GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 25, 2026

Marlene Burgess
Homes of Opportunity Inc
P.O. Box 190179
Burton, MI 48519

RE: License #: AS820014663
Investigation #: 2026A0992042
Jackson AFC Home

Dear Marlene Burgess:

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) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014663
Investigation #:	2026A0992042
Complaint Receipt Date:	07/21/2026
Investigation Initiation Date:	07/22/2026
Report Due Date:	09/19/2026
Licensee Name:	Homes of Opportunity Inc
Licensee Address:	Suite C 1110 Eldon Baker Drive Flint, MI 48507
Licensee Telephone #:	(248) 505-1987
Administrator:	Marlene Burgess
Licensee Designee:	Marlene Burgess
Name of Facility:	Jackson AFC Home
Facility Address:	14434 Jackson Taylor, MI 48180
Facility Telephone #:	(248) 505-1987
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	06/17/2025
Expiration Date:	06/16/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not given prescribed schizophrenia and seizure medications, placing her at risk for adverse health effects.	Yes

III. METHODOLOGY

07/21/2026	Special Investigation Intake 2026A0992042
07/21/2026	APS Referral Denied
07/22/2026	Special Investigation Initiated - On Site Assistant manager, Jeanette Jenkins, assistant director, Bridget Murphy and Resident A.
07/22/2026	Contact - Telephone call made Licensee designee, Marlene Burgess
07/22/2026	Contact - Telephone call made Guardian A1, Amy Torony with Faith Connection.
07/22/2026	Contact - Document Received Resident A's medication administration records (MARs)
08/04/2026	Contact - Telephone call made Direct care staff, Paris Carroll
08/04/2026	Contact - Telephone call made Direct care staff, Nakeisha Scott was not available. Message left.
08/04/2026	Contact - Telephone call received Message received from Ms. Scott.
08/12/2026	Contact - Telephone call made Ms. Scott
08/18/2026	Exit Conference Ms. Burgess

ALLEGATION: Resident A was not given prescribed schizophrenia and seizure medications, placing her at risk for adverse health effects.

INVESTIGATION: On 07/22/2026, I completed an unannounced onsite inspection and interviewed assistant manager, Jeanette Jenkins, assistant director, Bridget Murphy, regarding the allegation. Ms. Jenkins confirmed the allegation. She stated typically the midnight staff passes the morning medications before the shift ends. She stated for whatever reason on 06/28/2026 Resident A did not receive her morning medication. Ms. Jenkins stated direct care staff, Paris Carroll worked the midnight shift and Nakeisha Scott worked the day shift. She stated Ms. Carroll failed to pass Resident A's medication. Ms. Jenkins stated she did speak with Ms. Carroll regarding the allegation, and she accepted accountability and stated it was an oversight. Ms. Jenkins stated she also addressed the allegation with Ms. Scott because she should have reviewed the medication at the start of her shift to make sure the medication was passed.

I observed Resident A and attempted to interview her. Resident A appeared shy, she acknowledged my presence but did not engage in the interview. Resident A appeared to be clean and adequately dressed.

I reviewed Resident A's medication administration records (MARs) for June and July 2026. The facility uses electronic MARs. None of Resident A's morning medications were passed on 06/28/2026. The MARs were initialed "NS," with a circle around it. According to the explanation provided "medication not given, staff related." Upon further review, there were several medications that contained initials "NS" that were circled on multiple days with the explanation, "medication was not given pharmacy related or medication not given out of stock." It seemed unusual that the medication would be passed the first day of the month, initialed "NS" and circled on the second day of the month stating "medication was not given pharmacy" related and initialed the remainder of the month. I brought this issue to Ms. Jenkins' attention, and she was unable to explain what happened or why it was documented that the medication was not given. Resident A's medications are in a blister pack, if the medications were given the first day of the month, there's no explanation why the medication was not given the following days. None of the medications are "as needed." The blister pack contains a month worth of medication. Ms. Jenkins stated medication is received from the pharmacy around the 20th of the month. I also noticed that all the initials that were circled were "NS," Nakeisha Scott.

While onsite, assistant director, Bridget Murphy arrived onsite. I interviewed her regarding the allegation. Ms. Murphy was unable to explain what happened or why the medication was not given or documented as such; she agreed something's wrong.

On 07/22/2026, I contacted licensee designee, Marlene Burgess regarding the allegation. Ms. Burgess stated she was not aware of the allegation but would make

sure an internal investigation is completed. I made her aware that once the investigation is complete, I will follow up with her to conduct an exit conference.

On 07/22/2026, I contacted Guardian A1, Amy Torony with Faith Connection regarding the allegation. Ms. Torony stated she was made aware of the allegation by the direct care staff; she stated she believed it was Ms. Jenkins that contacted her. Ms. Torony stated the staff are very good with the residents and the home is one of her better homes. She stated she believed it was just an oversight and denied having any concerns.

On 07/22/2026, I contacted direct care staff, Paris Carroll, regarding the allegation, which she confirmed. She stated it was an oversight on her part. She stated that when she works midnight, she passes the morning medications before her shift ends. She stated for whatever reason on the day in question, she did not pass the medication for Resident A. She explained that she had been working doubles, midnight and day shift but since she didn't work a double on that particular day, it must have threw her off. Ms. Carroll stated there is no excuse for what happened and she takes full responsibility. She stated since the incident occurred, there is a new procedure in place. She stated each staff is responsible for checking the medication at the start of their shift. She stated the communication has improved as well. Ms. Carroll stated if for any reason she is unable to pass morning medication before the end of her shift, she communicates that to the next staff on shift.

On 08/12/2026, I contacted direct care staff, Nakeisha Scott, regarding the allegation; which she confirmed. Ms. Scott stated that typically the midnight staff passes the morning medication. Ms. Scott stated Ms. Carroll worked the midnight shift and didn't pass the medication. Ms. Scott stated although Ms. Carroll forgot, it is equally her responsibility as well to check the medications at the start of her shift, and she failed to do so. Ms. Scott stated she thinks they just fell into a routine of the midnight staff passing the morning medication, and there was an oversight. I made Ms. Scott aware that while reviewing Resident A's medication, I noticed that there were several medications that she initialed and circled and the explanation was "medication was not given pharmacy related or medication not given out of stock." Ms. Scott was unable to provide an explanation, she stated she passed the medication daily and denied the medications were not given due to it being pharmacy-related or out of stock. I explained, for example, the medication was given the first day of the month, her initials and circled on the second day of the month stating, "medication was not given pharmacy-related" and initialed the remainder of the month. I explained that since the medication comes in a blister pack with a month of medication it's odd that the explanation is pharmacy related. She stated maybe she didn't pay attention when initialing and accidentally circled her initials. I explained that it seems as though it was a deliberate act because an explanation was entered as well. She stated maybe there is a glitch in the system, but stated the medication was given.

On 08/18/2026, I conducted an exit conference with Ms. Burgess. I explained that based on the investigative findings, there is sufficient evidence to support the allegation. In addition, I made her aware that based on the MARs record, Resident A's medication was not administered as prescribed on several occasions. I explained that based on the interview with Ms. Scott she denied circling her initials or entering an explanation. I explained that Ms. Scott stated it was possibly an oversight on her behalf. I made Ms. Burgess aware that not administering the medications as prescribed jeopardizes residents' health, treatment, and care. Ms. Burgess stated corrective measures have already been implemented. I explained that based on the violations, a written corrective action plan is required, which she agreed to submit.

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:	During this investigation, I interviewed licensee designee Marlene Burgess; assistant manager Jeanette Jenkins; direct care staff Paris Carroll and Nakeisha Scott; Guardian A1 Amy Torony with Faith Connections; and attempted to interview Resident A regarding the allegation. Resident A appeared shy and did not engage in the interview. Therefore, no information regarding the allegation was obtained from Resident A. I reviewed Resident A's Medication Administration Records (MARs) for June and July 2026. Resident A's medication was not initialed on June 28, 2026. Additionally, several medication entries were initialed "NS" and circled; the explanation provided was that "medication was not given, pharmacy related" or "medication not given, out of stock." The explanations provided were not consistent, as the medication was documented as administered on the day before and the day after the dates in question. Furthermore, the medication was packaged in a blister pack containing a month's supply of medication. Based on the documentation reviewed, the stated reasons of pharmacy-related issues or the medication being out of stock do not adequately explain why the medication was not administered on the identified dates. Based on the investigative findings, there is sufficient evidence to support the allegation that Resident A's medication was not given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/19/2026

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Denasha Walker Date
Licensing Consultant

Approved By:

08/25/2026

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Ardra Hunter Date
Area Manager