias snapped his fingers by Resident A's ear and there was no response. When staff called Resident A's name he provided no response. MC Tobias called his bosses, and they instructed him to call 911. EMS arrived and transported Resident A to the hospital. MC Tobias stated he called the hospital for updates, and it was reported to him that Resident A's current condition was the result of the attack that occurred on May 4, 2025, and "the brain bleed came back."

MC Tobias reported that Resident A was autistic and nonverbal. Resident A caused no issues and was very curious. Resident A liked to walk around and liked to stay to himself.

MC Tobias reported that Resident B was high functioning however intellectually he "was not all there". Although Resident B was 21 years old his mentality was that of a person between the ages of 10-13 years old. Resident B reported to blacking out during behaviors and he displayed lots of aggression. Resident B could be extreme and would make threats and punch holes in walls. Resident B would say "I'm gonna hurt someone" or "I'm going to kill you." MC Tobias reported that Resident B was not a good fit for the home. All the other residents at Coldwater were autistic and nonverbal. Resident B was on a "higher level," verbal, and got bored. Resident B could do all his activities of daily living on his own without staff assistance unlike the other residents. MC Tobias stated he questioned why Resident B was placed at the Coldwater because he did not think Resident B was a good fit for the home. MC Tobias was unsure why Resident B was placed at Coldwater and he and his support team in his office discussed this. They did not know why Resident B was placed at Coldwater and MC Tobias was never given a reason why Resident B was living at Coldwater.

On June 9, 2025, I interviewed Staff Jazmyne Jimmerson who reported she has been employed at the facility since December 2024 and works 2nd shift. Staff Jimmerson was asked about the events that occurred on May 17, 2025, when Resident A was found unresponsive at the home. Staff Jimmerson reported she came in at approximately 2:45pm and was in the kitchen doing paperwork. Staff Ashanti Skipper came in also to work 2nd shift with her and Staff Skipper was "assigned" to Resident A. At 2:58pm Staff Skipper went to Staff Jimmerson and said Resident A was in the bathroom "just staring". Staff Jimmerson stated she remembers the time because she was doing paperwork near the stove, and the stove has a digital clock. Staff Skipper said Resident A was "sitting crisscross in the shower with the water running." Resident A was staring at the wall and was sitting on his buttocks with his legs crossed. Staff Jimmerson told Staff Skipper to monitor Resident A, and she would come see him after she was done completing paperwork. At 3pm-3:02pm, a male staff, Stanley Brown carried Resident A out of the bathroom and into his bedroom. Resident A "was lifeless" and not responding. The right side of Resident A's body "was having spasms" and twitching. At 3:07pm the medical coordinator was called and at 3:11pm 911 was called. Staff Jimmerson was not sure how long Resident A had been in the shower and first shift staff reported Resident A had gotten in the shower. There were no staff with Resident A in the shower because upper management said Resident A was not a 1 on 1 in the bathroom because there were no peers around. Resident A was to be a 1 on 1 in common areas of the home and not when he was in his bedroom or bathroom.

I asked Staff Jimmerson if she wrote the IR when Resident A was found unresponsive on May 17, 2025, and she confirmed she did. I asked why it was documented in the IR that Resident A was found unresponsive in his bedroom and not in the bathroom. Staff Jimmerson stated that she was told by the Medical Coordinator Eric Tobias not to document that Resident A was found in the bathroom. MC Tobias reasoning was when the incident occurred Staff Jimmerson did not tell MC Tobias that Resident A was found unresponsive in the shower and he in turn did not tell "medical on-call." Staff Jimmerson stated MC Tobias told her not to document Resident A was found in the bathroom by staff.

On June 9, 2025, I interviewed Staff Stephanie Borieo. Staff Borieo works 3rd shift and was working with Staff Malik McClure on May 4, 2025, when Resident A was assaulted by Resident B. Staff Borieo reported that she was dealing with Resident C who was trying to elope from the home. Resident C got out of the home and Staff McClure went after Resident C. Resident B was trying to get out of the home and Staff Borieo was holding the door shut so Resident B did not get out. Resident B was kicking and banging on the door. Staff Borieo heard Resident B say if he did not get out of the home, he was going to hurt someone. The kicking and banging stopped and Staff Borieo went inside the home. Staff Borieo observed Resident A on the floor and Resident B was "stomping on his head". Resident B stomped on Resident A's head twice and Resident A's ear was bloody. Staff Borieo was on the phone with the support team, Medical Coordinator Eric Tobias and he was on his way. Staff Borieo ran toward the residents and Resident B ran outside. Staff Borieo stated everything happened so fast and she was very upset. Staff Borieo stated MC Tobias may have told her to go

over to Resident B and get him off Resident A and he instructed her to call 911, which she did. Staff Borieo stated later during the shift, Resident B had a crushed pop can and threatened to cut his wrist and threatened to cut her with the can. Resident B ended up giving the pop can to Staff Borieo.

Staff Borieo stated there was not enough staff on duty during third shift. According to Staff Borieo, she did not think 2 staff were enough on third shift "in case something like this happened." Staff Borieo spoke to her coworker about this, and Staff Borieo believed they needed a 3rd staff person on third shift to ensure resident safety. Staff Borieo stated she was worried about making this statement and stated she did not want to lose her job.

On June 11, 2025, I interviewed Resident A's guardian, Guardian A1. Guardian A1 reported initially she was happy Resident A was placed in a home with other residents like him. Guardian A1 does not understand why the facility allowed Resident B to live in the home given his history of violence. Staff were afraid of Resident B and staff told Guardian A1 this. Staff told management about their concerns with Resident B and their response was "just deal with it." Resident B was arrested for several violent behaviors, and he was threatening the lives of other people. No other facility in Michigan would take Resident B and when Resident B moved into the home this created an unsafe environment for Resident A. Resident B was in a home with other people that could not defend themselves. Except for Resident B, the residents would just walk around the home and were very low functioning.

Guardian A1 reported Resident A was found in the shower with the water running on May 17, 2025. Someone got Resident A out of the shower, and he was unresponsive. Resident A had surgery and an MRI was conducted. Resident A still had a brain bleed and had another surgery. Resident A was awake and tried to talk and eat. Two days later he stopped eating and curled up in a fetal position. Two days later a feeding tube was inserted. He had strokes and Resident A was provided comfort medication. Resident A passed away the following day. Guardian A1 believed the injury was the result of being stomped on May 4, 2025, by Resident B.

On June 17, 2025, I conducted an exit conference with Licensee Designee, Nicholas Burnett. I advised Licensee Designee Burnett I would be requesting a corrective action plan for the cited rule violation and recommending a provisional license. Licensee Designee Burnett stated although he did not agree with the recommendation of a provisional license he understood the department's position.

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 that Resident A had unexplained bruises and injuries and there was concern staff abused or neglected Resident A. Upon completion of a review of documentation and interviews, there is a preponderance of evidence to conclude a rule violation. On April 13, 2025, Resident A was found to have an unexplained injury to his back. Two days later, Resident A was found to have significant swelling and bruising to his pelvic area and additional bruising to his arm. On April 24, 2025, Resident A was found to have an unexplained black eye. Resident A was nonverbal and unable to explain how he obtained the injuries. These injuries were not witnessed by anyone and were not explained. On May 4, 2025, Resident A was the victim of a serious assault by Resident B resulting in a skull fracture, fractured jaw, and a brain bleed. On May 27, 2025, Resident A died from his injuries. Given Resident A's cognitive impairment he relied on staff to keep him safe. Resident A's AFC Assessment Plan notes that he did not have the ability to assess and respond to dangerous situations to keep himself safe. Staff did not provide Resident A adequate supervision to ensure his safety given the multiple unexplained injuries he obtained in a short time. After each unexplained injury no adequate safety precautions were implemented to ensure Resident A's safety. When Resident A was assaulted by Resident B on May 4, 2025, both staff were outside the facility door leaving 5 residents unsupervised allowing for the assault of Resident A to occur. Resident B has a lengthy history of violent and assaultive behaviors and Coldwater staff, and management were aware. These violent behaviors continued when Resident B resided at Coldwater and Resident B admitted to causing Resident A's black eye that was noticed on or about April 24, 2025. The facility did not take adequate safety precautions to ensure Resident A's safety in the home resulting in his death. The facility did not take adequate safety measures to keep Resident B safe in the home given his known tendency to behave violently toward others which have led to his incarceration. There is a preponderance of evidence to conclude Resident A's safety and protection was not adhered to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 2, 2025, I reviewed Resident A's *Individual Plan of Service* (IPOS). The plan revealed Resident A is 38 years old and severely cognitively impaired. Resident A is diagnosed with autism and is nonverbal. The IPOS documented that "staff will monitor Resident A's movement in shared spaces" and provide redirection when he attempts to enter other resident rooms or personal areas. I reviewed Resident A's *Assessment Plan for AFC Residents* which revealed Resident A is not always alert to his surroundings. The plan stated that Resident A "has great difficulty in identifying possible risks and dangers." Resident A is noted to typically get along with others "however, interactions are minimal due to minimal ability to communicate with others." Resident A "shows minimal interest in interacting with peers." I reviewed Resident A *Behavioral Treatment Plan* which indicated Resident A "is unaware of how to assess and respond to dangerous situations to keep himself safe."

On June 2, 2025, I reviewed Resident B's *Assessment Plan for AFC Residents*. The plan indicated that Resident B is 21 years old and diagnosed with intermittent explosive disorder, post-traumatic stress disorder, severe intellectual disabilities. Resident B "is able to communicate his needs and wants verbally." Resident B "is able to understand when others are communicating with him." Resident B is noted to be alert to his surroundings. Resident A engages in behaviors that are harmful to himself and others. Resident B displays property destruction, physically aggressive behaviors, elopement, self-injurious behaviors, and impulsive behavior that places him and others at risk of harm. These behaviors have led to police contact and legal involvement. Resident B's legal history from 2024 includes property destruction, resisting/assaulting an officer, home invasion, assaulting a McDonalds employee.

On June 2, 2025, I reviewed Resident C's *Assessment Plan for AFC Residents*. The plan indicated that Resident C is 26 years old and diagnosed with autistic disorder and moderate intellectual disabilities. Resident C "is not able to communicate wants and needs fully. He has limited vocabulary and typically communicates with 1-4-word phrases. When he does speak, Resident C is hard to understand due to articulation challenges." Resident C "is alert to his surroundings but does not interpret risks and dangers in a reasonable manner. Resident C requires supervision and support of staff consequently. Resident C's safety skills especially in the community are very poor. Staff will provide supervision and assist him in remaining safe from dangers/risks."

On June 2, 2025, I reviewed Resident D's *Assessment Plan for AFC Residents*. The plan indicated that Resident D is 25 years old and diagnosed with autistic disorder and impulse disorder. Resident D "is vocal, but not verbal…" Resident D "is not able to remain safe and alert to his surroundings. Resident D requires total assistance to remain safe. Staff should be there to assist Resident D and redirecting him to another room/environment or safe place if danger is present."

On June 2, 2025, I reviewed Resident E's *Assessment Plan for AFC Residents* which revealed Resident E is 23 years old. The plan indicated that Resident E is diagnosed with autistic disorder, moderate intellectual disabilities, and attention-deficit hyperactivity disorder, predominantly inattentive type. It is noted that "due to cognitive limitations…Resident E has great difficulty in identifying possible risks and dangers." Resident E's "interactions are minimal due to minimal ability to communicate with others." Resident E "shows minimal interest in interacting with peers." I reviewed Resident E's *Behavioral Treatment Plan*. Resident E is nonverbal and unable to communicate his wants and needs. Resident E "is not aware of his surroundings; he is not cognizant of others in his environment or potential dangers that may arise."

On June 2, 2025, I reviewed Resident F's *Assessment Plan for AFC Residents* which revealed Resident F is 20 years old. The plan indicated that Resident F is diagnosed with autistic disorder, cerebral palsy, and moderate intellectual disabilities. Resident F "can verbally communicate using 1-syllable words." It is noted that Resident F "…can sometimes be aware of his surroundings, but other times is not. Staff should be there to assist Resident F and redirect him to another room/environment or safe place if danger is present."

On June 3, 2025, I interviewed Manager Schmock who reported she knew Resident A since 2018, when he lived at a different facility. Resident A was nonverbal, liked puzzles, and watching his tablet. Resident A did not interact with other clients and kept to himself. Resident A was not aggressive and there were times when he would hit himself with his fist however it was just a tap of the head. Resident A did not bang his head at Coldwater. He would put his forehead on the door and look at staff for their attention. Resident A would ball his fists and tap his forehead and not actually bang his head. Resident A would set off the door alarms for attention and not to elope from the facility. When the alarm would sound, Resident A would turn and walk away. Resident A may have liked the sound of the alarm.

Manager Schmock reported Resident B moved into Coldwater within the last 2 months. Resident B was verbal and could communicate well. Resident B had a "sensory need" and liked deep squeezes to his arms. Resident B started to display aggression toward staff and sometimes he would verbalize it. Resident B would try to hit staff, and staff would block Resident B's attacks and try to talk to him. Resident B would say "I'm going to punch you" or "I'm going to beat you up" and then try to punch staff. Sometimes Resident B could explain what was upsetting him or say, "I'm angry". Other times he did not verbalize things and there were certain staff Resident B preferred. According to Manager Schmock, Resident B did not match the other residents in the home. Coldwater was a low functioning home and Resident B was not low functioning. Manager Schmock told management that Resident B was not a good fit for the home and Resident B said he wanted to move to another home where there were residents he could talk to. Coldwater residents liked to be in their bedrooms or on a tablet. Manager Schmock reported she told the "clinical team" which consisted of the occupational therapist and behavior analyst, about a month and a half after Resident B moved to the facility that the home was not a good fit for Resident B. Manager Schmock noticed that

Resident B would associate more with staff than residents. Manager Schmock thought another Flatrock facility in Flushing would be a better fit for Resident A however they needed approval. Resident B discussed the issue of wanting to move with his case manager also.

On June 4, 2025, I interviewed Staff John Jones who used to be lead staff on first shift. Staff Jones no longer works at the Coldwater facility and now does maintenance/lawn care for the company. Staff Jones reported that Resident B was a new resident that recently moved to the home, and he would say what he was going to do. Resident B knew what staff will do their job and the ones that did not. Resident B was the only high functioning resident who resided at the home and the remaining residents were nonverbal. Resident B targeted weaker clients and he would not behave that way when Staff Jones was working. Staff Jones explained that there was an occasion when things were fine at the home when he worked first shift. Staff Jones left work at 3pm and then at 3:15pm he received a message that Resident B was having a behavior. According to Staff Jones, Resident B knew what he could get away with. Staff Jones stated Resident B was not a good fit for the home and "he liked to be active and doing stuff". Resident B would get bored and did not understand why he was placed at Coldwater. Resident B could not talk to anyone or have a full conversation with any of the other residents. Staff Jones stated he and other first shift staff agreed with this assessment of Resident B. Staff Jones told managers and other lead staff at meetings, and everyone knew Resident B was having difficulties at the home. All staff, managers, and leads talked about it and upper management said it was not their decision. They could not control the placement and would "tell the higher ups".

Staff Jones reported Resident B destroyed property, broke windows, and kicked the walls. Resident B targeted residents and he hit Resident A prior to Resident A's first unexplained injury. Resident B would get mad and "go after the weaker" clients. Staff Jones stated Resident B targeted lower functioning residents, those not capable of defending themselves. Staff Jones stated he believed everyone knew Resident A was Resident B's main target. Staff Jones stated when Resident A obtained the black eye he had already been transferred from the facility. He saw a picture of the black eye as he was still in a staff group chat, and he did not know how Resident A obtained the injury. Staff Jones believed some staff were afraid of Resident B and they may have not intervened. Staff may have not done what they were trained to do. Staff Jones would tell Resident B "you're not going to do that" when he engaged in problematic behaviors. Resident B wanted attention and Resident B said he wanted to go to the other house so he could talk to people.

On June 5, 2025, I interviewed Nikita Smith, first shift lead staff. Staff Smith reported she no longer works at Coldwater and stopped working at the home about 1 month ago. Regarding Resident A, Staff Smith reported Resident A was clingy and wanted a mom-figure. Resident A wanted someone to be around, and he was not aggressive at all.

Staff Smith stated that Resident B was "totally out of place" at Coldwater and she informed supports staff including the manager, administration, and the medical

coordinator. The response she received was “that’s where they put him”. She was never provided an answer as to why Resident B was placed at Coldwater, and she was not sure if another placement was being sought for Resident B. According to Staff Smith, the other residents distanced themselves from Resident B. Resident B was out of place, and he was different from the other residents. Resident B liked listening to music and wanted attention. Resident B said he did not want to live at the home. Resident B was easily triggered and when bored he would exhibit a behavior. Resident B would become aggressive with staff and would punch, kick, and pull staff’s hair. Resident B would “nit-pick” at other residents and would motion like he was going to hit clients. Resident B would do things he knew other residents did not like and cause them to have a behavior, which would trigger Resident B more.

On June 5, 2025, I interviewed Staff Braylon Daniel. Staff Daniel works 3rd shift at Coldwater and has been employed at the facility since September 2024. Staff Daniel stated Resident A liked to set off the alarms however not to elope. Resident A just walked around and tried to get in the kitchen for snacks. Resident A was not irritating, and he did not do anything to anyone. Resident A never hit anyone, and he was “in his own world”.

Staff Daniel stated Resident B was social and was the only resident in the home who could talk. On bad days, Resident B was overwhelming and would threaten staff. Resident B did not always tell the truth and would not tell everything that happened. Resident B never hit Staff Daniel however Staff Daniel heard Resident B would try to hit staff and do things to the residents. Resident B put Resident D in a headlock and Resident A was Resident B’s “main target”. Resident B pushed Resident A down before and he kept hearing Resident B was aggressive. Staff Daniel denied he was afraid of Resident B, but he believed other staff were afraid of Resident B. Staff were not used to being threatened by a resident and the residents who lived at the home did not have many behaviors. Resident B was aggressive, and no other residents were aggressive. The home was calm prior to Resident B moving into the facility and according to Staff Daniel, Resident B was not a good fit for the home given the other residents that resided there. Staff Daniel thought after 2 weeks of Resident B’s arrival that maybe he needed to go to another home. Staff Daniel reported Resident B said he had no one to talk to because none of the other residents could talk to him. Resident B reported to Staff Daniel he was bored and had nothing to do. The other residents do not interact with each other and are low functioning. Resident B was not low functioning. Staff Daniel believed Resident B to be lonely and bored.

On June 6, 2025, I interviewed Malik McClure, Coldwater 3rd shift staff. Staff McClure has worked at Coldwater since January 2025 and works from 11pm-7am. Staff McClure described Resident A as wanting attention. Resident A “wants to hold your hand”. Resident A liked Beauty and the Beast and was “like a toddler”.

Staff McClure was asked if Resident B was aggressive, and Staff McClure stated it depended “on who it is.” According to Staff McClure, Resident B would pick on weaker or smaller people, staff and residents. Resident B would “pick on” smaller people and

threaten them. Resident B was “a talker” and would say “I’m going to break your face” and other violent things. According to Staff McClure, Resident B was not a good fit with the other residents who resided at Coldwater. Resident B “was too advanced” and he could talk and none of the other residents could not talk. Resident B could lie, and the other residents could not. Resident B was smart and “too advanced to be in the home.”

On June 6, 2025, I interviewed Andrew Mahler, Berrien County Program Services Manager and Resident B’s acting Case Manager. Manager Mahler reported that he has known Resident B since November 2021. Resident B came through child services in his early teens as he was in foster care. Resident B was removed from his parental home due to sexual abuse by family members. When Resident B was aging out of foster care, the Michigan Department of Health and Human Services (MDHHS) came to Berrien County as they struggled to find placement for Resident B due to the behaviors he presented. Resident B was placed at an AFC home in Kalamazoo and even though Resident B had wrap around services in place, Resident B displayed “scary” behaviors including aggression and property destruction. The placement did not last, and Resident B had a 2–3-month inpatient stay as they could not find placement. Resident B moved to another AFC home and was there for 2-3 years. During this placement, Resident B eloped, destroyed property, displayed aggression, and fought and attacked the police. Resident B would run in the roads and there was concern for Resident B’s safety and the safety of others. Resident B spent time in jail and the forensic center and was deemed incompetent 2-3 times for crimes he committed. Resident B’s behaviors were escalating and nothing was helping. The county was paying for 1 on 1 staffing and Resident B continued to display maladaptive behaviors in his AFC home. Resident B was out of the AFC placement by September 2024, and Berrien County contracted services with a non-licensed setting. Resident B was the only resident in a Semi-Independent Living (SIL) program and resided there for 4 months. Resident B then required out of state inpatient hospitalization due to breaking out windows and threatening to murder staff. Resident B was in a psychiatric unit in Indiana and had serious aggressive episodes in the hospital. While in the hospital, Resident B broke into the nurse’s station and attacked nurses. Resident B was moved to a different inpatient facility in Indiana and Berrien County applied for Resident B to go to the state hospital as there was concern for the safety of the general public. MDHHS denied the request for state hospitalization for Resident B. In February 2025, they were referred to Flatrock/Coldwater and there was a provisional approval process. It was decided that Resident B would have 1 on 1 staffing upon arrival to Coldwater and titrate down. By May 2025, Resident B was to have no 1 on 1 staffing regardless of his behaviors in the home and this was direct guidance from the PIHP and MDHHS. There was “hyper focus” on removing the 1 on 1 once Resident B was to arrive at Coldwater. Manager Mahler did not agree with the 1 on 1 titration schedule and Flatrock “did not like it” either however they had to follow the guidelines. Coldwater was aware they had to follow the titration plan prior to accepting placement of Resident B. There was a huge meeting with Flatrock clinical management prior to Resident B’s placement and they were provided Resident B’s history and lots of documentation. Flatrock “was the only one to come to the table” in addition to the state hospital application, which was denied, for placement of Resident B. There was an initial meeting on January 21, 2025, with

Flatrock, clinical staff, MDHHS, Coldwater Staff, case managers, psychiatric staff and there were 40 people on the call. The hospital in Indiana wanted to discharge Resident B and they called many providers however no one would take him. Once it was decided that Flatrock/ Coldwater would place Resident B there was a delay due to a call with MDHHS, PIHP, and federal compliance. Coldwater was advised they had 60 days to titrate 1 on 1 staffing to none for Resident B. Genesee Health System was contracted for supports as they wanted an "objective group" involved. Manager Mahler met with Flatrock staff every month and his initial meeting was on February 10, 2025. Manager Mahler drove to Coldwater on February 24, 2025, to meet with Resident B's case manager and home manager and no one attended the meeting. Manager Mahler did meet with Resident B on this date. Manager Mahler got the impression that Coldwater did not care to collaborate. There was a meeting on March 14, 2025, via telephone and there was a meeting in April 2025, also. Manager Mahler stated Coldwater knew all Resident B's behaviors and "what he was bringing to the table". Manager Mahler wanted Resident B in the hospital and did not think he should have been living in the community. Manager Mahler was very concerned about Resident B and the placement however he was told he "had to do this."

On June 6, 2025, I interviewed Resident B's guardian, Guardian B1 who reported she has been Resident B's guardian since November 2022. Resident B is currently in jail according to his guardian. Guardian B1 reported Resident B has a long history of behaviors and assaulting others. Resident B has been in and out of jail a lot and some charges were dropped because it was determined he was unable to stand trial due to his mental illness. Recently in December 2024, Resident B had 3 charges of assault and battery and attempted home invasion. There was a past incident in Berrien County where Resident B strangled a staff member, and a staff member had to sit on him. Guardian B1 stated that Resident B knows what he is doing is wrong and he will go back and do the same thing. Resident B has assaulted police officers, thrown bricks through windows, and puts holes in walls. Resident B always said he would hurt himself or someone else. Resident B "did not respond to anything and remained violent." Guardian B1 explained that Resident B was in a behavior hospital in Indiana beginning December 12, 2024, right after he received the assault and attempted home invasion charges. On February 6, 2025, Resident B moved to Coldwater. Guardian B1 confirmed she was involved in Resident B's move to the facility. Coldwater personnel were provided with Resident B's information to decide to place him. There were lots of meetings prior to Resident B moving into Coldwater and after the move. Guardian B1 believed Coldwater personnel had all the necessary information on Resident B to make an informed decision about placing him at the facility. Coldwater was in communication with Guardian B1 biweekly and when there were any issues regarding Resident B.

On June 6, 2025, I interviewed Coldwater Medical Coordinator (MC) Eric Tobias. MC Tobias reported that Resident A was autistic and nonverbal. Resident A caused no issues and was very curious. Resident A liked to walk around and liked to stay to himself.

MC Tobias reported that Resident B was high functioning however intellectually he “was not all there”. Although Resident B was 21 years old his mentality was that of a person between the ages of 10-13 years old. Resident B reported to blacking out during behaviors and he displayed lots of aggression. Resident B could be extreme and would make threats and punch holes in walls. Resident B would say “I’m gonna hurt someone” or “I’m going to kill you.” MC Tobias reported that Resident B was not a good fit for the home. All the other residents at Coldwater were autistic and nonverbal. Resident B was on a “higher level,” verbal, and got bored. Resident B could do all his activities of daily living on his own without staff assistance unlike the other residents. MC Tobias stated he questioned why Resident B was placed at Coldwater because he did not think Resident B was a good fit for the home. MC Tobias was unsure why Resident B was placed at Coldwater and he and his support team in his office discussed this. They did not know why Resident B was placed at Coldwater and MC Tobias was never given a reason why Resident B was living at Coldwater.

On June 11, 2025, I interviewed Resident A’s guardian, Guardian A1. Guardian A1 reported initially she was happy Resident A was placed in a home with other residents like him. Guardian A1 does not understand why the facility allowed Resident B to live in the home given his history of violence. Staff were afraid of Resident B and staff told her this. Staff told management about their concerns with Resident B and their response was “just deal with it.” Resident B was arrested for several violent behaviors, and he was threatening the lives of other people. No other facility in Michigan would take Resident B and when Resident B moved into the home this created an unsafe environment for Resident A. Resident B was in a home with other residents that could not defend themselves. Except for Resident B, the residents would just walk around the home and were very low functioning.

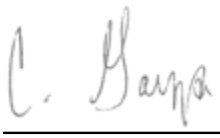
On June 17, 2025, I conducted an exit conference with Licensee Designee, Nicholas Burnett. I advised Licensee Designee Burnett I would be requesting a corrective action plan for the cited rule violation and recommending a provisional license. Licensee Designee Burnett did not agree with the recommendation of a provisional license and believed the residents were compatible as they had similar diagnoses.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**

ANALYSIS:	Resident records were viewed for all 6 residents and 5 Coldwater residents; Resident A, Resident C, Resident D, Resident E, and Resident F were noted to be nonverbal, autistic, and had moderate to severe cognitive and intellectual limitations. Records reveal these 5 residents relied on staff to keep them safe from danger. Resident B moved into the home in February 2025, and his primary diagnosis was intermittent explosive disorder. Resident B was noted to be verbal and could complete all activities of daily living on his own unlike his peers. Resident B has a significant trauma history beginning as a child resulting in foster care placement. Resident B displayed a long history of violence toward others and a disregard for other people and property. On May 4, 2025, Resident B severely assaulted Resident A resulting in his death shortly thereafter. Several Coldwater staff were interviewed and all agreed that Resident B was not compatible with the other residents who resided at the home. Staff explained that the facility housed low functioning residents and Resident B was not low functioning. There is a preponderance to conclude the licensee accepted and retained a resident that was not compatible with the other residents of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

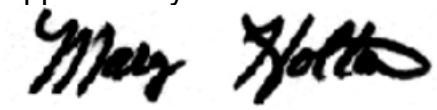
Contingent upon receipt of an acceptable corrective action plan, a provisional license is recommended.



6/17/2025

Christina Garza — Date
Licensing Consultant

Approved By:



6/17/2025

Mary E. Holton — Date
Area Manager