GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 12, 2026

Corrissa Weaver
Jacksons Home
470 Old Pine Way
Walled Lake, MI 48390

RE: License #: AS820415340
Investigation #: 2026A0901009
Jacksons Home

Dear Corrissa Weaver:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415340
Investigation #:	2026A0901009
Complaint Receipt Date:	11/17/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	01/16/2026
Licensee Name:	Jacksons Home
Licensee Address:	16160 Baylis Detroit, MI 48221
Licensee Telephone #:	(586) 557-3413
Administrator:	Corrissa Weaver
Licensee Designee:	Corrissa Weaver
Name of Facility:	Jacksons Home
Facility Address:	16160 Baylis Detroit, MI 48221
Facility Telephone #:	(586) 557-3413
Original Issuance Date:	06/07/2023
License Status:	REGULAR
Effective Date:	06/07/2024
Expiration Date:	06/06/2026
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's 1:1 supervision is not being provided.	No
Resident A was ill, and staff did not take him for medical care.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/17/2025	Special Investigation Intake 2026A0901009
11/17/2025	Adult Protective Services Referral
11/18/2025	Referral - Recipient Rights
11/19/2025	Special Investigation Initiated - Telephone Case manager, Kimberly Scott
11/24/2025	Inspection Completed On-site
11/24/2025	Contact - Face to Face Resident A
12/02/2025	Contact - Telephone call made Guardian A1
12/02/2025	Contact - Telephone call made Supervisor, Timothy Jackson
12/03/2025	Contact - Document Received Medication logs
12/12/2025	Contact - Telephone call made Licensee designee, Corrissa Weaver
01/08/2026	Inspection Completed-BCAL Sub. Compliance

01/08/2026	Exit Conference Licensee designee, Corrissa Weaver

ALLEGATION:

Resident A's 1:1 supervision is not being provided.

INVESTIGATION:

On 11/19/2025, I made a telephone call to Resident A's case manager Kimberly Scott, from MiSide. She verified Resident A requires 1:1 staffing. She stated she had never gone to the facility unannounced and that each time she went there, Resident A had a 1:1 staff person. Kimberly also said Resident A reported to his father, who is also his guardian, Guardian A1, on more than one occasion, that his 1:1 staff person was not with him. She explained that the licensee designee, Corrissa Weaver, also owns a community center that they take the residents to. Resident A recently told Guardian A1 that he was there and did not have a 1:1 staff person.

On 11/24/2025, I conducted an onsite inspection at the facility. The home manager, Octavia Whitted, was present and was interviewed. She denied the allegation. She stated Resident A always has a 1:1 staff person assigned to him. Resident A was not present during this onsite inspection.

On 11/24/2025, I had face to face contact with Resident A at his school. He stated he always has a 1:1 staff person when he is at the facility and at the community center. He stated he recently lied to Guardian A1 and told him he was at the community center by himself. Resident A said he was upset at the time and just wanted to get staff in trouble. He indicated that everyone did not go to the community center that day. It was only him and two other residents and there were two staff present, Donald Cunningham and Timothy Jackson. Resident A said he does not like it, but there is always someone with him and sometimes he just wants his privacy.

On 12/02/2025, I made a telephone call to Guardian A1. He stated there were times he went to the facility and there were multiple staff present, but it was not clear to him which one was assigned to Resident A. He explained there would be multiple staff because multiple residents required 1:1 staffing. Guardian A1 also said one

day he spoke with Resident A while he and the other residents were at the community center, and he said there was only one staff present.

On 12/02/2025, I made a telephone call to supervisor, Timothy Jackson. He denied the allegation. He stated Resident A is never without 1:1 staffing and that he is normally his assigned staff person during the day shift.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based on the information I obtained during this investigation; there is a lack of evidence to confirm that Resident A does not always have sufficient staffing. He denied the allegation and admitted to lying about not having 1:1 staffing. The home manager and supervisor also denied the allegation, and his case manager reported there was always sufficient staffing at the facility during her visits with him.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was ill, and staff did not take him for medical care.

INVESTIGATION:

On 11/19/2025, I made a telephone call to Resident A's case manager Kimberly Scott, from MiSide. She stated Guardian A1 informed her that Resident A was ill on 11/03/2025 and that he told staff to take him to the doctor. When he talked to Resident A on 11/04/2025, he found out he never saw the doctor so Guardian A1 took him on 11/05/2025. Kimberly said when she emailed the home manager, Octavia Whitted, regarding this, she said she left instructions for staff to take him but

that he could not be seen because they did not have his original ID. Therefore, he was seen by a nurse at the facility. However, Guardian A1 said Timothy Jackson, the supervisor, told him he was a doctor and that he saw Resident A.

On 11/24/2025, I conducted an onsite inspection at the facility and interviewed Octavia. She stated Resident A was sick. She said he was weak, coughing, nauseous, and his throat was bothering him. Guardian A1 requested that they take him to the doctor, so they took him to urgent care. She was unsure of the dates but said it was either 11/08/2025 or 11/09/2025. She indicated urgent care would not see him because they did not have Resident A's ID. Therefore, they brought him back to the facility and their home nurse, Corrissa Weaver, who is also the licensee designee, saw him the next day. Octavia said Corrissa examined him. She diagnosed him with having a viral infection and gave him sinus medication to take. When asked for verification of this, she said a consultation form was not done and that they no longer had the medication. Octavia explained that the day after Corrissa saw Resident A, Guardian A1 took him to urgent care and he was prescribed some different medication. Therefore, they discontinued the medication Corrissa prescribed and it was no longer available in the facility. When asked why staff did not contact Guardian A1 for the ID so he could see the doctor, Corrissa did not have an answer.

On 11/24/2025, I had face to face contact with Resident A at his school. He stated staff took him to urgent care, but he could not see the doctor, so staff took him back to the facility. He said a lady came and gave him some medication for his throat, but he did not remember her name. Resident A stated Guardian A1 took him to the doctor the next day and he was prescribed some more medication and stopped taking the throat medication.

On 12/02/2025, I made a telephone call to Guardian A1. He said he was given conflicting information regarding Resident A seeing the doctor. He explained that when he talked to Resident A on 11/03/2025 he was sick, so he requested staff take him to the doctor. Initially, Timothy told him that Resident A went to the doctor and was given medication. When he talked to Resident A the next day, he said he never saw the doctor and that staff gave him some medication. Guardian A1 did not know what medication Resident A was given. He said when he talked to Timothy again, he told him Resident A could not be seen at urgent care because they did not have his ID. Guardian A1 said he was upset about this because no one called him and asked for the ID and had he known, he would have brought it to them. He said Timothy told him he was a licensed doctor and that he saw Resident A and gave him medication. Guardian A1 stated after learning staff never took him to see a doctor, he took him on 11/05/2025. Resident A was diagnosed with an upper repository infection and a sore throat and was given antibiotics to take.

On 12/02/2025, I made a telephone call to the licensee designee, Corrissa Weaver. She denied being the facility's home nurse, indicating she is aware that this is a conflict of intertest. She stated she did go to the facility to see Resident A after

learning he was sick, but that she never examined him and gave staff medication to give him. Corrissa said she told Octavia to take him to urgent care and was told he was taken but could not be seen. Therefore, she told Corissa to contact Guardian A1.

On 12/02/2025, I made a telephone call to Timothy. He denied telling Guardian A1 he was a doctor or giving Resident A medication to take. He stated Corrissa told Octavia to take Resident A to urgent care and when staff took him, they brought him back saying he could not be seen because they did not have his ID. Timothy did not know why Guardian A1 was not contacted regarding the ID, but said Guardian A1 took Resident A to the doctor the next day. He also clarified that the dates given to me by Octavia were inaccurate. He said staff took him to urgent care on 11/04/2025 and Guadian A1 took him on 11/05/2025.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the information obtained during this investigation, Resident A was ill and did not obtain needed health care immediately. Resident A was exhibiting symptoms, which the home manager was reportedly aware of, but medical care was not attempted until requested by Guardian A1. Guardian A1 requested on 11/03/2025 that staff take him to the doctor. Resident A was not seen by a medical professional until 11/05/2025, when Guardian A1 took him. Staff took him to urgent care on 11/04/2025 but he could not be seen due to staff not having his ID. He was returned to the facility, and no other attempt was made to get him care and Guardian A1 was never contacted regarding the ID.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/24/2025, I conducted an onsite inspection at the facility and interviewed the home manager, Octavia Whitted. She said since Resident A could not be seen at urgent care without an ID, the licensee designee, Corrissa Weaver, examined him

and gave him medication. She said Corrissa diagnosed him with having a viral infection and gave him sinus medication to take.

On 11/24/2025, I had face to face contact with Resident A at his school. He said a lady came to the facility and gave him some medication for his throat. He did not remember her name and was unsure who she was. He said he took the medication until Guardian A1 took him to the doctor and he was given new medication.

On 12/02/2025, I made a telephone call to Guardian A1. He said when he spoke with Timothy regarding Resident A not being taken to the doctor, he said he was a doctor and gave him medication to take.

On 12/02/2025, I made a telephone call to Corrissa. She denied examining Resident A and giving him medication to take. I requested a copy of Resident A's November 2025 medication log sheets.

On 12/02/2025, I made a telephone call to Timothy. He denied giving Resident A medication to take.

On 12/02/2025, I received a copy of Resident A's November 2025 medication log sheets from Corrissa. Besides his regular daily medications and the medication prescribed by urgent care, the other medication he reportedly took was not listed.

On 01/08/2026, I conducted an exit conference with Corrissa. I informed her of my investigative findings, which she disagreed with. Timothy was also present on this telephone call. They stated the information reported to me by Octavia was inaccurate. They insisted that Resident A was not given medication other than what he was prescribed and felt although Resident A did not see the doctor when they took him, he still received prompt medical care. I explained that my findings were based on the information I received and would require a corrective action plan but that she could document her concerns or explanation and send it separately with the corrective action plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the information obtained during this investigation, Resident A was given medication that was not prescribed by a licensed healthcare professional. Although there was discrepancy regarding who saw him and directed that the medication be given, Resident A and the home manager confirmed he was given medication and that he took it until he was taken to urgent care and new medication was ordered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____01/08/2026
Regina Buchanan Date
Licensing Consultant

Approved By:

01/12/2026
_____
Ardra Hunter Date
Area Manager