GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2025

Sarah Mapili
New Genesis Senior Living LLC
856 Majestic Drive
Rochester Hills, MI 48306

RE: License #: AS630414005
Investigation #: 2025A0991009
New Genesis Senior Living - Renshaw

Dear Sarah Mapili:

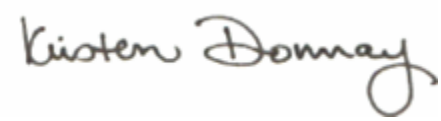
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630414005
Investigation #:	2025A0991009
Complaint Receipt Date:	01/02/2025
Investigation Initiation Date:	01/03/2025
Report Due Date:	03/03/2025
Licensee Name:	New Genesis Senior Living LLC
Licensee Address:	856 Majestic Drive Rochester Hills, MI 48306
Licensee Telephone #:	(248) 495-0493
Licensee Designee:	Sarah Mapili
Name of Facility:	New Genesis Senior Living - Renshaw
Facility Address:	2806 Renshaw Drive Troy, MI 48085
Facility Telephone #:	(248) 495-0493
Original Issuance Date:	02/17/2023
License Status:	REGULAR
Effective Date:	08/17/2023
Expiration Date:	08/16/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 12/30/24, Resident A was taken to the hospital for a broken hip. Staff could not provide an explanation for her injuries.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/02/2025	Special Investigation Intake 2025A0991009
01/02/2025	APS Referral Received from Adult Protective Services (APS)
01/03/2025	Special Investigation Initiated – Telephone Call to Adult Protective Services
01/15/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed staff
01/15/2025	Contact - Telephone call received Interviewed licensee designee, Sarah Mapili
01/15/2025	Contact - Telephone call made To direct care worker, Ludina Briggs
01/15/2025	Contact - Telephone call made To licensee designee, Sarah Mapili
01/15/2025	Contact - Telephone call made To Resident A's relative
01/15/2025	Contact - Telephone call made Interviewed Resident A's relatives
01/15/2025	Contact - Document Received Incident report, assessment plan
01/15/2025	Contact - Telephone call made Left message for Resident A’s physician

01/17/2025	Contact - Document Received Medical information and assistive device authorization
01/17/2025	Contact - Telephone call made To assigned APS worker, Gene Evans
01/28/2025	Contact - Face to Face Observed Resident A in new placement
02/03/2025	Contact - Telephone call received From APS worker, Gene Evans
02/05/2025	Contact - Telephone call made To Resident A's physician- out of the country until 02/18/25
02/05/2025	Exit Conference Via telephone with licensee designee

ALLEGATION:

On 12/30/24, Resident A was taken to the hospital for a broken hip. Staff could not provide an explanation for her injuries.

INVESTIGATION:

On 01/02/25, I received a complaint alleging that on 12/30/24, Resident A was showing signs of pain in her thigh and moaning. The owner contacted Resident A's husband and requested permission to contact EMS (emergency medical services) for Resident A. Resident A was taken to the hospital and it was found that she had sustained a broken hip, which required surgery. Staff could not provide any explanation for the injury. Resident A also fractured her wrist and lower back six months ago after a suspected fall, but staff could not provide any explanation. I initiated my investigation on 01/03/25 by contacting the assigned Adult Protective Services (APS) worker, Gene Evans.

On 01/14/25, I conducted an unannounced onsite inspection at New Genesis Senior Living – Renshaw. I interviewed direct care worker, Carmen Camitan. Ms. Camitan stated that she has been working in the home for ten years. Ms. Camitan stated that she was off on Saturday, 12/28/24, but she came in at 7:00pm on Sunday, 12/29/24. Resident A was in bed sleeping when she came in for her shift. The following morning, 12/30/24, she started to clean Resident A. Resident A began screaming in pain when Ms. Camitan went to put on her brief. Ms. Camitan called the owner/administrator to inform her that Resident A seemed to be in pain. She did not observe any bruising or redness on Resident A's hip. Ms. Camitan stated that the owner came out to look at Resident A later that day and decided that Resident A needed to be sent out to the

hospital, so they called 911 and had her transported to the hospital. Ms. Camitan stated that she did not know what happened to cause Resident A to fracture her hip. Resident A has dementia and was not able to say what happened. She stated that Lulu Briggs was working over the weekend on Saturday and Sunday. Ms. Camitan has never worked a shift with Ms. Briggs and does not know how she is as a caregiver. She was not sure if Ms. Briggs was working alone or not. She stated that there are always two caregivers working during the week, but she was not sure about the weekend. Ms. Camitan stated that Resident A can sit up in bed and one staff person assists her with transferring to her wheelchair.

On 01/15/25, I interviewed the licensee designee, Sarah Mapili, via telephone. She stated that on Monday, 12/30/24, Carmen Camitan alerted her around lunchtime that Resident A was in pain. She told her that she would stop by later that day to check on Resident A. Ms. Mapili stated that she is a physical therapist by profession, so she went to the home to assess Resident A. She touched on her thigh area and suspected that Resident A had a fracture, because she could not bear weight. She stated that Resident A was able to be transferred to her wheelchair that morning and was not in as much pain when she was stationary in her wheelchair. They transferred her back to her bed to assess her and determined that she should be sent to the hospital. Ms. Mapili stated that she did not observe any bruises or signs of trauma. She contacted Resident A's husband and told him that she thought Resident A should be sent to the emergency room for an x-ray. He initially wanted to wait until the following day to have Resident A sent to the hospital, but he agreed to have her sent that night. EMS was called to the home to transport Resident A to the hospital. Ms. Mapili stated that she offered to have staff assist EMS with transferring Resident A, as movement was causing her pain, but they did not want help and transferred her on their own.

Ms. Mapili stated that Ludina (Lulu) Briggs was the staff on shift over the weekend. Ms. Briggs was the only staff on shift. She stated that she checked with Ms. Briggs to see if anything happened during her shifts. Ms. Briggs stated that Resident A was fine. She was able to transfer to her wheelchair Sunday morning. Sunday afternoon, Resident A's husband was at the home visiting. Resident A seemed uncomfortable, but Ms. Briggs stated that she thought it was because Resident A had not slept well the night before. Ms. Mapili stated that Ms. Briggs told her Resident A did not have any trouble transferring to her bed Sunday night. She was still able to bear weight. Ms. Briggs told her that she told the night shift to keep an eye on Resident A because she seemed like she had some pain in her hip. Ms. Briggs stated that Resident A did not fall during her shift. Resident A would need assistance getting up if she had a fall. Ms. Mapili stated that Resident A has a history of severe osteoporosis, so it is possible that she sustained a fracture from bearing weight. Resident A can sit up on her own to transfer. She requires staff assistance to hold onto while she stands and transfers to her wheelchair or bed. Ms. Mapili stated that Resident A is compliant with transferring, as she knows the movements. Ms. Mapili stated that she did not believe her staff inflicted any trauma or harm to Resident A. Resident A had a previous fall in the home, which was

unwitnessed. When they took an x-ray after that fall, Resident A showed signs of severe osteoporosis.

On 01/15/25, I interviewed direct care worker, Ludina (Lulu) Briggs. Ms. Briggs stated that she has worked in the home for ten years. She was working over the weekend prior to Resident A's injury being discovered. She stated that on Sunday 12/29/24, Resident A was able to bear weight to transfer to her wheelchair. When she got Resident A up that morning, Resident A was in the corner of her bed. Resident A's legs were through the bed rails, hanging over the bed. She stated that Resident A was "stuck right there" and she probably got hurt in the railing. She stated that she removed the bed rail from the bed to get Resident A up and out of bed. Resident A did not appear to be injured. She stood and transferred without showing any signs of pain. Resident A did not have any marks or bruises. Ms. Briggs stated that Resident A has full bed rails on her bed and they are used every night. Resident A was not showing any signs of pain when she was sitting in her wheelchair that day. Around 3:00pm, she had some pain and was rubbing her leg. Ms. Briggs stated that Resident A's husband was visiting at that time. She told him that Resident A might have some cramping. Ms. Briggs stated that Resident A was still able to bear weight and help with transferring to bed that evening. Resident A was not crying or yelling out. She did not show any signs of pain other than rubbing on her leg. Ms. Briggs stated that Resident A did not fall during her shift. She stated that if Resident A fell, she would have needed assistance to get her back up. Ms. Briggs stated that she did not cause Resident A any harm and she did not believe any staff person was physically abusive towards Resident A. She stated that everyone loves Resident A.

I reviewed a copy of Resident A's assessment plan dated 02/20/24. It does not specify the use of bed rails or a wheelchair. No assistive devices are noted in the assessment plan. It notes that Resident A requires assistance with toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. It states, "caregiver will provide help" but does not provide any additional information.

On 01/15/25, I made a follow up call to the licensee designee, Sarah Mapili. Ms. Mapili stated that Resident A did have full bed rails, as she would try to get up on her own and it was unsafe. She stated that the bed rails were authorized by the physician, but they were not in the assessment plan, as they were prescribed after Resident A's last fall, which happened after Resident A's assessment plan was written. Ms. Mapili thought the assessment plan only needed to be updated annually, and it was not due to be updated until February 2025. Ms. Mapili stated that staff informed her that it was not unusual for Resident A to be found with her legs down through the bed rails in the morning. This was a common occurrence.

On 01/15/25, I interviewed Resident A's guardian/husband, Relative 1A. Relative 1A stated that overall, he did not have any complaints about the home. He stated that the staff were friendly and did as much as they could. He stated that they cared about Resident A, but "you get what you pay for." Relative 1A stated that Resident A does

have osteoporosis, and it is possible that the injury was due to that. He stated that he did not get a chance to speak to the doctor at the hospital. Resident A went to the hospital on the evening before New Year's Eve. On New Year's Eve, they scurried to get Resident A in for surgery and then everyone scattered to celebrate the holiday. He stated that the owner of the facility wanted to know if the injury was a stress fracture or caused by trauma. She asked if it was because of a fall or due to bowing, but Relative 1A did not talk to the doctor, so he could not answer that question. He stated that Resident A fractured her hip where the femur connects to the socket near the pelvis. They had to put a screw and a pin in to repair it. He stated that he was visiting with Resident A the day before the injury was discovered, and she appeared to be glazed over, watching tv. She usually smiles and reaches for him, but on that day, she seemed "like a zombie". Staff told him that she was tired because the resident in the next room had been banging on the walls and she did not sleep well the night before. He stated that while he was visiting Resident A said, "oh" and grabbed on her thigh. He asked staff what was going on, and the staff stated that Resident A was just tired and might have bumped her thigh on the bed rail. The next day, he received a call around 5:00pm stating that Resident A was in pain. The owner asked him if he wanted to come get Resident A or if she should send Resident A to the hospital. He stated that he could come the next morning to get her, as he does not see well to drive at night. The owner stated that she thought Resident A should go to the hospital, so he agreed to have her sent with EMS. Relative 1A stated that he thought the injury might have occurred while staff was getting Resident A in or out of bed or while transferring her to the wheelchair. Relative 1A stated that Resident A also broke her wrist in the home about six months ago. They also discovered that she had a fracture to her pelvis at that time. It is also unknown how those injuries occurred. Relative 1A stated that Resident A moved to a different facility and is not returning to the home.

On 01/15/25, I interviewed Resident A's daughter and son-in-law, Relative 2A and Relative 3A, via telephone. They stated that they had concerns because this was the second injury that Resident A sustained at the home in less than a year. During the first incident, Resident A broke her wrist, and staff did not know what happened. Resident A's arm was black and blue, and it took staff two days to notify the family. They stated that there was clear evidence that Resident A fell, as she had bruising on her arm and side. Nobody witnessed the fall. This incident was not investigated as Relative 1A was afraid of retribution and talked them out of reporting the incident. They stated that the process for obtaining care takes too long, as staff call the owner, the owner contacts Relative 1A and then asks him if he wants them to call 911. They stated that Resident A is in stage five of seven stages of dementia, so she cannot report when she is in pain or say what happened. They stated that staff should call 911 immediately, rather than contacting the owner and Relative 1A, as this process causes a delay in getting Resident A the care she needs. Most recently, Resident A broke her hip, and staff do not know what happened. Resident A is elderly and has brittle bones, but staff could not provide any explanation for the injury. Relative 2A and Relative 3A stated that there was no evidence of trauma with Resident A's hip injury, as there was no bruising or

discoloration. The attending physician at the hospital stated that he did not see signs of trauma. He asked the family how the injury happened, but they told him they did not know, as the caregivers could not provide an explanation. Resident A broke her hip joint into her pelvis, and she required surgery with a screw and pin to repair the injury. They stated that Resident A did have full bed rails on her bed, which were put in place after her wrist injury. Following that injury, Resident A was only in her bed or her wheelchair. She required staff assistance to transfer. Relative 2A and Relative 3A stated that the home is clean, and the residents appear to be well-cared for, but a lot of the staff are older and may have difficulty transferring the residents. They again expressed concern with the delay in obtaining care and the fact that staff could not provide an explanation for any of Resident A's injuries.

I received and reviewed a copy of an incident report that was dated 12/30/24 at 5:15pm. It notes that the caregiver, Carmen, reported that Resident A seemed in so much pain upon movement on her left thigh area and did not eat well. The incident report notes that the licensee, Sarah Mapili went to check on Resident A and did an assessment. It showed that Resident A might have a fracture on her hip, because she could not bear weight upon transfer and was in pain upon motion. Resident A's husband was called and they decided to call EMS to have Resident A transported to the hospital. The incident report notes that the corrective measures taken to remedy and/or prevent recurrence is to report any sudden changes as soon as possible.

I received and reviewed a video that the licensee designee, Sarah Mapili, took when she was assessing Resident A's injury on 12/30/24. In the video, there were no visible signs of bruising or redness on Resident A's hip or thigh area.

I received and reviewed medical records from Resident A's previous hospitalization on 06/28/24, which note that she had a compression fracture of L1 vertebra- initial encounter, compression fracture of L2 and L3 vertebra, closed fractures of the distal end of her right radius and ulna, a sacral fracture, and left hip pain. It notes that Resident A was previously diagnosed and being treated for post-menopausal osteoporosis.

I reviewed a home health referral form which notes that Resident A used a hospital bed and walker. I also reviewed an assistive device prescription list signed by Resident A's physician, which authorized the use of a walker, wheelchair, toilet raiser, gait belt, hospital bed, and full bed rails.

On 01/28/25, I observed Resident A at her new adult foster care placement. Resident A was resting in bed and appeared to be content. She could not participate in an interview due to advanced dementia and limited verbal/cognitive skills. Staff at the facility stated that Resident A was doing well. She is receiving occupational and physical therapy, and she was recently able to get up and walk with assistance from the physical therapist.

On 02/03/25, I spoke with the assigned APS worker, Gene Evans. Mr. Evans stated that he was not substantiating the allegations, as there was no evidence of trauma or abuse.

Mr. Evans stated that Resident A's relatives also expressed concern to him about the delay in getting Resident A care after she first shows signs of pain.

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 gathered through my investigation, there is sufficient information to conclude that staff did not ensure Resident A's safety and protection at all times. Resident A sustained a fractured hip, and staff could not provide an explanation as to how the injury occurred. Resident A's family members stated that the hospital staff did not find any evidence of abuse or trauma. Resident A was previously diagnosed with osteoporosis, so it is possible that she sustained a fracture from bearing weight. However, on 12/29/24, direct care worker, Ludina Briggs, found Resident A in the corner of her bed with her legs through the bed rails, hanging over the bed. The licensee designee stated that Resident A often put her legs through the bedrails. There were no safety measures put in place to prevent Resident A from putting her legs through the bed rails, such as a bed rail protective barrier or mesh cover.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not obtain needed care immediately when they observed that Resident A was showing signs of pain. Resident A has severe dementia and is not able to verbally communicate when she is in pain. Staff first noticed Resident A showing signs of discomfort on 12/29/24 when she was rubbing her thigh and appeared agitated. On the morning of 12/30/24, Resident A was screaming in pain when staff changed her brief and transferred her to her wheelchair. The licensee designee, Sarah Mapili,

	stated that staff alerted her to Resident A's pain around lunch time on 12/30/24, and she went to the home later that day to assess Resident A. The licensee designee suspected Resident A had a fractured hip and contacted Resident A's husband to see if he wanted to send her to the hospital. Resident A was not sent to the hospital until around 5:00pm that evening.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

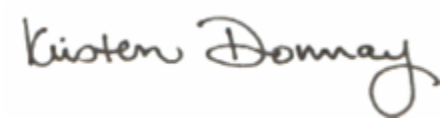
During the investigation, I reviewed a copy of Resident A's assessment plan dated 02/20/24. The assessment plan notes that Resident A does not use any special equipment (wheelchair, walker, cane, etc.). The box for use of assistive devices is checked "yes"; however, no assistive devices are listed. I reviewed an assistive device prescription list signed by Resident A's physician, which authorized the use of a walker, wheelchair, toilet raiser, gait belt, hospital bed, and full bed rails. None of these assistive devices were listed in the assessment plan. The licensee designee, Sarah Mapili, stated that the assistive devices were authorized by the physician, but they were not in the assessment plan, as they were prescribed after Resident A's last fall in June 2024. This happened after Resident A's assessment plan was written. Ms. Mapili stated that she thought the assessment plan only needed to be updated annually, and it was not due to be updated until February 2025.

On 02/05/25, I conducted an exit conference via telephone with the licensee designee, Sarah Mapili. I reviewed my findings and provided technical assistance regarding the use of bed rails. Ms. Mapili agreed to submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Resident A's assessment plan dated 02/20/24 was not updated to specify the use of any assistive devices, including the walker, wheelchair, toilet raiser, gait belt, hospital bed, and full bed rails which were authorized by her physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



02/05/2025

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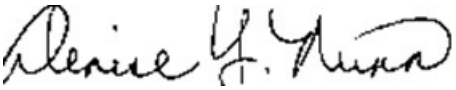
Kristen Donnay Date
Licensing Consultant

Approved By:



02/10/2025

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Denise Y. Nunn Date
Area Manager