GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 10, 2026

Nicholas Burnett
Flatrock Manor, Inc.
310 W. Oakley
Flint, MI 48503

RE: License #: AS250409449
Investigation #: 2026A0576043
Westwood

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.
- Be signed and dated.

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,

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 #:	AS250409449
Investigation #:	2026A0576043
Complaint Receipt Date:	06/13/2026
Investigation Initiation Date:	06/18/2026
Report Due Date:	08/12/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	310 W. Oakley St., Flint, MI 48503
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Westwood
Facility Address:	2811 Westwood Parkway Dr., Flint, MI 48503
Facility Telephone #:	(810) 407-6332
Original Issuance Date:	12/30/2025
License Status:	TEMPORARY
Effective Date:	12/30/2025
Expiration Date:	06/29/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff got in a physical and verbal altercation over who was going to take Resident A to urgent care.	Yes
Resident A has one-on-one staffing 24 hours per day and is able to swallow and insert items that they are restricted from having.	No
Resident A has missed several therapy appointments due to staff negligence.	Yes

III. METHODOLOGY

06/13/2026	Special Investigation Intake 2026A0576043
06/18/2026	Special Investigation Initiated - Telephone Call to Milessa Leach Office of Recipient Rights
06/30/2026	Inspection Completed On-site Interviewed Staff Heidi Creason, Imani Callaway, Resident B, and Resident C
07/06/2026	Contact – Telephone call made Left message for Mela Allen, Medical Coordinator to return call
07/29/2026	Contact - Telephone call made Interviewed Guardian B1
07/29/2026	Contact - Telephone call made Unsuccessful interview with Sherinda Gregory
07/29/2026	Contact - Telephone call made Left message for Sherinda Gregory to return call.
08/07/2026	Inspection Completed On-site Interviewed Staff Heidi Creason, Imoni Calloway, and Sierra Mosely
08/07/2026	Contact - Telephone call made Interviewed Anne McGibbon, Case Manager

08/07/2026	Contact - Document Received Reviewed therapist letter
08/07/2026	Exit Conference
08/07/2026	APS Referral
08/10/2026	Contact - Document Received Reviewed records for Resident A and Resident B

ALLEGATION:

Staff got in a physical and verbal altercation over who was going to take Resident A to urgent care.

INVESTIGATION:

On June 30, 2026, I conducted an unannounced on-site inspection at Westwood and interviewed Staff Heidi Creason. Staff Creason reported that Resident A was going to urgent care due to a tick bite. Staff Sherinda Gregroy became argumentative with Staff Creason when Staff Creason told Staff Gregory to transport Resident A. Staff Gregory became loud and stated she was not taking Resident A to urgent care as directed. Resident A was one the phone and said, “they’re fighting, they’re fighting”. Staff Creason called upper management and was directed to send Staff Gregory home for the remainder of the shift. Staff Creason denied there was a physical altercation among staff.

On June 30, 2026, I interviewed Staff Imoni Calloway regarding the allegations. Staff Calloway reported she was not working at the time of the allegations however she heard that Staff Heidi Creason directed Staff Sherinda Gregory to transport Resident A to urgent care. Staff Gregory said she did not want to transport Resident A as directed. The staff did not get into a physical fight and were talking.

On June 30, 2026, I interviewed Resident B regarding the allegations. Resident B reported she heard staff arguing and did not hear or witness staff fighting. Resident B heard staff yelling and their voices were raised. Resident B was not scared when the staff were arguing.

On June 30, 2026, I requested to interview Resident A regarding the allegations. Staff advised that Resident A was aware I was at the facility. Resident A reported to staff that they ate a rock and needed to go to the hospital. Resident A was transported to the hospital, and I was unable to interview Resident A.

On June 30, 2026, I interviewed Resident C regarding the allegations. Resident C reported that she was in her bedroom and heard loud yelling. Resident C went out of her room to see what was happening. Resident C witnessed Staff Sherinda Gregory get into Staff Heidi Creason's face after Staff Creason directed Staff Gregory to take Resident A to his appointment. Staff Gregory tried to grab Staff Creason's phone. Staff Gregory was yelling and Staff Gregory "was out of line". Resident C did not feel comfortable with Staff Gregory working at the home.

On July 29, 2026, I attempted to interview Staff Sherinda Gregory. Staff Gregory reported she no longer works at the facility and the phone hung up. I left a message for Sherinda Gregory to return my call.

On August 7, 2026, I conducted an unannounced on-site inspection at the home and requested to interview Resident A. Staff reported Resident A was arrested the day prior for assaulting a visitor at the facility and was in jail.

On August 7, 2026, I conducted an exit conference with Licensee Designee Nicholas Burnett. I advised Licensee Burnett of the findings of my investigation and that I would be requesting a corrective action plan.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	It was alleged that staff were in an altercation over staff duties. Upon conclusion of investigative interviews there is a preponderance of evidence to conclude a rule violation. Staff Heidi Creason reported she directed Staff Sherinda Gregroy to transport Resident A to urgent care. Staff Gregory refused and became argumentative. Resident B and Resident C witnessed staff yelling. According to Resident C, Staff Gregory got into Staff Creason's face and tried to grab Staff Creason's phone. Resident C described Staff Gregory as being "out of line". Attempts to interview Staff Gregory were unsuccessful as she hung up the phone.

	There is a preponderance of evidence to conclude that Staff Gregory is not capable of meeting the physical, emotional, intellectual and social needs of each resident given her refusal to transport residents when needed and her inability to resolve conflict appropriately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has one-on-one staffing 24 hours per day and is able to swallow and insert items that they are restricted from having.

INVESTIGATION:

On June 30, 2026, I conducted an unannounced on-site inspection at Westwood and interviewed Staff Heidi Creason. Staff Creason reported Resident A requires one-on-one supervision all the time. Resident A has behaviors including eloping, getting undressed, and swallowing things. Staff Creason reported she has heard staff say that Resident A has been to the hospital for swallowing things like rocks.

On June 30, 2026, I interviewed Staff Imani Calloway who reported Resident A does swallow things such as rocks and has inserted a battery. When Resident A inserted a battery, he was taken to the hospital, and it was removed. Staff Calloway explained that Resident A's behaviors "trickle over to multiple shifts when he gets agitated" and it does not take much for Resident A to become agitated. Resident A has one-on-one staffing, and Staff Calloway does not know how Resident A is able to get things to swallow or insert. As I was interviewing Staff Calloway, Staff Creason came and reported that Resident A was going to the hospital due to swallowing a rock.

On June 30, 2026, I reviewed Resident A's behavior treatment plan. The plan revealed Resident A will have 1 on 1 supervision 24 hours per day. The assigned 1 on 1 staff is to be 4-6 feet (arm's length) at all times. Staff will be there to ensure Resident A does not attempt to swallow or insert an item into her vagina or rectum. Resident A is noted to exhibit self-injurious behavior, physical aggression, stripping, elopement, and property damage.

On August 7, 2026, I conducted an unannounced on-site inspection to the home and interviewed Staff Sierra Mosely regarding the allegations. Staff Mosely reported that Resident A has one-on-one supervision and is smart. Resident A is quick and he is able to get things to self-harm even with having one-on-one staffing.

On August 7, 2026, I interviewed Resident A's Case Manager Anne McGibbon regarding the allegations. Case Manager McGibbon reported she has been Resident

A's case manager for one year. According to Case Manger McGibbon, Resident A requires one-on-one staffing and has a long history of inserting and ingesting when he is mad or upset at people. On one occasion, Resident A hit staff in the face and broke their glasses. Resident A grabbed a part of the broken lense and put it in his mouth. When Resident A is outside, he has eaten pebbles. Staff keep Resident A's television remote out of his bedroom, but he will get a battery from somewhere and insert it in his rectum. Resident A does not seem to be bothered, and he smiles when he talks about it. Resident A will say "they made me mad". Case Manager McGibbon was asked if staff are supervising Resident A appropriately and in accordance with his plan and she confirmed they are. Case Manager McGibbon reported that even when Resident A has one-on-one staff, if Resident A becomes combative 2 staff cannot handle him. Resident A will hit and kick and grab anything and try to ingest it. Resident A is still able to grab things when he is in a behavior. Resident A has taken off all his clothes and defecated in the hallway while 2 staff are trying to calm him. Resident A will grab something and run to the bathroom to insert. According to Case Manager McGibbon, staff are not leaving Resident A alone and staff are supervising him. In January 2026, Case Manager McGibbon witnessed Resident A get a hold of things and it was not because staff were being lax. Staff are supervising Resident A and when Resident A is out of control "it's difficult".

On August 7, 2026, I conducted an exit conference with Licensee Designee Nicholas Burnett. I advised Licensee Burnett of the findings of my investigation and that I would not be citing any rule violations.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that despite having one-on-one staff Resident A is able to self-harm with objects. Upon conclusion of investigative interviews and a review of documentation there is not a preponderance of evidence to conclude a rule violation. Staff were interviewed and confirmed that Resident A swallows and inserts objects. Staff report Resident A requires one-on-one staffing and during my visit to the home he had a one-on-one staff while in his bedroom. Resident A's Case Manager was interviewed and reported staff are adequately supervising Resident A and he has a long history of swallowing and inserting. When Resident A is having a behavior, he is

	combative and intentionally trying to self-harm. Case Manager McKibbon denied that staff are being lax allowing Resident A to self-harm. There is not a preponderance of evidence to conclude Resident A is not protected and safe.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has missed several therapy appointments due to staff negligence.

INVESTIGATION:

On June 30, 2026, I conducted an unannounced on-site inspection at Westwood and interviewed Staff Heidi Creason. Staff Creason reported that Resident A had therapy appointments via Zoom, usually on first shift, once a week. Resident A missed therapy appointments because Resident A refused to attend and said he was tired. Resident A had knee surgery about 2 months ago and he was prescribed pain medication causing Resident A to be tired. Prior to the surgery, Resident A was attending his therapy sessions, however after his surgery he began to miss appointments due to the pain medication he was prescribed. After Resident A missed therapy appointments his therapist said Resident A would be discharged. Resident A became upset because therapy is court-ordered. Staff are made aware of all resident appointments by the medical coordinator the day before appointments. Staff Creason stated Resident A does not miss therapy appointments because of staff negligence.

On August 7, 2026, I conducted a follow-up interview with Staff Creason who reported Resident A was no longer doing therapy. Therapy was court-ordered and his therapist discharged him.

On June 30, 2026, I interviewed Staff Imoni Calloway regarding the allegations. Staff Calloway denied any knowledge of Resident A missing therapy appointments. Resident A's therapy appointments are usually on first shift, and he attends via Zoom using a tablet. The medical coordinator will apprise staff of resident appointments the day prior. Staff Calloway reported Resident A went to the hospital and Resident A was unable to be interviewed. On August 7, 2026, I conducted a follow-up interview with Staff Calloway at the facility. Resident A was discharged from the home yesterday due to assaulting a visitor at the home and is currently in jail.

On June 30, 2026, I interviewed Resident B who reported she has appointments she attends and usually attends appointments on first shift. Resident A goes to the doctor

and a stomach doctor. Staff take Resident A to her doctor's appointments, and she does not miss any appointments.

On June 30, 2026, I interviewed Resident C who reported Resident A refuses appointments sometimes. Resident A will say he does not want to go get his shot. Resident C has heard Resident A say he is not going to appointments, or he will leave and go on an outing. Resident C has appointments she needs to attend and staff take her. The medical coordinator tells staff when appointments are, and Resident C denied she is missing any appointments.

On August 7, 2026, I conducted an unannounced on-site inspection at Westwood and interviewed Staff Sierra Mosely regarding the allegations. Staff Mosely reported Resident A had therapy appointments at the same time and he was aware of when his appointments were. Resident A would refuse to attend his therapy appointments.

On July 29, 2026, I interviewed Resident B's guardian, Guardian B1 who stated she is not happy with the home, and the staff do not do well communicating or responding to emails. Resident B has virtual therapy appointments, and she has missed appointments "a number of times" due to staff having the wrong day or time. Resident B is on probation, and a requirement is that she complete therapy. Resident B has also missed a doctor appointment per Guardian B1.

On August 7, 2026, I interviewed Resident A's Case Manager, Anne McGibbon who reported Resident A was doing telehealth therapy appointments twice per week and Resident A would refuse to get up. On July 27, 2026, Resident A refused a therapy appointment because he was tired. Resident A's therapist wrote a letter saying they would not keep Resident A as a client due to missing many appointments. There was a time when Resident A could not find the tablet or it was not charged causing a missed appointment. Staff were responsible for ensuring the tablet was available and charged for Resident A and Resident A did not have much experience with technology. Resident A has a long history of refusing appointments and staff maybe did not push too hard due to concerns of him having a behavior. Resident A could escalate very fast. Staff would remind Resident A 3 times of when he had appointments.

On August 7, 2026, I reviewed a letter from Stephanie Jackson LMSW regarding Resident A. The letter documents that Resident A had 9 no-show therapy appointments or late cancelations for 2025. As of June 4, Resident A had 5 no-shows and one late cancelation for therapy. The letter notes that "most times, Resident A does not have access to the assigned tablet to do sessions with. There have been many times this year when the therapist calls after the client does not show for a scheduled appointment and the staff is unaware of the appointment. Sometimes Resident A is at another appointment or on an outing instead." The letter also notes "Several times this year, Resident A is asleep and the staff member hands Resident A the phone. Resident A then states he is too tired, I'm not talking today, or I'm not doing therapy today." The letter notes that outpatient mental health therapy through telehealth is not appropriate at this time.

On August 7, 2026, I conducted an exit conference with Licensee Designee Nicholas Burnett. I advised Licensee Burnett of the findings of my investigation and that I would be requesting a corrective action plan for the cited rule violation. Licensee Designee advised that he did not think Resident A was missing appointments as alleged. Licensee Designee advised that it could have been that Resident A's tablet was damaged by Resident A. Licensee Designee Burnett advised he would provide documentation of appointments for Resident A and Resident B for my review.

On July 6, 2026, I left a message for Medical Coordinator Mila Allen to return call. On August 7, 2026, I received a message from Medical Coordinator Allen returning call. On August 10, 2026, I interviewed Medical Coordinator Mila Allen regarding the allegations. Coordinator Allen reported that Resident A has missed therapy appointments due to being asleep after staying up all night. Resident A does not miss any other appointments. Resident A was provided with a tablet to complete therapy appointments and staff are responsible for ensuring the tablet is ready for Resident A to use. When the tablet is not used it is locked up in the medication room. Coordinator Allen was asked if there were any times the tablet was not charged for Resident A's use and she was not aware. Coordinator Allen was asked if there were occasions when Resident A did not have access to the tablet for therapy as reported by his therapist and she stated she does not know why Resident A would not have access to the tablet. Coordinator Allen stated that it could be that staff were being lazy and not giving Resident A the tablet in time for his appointments.

On August 10, 2026, I reviewed medical records for Resident A and Resident B. Resident A was noted to have several appointments in June 2026, and July 2026, with his primary care physician, dentist, physical therapist, cardiologist, OBGYN, and had appointments for various reasons including x-ray, PT, follow-up, and medication reviews. There were several times when Resident A refused care. Resident B was noted to have appointments with her primary care physician, OBGYN, and cardiologist.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	It was alleged that Resident A missed several therapy appointments due to staff negligence causing him to be discharged from therapy. Upon conclusion of investigative interviews and a review of documentation there is a preponderance of evidence to conclude a rule violation.

	Resident A's Therapist Stephanie Jackson wrote a letter documenting several missed therapy appointments by Resident A. Therapist Jackson noted that Resident A missed many appointments due to his refusal. Therapist Jackson also noted that several appointments were missed due to staff not being aware that Resident A had therapy and because Resident A did not have access to the tablet needed to complete sessions. According to Medical Coordinator Mila Allen, staff are responsible for ensuring Resident A's tablet is ready and available for use when Resident A has therapy appointments. Coordinator Allen reported it could be that staff were not ensuring Resident A had the tablet for his therapy sessions. Guardian B1 was interviewed and reported that Resident B has missed several therapy appointments due to staff errors. There is a preponderance of evidence to conclude that the licensee is not following the instructions and recommendations of a resident's health care professional as evidenced by Resident A and Resident B missing several therapy appointments.
CONCLUSION:	**VIOLATION ESTABLISHED**

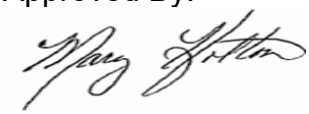
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan no change in the license status is recommended.

8/10/2026

Christina Garza — Date
Licensing Consultant

Approved By:



8/10/2026

Mary E. Holton — Date
Area Manager