GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2026

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

RE: License #:	AS250419007
Investigation #:	2026A0123030
	Tanbark

Dear Nicholas Burnett:

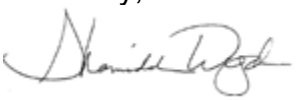
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
THIS REPORT CONTAINS QUOTED PROFANITY.

I. IDENTIFYING INFORMATION

License #:	AS250419007
Investigation #:	2026A0123030
Complaint Receipt Date:	04/29/2026
Investigation Initiation Date:	04/30/2026
Report Due Date:	06/28/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	310 W. Oakley St. Flint, MI 48503
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldridge
Licensee Designee:	Nicholas Burnett
Name of Facility:	Tanbark
Facility Address:	6294 Tanbark Ct. Flint, MI 48532
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	04/06/2026
License Status:	TEMPORARY
Effective Date:	04/06/2026
Expiration Date:	10/05/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On an unknown date, a staff person at Tanbark smacked Resident A in the face.	Yes
On 04/30/2026, staff Francheska Triplett physically assaulted Resident A during an outing.	Yes

III. METHODOLOGY

04/29/2026	Special Investigation Intake 2026A0123030
04/30/2026	APS Referral Information received regarding APS referral.
04/30/2026	Special Investigation Initiated - On Site I conducted an unannounced on-site. I interviewed staff and residents.
04/30/2026	Contact - Document Sent I sent an email requesting documentation.
05/01/2026	Contact- Telephone call received I spoke with APS worker Brandi Morris.
05/06/2026	Inspection Completed Onsite I conducted a follow-up unannounced on-site.
05/08/2026	Contact- Document Received Requested documentation received.
05/11/2026	Contact- Document Received Requested documentation received.
05/26/2026	Contact- Telephone call made I left a voicemail requesting a return call from Resident A's public guardian's office.
05/26/2026	Contact- Telephone call made I interviewed staff Francheska Triplett.
05/26/2026	Contact- Telephone call made

	I left a voicemail requesting a return call from staff Lavon Blake.
05/26/2026	Contact-Document Sent I requested additional documentation via email from facility.
05/27/2026	Contact- Telephone call received I received a voicemail from Resident A's Guardian 1's office.
05/27/2026	Contact- Telephone call made Attempted call back to Guardian 1's office. No answer.
06/01/2026	Contact- Document Received I received requested documentation via email.
06/08/2026	Contact- Document Sent I sent a follow-up email to Detective Weber regarding the police report.
06/08/2026	Contact- Document Received Email response received from Detective Weber.
06/09/2026	Contact- Telephone call made I interviewed staff Lavon Blake.
06/09/2026	Contact- Telephone call made I interviewed staff Shanay Lee.
06/09/2026	Contact- Telephone call made Attempted call back to Guardian 1's office. No answer.
06/09/2026	Contact- Telephone call made I left a voicemail requesting a return call from LD Nicholas Burnett.
06/17/2026	Exit Conference I spoke with LD Nicholas Burnett.

ALLEGATION: **On an unknown date, a staff person at Tanbark smacked Resident A in the face.**

INVESTIGATION: On 04/28/2026, the Bureau of Community and Health Systems receive an online complaint regarding the allegations noted above. The complaint

notes that on an unknown date, one of the staff at Tanbark smacked Resident A in the face. Resident A did not sustain any injuries from the incident.

On 04/30/2026, I conducted an unannounced on-site at the facility. I interviewed Resident A in the dining room of the facility. Resident A denied knowing how long she had lived in the facility but reported previously being in the hospital. When asked how do you like living here so far, Resident A stated, "*It's good*." Resident A stated that she does not like staff because they took her pop but denied knowing the staff person's name. Resident A reported feeling safe. When asked if there was anything that made Resident A feel unsafe, Resident A mentioned a previous group home. Resident A stated that she gets along with staff at Tanbark. Resident A stated that a woman who wears glasses hit her in the eye. Resident A stated that she does not remember when it occurred. Resident A stated that the staff person did not say anything to her, and she did not say anything to staff person after it happened. Resident A stated it happened in her room. When asked where her 1:1 staff person was during the incident, Resident A said the staff was not in her room.

During this on-site I interviewed staff Francheska Triplett. Staff Triplett stated that she received a phone call at the facility from adult protective services (APS) and gave the phone to the manager on 04/28/2026. The manager told her that APS would be visiting the facility either today or tomorrow. Staff Triplett stated that she has never witnessed any staff do anything to Resident A as alleged. Staff Triplett stated there are six residents in the facility, and Resident A has a 1:1 staff person assigned to her each shift. Staff Triplett stated that Resident A is new to the facility and has only been here about a month. Staff Triplett stated that she has not heard Resident A say anyone slapped her, and that there are several staff who wear glasses. She stated that some fill-in staff from other homes also work in the facility.

During this on-site, I interviewed staff Antinyah Williams. Staff Williams stated that she is Resident A's 1:1 staff for this shift. Staff Williams stated that Resident A has never said anything to her about a staff being inappropriate with her. She stated Resident A has not had any marks, bruises, or anything on her face. She stated that no other residents have reported anything to her either.

During this on-site, I interviewed Resident B in Resident B's bedroom. Resident B stated that she has had no issues with any of the staff. Resident B stated that a staff person named Kyah Grimsley hit Resident A. Resident B stated that staff Kyah Grimsley hit Resident A in the face during first shift (date unknown). Resident B described Staff Grimsley as the staff person who is currently on a 1:1 in Resident E's bedroom. Resident B described Staff Kyah Grimsley as a white woman, with red hair, and wears glasses. Resident B stated that Staff Grimsley was upset, but Resident B does not know why. Resident B stated Resident A went into a behavior after it occurred. Resident B stated that she has not witnessed anything similar since. Resident B reported feeling safe in the facility. Resident B stated that Resident A was sitting down minding her business, when Staff Grimsley slapped Resident A.

During this on-site, I interviewed Resident C. Resident C stated that she likes living in the facility, and feels safe, but there is a staff person in the home who slapped another resident. Resident C stated that it happened, then that same staff person transported Resident C to Adrian, MI for an appointment. Resident C stated that the staff person told her to "*Get your ass in the van*" and also told Resident C to "*Get your ass in the shower*." Resident C stated that the staff person who did it, is a white woman who has red hair, and wears glasses. Resident C reported witnessing the staff person slap Resident A and reported that another resident also witnessed the incident. Resident C could not provide the names of the other resident witness, or the staff person. Resident C stated that this incident occurred a couple weeks ago and could not remember the date. Resident C reported telling the manager about the staff person speaking to Resident C disrespectfully. Resident C stated that the staff person was both mean to Resident A and Resident C.

On 04/30/2026, I interviewed Resident D. Resident D stated that she likes living in the home. Resident D stated that she thinks only one staff person is rude, because the staff will talk to Resident D, but won't. Resident D denied that the staff person has ever said anything rude to Resident D. Resident D denied ever seeing a staff person be rude or disrespectful to any residents and denied having any knowledge of any resident getting slapped by staff. Resident D reported only going outside her room sometimes to socialize.

During this on-site, I interviewed staff Kyah Grimsley. Staff Grimsley stated that she has been Resident A's 1:1 staff. Staff Grimsley stated that during Resident A's first couple of days, Resident A kept saying that someone with "*brown hair*" slapped her, and has been saying so since Resident A moved in. Resident A never said who, just said "*brown hair*" and that she does not like her group home. Staff Grimsley stated that no residents have told her anything about any staff acting inappropriately to residents. Staff Grimsley denied cursing or hitting any residents.

On 05/26/2026, I interviewed staff Francheska Triplett via phone. During this interview, I asked Staff Triplett follow-up questions regarding the allegations that Resident A was slapped by a staff member. Staff Triplett confirmed that staff Kyah Grimsley took Resident C to the appointment Resident C mentioned in her interview on 04/30/2026. Staff Triplett stated that Resident C did report that Staff Grimsley told Resident C to "*get your ass in the van*." Staff Triplett stated that she reported this to management. Staff Triplett stated that she did hear Resident C say that Staff Grimsley slapped Resident A, and she also reported this to manager Lavon Blake, and Staff Blake spoke with Resident C. Staff Triplett stated that this was a couple days before my initial on-site on 04/30/2026. Staff Triplett stated that she has never personally witnessed Staff Grimsley being inappropriate with other staff or residents.

On 06/09/2026, I interviewed staff Lavon Blake. Staff Blake reported he is a manager in the facility. Staff Blake stated that he received a call about the slapping incident, then dug into it. Staff Blake stated that he doesn't recall everything about the incident as it occurred some time ago. Staff Blake stated Resident A reported to Staff Blake

about being slapped but Resident A could not remember the name of the staff, which shift, or day it occurred. When asked if he had any concerns regarding staff Kyah Grimsley, Staff Blake stated that Resident A did describe the staff person as a white female who wore glasses. Staff Blake stated that staff Kyah Grimsley was reassigned to another home out of precaution, as she was the only staff to fit the description.

On 06/17/2026, I conducted an exit conference with licensee designee Nicholas Burnett via phone. I informed LD Burnett of the findings and conclusion. LD Burnett stated that he will complete a corrective action plan, including termination of employment.

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:	On 04/30/2026, I conducted an unannounced on-site at the facility. I interviewed Resident A, Resident B, Resident C, and Resident D. Resident A reported that a staff person hit Resident A in the eye. Resident A reported that the staff person wears glasses. Resident B reported witnessing staff Kyah Grimsley hit Resident A in the face on an unknown date. Resident C also reported that a staff person slapped Resident A, and that the staff person also verbally inappropriate with Resident C. Resident D was interviewed and denied witnessing or having any knowledge of the alleged incident. Both Resident B and Resident C physically described the staff person. Resident B verbally named the staff person Kyah Grimsley. On 04/30/2026, I interviewed staff Kyah Grimsley, staff Francheska Triplett, and staff Antiyah Williams. Staff Williams stated that she had not heard Resident A report that any staff were inappropriate with her. Staff Triplett denied witnessing anything. Staff Grimsley denied the allegations. On 05/26/2026, I interviewed staff Francheska Triplett. Staff Triplett stated that she did hear Resident C say that Staff

	Grimsley slapped Resident A, and she also reported this to manager Lavon Blake, and Staff Blake spoke with Resident C. On 06/09/2026, I interviewed staff Lavon Blake. Staff Blake stated that Resident A described the staff person who slapped Resident A. Staff Grimsley fit the description and was reassigned to another facility. There is a preponderance of evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: **On 04/30/2026, staff Francheska Triplett physically assaulted Resident A during an outing.**

INVESTIGATION: On 05/01/2026, the Bureau of Community and Health Systems receive an online complaint regarding the allegations noted above. The complaint also notes that on 04/30/2026, at approximately 6:15 pm staff Francheska Triplett was on an outing with Resident A. They stopped at Speedway for Resident A to get a drink. Resident A did not have any money and could not purchase the drink. Resident A had a behavior. The security footage shows Staff Triplett was trying to work with Resident A. Resident A was agitated and began kicking racks over and busted glass wine bottles. Staff Triplett then dragged Resident A around by their hair. Staff Triplett was kneeling over Resident A's head a one point. A witness tried to intervene. Resident A sustained cuts all over and was bleeding from the glass bottles. No big clumps of hair were observed on the floor, but Resident A did have some strands of her own hair on her. Resident A was scared and did not want to return to the AFC home.

On 05/01/2026, I spoke with adult protective services investigator Brandi Morris. Brandi Morris stated that on 04/30/2026, there was a reported incident that occurred between staff Francheska Triplett and Resident A at a Speedway gas station in Flint Township, MI. Resident A wanted to buy something in the store and ended up having a behavior. Resident A destroyed aisles in the store, and broke wine bottles. Staff Triplett tried to drag Resident A with their hair out of the store. It was captured on surveillance video.

On 05/06/2026, I conducted a follow-up unannounced on-site at the facility. I interviewed Resident A, in Resident A's bedroom. Resident A's 1:1 staff Destiny Waters was present. Resident A stated that a woman hit her at the gas station. Resident A reported wanting to purchase a pop and was pulled by her hair. Resident A denied remembering why she was pulled by her hair and denied getting upset while in the store. Resident A stated she went to the hospital after the incident. Resident A showed scratches and bruises on her elbow.

Staff Destiny Waters was interviewed and stated that herself, Staff Triplett, and another staff person were at the Speedway gas station on an outing with residents. She stated that the incident occurred while she was in the van parking lot with a resident, she was assigned a 1:1 with. Staff Waters denied witnessing the incident. She stated that Resident A's 1:1 assigned staff came out of the store and went to Staff Triplett and reported Resident A was having a behavior. She stated that Resident A only had $4.00 and wanted to purchase more items but did not have enough money. When Resident A's assigned 1:1 staff expressed this to Resident A, Resident A went into a behavior. Staff Triplett told the staff person to stay in the van, and Staff Triplett then went inside the store. Staff Waters stated after about 20 minutes of Staff Triplett being in the store with Resident A, she and her resident went inside. Resident A was sitting on the floor with her legs crossed, and at that time there was no physical damage done to the store. Staff Waters stated that she and her resident came back outside. Staff Waters stated that they were at the gas station for about two hours. The home manager arrived at the gas station, and the police and ambulance were called.

On 05/08/2026, I received requested documents via email. A copy of the *AFC Licensing Division- Incident/Accident Report* dated 04/30/2026 written by home manager Monica McKeller notes "*At 6:07 pm staff was notified of resident having a behavior in the community. Staff and resident were injured. Resident was taken to the hospital. Staff followed. Resident was treated and released. Recipient rights was called following this incident.*" It notes that staff's actions were "*followed resident to hospital*" and "*contacted recipient rights*." For corrective measures, it notes "*staff will continue to follow residents behavior plan to ensure safety in the community*."

A copy of Resident A's *Assessment Plan for AFC Residents* dated 04/20/2026 notes that *"[Resident A] has struggled with emotional dysregulation and internal impulses most of her life, resulting in severe mood episodes, disorganized thinking, violent outbursts, and potentional for significant injury to herself and others. These episodes can be intense and last from moments to hours. Moreover, [Resident A's] target behaviors of property destruction, aggression toward staff, severe self-injury, threats of harm to family and staff."*

For *Controls Aggressive Behavior* the assessment plan notes, *"[Resident A] has displayed physical aggression, consisting of swinging her arms at staff. The aggression is mild to moderate with minimal injury. Staff will monitor [Resident A] closely and regulate her emotions as needed and redirect any physical aggression. Please note: If the above intervention fails, Flatrock staff are trained to use CPI techniques to keep the client safe.*"

For *Moves Independently in Community* the assessment plan notes, *"[Resident A] requires line of site staff supervision at all times in the community. Because of frequent self- harm, physical aggression, and cognitive limitations, she needs to be closely supervised while in the community. Staff will provide guidance, emotional support and redirect any challenging behaviors. This supervision will be provided by*

Flatrock staff, except during authorized leave of absence, titration trials, or incidents of elopement."

For *Manages Money* the assessment plan notes, *"[Resident A] does not understand the value of money and how to use it in the community. She has had access to her money in the past to purchase items while out on an outing. [Resident A] can shop for herself using digital currency. However, she will need staff support to complete money transactions for item purchases*."

A copy of Resident A's *Hurley Medical Center After Visit Summary* dated 04/30/2026 states Resident A's reason for visit is *Alcohol Intoxication* but notes Resident A's diagnosis is *Intermittent explosive behavioral outbursts*.

A copy of Resident A's Interim *Behavioral Treatment Plan* dated 04/17/2026 notes that *"[Resident A's] transition into Tanbark will include a one-on-one staffing for 24 hours to titrate from. Staff will be in close proximity at all times to help eliminate triggers that could elicit the target behaviors that [Resident A] has been diagnosed with. This monitoring will include community & personal outings."*

On 05/15/2026, I spoke with Flint Township Police Detective Chris Weber. Detective Weber confirmed there was Speedway's security camera footage as well as cell phone footage from one of the gas station employee's phones. He stated that Resident A was dragged by the hair. There was no punching or stomping observed. Detective Weber stated that the case has not been submitted to a prosecutor yet.

On 05/15/2026, I received an email from Detective Chris Weber, containing security camera footage and cell phone footage of the 04/30/2026 incident at Speedway between Resident A and Staff Francheska Triplett. I was unable to view the security camera footage but was able to watch the clip from the gas station employee's phone. The video shows staff Francheska Triplett pulling Resident A by the hair three separate times. It also shows Staff Triplett sitting on/straddling Resident A's back while Resident A was lying face down on the store's floor. The store was observed to be in disarray with multiple items strewn around the store on the floor. In the video you can also see Resident A banging the back of her head against a glass refrigerator door.

On 05/26/2026, I interviewed staff Francheska Triplett via phone. Staff Triplett stated that she cannot speak to what originally started Resident A's behavior at the Speedway gas station on 04/30/2026, because she was not in the store when Resident A initially went into a behavior. She stated that Resident A's assigned 1:1 staff person that day, came to the door and said that Resident A couldn't afford something, and went into a behavior. Staff Triplett stated she went into the store, then that staff came outside to the van. Resident A was beating her head against a glass freezer door, was throwing wine bottles, headbutted Staff Triplett, and chipped Staff Triplett's tooth. Resident A attempted to headbutt Staff Triplett multiple times but was hitting Staff Triplett in the stomach and legs. Staff Triplett stated she attempted

CPI, but Resident A was hurting herself, Staff Triplett, and other customers. Resident A would not stop her behaviors, and Staff Triplett stated she could not do any blocking when Resident A removed her shirt. Staff Triplett stated that she did grab Resident A's hair to get Resident A away from danger, then let Resident A go. Staff Triplett stated that every time Resident A calmed down, Resident A would try to go back to the wine bottles to throw them at Staff Triplett. Staff Triplett stated that she did at one point, squat over Resident A, and stated that she had to pull Resident A by the hair to keep everyone safe. Resident A got cut from rolling over broken glass. Staff Triplett stated that the other two staff were not in the store assisting her with Resident A.

Staff Triplett denied hitting Resident A and stated she was just trying to keep everyone safe. Staff Triplett stated a Flatrock office staff asked her why she did not put her hand between Resident A's head and the freezer door, and she replied saying she did not have blocking pads and was not going to get her hand broken. She stated she tried to get Resident A in a child control hold, but Resident A chipped her (Staff Triplett's) tooth. Staff Triplett stated Resident A is very violent and tore the store up. Staff Triplett stated that all six residents were at the gas station that day, and that staff drove a van and staff Destiny Waters' personal car because everyone couldn't fit in the van. There were three staff present at the store, because the lead staff on shift that day (staff Charmere McCadden) had stayed behind at the facility. Staff Triplett stated it took home manager Monica McKellar about 30 minutes to respond to the gas station, and the police arrived before Staff McKellar and another staff member named Trachelle arrived at the store. Staff Triplett stated that the responding officers had to grab Resident A by the neck, almost cuffed and pepper sprayed Resident A, but Resident A had immediately calmed down. Staff Triplett stated that Resident D and Resident E also had one on one staff, and all staff on shift that day should have been on that outing. Staff Triplett stated she wrote a detailed incident report and stated that she "*went through hell in that gas station with no help*." She stated that every time she tried to grab Resident A, Resident A attempted to bite her.

During this interview, Staff Triplett text me a copy of the written statement she wrote regarding this incident. The written statement says the following:

"*Staff took [Resident A] into Speedway. [Resident A] was picking up items she couldn't afford. Staff tried to give [Resident A] money management training but [Resident A] didn't understand fully. [Resident A] wanted to buy diet Pepsi and gum but couldn't afford it. Staff once again told [Resident A] she couldn't afford bottle pop and gum but she could get and fountain drink the counter lady said let me ring her up for the gum and then she could go get and fountain drink. Staff said ok. [Resident A] started to cry and say sorry. Staff redirected [Resident A] and told [Resident A] everything will be fine. [Resident A] said ok. Staff and [Resident A] walked to the fountain drink but [Resident A] walked passed the fountain drink to try to grab a bottle of Pepsi. Staff said we can't get that Pepsi bottle you don't have enough and just paid for the fountain drink. She told staff no then proceeds to knock staff down. Staff tried*

to put [Resident A] on child control but was unsuccessful. [Resident A] head bump staff in mouth. Staff process to let [Resident A] go to grab mouth. [Resident A] fell on ground. Staff tried to validate [Resident A] feeling but was unsuccessful. [Resident A] proceeds to tear the gas station up more. [Resident A] started to throw wine bottle while on the floor. Staff stopped [Resident A] by pulling [Resident A] away for the glass. Staff pulled [Resident A] by her hair cause [Resident A] kept trying to bite staff. Staff immediately let [Resident A] go once [Resident A] was out of harms way. Staff had to grab [Resident A] a couple of times by hair cause [Resident A] was trying to self harm and harm staff. Staff had to sit on [Resident A] so [Resident A] couldn't continue hurting herself or staff. Staff called manager to come help. Manager came. Gas station called police. Police came and took [Resident A] to hospital. Staff action: staff validate resident feeling, staff called manager. Corrective measures: staff will do 10 minute check for health and safety reason. [Resident A] was sent to hospital."

On 06/08/2026, I sent a follow-up email to Detective Weber from the Flint Township Police Department inquiring about the police report for the incident that occurred on 04/30/2026 at the gas station. Detective Weber provided a copy of the police report. The date of the report is 04/30/2026, 6:20 pm, and is listed as a *Vulnerable Adult Abuse- 4th Degree Domestic Relationship File Class/Offense*. The following excerpts are narratives from the police report by Officer Jestin McWilliams:

"*Upon arrival Officer Sleva advised the female was identified as [Resident A] who was being uncooperative. Approaching the female I did observe [Resident A] to be spitting as she was yelling and screaming seated on the floor. [Resident A] was bleeding from multiple locations as she had broken wine bottles and knocked over racks that were holding goods. Upon Officer Sleva's return, [Resident A] attempted to grab another wine bottle. At that time [Resident A] was secured in handcuffs behind the back without further incident. [Resident A] who appeared to be still in distress did state multiple times she did not want to return to the home and she was scared. [Resident A] also said her stomach hurt. Having requested an ambulance from Central Dispatch, Patriot ambulance arrived on scene, transporting [Resident A] to Hurley Hospital for further medical treatment. At this time, I followed the ambulance until [Resident A] was secured in the behavioral health unit at Hurley Hospital as she has an extensive mental health history along with cognitive impairment*."

"I later returned to Speedway to review video footage and to speak with store employee [Witness 1]. [Witness 1] providing video footage of the incident said that the incident started over [Resident A] attempting to get a drink but she did not have the money. As I reviewed the video footage, [Resident A] could be observed having behavioral issues as she was seated on the floor kicking and flailing her arms. [Resident A] at one point could be observed taking her top off and throwing it at Triplett. [Resident A] is then observed knocking over a rack with multiple goods on it before Triplett is seen kneeling on the back of [Resident A]. Triplett can then be observed pulling [Resident A] around by her hair back and forth across the camera viewing area on multiple occasions. An unknown black female witness was also observed who [Witness 1] said was attempting to intervene as Triplett was assaulting

[Resident A]. [Witness 1] said Triplett made a threat to the witness to "whoop your ass." [Witness 1] did also advise that the witness has video footage of the incident. After reviewing the video footage, I asked [Witness 1] if a copy of the video was available and could be obtained. [Witness 1] said it could but her boss would have to do it at a later time. Contacting Detective Weber I advised him of the incident and secured suspect info."

On 06/09/2026, I spoke with staff Lavon Blake. Staff Blake reported he is a manager in the facility. He stated that prior to this incident he never had any concerns about staff Francheska Triplett. He stated that the incident was shocking, as Staff Triplett never gave off any signs that something like this would occur. He stated that the incident was triggered by Resident A not having enough money to purchase a pop.

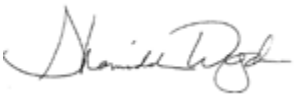
On 06/09/2026, I interviewed staff Shanay Lee. Staff Lee stated that they pulled up to the Speedway before heading for an outing. She and Resident A went inside Speedway, because they were the only two who wanted to go inside. Staff Lee stated that this was her first time interacting with Resident A. She stated that she could tell Resident A didn't know what her limits were spending wise, and Staff Lee decided to let the cashier explain it, after attempting to redirect Resident A about the issue. Resident A had Coke and a pack of gum but could not afford the Coke. It was explained to Resident A, that Resident A could afford a fountain drink and gum. Staff Lee and Resident A walked toward the fountain drinks, but Resident A went towards where the Cokes were. Staff Lee tried to redirect Resident A, Resident A told Staff Lee no, then started knocking some items off a shelf. Staff Lee stated that she went to the door and called out for staff. Staff Francheska Triplett switched with Staff Lee, and Staff Lee returned to the car. Staff Lee stated that she did not witness anything else after returning to the car, and Staff Triplett did not come to the door to ask for assistance. Staff Lee stated that they were outside about 15 minutes before an ambulance arrived. She stated that she was only Resident A's 1:1 staff while they were in the store together. She stated that she thinks Staff Triplett may have been Resident A's 1:1 staff on that shift. Staff Lee stated that there were two vehicles at the gas station. She stated she could not remember how many residents and staff were in the other vehicle, but there were two staff and two residents riding with her. She stated that this was her first time working at Tanbark, and she was a fill-in staff person. She stated that she thinks the lead staff that day stayed back at the facility and did not go on the outing with them. She stated that there could have been other residents still at the facility, but she was unsure. She stated that she saw Resident A when Resident A arrived home from the emergency room, but she cannot recall seeing any injuries. She stated that she wrote an incident report.

On 06/17/2026, I conducted an exit conference with licensee designee Nicholas Burnett via phone. I informed LD Burnett of the findings and conclusion. LD Burnett stated that he will complete a corrective action plan, including termination of employment.

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:	On 05/06/2026, I conducted a follow-up unannounced on-site at the facility. I interviewed Resident A. Resident A stated that a woman hit her at the gas station. Resident A reported wanting to purchase a pop and was pulled by her hair. Resident A stated she went to the hospital after the incident. Resident A showed scratches and bruises on her elbow. On 5/05/2026, Staff Waters denied witnessing the incident and reported being in the van at the time. On 05/15/2026, I received a video of the incident from Detective Chris Weber of the Flint Township Police Department. The video shows staff Francheska Triplett pulling Resident A by her hair multiple times and sitting on Resident A's back. In the video you can also see Resident A banging the back of her head against a glass refrigerator door. On 05/26/2026, Staff Triplett admitted to pulling Resident A by the hair. Staff Triplett stated she attempted CPI, but Resident A was hurting herself, Staff Triplett, and other customers. On 06/08/2026, I received a copy of the Flint Township Police Department report. The date of the report is 04/30/2026, 6:20 pm, and is listed as a *Vulnerable Adult Abuse- 4th Degree Domestic Relationship File Class/Offense*. On 06/09/2026, Staff Lee reported being present in the store with Resident A. She confirmed that she and Staff Triplett switched roles with handling Resident A's behavior. Staff Lee denied witnessing what took place between Staff Triplett and Resident A. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

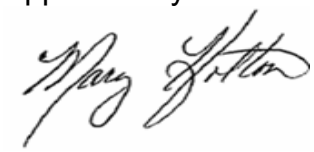
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 3-6).



06/17/2026

Shamidah Wyden — Date
Licensing Consultant

Approved By:



06/18/2026

Mary E. Holton — Date
Area Manager