GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 17, 2025

Phillip Mastrofrancesco
Mastrofrancesco AFC Inc
Suite #5
23933 Allen Road
Woodhaven, MI 48183

RE: License #: AS580067669
Investigation #: 2025A0116033
Binkley Manor

Dear Mr. Mastrofrancesco:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580067669
Investigation #:	2025A0116033
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/17/2025
Report Due Date:	08/16/2025
Licensee Name:	Mastrofrancesco AFC Inc
Licensee Address:	Suite #5 23933 Allen Road Woodhaven, MI 48183
Licensee Telephone #:	(737) 671-3654
Administrator:	Phillip Mastrofrancesco
Licensee Designee:	Phillip Mastrofrancesco
Name of Facility:	Binkley Manor
Facility Address:	5041 Northfield Dr Monroe, MI 48161
Facility Telephone #:	(734) 241-1694
Original Issuance Date:	11/06/1995
License **Status:**	REGULAR
Effective Date:	07/21/2024
Expiration Date:	07/20/2026
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/16/25, staff, Diana Williamson, reported that she and other staff members suspect staff, Aurora Boring, may have bitten Resident A and Resident B. Resident B was observed to have what looked like a bite mark on his left wrist and a small cut on the top his head. It is alleged that, staff, Aurora Boring may also be spraying Resident A in the face with the showerhead when she is having behavioral episodes to prevent her from yelling.	No
Additional Findings	Yes

III. METHODOLOGY

06/17/2025	Special Investigation Intake 2025A0116033
06/17/2025	Referral - Recipient Rights Received.
06/17/2025	Contact - Telephone call received Licensee designee, Phillip Mastrofrancesco.
06/17/2025	APS Referral Made by home manager, Keely Green.
06/17/2025	Contact - Document Received Resident B's medical consultation form.
06/17/2025	Special Investigation Initiated - Telephone Resident A's supports coordinator, Sarah Czarnik.
06/24/2025	Inspection Completed On-site Home manager Keely Green, staff Aurora Boring and Danielle Corser, visually observed Resident's A-D.
06/24/2025	Inspection Completed-BCAL Sub. Compliance
06/25/2025	Contact - Telephone call received Ashley Rohr, Resident B's case manager.

06/26/2025	Contact - Telephone call made Guardian B1.
06/26/2025	Contact - Telephone call made Guardian A1.
06/26/2025	Contact - Telephone call made Staff, Dianna Williamson.
07/08/2025	Exit Conference With licensee designee, Phillip Mastrofrancesco.

ALLEGATION:

On 06/16/25, staff, Diana Williamson, reported that she and other staff members suspect staff, Aurora Boring, may have bitten Resident A and Resident B. Resident B was observed to have what looked like a bite mark on his left wrist and a small cut on the top his head. It is alleged that, staff, Aurora Boring may also be spraying Resident A in the face with the showerhead when she is having behavioral episodes to prevent her from yelling.

INVESTIGATION:

On 06/17/25, I interviewed licensee designee, Phillip Mastrofrancesco, and he reported that he was made aware of the allegations by home manager, Keely Green, and is taking the matter seriously. Ms. Green is holding a staff meeting to address the allegations, has reported the allegations to APS and ORR, and is getting Resident B an appointment with his doctor for the mark to be evaluated. Ms. Green is going to schedule Ms. Boring to dayshift only, pending the outcome of the investigations, so that she can keep a close eye on her and her interactions with the residents. Mr. Mastrofrancesco reported that based on his observation of the mark on Resident B's arm, it does not appear to be a bite mark. There are no marks or bruises on Resident A.

On 06/17/25, I received the medical consultation form that was completed by Resident B's doctor. The consultation form documents that the mark on Resident B's arm is not a bite mark, and based on his history of falling, it is likely the result of fall. There was no visible mark on Resident B's head.

On 06/17/25, I interviewed Sarah Czarnik, Resident A's supports coordinator. Ms. Czarnik reported that Resident A self-harms, head bangs, punches self, and usually has marks and bruises. Resident A uses a wheelchair but can ambulate with a walker. She is non-verbal, although she is able to say some words, however, is

unable to self-report. Resident A does not currently have any marks or bruises. Ms. Czarnik reported she does not have any concerns regarding the care provided in the home.

On 06/24/25, I conducted an unscheduled onsite inspection, and interviewed home manager, Keely Green, staff, Aurora Boring and Danielle Corser, visually observed Residents A-D, as they could not be interviewed due to their developmental disabilities.

Ms. Green reported that she completed a body chart audit of Resident A and there were no marks or bruises observed. She did not witness any staff spraying Resident A in the face with the showerhead as alleged. She spoke with all the staff and none of the staff witnessed Ms. Boring or anyone else spray Resident A in the face with the showerhead. Resident B normally has marks or bruises on his body due to falling. Resident B requires the regular use of a wheelchair, forgets that he is unable to walk, but tries to and constantly falls. While in bed Resident B attempts to get up and will also fall. His bed is equipped with bedrails, but he is able to maneuver them and gets out of bed. Staff are constantly reminding Resident B to stay in his wheelchair and/or bed, and are constantly checking on him, to no avail. Ms. Green reported 1:1 staffing has been discussed with Resident B's case manager, however, if that becomes a requirement for Resident B he will likely need to be moved to another home, as they currently do not have the staffing to meet that need.

Ms. Green reported that APS has been to the home and the assigned investigator is Ms. Sparks.

I interviewed Aurora Boring, and she denied the allegations. She would never bite or mistreat a resident in any way and was shocked to hear her name attached to these allegations. She denied biting Resident A and B and spraying Resident A in the face with the showerhead. Two staff shower Resident A due to her combativeness, and she has never showered Resident A alone. Ms. Boring has worked in the field since 2019 and would quit before she went as low as to hurt or mistreat a vulnerable adult.

I interviewed Danille Corser, and she reported that she has not witnessed Ms. Boring or any of the staff bite or mistreating any of the residents. She denied witnessing Ms. Boring, allegedly spraying Resident A in the face with the showerhead. She has worked a few shifts with Ms. Boring and has not observed anything concerning during her interactions with the residents. Ms. Corser has worked in the home for 13 years and would not hesitate to report any staff she observed hurting or mistreating the residents.

I visually observed Residents A-D. They were all neatly dressed and groomed. No concerns noted.

On 06/25/25, I interviewed Ashley Rohr, Resident B's case manager, and she reported that Resident B has a history of falls and it's not uncommon for him to have

marks, bruises, or broken bones. Resident B requires the regular use of a wheelchair but gets up believing he can walk and falls which results in injuries. Resident B also moves his bedrails, gets out of bed and falls. Ms. Rohr is considering 1:1 staffing for Resident B if the falls continue. Ms. Rohr has no concerns regarding abuse or neglect.

On 06/26/25, I interviewed Guardian B1, and she reported that Resident B has thrived in this home and is doing exceptionally well. Staff at the home have done a great job with Resident B and she is happy he was moved from an unlicensed setting to this home. Guardian B1 does not have any concerns regarding the care provided at all and does not want Resident B moved. Resident B has a history of falling and struggles because he used to walk and believes in his mind he still can. He falls because he continues to get out of his wheelchair and bed trying to walk and this causes injuries because he falls. Guardian B1 believes that 1:1 staffing may be the next step if the falls continue.

On 06/26/25, I interviewed Guardian A1, and she reported that Resident A is doing well in the home and reported no concerns regarding the staff or the care they provide. Staff are patient and take good care of Resident A. Guardian A1 reported being aware of the allegations and does not believe them to be true. She and her husband are at the home a lot without notice and have had no concerns.

On 06/26/25, I interviewed staff, Diana Williamson, and she reported that she has not personally witnessed staff, Aurora Boring, bite or harm any of the residents, in any way. Ms. Williamson does have concerns regarding Ms. Boring's approach and sternness with the residents. Although it does not rise to the level of abuse, it's still a concern for her. She is keeping an eye on her and will not hesitate to report concerns to the manager.

On 07/08/25, I conducted the exit conference with licensee designee, Phillip Mastrofrancesco, and informed him of the findings of the investigation. He agreed with the findings.

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:	Based on the findings of the investigation, there is not a preponderance of evidence to substantiate the allegations. Home manager, Keely Green, and staff, Danielle Corser and Diane Williamson, denied observing, staff, Aurora Boring bite Resident A and B or use the shower head to spray Resident A in the face as alleged. Staff, Aurora Boring also denied biting Resident A and B and spraying Resident A in the face with the showerhead. Resident B's doctor evaluated the mark on his arm and determined that it was not a bite mark. He concluded that the bruise was likely from a fall due to Resident B's history of falling. Guardian A1 and B1 both reported not having any concerns regarding the care provided in the home and reported that Resident A and Resident B are doing very well in the home. Case managers, Sarah Czarnik and Ashly Rohr, both reported no concerns regarding the care the staff provide in the home and based on the history of Residents A and B, it is not uncommon for them to have marks and bruises due to their behaviors and history of falls. This violation is not established as Resident A and B are treated with dignity and their personal needs, including protection and safety, are attended to.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/24/25, I conducted an unscheduled onsite inspection and observed audio recorders in Resident B's bedroom and in the kitchen/dining area. I interviewed home manager, Keely Green, and she reported that the audio recorders are being used so that staff can hear and better monitor Resident B. Ms. Green reported that the use of the monitors were approved through Monroe County Community Mental Health, and she was not aware that this is a violation of Resident B's privacy. I informed Ms. Green that the audio recorders needed to be removed and reminded her that it is the staff's responsibility to monitor the residents. Ms. Green reported an understanding.

On 06/26/25, I interviewed Resident B's case manager, Ashley Rohr. Ms. Rohr reported that Ms. Green informed her that the audio recorders were in violation of the licensing rules and needed to be removed. Ms. Rohr reported that they were approved through their behavioral committee and believed they could be used. I informed Ms. Rohr that if Resident B required increased supervision due to the increase in falls, that it should be addressed through staffing. Ms. Rohr reported an understanding.

On 07/08/25, I conducted the exit conference with licensee designee, Phillip Mastrofrancesco, and informed him of the findings of the investigation. Mr. Mastrofrancesco reported that the audio recorders have been removed from the home, and he was not aware that they could not be used. Mr. Mastrofrancesco will submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	Based on the findings of the investigation, there is a preponderance of evidence to establish this rule violation. During my onsite inspection, I observed audio recorders in the kitchen/dining area and in Resident B's bedroom. Ms. Green reported that the audio recorders are used to better monitor Resident B due to his history and risk of falls. Ms. Green was not aware that audio recorders could not be used. During my exit conference with licensee designee, Phillip Mastrofrancesco, he reported being unaware that audio recorders could not be used. He reported the audio recorders have since been removed. This violation is established as Resident B's right and need for privacy was violated, by use of audio recorders being placed in his bedroom and other areas of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/17/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

07/17/25

Ardra Hunter
Area Manager

Date