



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

August 1, 2025

Jennifer Bhaskaran  
Alternative Services Inc.  
Suite 10  
32625 W Seven Mile Rd  
Livonia, MI 48152

RE: License #: AS440265050  
Investigation #: 2025A0569041  
Lake Nepessing

Dear Jennifer Bhaskaran:

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 party responsible 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 dark ink, reading "Kent W. Gieselman". The signature is fluid and cursive, with the first name "Kent" being more prominent and the last name "Gieselman" following in a similar style.

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**

<b>License #:</b>	AS440265050
<b>Investigation #:</b>	2025A0569041
<b>Complaint Receipt Date:</b>	06/27/2025
<b>Investigation Initiation Date:</b>	06/27/2025
<b>Report Due Date:</b>	08/26/2025
<b>Licensee Name:</b>	Alternative Services Inc.
<b>Licensee Address:</b>	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
<b>Licensee Telephone #:</b>	(248) 471-4880
<b>Administrator:</b>	Amber Harris
<b>Licensee Designee:</b>	Jennifer Bhaskaran
<b>Name of Facility:</b>	Lake Nepessing
<b>Facility Address:</b>	1430 Lake Nepessing Lapeer, MI 48446
<b>Facility Telephone #:</b>	(734) 453-8804
<b>Original Issuance Date:</b>	11/08/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	06/17/2025
<b>Expiration Date:</b>	06/16/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	Violation Established?
Briahna Dukes, staff person, left the facility on 6/24/25 with no other staff present.	Yes

## III. METHODOLOGY

06/27/2025	Special Investigation Intake 2025A0569041
06/27/2025	APS Referral
06/27/2025	Special Investigation Initiated - Letter APS referral completed. Lapeer County APS worker Rose Koss notified.
06/27/2025	Contact - Document Received Email received from Lisa Jolly, RRO.
07/30/2025	Contact - Telephone call made Attempted contact with Briahna Dukes, staff person. left voicemail requesting return phone call.
07/31/2025	Inspection Completed On-site
07/31/2025	Contact - Face to Face Interview with Morgan Watts, assistant manager.
07/31/2025	Contact- Telephone call made Contact with Jamie Hascall, home manager.
07/31/2025	Contact- Telephone call made. Attempted contact with Briahna Dukes. Left voicemail.
07/31/2025	Inspection Completed-BCAL Sub. Compliance
07/31/2025	Exit Conference Exit conference with Jennifer Bhaskaran, licensee designee.
07/31/2025	Corrective Action Plan Requested and Due on 08/15/2025

## **ALLEGATION:**

**Briahna Dukes, staff person, left the facility on 6/24/25 with no other staff present.**

## **INVESTIGATION:**

This complaint was received via [LARA-BCHS-Complaints@michigan.gov](mailto:LARA-BCHS-Complaints@michigan.gov). The complainant reported that on 06/24/2025 Briahna Dukes was working the third shift and was the only staff person present at the facility. The complainant reported that Briahna Dukes left the facility during the shift, and the residents were all left in the facility with no staff present.

Lisa Jolly, Lapeer County recipient rights officer, stated on 06/27/2025 that she investigated this allegation. Lisa Jolly stated that she has confirmed that the residents were left unsupervised in this facility by Briahna Dukes on 06/24/2025. Lisa Jolly stated that she is substantiating a violation of the residents' rights. Lisa Jolly stated that none of the residents woke up during the time that the staff was absent, and Morgan Watts, the assistant manager arrived at the facility while Briahna Dukes was absent.

An unannounced inspection of this facility was conducted on 07/31/2025. All of the residents were observed to be appropriately dressed and groomed with no visible injuries. The facility was observed to be clean and sanitized. None of the residents were awake when this incident occurred and could not give a statement regarding this allegation.

Morgan Watts, assistant home manager, stated on 07/31/2025 that she lives next door to this facility. Morgan Watts stated that she received a phone call from Briahna Dukes at 12:58am on 06/24/2025. Morgan Watts stated that Briahna Dukes informed Morgan Watts that Briahna Dukes was at a McDonald's restaurant to use the internet, because the internet at the facility was not working. Morgan Watts stated that Briahna Dukes reported that she did not know what to do if there was an emergency since the internet was not working. Morgan Watts stated that the facility has a land line phone that was working fine, so the excuse did not make any sense. Morgan Watts stated that she asked Briahna Dukes if the residents were at the facility alone with no staff. Morgan Watts stated that Briahna Dukes stated that the residents were alone. Morgan Watts stated that she immediately ran next door to the facility and found the residents alone. Morgan Watts stated that all of the residents were still in bed and none of the residents had gotten out of bed. Morgan Watts stated that she stayed at the facility and Briahna Dukes arrived back to the facility at 1:11am. Morgan Watts stated that she has a ring camera at her house, and when reviewing the video, a car was observed leaving the facility at 11:38pm on 06/23/2025. Morgan Watts stated that she believes that the video show Briahna Dukes leaving the facility at 11:38pm and did not return until 1:11am. Morgan Watts stated that Briahna Dukes was terminated from employment for leaving the residents unsupervised on 06/24/2025.

Jamie Hascall, facility manager, stated on 07/31/2025 that Morgan Watts contacted her to inform her that Briahna Dukes had left the residents alone in the facility during the third shift of 06/23/2025 to 06/24/2025. Jamie Hascall stated that she called Briahna Dukes to confront her about the incident, and Briahna admitted to leaving the residents alone at the facility. Jamie Hascall stated that Briahna Dukes responded by saying that she didn't know what the big deal was because no one got hurt. Jamie Hascall stated that Briahna Dukes had never worked alone prior to this incident so she had not left the residents alone prior to this incident. Jamie Hascall stated that Briahna Dukes was terminated from employment due to this incident.

Attempted contacts with Briahna Dukes were made. Briahna Dukes has not responded to the attempts.

An exit conference was conducted with Jennifer Bhaskaran, licensee designee, on 7/31/2025. The findings in this report were reviewed and a corrective action plan was requested. Jennifer Bhaskaran stated that she accepted the findings in this report and that Briahna Dukes has been terminated from employment. Jennifer Bhaskaran stated that she would submit a corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>
<b>ANALYSIS:</b>	The complainant reported that Briahna Dukes, staff person, left the residents unsupervised in the facility on 06/24/2025. Morgan Watts stated that Briahna Dukes called her at 12:58am on 06/24/2025 and reported that she was at a McDonalds and that the residents were alone in this facility. Morgan Watts stated that she immediately went to the facility and found the residents alone in the facility. Jamie Hascall stated that she confronted Briahna Dukes about this incident, and Briahna Dukes admitted to leaving the residents alone in the facility by stating that she did not think it was a big deal since none of the residents were injured. Lisa Jolly stated that she has substantiated a violation of recipient rights against Briahna Dukes for leaving the residents

	unsupervised in the facility. Based on the statements given, it is determined that there has been a violation of this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



07/31/2025

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Kent W Gieselman  
Licensing Consultant

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Date

Approved By:



August 1, 2025

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Mary E. Holton  
Area Manager

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Date