



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2026

Morgan Bailey
Serenity Homes - North, L.L.C.
747 Tamarack Ave NW
Grand Rapids, MI 49504

RE: License #: AL700382076
Investigation #: 2026A0467023
Serenity Homes - North

Dear Ms. Bailey:

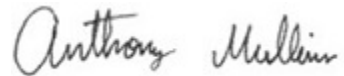
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700382076
Investigation #:	2026A0467023
Complaint Receipt Date:	03/26/2026
Investigation Initiation Date:	03/27/2026
Report Due Date:	05/25/2026
Licensee Name:	Serenity Homes - North, L.L.C.
Licensee Address:	747 Tamarack Ave NW Grand Rapids, MI 49504
Licensee Telephone #:	(419) 494-4008
Administrator:	Morgan Bailey
Licensee Designee:	Morgan Bailey
Name of Facility:	Serenity Homes - North
Facility Address:	830 Hayes Street Marne, MI 49435
Facility Telephone #:	(616) 677-6015
Original Issuance Date:	06/02/2016
License Status:	REGULAR
Effective Date:	09/26/2024
Expiration Date:	09/25/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 3/25/25, Resident A was last seen at 7:30pm but staff did not report her missing until 9:30pm	No
Additional Findings	Yes

III. METHODOLOGY

03/26/2026	Special Investigation Intake 2026A0467023
03/27/2026	Special Investigation Initiated - On Site
03/27/2026	APS Referral – not warranted based on findings
03/27/2026	Contact – telephone call made to Josh Mickle and Wynnee Boda
05/12/2026	Exit conference with Chief Operations Officer, Jessica Engstrom on behalf of licensee designee, Morgan Bailey.

ALLEGATION: On 3/25/26, Resident A was last seen at 7:30pm but staff did not report her missing to law enforcement until 9:30pm.

INVESTIGATION: On 3/26/26, I received an online complaint alleging that on 3/25/26, Resident A was last seen by staff at 7:30pm, but staff did not report him missing until 9:30pm. The complaint also stated that in recent weeks, other residents have been leaving the facility without staff’s knowledge.

On 3/27/26, I conducted an unannounced onsite investigation at the facility. Upon arrival, introductions were made with staff member, Gabriel Diamond. Mr. Diamond reported that staff members Josh Mickle and Wynnee Boda stated that they last saw Resident A at 7:30pm on 3/25/26. However, Mr. Diamond worked until 8:00pm that night and confirmed seeing Resident inside the facility before he left. When Resident A did not come for her 9:00pm medication as expected, staff began searching for her but were unable to find her. Mr. Diamond instructed Mr. Mickle and Mrs. Boda to call 911, which they did at approximately 9:30pm.

Mr. Diamond stated that Resident A was eventually found outside the window of Room 2 on the property, despite initial concerns that she had left the premises. Resident A reportedly told EMS and AFC staff that she had smoked marijuana prior to the incident and obtained it from Resident B, who is known to use marijuana. Staff reported searching inside the home and the perimeter of the building but did not check the side of the home where Resident A was located. Mr. Diamond stated that both Mr. Mickle and Mrs. Boda were written up and completed in-service training following the incident. Mr. Diamond also confirmed an increase in recent police calls

related to resident elopement, noting that Resident B is a significant elopement risk and involved in the most recent incidents.

Mr. Diamond then introduced me to Resident A. Resident A reported that on the night of 3/25/26, she “hid around the corner,” on side of the house so staff would not know where she was. She stated she sat on the ground but could not get up, and staff later heard her before EMS transported her to the hospital due to elevated blood sugar. When asked whether she was under the influence of marijuana or any other substances, Resident A refused to answer and ended the interview.

Mr. Diamond provided Resident A’s “After Visit Summary” from Trinity Health dated 3/25/26, which listed “drug overdose” as the reason for the visit and identified marijuana as the substance involved.

Later that day, I spoke with staff member Josh Mickle via phone regarding the allegation. Mr. Mickle confirmed last seeing Resident A at 7:30pm on 3/25/26 due to attending to other resident’s needs. When she did not come for her 9:00pm medications, Mr. Mickle brought them to her room and discovered she was missing. He later learned she had been “high on weed outside,” noting that this behavior was uncharacteristic for her. Mr. Mickle confirmed that Resident A had been hiding outside near Room 2. He and his wife, Mrs. Boda checked the perimeter and called out for Resident A but received no response. Mr. Mickle acknowledged that “in retrospect, we should have used a flashlight” due to the time of the day and it being dark outside. He stated that Mrs. Boda contacted Ottawa County dispatch but he did not know the exact time. EMS arrived and transported Resident A to the hospital. Mr. Mickle stated that Resident B consistently has marijuana and often shares it with other residents, making it likely he supplied Resident A. Mr. Mickle believes that Resident A hid outside due to being under the influence of marijuana. Regarding the elopement policy, Mr. Mickle stated that nightly checks typically begin after nightly medications have been passed and sundown. He stated that management informed staff they cannot physically prevent a resident from leaving. However, I shared with him that staff may attempt to verbally redirect residents for their safety. Mr. Mickle was receptive to this.

I also spoke with staff member Wynee Boda via phone. Mrs. Boda stated that on the day of the incident, she was assigned to work one-to-one with Resident B. Therefore, she was unaware that Resident A was missing until she was informed by Mr. Mickle around 9:00pm. She and Mr. Mickle searched around the home and spoke with other residents to inquire about Resident A’s whereabouts but were unable to locate her. She noted that it was dark and that she has difficulty seeing at night. Mrs. Boda stated that she called police at 9:28pm, which was within the 30-minute reporting requirement under AFC licensing rules. She also confirmed that Resident A did not receive her nighttime medications due to being transported to the hospital, as reflected in her Medication Administration Record. Mrs. Boda reported that Resident A’s behavior was unusual and believed Resident B had negatively influenced her, noting that Resident A is typically against marijuana use.

On 05/12/26, I conducted an exit conference with Chief Operations Officer Jessica Engstrom on behalf of licensee designee, Morgan Bailey. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	(2) If elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.
ANALYSIS:	Resident A was considered missing around 9:00pm and staff were unable to locate her. Staff member Mrs. Boda called 911 at 9:28pm, which was within the 30-minute window per AFC licensing rules. Resident A was found hiding on side of the building and was transported to the hospital for a medical evaluation. Therefore, there is not a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the above allegation, staff member Gabriel Diamond informed me that staff members purchase marijuana for Resident B at the dispensary and provide it to him. Mr. Diamond stated this is primarily done by staff member Kimmy Doctor. I informed Mr. Diamond that this needs to stop immediately and Mr. Diamond was receptive to this.

Mrs. Boda had no knowledge of staff purchasing marijuana for Resident B, but she was aware of staff transporting him to the dispensary to purchase it. I also spoke to licensee designee, Morgan Bailey and she agreed that staff will no longer purchase marijuana for Resident B.

On 05/12/26, I conducted an exit conference with Chief Operations Officer Jessica Engstrom on behalf of licensee designee, Morgan Bailey. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report. She also agreed that staff will no longer purchase marijuana for any residents to ensure normalcy.

APPLICABLE RULE	
R 400.671	Resident care.

	(3) A licensee shall ensure that interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Staff Gabriel Diamond and licensee designee Morgan Bailey confirmed that staff have purchased marijuana for Resident B. Resident B reportedly has a history of sharing his marijuana with other residents, which presents ongoing concerns. Based on the information gathered, there is a preponderance of evidence to support this licensing rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's assessment plan. In doing so, I observed the assessment plan was not signed by Resident A's guardian, which is required per licensing rules.

On 05/12/26, I conducted an exit conference with Chief Operations Officer Jessica Engstrom on behalf of licensee designee, Morgan Bailey. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's assessment plan was not signed by his guardian. Therefore, there is a preponderance of evidence to support this licensing rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins

05/12/2026

Anthony Mullins
Licensing Consultant

Date

Approved By:



05/12/2026

Jerry Hendrick
Area Manager

Date