



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2025

Nicholas Burnett
Flatrock Manor, Inc.
7012 River Road
Flushing, MI 48433

RE: License #: AM250388519
Investigation #: 2026A0569004
Flint Township North

Dear Nicholas Burnett:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

A handwritten signature in blue ink that reads "Kent W. Gieselman". The signature is fluid and cursive, with the first name "Kent" being the most prominent.

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250388519
Investigation #:	2026A0569004
Complaint Receipt Date:	10/15/2025
Investigation Initiation Date:	10/16/2025
Report Due Date:	12/14/2025
LicenseeName:	Flatrock Manor, Inc.
Licensee Address:	7012 River Road Flushing, MI 48433
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Flint Township North
Facility Address:	2360 Stonebridge Drive Flint, MI 48532
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	11/16/2017
License Status:	REGULAR
Effective Date:	12/22/2024
Expiration Date:	12/21/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• Resident A cut herself with glass.	Yes
• A staff person hit Resident A	No
• Resident B was left in soiled bedding.	No

III. METHODOLOGY

10/15/2025	Special Investigation Intake 2026A0569004
10/16/2025	APS Referral Referral to APS.
10/16/2025	Special Investigation Initiated - Letter email to Kim Nguyen. RRO.
12/02/2025	Inspection Completed On-site
12/08/2025	Contact - Telephone call made Contact with Penny Thom, GHS case manager.
12/08/2025	Contact - Telephone call made Contact with I'nylree Fair, staff person.
12/08/2025	Contact - Telephone call made Contact with Nolan Burnett, facility manager.
12/08/2025	Inspection complete- sub. Compliance.
12/08/2025	Exit conference Exit conference with Nicholas Burnett, licensee designee.
12/08/2025	Corrective action plan requested and due on 12/31/2025.

ALLEGATION:

Resident A cut herself with glass.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that Resident A requires a 1:1 staffing ratio. The complainant reported that Resident A was taken to the emergency room for medical treatment on 11/02/2025 after grabbing a piece of broken glass and stabbing herself with the glass.

An unannounced inspection of this facility was conducted on 12/02/2025. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A was in bed and refused to be interviewed regarding this allegation. Numerous investigations have been completed regarding Resident A harming herself. Resident A has been alert and oriented to person, place, and time when interviewed in prior investigations.

Resident A's file was reviewed. The file contains an incident report (IR) dated 11/01/2025 with the time of the incident at 11:30pm. The IR documents that Resident A started yelling at staff around 11:30pm, because she did not like the staff person assigned to be her 1:1 staff person. The IR documents that Resident A was verbally redirected but continued to escalate her behavior. The IR documents that Resident A continued being verbally aggressive with staff and then began verbally antagonizing another resident (Resident C). The IR documents that Resident A then attempted to elope, but the staff person was able to prevent this by utilizing blocking techniques. The IR documents that Resident A continued to antagonize Resident C to the point that Resident C then punched a window in the dining room, causing the window to shatter. The IR documents that Resident A then grabbed a piece of broken glass and used it to cut open a pre-existing wound on her stomach. The IR documents that staff called 911 and Resident A and Resident C were taken to the hospital for medical treatment. The corrective measures documented in the IR were "staff will continue to prompt (Resident A) with coping skills during times of regulated moods, so as to be utilized most effectively during times of escalation". Resident A's plan of service was reviewed. Resident A's plan of service is dated 12/30/2024, however, a new plan of service meeting was conducted in November 2025. Resident A's plan of service documents her history of self-injury by reopening and picking at a wound on her stomach from a previous colostomy bag that she had. The plan of service documents that Resident A was taken off of a 1:1 staff ratio on 2/15/2024. The plan of service states specifically;

"A. Supervision Needs:

1. (Resident A) will be provided with 24 hour supervision of her group home staff when not on leave of absence approved by guardian or otherwise on a leave of absence from the AFC home (e.g. hospital admission) or in the event of elopement. Staff will encourage (Resident A) to remain active and busy and

follow a Structured Daily Routine. Staff will provide the more intensive supervision while moving in the community (that is outside of the group home) and during specific situations as described below.

- (a) (Resident A) will no longer receive 1:1 staff support continuously on 1st Shift, 2nd Shift or 3rd Shift . This is ended starting 2/15/2024. (Resident A) has a history of intensive 1:1 staff support, and the current plan reflects a large reduction of this supervision and support. Notify Supports Coordinator / Case Manager and LLP by the end of the following business day in the event that significant problems arise related to reduced supervision. Such reporting include: any self-injurious behavior with injury; any behavior that places (Resident A) or others at risk of physical and/or emotional harm; or if more than 8 hours total temporary /emergency 1:1 supervision is needed in case of a crisis.”

Resident C was alert and oriented to person, place, and time. Resident C was appropriately dressed and groomed with no visible injuries. Resident C stated that he was in bed when this incident occurred. Resident C stated that Resident A was upset at staff and was in the hallway yelling and swearing at staff. Resident C stated that he then went into the hallway to see what was going on, and Resident A started yelling and swearing at Resident C. Resident C stated that he told Resident A to “leave me alone” and tried to “get away from her”. Resident C stated that he was trying to walk away from Resident A, but Resident A kept following him. Resident C stated that he was in the dining room and became upset that Resident A wouldn’t leave him alone, so he punched a window, and it broke. Resident C stated that he cut his arm and had to go to the hospital. Resident C stated that staff were helping him with his cut and does not recall Resident A picking up a piece of glass and cutting herself with it. Resident C stated that he remembers staff “acting fast” to help him with his cut.

Penny Thom, Resident A’s GHS case manager, stated on 12/08/2025 that she was notified on this incident. Penny Thom stated that Resident A has a long history of self-injury as an attention seeking behavior. Penny Thom stated that Resident A admitted to her that Resident A cut herself with the glass because she was jealous of how much attention Resident C was getting. Penny Thom stated that Resident A had been taken off of the 1:1 staff ratio, but after several incidents of reopening her stomach wound where the colostomy bag was attached, Resident A was placed back onto a 1:1 staffing ratio in August 2025. Penny Thom stated that she was not present when this incident occurred and does not know how the staff person supervised Resident A. Penny Thom stated that, in general, she does not have any concerns regarding the level of supervision that Resident A receives at this facility. Penny Thom stated that Resident A can be very quick and compulsive in her behaviors but did require medical attention for this incident.

l’Nylree Fair, staff person, stated on 12/08/2025 that she was assigned as Resident A’s 1:1 staff person on 11/01/2025. l’Nylree Fair stated that she reported for her shift at about 10:50pm and that she is a newer staff person. l’Nylree Fair stated that she

has experience working in AFC, but not with residents that have high behaviors like this facility. I’Nylree Fair stated that Resident A was not happy that I’Nylree Fair was assigned as her 1:1 staff person because I’Nylree Fair does not let Resident A manipulate her into not supervising Resident A per her plan of service. I’Nylree Fair stated that Resident A’s behavior escalated quickly, and she began yelling and swearing at her and other residents. I’Nylree Fair stated that Resident A then started antagonizing Resident C who had come out of his room into the hallway. I’Nylree Fair stated that she attempted to deescalate Resident A by verbally redirecting her and offering to do a “preferred activity” with Resident A like coloring or dancing to help Resident A calm down. I’Nylree Fair stated that Resident A continued to antagonize Resident C, and Resident C was trying to get away from Resident A. I’Nylree Fair stated that she was trying to separate Resident A and Resident C, when Resident C punched a window in the dining room. I’Nylree Fair stated that she thought the window was plexiglass and was surprised when it shattered. I’Nylree Fair stated that Resident C cut his arm, and she immediately reacted to assist Resident C. I’Nylree Fair stated that she did momentarily leave the dining room to look for something to stop Resident C’s bleeding and to clean up the broken glass. I’Nylree Fair stated that she made a mistake by leaving Resident A without 1:1 supervision and Resident A was able to pick up a piece of broken glass and cut her stomach wound back open. I’Nylree Fair stated that while assisting Resident C, she had called 911 and both Resident A and Resident C were taken to the emergency room for medical attention.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	The complainant reported that Resident A was able to get a piece of broken glass on 11/01/2025 and use it to cut open a pre-existing wound on her stomach. Resident A has a long history of self-injury and has been on and off a 1:1 staffing ratio. An incident occurred on 11/01/2025 at about 11:30pm where Resident C punched a window, causing it to break and Resident A then grabbed a piece of glass and cut her stomach wound with hit. This incident was documented in an IR dated 11/01/2025 and a verbal account given by I’Nylree Fair who was assigned as Resident A’s 1:1 staff when the incident occurred. Penny Thom confirmed that Resident A is on a 1:1 staffing ratio due to several attempts to self-harm. I’Nylree Fair admitted that she left the dining room and, thus, left Resident A without a 1:1

	staff ratio during the incident on 11/01/2025 to assist Resident C and get something to clean up the glass. Resident A was able to use a piece of the broken glass to cut her stomach wound during the time that l’Nylree Fair had left the room. Based on the documentation reviewed, and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

A staff person hit Resident A

INVESTIGATION:

The complainant reported that Resident A stated a staff person hit her. The complainant reported that Resident A stated that the incident occurred in her bedroom and there were no other witnesses to this incident. The complainant had no additional information regarding this incident.

Resident A has a long history of making allegations against staff that were found to be not credible. I have investigated more than a dozen allegations made by Resident A alleging that staff have physically mistreated her and were not substantiated.

An attempt was made during the inspection on 12/02/2025 to interview Resident A. Resident A was in bed and refused to be interviewed regarding this allegation. Resident A refused to identify a staff person who physically mistreated her or when this incident occurred. Resident A was observed to be appropriately dressed and groomed with no visible injuries.

Penny Thom stated on 12/08/2025 that Resident A has not reported this incident to her. Penny Thom stated that Resident A “often lies” about staff mistreating her and then will refuse to give a statement regarding the specific incident. Penny Thom stated that she has no concerns regarding a staff person physically mistreating Resident A because Resident A cannot give specific information regarding the incident.

Resident C stated on 12/02/2025 that he has never seen any of the staff physically mistreat Resident A. Resident C stated that he has never observed any of the staff physically mistreat any of the residents. Resident C stated that he feels safe residing in this facility.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	The complainant reported that Resident A stated a staff person hit her while in her bedroom, and there were no other witnesses. Resident A has a long history of making allegations of physical mistreatment by staff that were not credible. Resident A refused to give a statement regarding this allegation on 12/02/2025. Resident C stated that he has never observed any staff person mistreat Resident A. Penny Thom stated that Resident A has a long history of “telling lies” about staff, then refusing to be interviewed. Penny Thom stated that she has no concerns regarding Resident A’s treatment by staff, and she does not believe that this allegation is credible. Based on the statements given and experienced history with this resident, it is determined that there is insufficient evidence to substantiate this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B was left in soiled bedding.

INVESTIGATION:

The complainant reported that in August 2025 Resident B urinated in his bed. The complainant reported that Resident B then took his bedding to the laundry room to get clean ones, but staff sent him back to his room to sleep in the soiled bedding.

Resident B was observed in his bedroom on 12/02/2025. Resident B was appropriately dressed and groomed with no visible injuries. Resident A’s bed had clean linens, and the bedroom was observed to be clean and sanitized. Resident A was unable to give a statement regarding this allegation and is non-verbal.

Resident B’s plan of service (POS) was reviewed. The POS documents that Resident A has been diagnosed with Autistic Disorder and severe intellectual disabilities. The IPOS documents that Resident A is non-verbal and requires staff assistance and supervision

to insure his safety. The POS documents that Resident A does not currently require an elevated level of supervision and that staff will launder his bedding and clothing as needed.

Penny Thom stated on 12/08/2025 that she is Resident B’s case manager. Penny Thom stated that Resident B frequently urinates on his bedding and clothing “on purpose”. Penny Thom stated that Resident B is capable of toileting without staff assistance but will “tear his bedding to shreds” and “strip his clothing off”, throw them in a pile in the middle of his floor, then urinate on them. Penny Thom stated that Resident B will also tear his mattress apart, and that staff have replaced his mattress “many times”. Penny Thom stated that she has never observed Resident B’s bed to have soiled bedding and does not believe that staff made Resident B sleep in soiled bedding. Penny Thom stated that she has never had any concerns regarding Resident B’s hygiene or the conditions of his bedroom.

Nolan Burnett, facility manager, stated on 12/08/2025 that he is unaware of any incident when Resident B was made to sleep in soiled bedding. Nolan Burnett stated that he has never observed this happen, and no staff have reported an incident like this to him. Nolan Burnett stated that Resident A’s bedding is changed as needed and he has never been made to sleep in soiled bedding.

APPLICABLE RULE	
R 400.669	Linens.
	(1) A licensee shall provide all of the following: (a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.
ANALYSIS:	The complainant reported that in August 2025, Resident B was made to sleep in soiled bedding. Penny Thom stated that Resident B frequently tears his bedding and clothing, then throws them in a pile on his floor and urinates on them. Penny Thom stated that staff have always gotten new bedding and clothing for Resident B when needed. Penny Thom stated that she has never observed Resident B is soiled clothing or bedding and has no concerns regarding Resident B’s care at this facility. Nolan Burnett stated that he has never observed Resident B sleeping in soiled bedding and no staff have reported any incidents of Resident B sleeping in soiled bedding. Resident B’s bed was observed to have clean bedding, and his bedroom was clean and sanitized during the unannounced inspection on

	12/02/2025. Based on the statements given and observations made, it is determined that there is insufficient evidence to substantiate a violation of this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted with Nicholas Burnett, licensee designee, on 12/08/2025. The findings in this report were reviewed, and a corrective action plan was requested.

IV. RECOMMENDATION

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

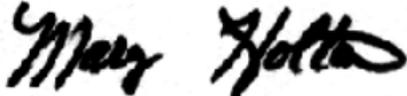


12/08/2025

Kent W Gieselman
Licensing Consultant

Date

Approved By:



12/09/2025

Mary E. Holton
Area Manager

Date