GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2026

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

RE: License #:	AS250420168
Investigation #:	2026A0123058
	Flatrock of Linden South

Dear Nicholas Burnett:

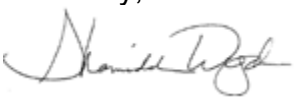
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250420168
Investigation #:	2026A0123058
Complaint Receipt Date:	09/10/2026
Investigation Initiation Date:	09/14/2026
Report Due Date:	11/09/2026
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:	Flatrock of Linden South
Facility Address:	1065 N Linden Rd Flint, MI 48503
Facility Telephone #:	(810) 964-1430
Original Issuance Date:	04/09/2026
License Status:	TEMPORARY
Effective Date:	04/09/2026
Expiration Date:	10/08/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
There is concern that staff are not monitoring Resident A based on Resident A's plan of service.	Yes

III. METHODOLOGY

09/10/2026	Special Investigation Intake 2026A0123058
09/14/2026	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Kim Nguyen.
09/18/2026	APS Referral- APS referral completed.
09/23/2026	Inspection Completed On-site I conducted an unannounced onsite at the facility.
09/23/2026	Contact- Telephone call made I spoke with Witness 1 via phone.
09/30/2026	Exit Conference I spoke with licensee designee Nick Burnett via phone.
10/01/2026	Contact - Telephone call made I left a voicemail requesting a return call from staff Serena Rice.
10/01/2026	Contact - Telephone call received I interviewed staff Serena Rice.
10/06/2026	Contact- Document Sent I sent an email requesting documentation.
10/06/2026	Contact- Document Received I received requested documentation via email.

ALLEGATION: There is concern that staff are not monitoring Resident A based on Resident A's plan of service.

INVESTIGATION: On 09/10/2026, the Bureau of Community and Health Systems received an online complaint regarding the allegations noted above. The complaint specifically states that on 08/14/2026, during first shift, Resident A was observed in

the common area of the home without a one to one staff. Resident A's plan states 1:1 indirect monitoring (line of sight), within 20 feet, in the common areas of the home for 16 waking hours each day, except when alone in his bedroom, or bathroom, unless Resident A requires assistance or when Resident A is in the sensory room alone.

On 09/14/2026, I spoke with Kim Nguyen, recipient rights investigator from Genesee Health System. Kim Nguyen stated that she does not think Resident A had a behavior when Resident A was observed on 08/14/2026 with no 1:1 staff present. Resident A has a history of physical aggression. Resident A was observed walking out of his bedroom and down the hall towards the kitchen. Resident A is supposed to be line of sight. There was a female staff person that was in the kitchen who was supposed to be Resident A's 1:1 staff. The name of the staff person is unknown.

On 09/23/2026, I spoke with Witness 1 via phone. Witness 1 stated they observed Resident A without a 1:1 staff present. The staff person was not acting like they were assigned 1:1, as the staff person was in the kitchen doing something else. A second staff and Resident B were leaving to go on an outing. Resident A was in his bedroom, left the bedroom to get food, and walked back to his bedroom. Resident A can be in the bedroom and bathroom alone. Staff have to be in view of the bedroom door to see Resident A exit the room. When the other staff and Resident B arrived back home, Resident A's 1:1 staff went back to sitting outside Resident A's bedroom. There was another staff person present in the facility that was also a 1:1 staff for another resident. Resident A's 1:1 staff said the facility was short staffed that day.

On 09/23/2026, I conducted an inspection at the facility. During this inspection, I observed Resident A. Resident A was in the dining room playing with bubbles. Resident A was accompanied by staff, Resident B, and Resident B's Relative 1. Staff Brianna Crofton identified herself as Resident A's 1:1 staff.

During the course of the onsite, I did observe Resident A walk from the back hallway back into the common area/dining room. Resident A appeared agitated. At the time, there was another resident in the facility you could hear, that was either in a bedroom or in the hallway of where the bedrooms are yelling loudly and actively having a behavior. There was no 1:1 staffing with Resident A. Resident A was interacting again with Relative 1, and Resident B at the dining room table. Resident A's 1:1 staff, staff Aniyah Bird was in the kitchen, behind a closed kitchen door.

During this onsite, I interviewed Relative 1. Relative 1 reported seeing Resident A walking around the facility a lot without being supervised by Resident A's 1:1 staff. Resident A has been able to break a lot of things as a result. Relative 1 reported visiting the facility about two times a week.

On 10/01/2026, I interviewed staff Serena Rice via phone. Staff Rice reported being aware that first and second shift have been having issues doing their 1:1 supervision

because there was a recent meeting about it. She stated that Resident A is not a 1:1 on third shift. She stated that Resident A's 1:1 staffing should be line of sight.

On 10/06/2026, I received a copy of Resident A's Genesee Health System *Individual Plan of Service* (dated 01/04/2026), *Assessment Plan for AFC Residents* (dated 04/22/2026), and a copy of Resident A's *Behavioral Treatment Plan* (dated 11/21/2025). Resident A's *Individual Plan of Service* states that Resident A has 1:1 indirect staffing. Staff need to be within 20 feet of Resident A, while Resident A is in the common area of the home, for 16 hours a day during waking hours. The 1:1 staffing is utilized to help reduce instances of property destruction, self-injurious behaviors, physical aggression, and elopement behaviors. Exceptions noted include when Resident A is in his bedroom or in the bathroom, unless he requires direct personal care assistance. The plan further notes that, "*Whenever another peer is in the same room as [Resident A], his 1:1 staff needs to be present as well. [Resident A's] physical aggression can be quick, and it can be difficult to know when he will go after a peer, which makes it important for staff to stand between him and his peers while a noisy/crowded area is present.*" Resident A's assessment plan and behavioral treatment plan also details Resident A's need for 1:1 staffing in the home on first and second shifts. The *Behavioral Treatment Plan* notes that Resident A is highly sensitive to loud noises, peer dysregulation, and environmental changes (i.e., new staff, new peers, and household maintenance.)

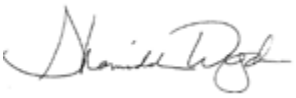
On 09/30/2026, I spoke with licensee designee Nicholas Burnett via phone. LD Burnett expressed being aware of the issue and reported that he would respond with a corrective action plan.

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:	On 09/23/2026, I spoke with Witness 1 who confirmed observing Resident A in the common area of the home without a 1:1 staff person with Resident A. On 09/23/2026, I conducted an onsite inspection. During this inspection, I witnessed Resident A in the dining room of the home, unaccompanied by a 1:1 staff member. Resident A appeared agitated. Resident A's 1:1 staff person was observed entering the kitchen, which is closed off from the common area, and separated by a door, while Resident A was in the common area unsupervised.

	During this onsite, I interviewed Relative 1 who was present, and visiting the facility at the time. Relative 1 reported frequently seeing Resident A without a 1:1 staff person present. On 10/01/2026, I interviewed staff Serena Rice via phone. Staff Rice reported being aware there are issues on first and second shifts with staff doing their 1:1 supervision with Resident A, and that there was a recent meeting with staff addressing the issue. On 10/06/2026, I received copies of Resident A's *Individual Plan of Service*, *Behavioral Treatment Plan*, and *Assessment Plan for AFC Residents* confirming Resident A has a 1:1 staff for 16 hours a day (waking hours). Staff are to be within 20 feet of Resident A, while Resident A is in the common area of the facility. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

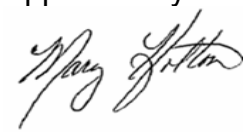
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



10/07/2026

Shamidah Wyden — Date
Licensing Consultant

Approved By:



10/07/2026

Mary E. Holton — Date
Area Manager