



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2025

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

RE: License #: AS820415340
Investigation #: 2025A0901039
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,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive style with a large initial 'R'.

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 #:	2025A0901039
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/09/2025
Report Due Date:	09/05/2025
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
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II. ALLEGATION(S)

	Violation Established?
On 05/20/2025, staff, Andray Higgins, was arguing with Resident A and threatened to blow his head off. Andray has also been heard being verbally abusive towards Resident B.	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0901039
07/07/2025	Referral - Recipient Rights
07/09/2025	Special Investigation Initiated - Telephone Recipient Rights
07/09/2025	APS Referral
07/10/2025	Inspection Completed On-site
07/22/2025	Contact - Telephone call made Licensee designee, Corriisa Weaver
07/24/2025	Contact - Telephone call made Staff, Andray Higgins
07/31/2025	Contact - Telephone call made Staff, Mary Sandifer
07/31/2025	Contact - Telephone call made Staff, John Hutchins
07/31/2025	Contact - Telephone call made Staff, Larry Goodwin
07/31/2025	Contact - Telephone call made Staff, Aleda Dunbar
07/31/2025	Contact - Telephone call made

	Staff, Timothy Jackson
07/31/2025	Contact - Telephone call made Staff, Taleor Cofield
08/01/2025	Contact - Telephone call made Staff, Taleor Cofield
08/01/2025	Contact - Telephone call made Resident B's case manager, Robert Simms
08/01/2025	Contact - Telephone call made Resident A
08/01/2025	Contact - Telephone call made Staff, Ashly Willer
08/05/2025	Contact - Telephone call made Resident A's case manager, Ayat Al-Hachami
08/05/2025	Contact - Telephone call made Resident A's mother
08/05/2025	Contact - Telephone call made Staff, Andray Higgins
08/05/2025	Contact - Telephone call made Staff, Taleor Cofield
08/18/2025	Contact - Telephone call made Staff, John Hutchins
08/26/2025	Exit Conference Licensee designee, Corriisa Weaver
08/27/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 05/20/2025, staff, Andray Higgins, was arguing with Resident A and threatened to blow his head off. Andray has also been heard being verbally abusive towards Resident B.

INVESTIGATION:

On 07/09/2025, I made a telephone call to Sherry Underwood, from the Office of Recipient Rights. She stated both residents remain at the facility and that staff, Andray Higgins, was suspended.

On 07/10/2025, I conducted an onsite inspection at the facility. The home manager, Octavia Whitted, was present and was interviewed. She explained that Resident A jokes a lot and on 05/20/2025, he told Andray to come sleep in his bed. Andray corrected Resident A and told him not to talk like that. Resident A then threatened to kill Andray's daughter. Octavia said Andray jumped up and was cursing at Resident A and said, "We can take it outside." She denied hearing him threatened to blow his head off and said he did not physically touch Resident A. She also denied ever hearing him be verbally abusive towards Resident B. Octavia further stated most of the residents at the facility are nonverbal, including Resident B. He was not present during this onsite inspection due to being on an outing with staff and Resident A was on leave of absence with his mother, Mother A1, who is also his guardian.

On 07/22/2025, I made a telephone call to the licensee designee, Corriisa Weaver. She stated she was not present during the incident with Resident A but when she learned of it, she reported it to Recipient Rights. Corriisa said Octavia was present and gave me the contact information for other staff that may have been present. She stated staff, Mary Sandifer, observed Andray being verbally abusive towards Resident B and could give me more details.

On 07/24/2025, I made a telephone call to Andray and left a voice message, but the call was not returned. I made another call on 08/05/2025 and interviewed him. He denied verbally abusing Resident A or Resident B and denied threatening either of them. He reported Resident A was upset because he told him he did not want to lay in bed with him. Andray said Resident A "flipped out" and said he would hurt his children. He told Resident A if anyone hurt his children, they would have a problem, but said he did not directly threaten him or use profanity towards him.

On 07/31/2025, I made a telephone call to Mary. She stated she was present on 05/20/2025 and explained that Resident A asked Andray to come lay with him and made a comment about Andray's daughters. Andray got upset and said, "You keep talking to me like that, your mom will have to bury you soon. You got one more time to say something about my daughters. I will cold smack you." She said she and the other staff tried to get Andray to calm down, but he would not. Mary also reported

hearing Andray yell and use profanity towards Resident B before and said when she tried to intervene, he threatened her and said he did not care if she reported him.

On 07/31/2025 and 8/18/2025, I made telephone calls to staff John Hutchins and left voice messages, but the calls were not returned.

On 07/31/2025, I made a telephone call to Witness 1. She reported an incident in which she heard Resident B yelling and when she went to check on him, Andray was choking him and was cursing at him. Witness 1 also said Resident B's 1:1 staff person, Taleor Cofield, was present as well but did not intervene.

On 07/31/2025, I made a telephone call to staff, Larry Goodwin. He said on 05/202/2025, he had just arrived to work, and Andre and Resident A were arguing. He reported Resident A had said something about touching Andray's daughters. Andray got in Resident A's face and was loud and threatening him. Larry said other than this incident, he never observed Andray being inappropriate with the residents.

On 07/31/2025, I made a telephone call to staff, Aleda Dunbar. She stated she was upstairs when the argument with Andray and Resident A took place. She heard raised voices and knew something was wrong but by the time she made it downstairs, it was over. Aleda also stated she never observed any negative interactions between Andray and the residents. She said overall he seemed compassionate.

On 07/31/2025, I made a telephone call to Taleor. She said she was not able to talk at the moment and would call me back.

On 07/31/2025, I made a telephone call to supervisor, Timothy Jackson. He stated Mary informed him that she observed Andray on occasion being verbally abusive to some of the residents. When he questioned some of the other staff, they seemed reluctant to talk but admitted witnessing Andray yell and use profanity towards the residents as well. Timothy said he informed Corriisa and had Andray taken off the schedule.

On 08/01/2025, I made a telephone call to Taleor. There was no answer, so I left a voice message. I called again on 08/05/2025 and interviewed her. She stated she never observed Andray physically mistreat any of the residents but observed him talking aggressively and using profanity towards them. Taleor recalled an incident that happened a couple of months ago in which Andray was in Resident B's room cursing at him. She said she did not intervene because he seemed to be having a bad day.

On 08/01/2025, I made a telephone call to Resident B's case manager, Robert Simms, from Community Living Services. He stated he was not aware of the allegations and was shocked by them. Robert indicated that neither him or the family had any concerns about the facility. He reported he visits monthly, sometimes

unannounced, and never saw any “red flags.” He stated there was always appropriate staffing and staff was always positive and engaging, and good at deescalating Resident B.

On 08/01/2025, I made a telephone call to the facility and interviewed Resident A. He kept saying Andray was mean to him but that he was gone now. He said he made Andray mad, and Andray started calling him names and threatened him. Resident A could not remember exactly what Andray said because he indicated he was not good at remembering words.

On 08/01/2025, I made a telephone call to staff, Ashly Willer. She stated she was not present on 05/20/2025 and never observed Andray mistreating any of the residents.

On 08/05/2025, I made a telephone call to Resident A’s case manager, Ayat Al-Hachami, from Community Living Services. She said Resident A was assigned to her in June 2025, so she was not aware of the incident. Ayat said she never had any issues with the facility. She indicated every time she went there, his 1:1 staffing was provided, and she always observed appropriate interaction between staff and him, as well as with the other residents. Ayat explained that part of Resident A’s behavior includes talking and randomly saying inappropriate things that can be provoking at times. She said staff should be aware of this and know how to handle it.

On 08/05/2025, I made a telephone call to Mother A1. She explained Resident A has the mindset of a five-year-old child and tends to joke a lot. He told Andray to come lay in his bed with him and he took it personally. She said Resident A told her that Andray threatened him, but he could not remember what Andray said. Mother A1 stated she never spoke with Andray about the incident because he was taken off the schedule. She further said she spoke with Octavia about the incident and since Andray was removed from the schedule and she was assured that he would not have contact with Resident A again, she was satisfied and Resident A felt safe.

On 08/26/2025, I made a telephone call to Corriisa for an exit conference. I informed her of my investigative findings. She stated Andray was removed from the schedule pending the investigation and that she does not plan on letting him return.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information I obtained during this investigation, Residents A and B was not treated with dignity and their protection and safety was not attended to at all times. Resident A reported Andray called him names and threatened him. The incident was witnessed by other staff who reported Andray used profanity towards Resident A, yelled at him, and threatened him. Resident B could not be interviewed, but some staff reported also witnessing Andray be verbally inappropriate with Resident B by yelling at him and using profanity. I was unable to confirm physical abuse. Although Witness 1 reported seeing Andray choke Resident B, Andray denied it and there were no other witnesses.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Regina Buchanan
Licensing Consultant

08/27/2025
Date

Approved By:



Ardra Hunter
Area Manager

09/04/2025
Date