GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 15, 2025

Ebrima Drammeh
1531 Giddings Ave
Grand Rapids, MI 49507

RE: License #: AS410414693
Investigation #: 2026A0583013
Giddings AFC II

Dear Mr. Drammeh:

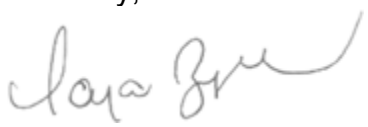
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410414693
Investigation #:	2026A0583013
Complaint Receipt Date:	12/04/2025
Investigation Initiation Date:	12/05/2025
Report Due Date:	01/03/2026
LicenseeName:	Ebrima Drammeh
Licensee Address:	1531 Giddings Ave Grand Rapids, MI 49507
Licensee Telephone #:	(269) 365-8224
Administrator:	Fatumata Kanuteh
Licensee Designee:	N/A
Name of Facility:	Giddings AFC II
Facility Address:	1676 Summerfield St. SE, Apt 1 Kentwood, MI 49508
Facility Telephone #:	(269) 447-5460
Original Issuance Date:	01/11/2023
License Status:	REGULAR
Effective Date:	07/11/2025
Expiration Date:	07/10/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS, DEV DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Gulain Basengezi assaulted Resident A.	Yes

III. METHODOLOGY

12/04/2025	Special Investigation Intake 2026A0583013
12/04/2025	APS Referral
12/05/2025	Special Investigation Initiated - Letter APS Ashleigh Wassenaar
12/05/2025	Inspection Completed On-site
12/12/2025	Exit Conference Licensee Ebrima Drammeh

ALLEGATION: Staff Gulain Basengezi assaulted Resident A.

INVESTIGATION: On 12/04/2025 complaint allegations were received from Adult Protective Services via the LARA-BCHS-Complaints. The complaint stated that staff Gulain Basengezi assaulted Resident A. The complaint stated, "*On 10/30/25, (Resident A) attempted to hug Gulian. (Resident A) often walks up and hugs others. Gulian did not want (Resident A) to hug him. Gulian bent (Resident A's) finger back to his palm on both hands and held it for about 10 minutes and then pushed him away. Gulian pushed (Resident A) into his room and then kicked him in the buttocks. On 10/31/25, it was noticed that both of (Resident A's) hands were red and swollen. (Resident A) was taken to the ER both his hands are fractured. Gulian denied bending (Resident A's) finger back. Gulian reports that he was cooking, and (Resident A) attempted to hug him. Gulian did not want (Resident A) to get hurt so he grabbed him by his wrist and directed him towards his room which he always does".*

On 12/05/2025 I received an email from Adult Protective Services (APS) staff Ashleigh Wassenaar. Ms. Wassenaar stated that she is substantiating her APS case due to physical abuse perpetuated by Mr. Basengezi towards Resident A. She stated that Mr. Basengezi was suspended from his employment at the facility and arrested by law enforcement. Ms. Wassenaar stated that she spoke to Resident A's guardian who reported that Resident A is safe at the facility. Ms. Wassenaar stated that she visited the facility, and Resident A appears to be "doing well".

On 12/05/2025 I completed an unannounced onsite investigation at the facility and interviewed staff Ghyslain Mwenebantu, Staff Solayman Bayo, Resident B, and Resident C. While onsite I observed the wellbeing of Resident A who presents with

limited verbal skills therefore an interview was not completed. Resident A was clean and displayed no signs of distress.

Mr. Mwenebantu stated that Mr. Basengezi is currently on leave because of the allegation that he fractured Resident A's fingers at the end of October 2025. Mr. Mwenebantu stated that he was not present during the incident and has never observed Mr. Basengezi mistreat any resident of the facility.

Mr. Bayo stated that he observed Resident A's swollen hands on the morning of 10/31/2025 and immediately informed licensee Ebrima Drammeh. He stated that Mr. Drammeh informed law enforcement of Resident A's injury that same day. Mr. Bayo stated that he has never observed Mr. Basengezi mistreat any resident of the facility.

Resident B stated that on 10/30/2025 he was outside on the porch of the facility. He stated that he overheard and observed through the window, Resident A attempt to hug Mr. Basengezi. He stated that Mr. Basengezi yelled at Resident A to "get the fuck off me". Resident B stated that he observed Mr. Basengezi "push him and kicked him in the butt into his bedroom". Resident B stated that the next day he observed Resident A's hands were swollen.

Resident C stated that Mr. Basengezi "broke (Resident A's) hands" and his hands are now "healed up". Resident C then stated he had "no comment" to all additional questions.

On 12/09/2025 I interviewed licensee Ebrima Drammeh via telephone. He stated that Mr. Basengezi worked independently at the facility on 10/30/2025 from 8:00 AM until 8:00 PM. He stated that on that same day, staff Mohamed Kanuteh picked up Resident A from the facility at approximately 5:00 PM and brought him to a trunk or treat event and dropped him back off to the facility at approximately 6:30 PM. Mr. Drammeh stated that Resident A was in bed when staff Hugo Longangie arrived at the facility at 8:00 PM to work. Mr. Drammeh stated that on the morning of 10/31/2025, Mr. Longangie called Mr. Brayo and reported that Resident A's hands were both swollen. Mr. Drammeh stated that he went to the facility that same morning and observed Resident A's hands were swollen and he appeared to be in pain as evidenced by his facial expressions. He stated that he transported Resident A to a local urgent care center and Resident A was diagnosed with two finger fractures in one hand and one finger fracture in the other hand. He stated that he returned to the facility and interviewed Resident B and Resident C who both stated that Mr. Basengezi had squeezed Resident A's hands on 10/30/2025 thus causing the injuries. He stated that he immediately called the Kentwood Police Department who came to the facility and interviewed staff and residents. He stated that on 11/10/2025 Resident A was seen at Corewell Orthopedics and Dr. Hinkleman stated that Resident A's injuries are consistent with a fall, rather than a squeeze. He stated that staff observed a healing scab on Resident A's knee around 11/10/2025, but no staff observed Resident A fall. He stated that Mr. Basengezi has been on

administrative leave since 10/31/2025 and he has no history of mistreating residents. He stated that he has spoken to Mr. Basengezi “multiple times” and he denies causing Resident A’s injuries. He stated that Resident B and Resident C have a history of being untruthful and have since recanted observing Mr. Basengezi causing Resident A’s injuries.

On 12/02/2025 I received an email from Mr. Drammeh which included Resident A’s Assessment Plan signed 11/03/2025, Incident Report dated 10/31/2025, and MyChart Medical Note dated 11/11/2025. Resident A’s Assessment Plan states that he does not exhibit self-harming behavior and lacks verbal skills. The Incident Report states that “at 7 am staff was preparing (Resident A) “for shower and saw his hands swollen”. The incident Report states that Resident A was taken to the urgent care, contacted 911, and “suspended staff member pending investigation”. I observed a MyChart Medical Note from Dr. Hinkleman in which Dr. Hinkleman stated “Unfortunately, I cannot really guess at a particular mechanism. The only thing I can say confidently is that it was some type of hyperextension injury. This injury occurs most frequently from a fall when a person catches themselves just with a finger and it forces the finger into hyperextension”.

On 12/09/2025 I interviewed Mr. Basengezi via telephone. He stated that he worked independently at the facility on 10/30/2025 from 8:00 AM to 8:00 PM. He stated that during that time Mr. Longangie transported Resident A to a trunk or treat event from approximately 6:00 PM to 7:00 PM and Resident A appeared uninjured upon his return to the facility. He stated that at approximately 7:30 PM he observed Resident A attempting to hug Resident D in the living room. He stated that he took Resident A with both hands and led him to his bedroom to stop Resident A from hugging Resident D. He stated that Resident A went to his bedroom until he continued coming out multiple times before Mr. Basengezi left at approximately 8:00 PM. He denied harming Resident A in any manner. He stated that he was recently arrested by the Kentwood Police Department and spent one night in jail due to charges of felony 2nd degree abuse. He stated that he has been assigned an attorney and will be pleading not guilty at his next court hearing scheduled 12/11/2025.

On 12/10/2025 I interviewed Detective Mike Chapman of the Kentwood Police Department via telephone. Detective Chapman stated that he was assigned to investigate the complaint and Prosecutor Becker issued an arrest warrant for 2nd degree vulnerable adult abuse against Mr. Basengezi. He stated that Mr. Basengezi admitted to grabbing Resident A’s hands and residents stated that they observed Mr. Basengezi bend Resident A’s hands backwards.

On 12/10/2025 I received an email from Detective Chapman which contained Incident Report 2025-00023163. The document stated the following information:

‘(Resident A) was found on 10-31-2025 to have both hands swollen and bruised and later confirmed to be fractured by urgent care. Witnesses stated Gulain was seen on 10-30-2025 squeezing (Resident A's) fingers and pushing them to the back of his

hand because (Resident A) kept trying to hug him. (Resident A) is nonverbal, but when asked who assaulted him, he stated “G,” referencing Gulain. Gulain denied grabbing (Resident A's) fingers but admitted to grabbing (Resident A's) wrists to direct him away from the kitchen and into the room.

CONTACT WITH WITNESS (Ebrima Dremmeh):
I spoke with Ebrima regarding the incident. Ebrima stated he was notified on 10-31-2025 that resident (Resident A) had injuries to his hand. Ebrima asked (Resident A) who did this to him, and (Resident A) responded by stating "G." Ebrahim stated the residence in the home call Gulain Basengezi "G." Ebrima stated (Resident A) went to Trunk or Treat on 10-30-2025 and had his picture taken in a costume, and his hands were not swollen or bruised in the picture. Ebrima advised the staff that was with (Resident A) at trunk or treat did not observe (Resident A) fall or injure himself. Ebrima stated Gulain was the caregiver for the residence until 2000 on 10-30-2025. Ebrima was advised by other residents that after (Resident A) got home, Gulain at one point grabbed (Resident A) by the fingers and squeezed them very hard along with bending them back to the back of his hand. Gulain then directed (Resident A) into his room and did not report any of (Resident A’s) injuries.

Ebrima stated the nightshift caregiver, Hugo Longangi, arrived and took care of the residents as normal. Hugo noticed in the morning around 0700 that (Resident A) had injuries to both of his hands. Hugo took a picture of the injuries and reported it to staff. Ebrima later arrived at the residence to confirm the injuries and took (Resident A) to urgent care for treatment.

Ebrima stated (Resident A) is nonverbal and has the mental capacity of a 2-year-old but stated (Resident A) can remember all names of the staff and believed that (Resident A) would not make a false accusation of Gulain assaulting him. Ebrima stated he advised (Resident A’s) guardian, Vicky Harnfaber, of the incident.

I briefly spoke with (Resident A) regarding the incident. I asked (Resident A) who injured his hands. (Resident A) replied by stating "G." I did not ask (Resident A) any more questions due to his mental capacity.

CONTACT WITH OTHER RESIDENTS // WITNESSES:
I spoke with residents in the home that witnessed the assault. I first spoke with (Resident C), who stated he observed Gulain grab (Resident A's) fingers and bend them back to the back of his hand because (Resident A) was attempting to give Gulain a hug. (Resident C) stated Gulain held (Resident A's) hands down and squeezed his fingers for approximately 10-15 minutes. (Resident C) stated Gulain then pushed (Resident A) down the hallway and into his room.

I spoke with (Resident B) regarding the incident. (Resident B) stated he observed Gulain grab (Resident A) by both of his hands and squeeze his fingers. (Resident B) stated Gulain then pulled (Resident A) towards him very hard, and he thinks that he heard (Resident A's) hands "snap." (Resident B) stated Gulain then began pushing

(Resident A) into his room, and just before (Resident A) entered his room, Gulain kicked him once on the butt.

CONTACT WITH WITNESS (Hugo Longangi):
I spoke with the nightshift caregiver, Hugo, regarding the incident. Hugo stated he arrived for his shift and was advised by Gulain that he was very annoyed by (Resident A's) actions today. Hugo stated he did not observe any injuries on (Resident A) at the time of starting his shift. Hugo stated (Resident A) was not able to sleep throughout the whole night and believed it was due to (Resident A) being agitated. Hugo stated that at around 0710 the next day he was attempting to give (Resident A) a bath and noticed that both of (Resident A's) hands were swollen, red, and bruised. Hugo immediately took pictures of (Resident A's) injuries and advised staff. Hugo advised (Resident A) did not get injured throughout the night.

CONTACT WITH SUSPECT (Gulain Basengezi):
I spoke with Gulain regarding the incident. Gulain stated he was working with (Resident A) prior to the trunk-or-treat event and stated (Resident A) was getting too close to him while he was cooking. Gulain stated he grabbed (Resident A's) wrists and directed him away from the kitchen and into his room to play games for his saftey. Gulain denied ever grabbing (Resident A's) fingers or squeezing them. Gulain stated after (Resident A) came back from the trunk-or-treat event, Gulain gave (Resident A) his medication and put him to bed. Gulain stated he did not observe any injuries on (Resident A) until it was brought to his attention in the morning. Gulain advised it is normal for him to grab (Resident A) anywhere on his body and direct him where he needs to go.

INJURIES:
(Resident A) had swelling, bruising, and redness on both of his hands. Medical documents from the urgent care that (Resident A) visited stated both hands had a fracture.'

On 12/10/2025 I interviewed Resident D via telephone. He stated that Resident A often hugs him, but it does not bother Resident D. He stated that he did not observe Mr. Basengezi taking Resident A by the hands and did not injure Resident A.

On 12/12/2025 I completed an exit conference via telephone with licensee Ebrima Drammeh. He stated that he did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident

	to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Per Kentwood Police Department Incident Report 2025-00023163, on 10/31/2025 Resident A had injuries to his hands. Resident A identified staff Gulian Basengezi caused these injuries. Mr. Gulian Basengezi has been charged with 2nd degree vulnerable adult abuse. Resident B and Resident C both stated that Mr. Basengezi bent Resident A's fingers backwards thus causing the injuries because Mr. Basengezi did not want Resident A to hug him. Mr. Basengezi denied injuring Resident A. Based upon my investigation, which included interviews and a review of pertinent documentation, a preponderance of evidence does support that a violation of the applicable rule occurred. Mr. Basengezi physically assaulted Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

12/12/2025

Toya Zylstra Date
Licensing Consultant

Approved By:

12/15/2025

Jerry Hendrick Date
Area Manager