GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

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

RE: License #: AS630414005
Investigation #: 2026A0991010
New Genesis Senior Living- Renshaw

Dear Sarah Mapili:

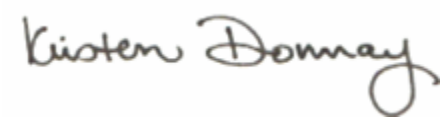
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
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Cadillac Place
3026 W. Grand Blvd. Ste 9-100
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(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 #:	2026A0991010
Complaint Receipt Date:	01/15/2026
Investigation Initiation Date:	01/16/2026
Report Due Date:	03/16/2026
Licensee Name:	New Genesis Senior Living LLC
Licensee Address:	856 Majestic Drive Rochester Hills, MI 48306
Licensee Telephone #:	(248) 495-0493
Administrator:	Sarah Mapili
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:	08/17/2025
Expiration Date:	08/16/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
New Genesis Senior Living has had seven residents living in the home for months. The home is licensed to care for six residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/15/2026	Special Investigation Intake 2026A0991010
01/16/2026	Special Investigation Initiated - On Site Unannounced onsite inspection- interviewed staff and licensee designee, observed residents
01/16/2026	Contact - Document Received Resident Register
01/16/2026	Contact - Telephone call made To licensee designee
01/27/2026	Contact - Document Sent Requested assessment plan and physician authorization
01/27/2026	Contact - Document Received Received assessment plan and hospice nursing assessment
01/29/2026	Exit Conference Via telephone with licensee designee, Sarah Mapili

ALLEGATION:

New Genesis Senior Living has had seven residents living in the home for months. The home is licensed to care for six residents.

INVESTIGATION:

On 01/15/26, I received an anonymous complaint alleging that New Genesis Senior Living- Renshaw has had seven residents living in the home for months. They are only licensed to care for six residents. The complaint was not referred to Adult Protective Services (APS), as there were no allegations of abuse or neglect.

On 01/16/26, I initiated my investigation by conducting an unannounced onsite inspection at New Genesis Senior Living- Renshaw. Direct care worker, Carla Rokicki,

confirmed that there are seven residents currently living in the home. She contacted the licensee designee, Sarah Mapili. I interviewed Ms. Mapili via telephone. She stated that they had a plumbing issue at their other licensed home in Troy (Touch of Care, LLC/AS630370904), so one of the residents, Resident G, moved to the Renshaw home temporarily. She stated that "nobody had vacancy" and Resident G's family agreed to the temporary move, so she moved him into the Renshaw home. She did not inform her licensing consultant of the situation. Ms. Mapili stated that staff from the Touch of Care home are working at Renshaw, so she has two or three caregivers on shift during the day to supervise the seven residents. One of the single occupancy bedrooms was temporarily converted to a double occupancy bedroom. Ms. Mapili stated that the repairs at Touch of Care should be completed by next week. The plumbing collapsed under the cement slab, so they had to dig under the cement to replace the plumbing. She stated that they are finishing up putting in new floors, which should be completed by 01/25/26 or 01/26/26. Ms. Mapili stated that there were three residents at Touch of Care. Resident G moved to Renshaw and the other two residents moved to her licensed home in Warren. The home in Warren had vacancies and is not over capacity. Ms. Mapili stated that the plumbing issues began at the end of October, and the residents moved out in December.

During the onsite inspection, I conducted a walkthrough of the facility. I observed seven residents in the home. The home has six bedrooms, which are licensed as single occupancy bedrooms. A second bed was added to bedroom #2, which is now being shared by Resident B and Resident G.

I received and reviewed a copy of the home's resident register. It lists six residents in the home, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F. Resident G is not listed on the resident register.

I reviewed a text message that the licensee designee, Sarah Mapili sent to the relatives of the residents who were residing at Touch of Care. It states, "Good day Touch of Care Family. I am very sorry to inform you that a move is a must as of now. Upon starting the work in the kitchen plumbing, the contractors need to extend the work in the living area, it might not be as safe for the residents and staff for the extended work, so we need to execute the move to the other house. This will be temporary and will be back next week or longer as we deem safe to go back. The caregivers will move with them so not to break familiarity and we will make the move as safe and smooth as possible. We really apologize for the inconvenience. Please feel free to call me if you have concerns and questions."

APPLICABLE RULE	
R 400.613	**Licensed capacity, occupants.**
	(1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the number of residents and resident beds is greater than the capacity authorized on the license. New Genesis Senior Living- Renshaw is licensed for six residents. At the time of my onsite inspection on 01/16/26, there were seven residents living in the home. Resident G moved into the home after he was displaced from Touch of Care, LLC (AS630370904) due to plumbing issues at that home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection, I observed Resident D in her bedroom alone. She was slumped forward in a Geri chair, which was pushed up against the wall in her bedroom, with her facing the wall. Resident D appeared to be agitated and was yelling out. The Geri chair had a tray on it, preventing Resident D from getting out of the chair. The licensee designee, Sarah Mapili, stated that Resident D is a fall risk, and the Geri chair was prescribed by a physician. The direct care worker on shift, Carla Rokicki, stated that she had gotten Resident D out of bed and put her in the Geri chair. She could not provide an explanation as to why Resident D was facing the wall or why she was in her bedroom alone, while the other residents were in the common area of the home.

I reviewed a copy of Resident D's initial nursing assessment from Serenity Hospice Care. It notes that the caregivers were instructed to closely monitor Resident D due to increased risk for falls. The nursing assessment includes a list of Resident D's assistive devices, and it indicates that she has a Geri chair. The assistive device list does not note the use of a tray table, which restricts Resident D's movement. I reviewed Resident D's assessment plan dated 10/26/25. It notes that she uses a Geri chair as an assistive device and that she is wheelchair and Geri chair bound, but it does not specify the use of a tray table with the Geri chair.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the facility was using restraint without an order from an appropriately licensed health care professional. I observed Resident D in a Geri chair with a tray table, which prevented her from getting out of the chair. Resident D had a nursing assessment completed by hospice, which noted the need for a Geri chair, but it did not specify that a tray table could be used to restrain Resident D's movement.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident D was not treated with dignity and respect with consideration of her safety. During my onsite inspection on 01/16/26, I observed Resident D slumped forward in a Geri chair that was pushed against the wall, so that Resident D was facing the wall. She was alone in her bedroom and appeared to be agitated. Staff could not explain why they positioned Resident D in this manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 01/16/26, I observed that the window next to Resident D's bed was boarded up. The licensee designee, Sarah Mapili, stated that Resident D gets agitated and kicks the window, so they had to cover it with a board. Her bed was positioned directly next to the window, with the window near her feet. Resident D's assessment plan dated 10/26/25 does not include any information about Resident D kicking the window or behaving aggressively.

I also observed that Resident D's bedroom was being used as a storage area. There was a wheelchair, bed rails, floor mats, a curtain rod, a mattress, a laundry basket, and personal items piled up on the side of the room opposite Resident D's bed. The licensee designee, Sarah Mapili, stated that some things had to be moved into the home due to the work being done at the other home. I informed Ms. Mapili that a resident's bedroom cannot be used as a storage area.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home was not maintained to provide for the safety and well-being of the residents. During my onsite inspection, I observed a window that was boarded up in Resident D's bedroom. Resident D's bedroom was also being used as a storage space, with mattresses, wheelchairs, floor mats, bed rails, and personal items piled up on one side of the room.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I observed a bed and chair in the hallway area to the right of the front door. The bed was made with sheets, a comforter, and pillows. There was a lamp attached to the bed. There were two pairs of shoes by the bed, as well as an overnight bag with personal belongings. The staff on shift, Carla Rokicki, and the licensee designee, Sarah Mapili, stated that staff do not live in the home and do not sleep on shift. They stated that Resident F, whose bedroom is located to the right of the front door, wakes up frequently and calls out during the night. They stated that they put the bed there for staff to use so they can be near Resident F.

APPLICABLE RULE	
R 400.657	**Bedrooms.**
	(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the hallway is being used as a sleeping area. During the onsite inspection, I observed a bed and chair in the hallway to the right of the front door. While the licensee designee and staff denied that staff sleep in the home, the bed was fully made up and there were

	personal belongings including shoes and an overnight bag next to the bed, indicating that the area is used for sleeping.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I observed that the bedroom doors throughout the facility had hook and eye latches installed on the outside of each bedroom door. Staff stated that they had a resident who wandered into bedrooms, so they were installed. I informed the licensee designee, Sarah Mapili, that the bedroom doors could not have hook and eye latches. She stated that the contractor would go to the home to remove them.

APPLICABLE RULE	
R 400.657	**Bedrooms.**
	(4) Interior doorways of a resident bedroom must be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	Based on the information gathered through my investigation, the bedroom doors were not equipped with non-locking against egress hardware. Each of the bedroom doors had hook and eye latches installed on the outside of the door, which could allow the residents to be locked inside their bedrooms and could prevent safe egress from the rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I observed a space heater being used in Resident E's bedroom. The space heater appeared to be very old. I informed the licensee designee, Sarah Mapili, that the space heater must be UL listed and equipped with a tip over sensor and a temperature overheat sensor per the licensing rules. She did not provide verification that the space heater met these requirements.

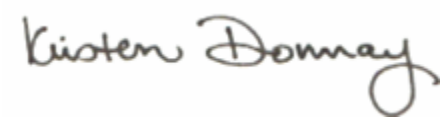
On 01/29/26, I conducted an exit conference via telephone with the licensee designee, Sarah Mapili. She stated that Resident G moved back to the Touch of Care home on 01/27/26. The home now has six residents. Ms. Mapili stated that the hook and eye latches and space heater have been removed. I provided technical assistance to Ms. Mapili regarding non-locking against egress door locks and maintaining documentation for any approved space heaters. Ms. Mapili stated that the window in Resident D's bedroom is no longer boarded up and the items that were being stored in her room have

been removed. She stated that she would submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.739	**Heating.**
	(2) Portable heating units are allowed if they are UL listed and equipped with a tip over sensor and a temperature overheat sensor. Portable heating units must not be plugged into an extension cord or power strip and must be used in accordance with manufacturer's recommendations and guidelines. Documentation showing compliance with these requirements must be maintained at the facility and available for inspection. When determining if use and placement of a portable heating unit is appropriate, the resident population served and ensuring their safety must be taken into account.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the space heater in Resident E's bedroom was not UL listed and equipped with a tip over sensor and a temperature overheat sensor. The space heater appeared to be very old and the licensee designee did not provide documentation to show that it met the requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

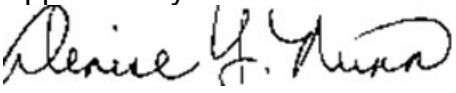
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



01/29/2026

Kristen Donnay Date
Licensing Consultant

Approved By:



01/29/2026

Denise Y. Nunn Date
Area Manager