GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2026

Gary Ray
Genesee Manor, Inc.
30002 Saint Martins
Livonia, MI 48152

RE: License #: AS630417946
Investigation #: 2026A0605008
Nat West Home 1

Dear Gary Ray:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd., Ste 9-100
Cadillac Place
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630417946
Investigation #:	2026A0605008
Complaint Receipt Date:	01/20/2026
Investigation Initiation Date:	01/20/2026
Report Due Date:	03/21/2026
Licensee Name:	Genesee Manor, Inc.
Licensee Address:	30002 Saint Martins Livonia, MI 48152
Licensee Telephone #:	(313) 949-2501
Administrator:	Michele Ray
Licensee Designee:	Gary Ray
Name of Facility:	Nat West Home 1
Facility Address:	31835 Alameda Farmington Hills, MI 48336
Facility Telephone #:	(313) 949-2501
Original Issuance Date:	01/29/2025
License Status:	REGULAR
Effective Date:	07/29/2025
Expiration Date:	07/28/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A became upset on 01/08/2026 after being told “No,” she could not take her tablet to school. Resident A’s behavioral plan was not followed by staff. Resident A made a statement, “he touched me.” Staff called police and Resident A was arrested.	Yes
Resident B had a seizure; however, her seizure protocol was not followed, and it was unclear how long the seizure lasted, but staff administered Resident B’s seizure medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/20/2026	Special Investigation Intake 2026A0605008
01/20/2026	Special Investigation Initiated - On Site Conducted unannounced on-site investigation
01/20/2026	APS Referral Referral made by Adult Protective Services (APS) but will not be investigating these allegations.
01/21/2026	Contact - Telephone call made Discussed allegations with direct care staff (DCS), Resident A's maternal grandmother (MGM)/legal guardian and Resident A's case coordinator Tai'Escia Gibson with Easterseals/Macomb-Oakland Regional Center (MORC)
01/22/2026	Contact - Telephone call made Discussed allegations with home manager (HM) Steven Price, assistant case coordinator Devonier Murphy and Behavior Support Clinician Talia Pruett with Easterseals/MORC
01/22/2026	Contact - Document Received Email from administrator Michele Ray
01/26/2026	Contact - Document Received Email from Michele Ray

01/26/2026	Contact - Document Sent Email to Michele Ray
01/26/2026	Contact - Telephone call made Discussed allegations with administrator Michele Ray and DCS
01/27/2026	Referral - Recipient Rights Referral to Wayne County Office of Recipient Rights (WCORR) was made
01/28/2026	Contact - Telephone call received Message left by WCORR Frank Lewis
01/28/2026	Contact - Telephone call made Discussed allegations with WCORR Frank Lewis
01/28/2026	Contact - Document Sent Made another referral to WCORR regarding allegations pertaining to Resident B's seizure
01/28/2026	Contact - Document Sent Sent email to administrator Michele Ray
01/29/2026	Contact - Face to Face Made attempt to interview Resident A at Vision's Unlimited, but she was not present
02/02/2026	Contact - Document Received Email from Michele Ray
02/02/2026	Contact - Document Sent Email to WCORR Frank Lewis
02/02/2026	Contact - Document Sent Email to case coordinator with Easterseals/MORC
02/02/2026	Contact - Telephone call made Discussed allegations with day team lead Shauna Minter, HM Steven Price, direct care staff (DCS) Riyanna Tigner and left messages for Resident B's mother, DCS Lerise Clark and Nadra Kidd. Attempted to leave message for lead DCS Kiana Kidd, but her mailbox is full.

02/02/2026	Contact - Telephone call made Discussed allegations with Human Resource Meghan Williams and DCS Kiana Kidd
02/02/2026	Contact - Document Received Email from Michele Ray
02/03/2026	Contact - Document Received Email from Michele Ray
02/04/2026	Contact - Telephone call received Discussed allegations with DCS Nadra Kidd
02/05/2026	Contact - Telephone call received Discussed allegations with Resident B and Resident C mother
02/05/2026	Contact - Document Sent Email to Farmington Police Department Records
02/05/2026	Contact - Document Received Email from Farmington Police Department Records
02/11/2026	Contact - Telephone call received Discussed allegations with Joy Mathias with WCORR regarding Resident B
02/11/2026	Contact - Telephone call made Left message for DCS Lerise Clark
02/12/2026	Contact - Telephone call made Left message for licensee designee Gary Ray
02/12/2026	Contact - Telephone call made Call with the secretary Kate from Vision's Unlimited regarding Resident C
02/12/2026	Contact - Telephone call received Received call from Kate from Vision's Unlimited regarding Resident C
02/17/2026	Contact - Face to Face Observed Resident A, Resident B, and Resident C
02/18/2026	Contact - Document Sent Email to Michele Ray

02/18/2026	Contact - Telephone call made Discussed allegations with team leads
02/18/2026	Exit Conference I conducted an exit conference with the licensee designee and administrator Michele Ray with my findings.

ALLEGATION:

Resident A became upset on 01/08/2026 after being told "No," she could not take her tablet to school. Resident A's behavioral plan was not followed by staff. Resident A made a statement, "he touched me." Staff called police and Resident A was arrested.

INVESTIGATION:

On 01/20/2026, intake 209019 was referred by Adult Protective Services (APS) who denied the referral. Initially this investigation was sent to Wayne County Adult Foster Care (WCAFC) under Genesee Manor, Inc., but then it was determined that Resident A resides in Genesee Manor, Inc., Oakland County AFC home, Nat West Home 1.

On 01/20/2026, I initiated this investigation by conducting an unannounced on-site visit. Present were Shauna Minter, shift team lead, direct care staff (DCS) Chequia Webb, Resident B and Resident D. Resident A and Resident C were at school, Visions Unlimited.

I interviewed direct care staff (DCS) Shauna Minter regarding the allegations. Shauna works Mondays-Thursdays 8AM-4PM. There are four residents that live in the home. Resident A, Resident B, and Resident C each have a one-to-one staff; however, when all four residents are present at home, there must be four DCS always. Resident A had been upset agitated the week prior after returning from a visit with her father. On 01/08/2026, Shauna began her shift at 8AM. DCS Chequia Webb, called in that morning, so Shauna was the only staff at the home with all four residents. The bus arrived, but Resident A did not want to go to school. Resident C went to school. Shauna explained to Resident A that it was important to go to school, but Resident A was upset and agitated. Resident A then asked to take her tablet with her to school. Shauna was under the impression that Resident A's maternal grandmother (MGM)/legal guardian did not want the tablet at school, so Shauna told Resident A, "No." Resident began calling Shauna "N**ger," and became verbally aggressive towards Shauna. Shauna had Resident A go into her bedroom and while in her bedroom, Resident A said something about "rape." Shauna went after her to ask her why she said, "rape." Resident A said, "your boyfriend is going to rape me while you hold me down." Shauna asked Resident A, "Where did you hear that?" Resident A said, "I don't know." Shauna called the home manager (HM) Steven Price to come to the home and transport Resident A to school. Steven and the assistant HM Shakita Lloyd arrived at the home, put Resident A into the

van and transported her to school. Around 11:30AM, Shauna received a telephone call from Visions Unlimited asking her if they're still bringing the tablet. Shauna asked the school if it was ok to bring the tablet and the school said, "Yes." Shauna called the MGM to make sure it was ok to take the tablet to school. The MGM told Shauna the principal said it was ok because "Resident A was acting up." Shauna called the HM Steven and advised him that the school and the MGM stated it was ok to bring the tablet, so he took the tablet to Resident A at school. I was unable to complete my interview with Shauna because she had to get on a Zoom call. I advised her that I would call her tomorrow.

I interviewed DCS Chequia Webb regarding the allegations. Chequia has been working for this corporation since April 2025. She works Mondays-Thursdays from 8AM-4PM. She too reported that if all four residents are home, then there should always be four DCS. On 01/08/2026, Chequia called off work for personal reasons, leaving Shauna working the shift alone. She was not present during the incident and had not heard about what happened. She stated she cannot provide any information about the incident because "she does not know anything." Resident A has a tablet that she uses at home in her bedroom and does not know anything about taking her tablet to school. Resident A has never reported to Chequia about anyone touching her inappropriately or anything about rape. Again, she stated she had no further information to offer about these allegations.

I was unable to interview Resident B as she is non-verbal and was sleeping during this visit. I did see her in her bedroom; she was under the covers so Chequia pulled the covers off her face and I saw her sleeping. Resident B woke up for a few minutes but then went back to sleep. No concerns noted.

I interviewed Resident D regarding the allegations in her bedroom. Resident D is her own guardian. She was present on 01/08/2026 when she observed Resident A yelling, spitting, and hitting Shauna. The night before, Resident A was upset and doing the same thing with staff, spitting and hitting them. Resident D stated, "she spit on me, but I didn't react. I just came into my bedroom." The incident started because Resident A wanted to take her tablet to school and was told no. She was upset, became verbal towards Shauna and then escalated to hitting and spitting at staff. Resident A also spit at HM Steven who arrived at the home and took Resident A to school. Prior to Resident A going to school, Resident D heard Resident A say, "Kennesha is trying to rape me." Resident D stated that Kennesha is an afternoon staff and was not present at the home on 01/08/2026 during the day. Then Resident D heard Resident A say, "Shauna is gonna get her boyfriend to rape me." Resident D has never seen Shauna's boyfriend at this home.

On 01/21/2026, I contacted Shauna Minter via telephone and completed the interview regarding these allegations. HM Steven had promised Resident A that if she went to school, he would bring her tablet to her, so Resident A agreed and Steven dropped her off around 9:30AM. About two hours later, the secretary at the school called asking where Steven was because Resident A's behavior was escalating. Resident A was upset she did not have her tablet as promised by Steven. Shauna called the MGM to

see if it was ok to have the tablet taken to the school and that is when MGM stated it was because the principal called the MGM saying that Resident A was acting up, throwing chairs around the classroom. Steven took the tablet to Resident A and Resident A stayed at school the rest of the day. Resident A returned home from school and apologized to Shauna. Shauna ended her shift at 4PM but then heard that there was another incident on 01/08/2026 during the afternoon shift. Resident A was again yelling, hitting, spitting at staff and using racial slurs. Staff called the police and Resident A was arrested. She does not know what happened during the afternoon shift but heard that Southfield Police were tired of coming out to the home regarding Resident A, so they arrested her for domestic assault. Shauna stated that Resident A's behavior changed after Resident A visited with her father. That was the first visit with her father. Whenever Resident A has a behavior, Shauna deescalates the behavior by redirecting her to her bedroom and using a calm voice which is part of her plan of care. Shauna stated there are minimal incidents during the day shift because Resident A is usually at school.

On 01/21/2026, I interviewed Resident A's MGM/legal guardian regarding the allegations. Resident A has one-to-one staff at this home. The week before the incident on 01/08/2026, Resident A was having lots of issues. Her main issue was being told "No." The day of the incident, Resident A wanted to take her tablet to school with her but was told "No," because Resident A has a chrome tablet the school provides and having her tablet at the school was not necessary. The MGM stated that during the morning, Shauna was able to deescalate Resident A by sending her to her bedroom and eventually Resident A calmed down and went to school. However, the MGM stated that there was another incident during the afternoon shift where the police were called and Resident A was arrested. There have been multiple issues with the afternoon shift in redirecting Resident A. Resident A has tendencies of using inappropriate words, such as the "N," word with staff. The protocol with Resident A is to redirect her and remind her to go into her bedroom to calm down. If that does not work, then staff know to call the MGM who helps calm her down.

The MGM stated, "until now, everything was going well. I have a feeling it was not handled the correct way by staff because police were called and she was arrested. Some of the newer staff are unable to deescalate these issues." The MGM was informed by Shauna that Resident A must go to school in the morning even if she does not want to go to school because "there's nobody here during the day, referring to staff." The MGM stated that "Shauna is the one who can deal with Resident A the best and can deescalate Resident A's behaviors." The MGM is concerned that there is lack of training in Resident A's plan of service with staff as evidenced by Resident A's arrest. Resident A yelled "rape," to Shauna who informed the MGM of this, and the MGM has never heard Resident A ever say rape. Resident A repeats things and sometimes does not know the word she says. The MGM's concern is that there are new afternoon and midnight staff and that problems are occurring during those shifts, and these staff are finding it difficult to address Resident A's behavior. However, the MGM feels that Resident A is safe at this home. The MGM provided me with Resident A's case

coordinator's contact information with Easterseals/Macomb-Oakland Regional Center (MORC).

On 01/21/2026, I contacted Tai'Escia Gibson, the case coordinator with Easterseals/ MORC via telephone and discussed the allegations. Ms. Gibson provides services to Resident A and the other residents at this home. Ms. Gibson has been having issues with staff at Nat West Home 1 following Resident A's behavioral plan. Ms. Gibson stated, "there is verbiage directly in Resident A's behavioral plan that states how to redirect Resident A, but staff are not following her plan." She scheduled an appointment with HM Steven Price and the afternoon staff at this home on 01/06/2026, but when she arrived, the only staff present was the day shift staff. Due to the numerous incident reports (IR) received regarding Resident A, she and the behavioralist Talia Pruiett scheduled a meeting with the provider. Ms. Gibson stated, "I'm not comfortable with the level of care being provided at this home to Resident A and the other residents." She stated, three out of the four residents require one-to-one staffing and staffing should always be available, even when Resident A does not want to go to school. This home "makes," Resident A go to school due to staffing issues. Ms. Gibson was not aware of Resident A visiting with her father and saying the word, rape. The staff advised Ms. Gibson that rape was reported to police when Resident A was arrested.

On 01/22/2026, I interviewed HM Steven Price regarding the allegations via telephone. Steven has been with this corporation for nine years. He works 8AM-4PM but oversee multiple homes. On 01/08/2026, he was contacted by Shauna advising him that DCS Chequia Webb called in and Resident A did not want to go to school. He and the assistant manager Shakita Lloyd went to the home. Resident A wanted to take her tablet to school with her, but the school would not allow it. He took her to school and talked to the principal who explained that she could not have her tablet at school because the school already had a tablet for her. He left and then stated that he received a call from the school because now, "Resident A was throwing chairs and books." He and Shakita went to the school with the tablet and found the school staff hiding behind the door due to Resident A throwing chairs. Resident A was then returned home and was still agitated. The afternoon staff reported that Resident A was "disrespecting staff," and then went to Resident C and began hitting Resident C. Resident A then began hitting and spitting at staff so staff called the police and the police arrested Resident A for domestic assault. She was in jail until Steven went and picked her up and took her to Team Wellness, a crisis center. She was there for a few days then he was contacted to pick her up. He and the administrator Michele Ray refused to pick her up without any as needed medication. Team Wellness prescribed Resident A with a as needed medication, so Steven picked her up. Since returning, Resident A has only required the as needed medication a couple of times. He feels that staff are doing everything to provide care for all the residents and that Resident A's behaviors are too much because staff are tired of being called "Ni**ers, spit on, and hit." He stated, "staff are present and still show up and provide care." It was difficult to get Steven to acknowledge that staff are not utilizing Resident A's behavior plan as stated to deescalate these behaviors. Steven believes that staff are doing everything for Resident A, even though prior to the as needed medication, staff were submitting numerous IRs to Easterseals/MORC

regarding her hospitalizations. Steven stated he has been working with the behavioralist Talia Pruiett and will be utilizing the reward system with Resident A. He suggested I speak with Ms. Pruiett.

On 01/22/2026, I interviewed Talia Pruiett, the Behavior Support Clinician with Easterseals/MORC regarding the allegations. Ms. Pruiett is new to New West Home 1 as of August 2021. The previous clinician in-serviced HM Steven Price on Resident A's behavioral plan and Steven "understood," that it is his responsibility to in-service all staff. Data sheets were being completed; however, when behaviors were documented on the data sheets, there were no strategies or interventions stated on how they were being implemented with Resident A. This concerned Ms. Pruiett due to the many IR's received regarding Resident A's behaviors escalating. First shift staff have minimal interactions with Resident A because she is in school most of the day and when Resident A did not go to school, first shift staff could deescalate her behavior. However, her concern is with second shift staff as she spoke with a female staff, name unknown that could not provide her with one strategy intervention that was on Resident A's behavioral plan. There are specific verbiage directly in Resident A's behavioral plan that must be used to deescalate Resident A and staff are not utilizing the plan.

On 01/06/2026, a meeting was scheduled at the home with all staff, specifically HM Steven and the afternoon staff. When Ms. Pruiett and Ms. Gibson arrived, the HM and afternoon staff were not present. The only staff present were the dayshift staff. This was concerning since both Ms. Pruiett and Ms. Gibson received numerous IR's regarding Resident A who was being hospitalized multiple times during the afternoon. The plan of care is in place to keep Resident A in her home and safe but according to the IR's, staff are utilizing hospitalization instead of following the behavioral plan when Resident A's behavior escalates. On 01/08/2026, Resident A was arrested, which caused serious concerns about the safety of Resident A. Prior to this incident, Ms. Pruiett offered to increase her visits at home and offered to provide additional training to staff, but her offers were not accepted until after 01/08/2026. Ms. Pruiett had a meeting with the provider, Michele Ray and HM Steven, expressing concerns about staff not following Resident A's behavioral plan. Ms. Ray told Ms. Pruiett that because she does not pay staff well, there is a high turnover and because of that, it is so hard to "reinforce," the plan with staff. After this meeting, Ms. Pruiett is meeting with residents and staff twice monthly at the home, all staff have been trained and in-serviced on Resident A's behavioral plan and it was suggested that a "reward system," be put in place for Resident A, which was suggested previously in September 2025, but not followed. Resident A returned home only after she was prescribed medication. Ms. Pruiett is concerned that staff will use the as needed medication as a form of deescalation instead of her one-to-one staff working with her.

On 01/22/2026, I contacted the assistant case coordinator DeVonier Murphy with Easterseals/MORC regarding the allegations. He went to Visions Unlimited today and saw Resident A after her release from jail. She was flashing her breasts and stomach which was reported by her teacher and giving the middle finger. These are new behaviors. He sees her monthly and has not received any reports from the group home

about these behaviors. He has a close relationship with the MGM who texts him regularly regarding Resident A. Resident A was upset prior to the incident on 01/08/2026. He had visited with Resident A again at school on 01/07/2026 and he let Shauna Minter know that “Resident A seemed frustrated and agitated,” and told Shauna that was a “precursor of her possibly escalating,” and to “not leave her alone.” Resident A had requested to go home, so Mr. Murphy called Shauna who advised him that there was no additional staff for Resident A and that Resident A had to wait until she was dropped home from school as that is when her one-on-one staff will be at home. Mr. Murphy reviewed the numerous IRs received and he too believes the behavior plan in place for Resident A is not being followed by staff. Staff told Mr. Murphy, “Resident A does not like black people.” He explained to the staff that these concerns are Resident A’s behaviors and the behavior plan if followed, will assist in addressing these concerns. Staff is always changing so the behavior plan is not be reviewed nor implemented by new staff. The staff is given the tools they need by Easterseals/MORC, but they are not utilizing these tools. Instead, Resident A is being hospitalized and now arrested.

On 01/26/2026, I contacted the administrator Michele Ray via telephone regarding these allegations. Mondays-Thursday, there are three shifts, 8AM-4PM, 4PM-12AM and 12AM-8AM. On Fridays-Sundays, there are only two shifts, 8AM-8PM and 8PM-8AM. Residents A, B, and C are each one-to-one, therefore, if all four residents are home, then there are four DCS on shift. During the morning shift 8AM-4PM, Resident A and Resident C attend school, so there are only two DCS during that shift. On 01/08/2026, Resident A did not want to go to school. She was yelling and screaming and cursing. The management team, HM Steven Price and assistant HM Shakita Lloyd, went to the group home to assist and were able to transport Resident A to school.

Ms. Ray stated that at school there was a situation with Resident A because she wanted her personal tablet. The school called the group home and asked them to bring the tablet even though Resident A had the school’s tablet. Steven dropped off the tablet to school, and everything was ok. Later that day, Shauna told Mrs. Ray that Resident A stated, “she had been raped.” There was no other information provided to Mrs. Ray. Mrs. Ray stated that Resident A has never made any reports to her nor to staff about being touched in appropriately nor has she ever said the word rape. It is unclear where she heard it from. Resident A returned home from school. She was still agitated. Around 5PM, Resident A stated she wanted to go to Corewell Health Hospital. She was cursing and yelling at staff. Resident A was using racial slurs towards DCS Margaret Hilton and Kenesha McConnico who were working the afternoon shift. Margaret called 911 due to Resident A hitting and spitting at the residents and staff. The police arrived at the group home and because they had already been there regarding Resident A hitting and spitting at staff, police arrested Resident A. The HM Steven attempted to intervene and request the police not to arrest Resident A, but police stated that they had to due to Resident A assaulting staff and Resident C. Resident A spent a couple of nights in jail and then the court wanted to discharge her back to the group home, but Mrs. Ray requested Resident A to go to Team Wellness for a mental health evaluation with the hopes of getting an as needed medication prescribed. Team Wellness completed an assessment and discharged her with Olanzapine 10MG. Resident A was discharged

back to the group home. The next day, Resident A was agitated and as soon as staff observed her behavior, she was administered the Olanzapine and there were no issues. Since returning, the medication has only been administered a couple of times by staff. Resident A's aggression has decreased as Team Wellness also modified one of her other medications.

Mrs. Ray stated she was unaware that Shauna was the only DCS on the morning shift on 01/08/2026 after DCS Chequia Webb called in. The human resources (HR) department, Meghan Williams is responsible for staff scheduling and because she was out, staff were not filled in for that shift. Mrs. Ray had a meeting with Easterseals/MORC regarding Resident A's IPOS and stated that she has strong staff during the day shift, but the staff during the afternoon shifts had to be in-serviced and retrained. There is a high turnover during the afternoon, and midnight shift so when staff are trained, they quit. Mrs. Ray stated that staff redirect Resident A and remove Resident C because Resident A tends to become aggressive towards Resident C when Resident A is upset and agitated. Mrs. Ray stated that she and staff have been verbalizing to the case coordinator Tai-Escha Milton and the behavioralist Talia Pruiett about verbiage staff should say to Resident A, and after the incident on 01/08/2026, Mrs. Ray stated, "I feel good about all staff because of this situation, they have all been in-serviced and everyone's on board." She and Easterseals have reviewed Resident A's IPOS, progress notes, and what to focus on and work on regarding Resident A's behavioral plan. She also has reviewed Genessee Manor's personnel policies and feels "confident," in her staff that "they know what to do."

On 01/26/2026, I contacted DCS Kennesha McConnico via telephone regarding the allegations. Kennesha has been working for this corporation for about two years. She works Mondays-Thursdays 4PM-12AM. There are usually four DCS during her shift, but on 01/08/2026 and today there are only two DCS when all four residents are home. On 01/08/2026, she arrived at 4PM along with DCS Margaret Hilton. Resident A was in her bedroom. Resident A came out of her bedroom asking for "pop." Kennesha told Resident A that staff could not leave the home which upset Resident A. The group home's policy is that staff cannot take the residents out of the home nor can staff use personal funds on residents. Resident A began yelling, cursing and hitting all the residents and staff. Kennesha stated, "I asked her to calm down, then she went into Resident B's and Resident C's bedroom and locked herself in there with Resident B. Resident C was in the living room. Kennesha tried to get Resident A to open the door, but Resident A refused. Kennesha went outside to look through the bedroom window and saw Resident A climbing out of the bedroom window. After several attempts, Resident A went back inside the house. Resident A escalated to hitting and spitting at all the residents and both her and Margaret. Kennesha called the HM Steven who contacted Resident A's MGM who advised them to call the police. The police were contacted and arrested because the police had already been to the group home regarding Resident A assaulting residents and staff. Kennesha stated she tried redirecting Resident A and "get her to calm down," and "asks her what she wants," but redirection did not work. Resident A returned to the group home with an as needed

medication that Kennesha has only administered once since Resident A has returned home.

On 01/26/2026, I interviewed DCS Margaret Hilton regarding the allegation via telephone. Margaret has been working for this corporation for one year. She too works Mondays-Thursdays 4PM-12AM. On 01/08/2026, she was working with Kennesha and there were only two DCS during their shift with all four resident's home. There should be four DCS when all the residents are present. Margaret was responsible for Resident C and Resident D, and Kennesha was responsible for Resident A and Resident B. Resident A had been agitated during the day and her agitation continued after not getting pop as she wanted. Resident A began hollering and hitting staff and the residents. Resident A then went into Resident B's and Resident C's bedroom and locked herself in the bedroom with Resident B. Both Margaret and Kennesha tried to get Resident A to open the door, but she refused. Kennesha went outside to look through the window and saw Resident A climbing out of the window. After several attempts trying to redirect Resident A, she finally returned inside. Resident A continued to hit, spit, and curse both the residents and staff. Kennesha called the HM Steven who advised them to call 911. The police arrived at the home, and both staff informed the police what happened. Resident A was arrested because police had come out to the home prior regarding Resident A hitting staff and the residents. Margaret stated she does not work with Resident A so other than "trying to talk to her to calm her down," Margaret "does not know what Resident A's behavioral plan is."

On 01/26/2026, I received an email from the administrator Michele Ray with documents requested. Here is the summary of the documents:

- Resident A's January logs of her social interactions recorded by staff show that staff have recorded her overall behavior for the day, but there is no record of how staff are addressing those behaviors. For example, 01/08/2026 "disruptive behavior before school. She was yelling, cussing, hitting, spitting of peers and staff." There is no other documentation on how staff attempted to address those behaviors.
- IR dated 01/08/2026 at 8:10AM regarding Resident A hitting peers and staff. MGM and management contacted.
- IR dated 01/08/2026 at 9AM regarding Resident A's disruptive behavior, due to Resident A not wanting to attend school. Management was contacted and eventually Resident A went to school.
- IR dated 01/08/2026 at 5PM regarding Resident A having a behavior and asking to go to Corewell Health Hospital. Staff try to redirect her to become calm, she start cussing, yelling, saying racist slur to staff. Supervisor, MGM and police were called. Resident A was arrested.

On 01/27/2026, I interviewed assistant HM Shakita Lloyd via telephone regarding the allegations. Shakita has been working for this corporation for two years. On 01/08/2026, Shauna called saying that Resident A did not want to go to school. She and the HM Steven rushed to the home. Resident A was agitated and upset because she wanted to take her tablet to school. Steven told Resident A, if the school's tablet does not work, he

will bring Resident A's tablet to her. Resident A agreed so Steven dropped her off at school. After school, Resident A returned home, was agitated and began hitting and spitting at staff working the afternoon shift and hitting and spitting. Resident A always picks on Resident C who is non-verbal and was hitting and spitting on her. Staff attempted to calm Resident A down but were unsuccessful so they contacted 911. The police arrived and arrested Resident A for domestic assault. Resident A was sent to the crisis center, evaluated and discharged back to the group home with an as needed medication. Staff are to administer this as needed medication the first signs of agitation by Resident A. So far, the medication has been working and currently, staff are not having to administer the medication often as Resident A's aggression has minimized. HR is responsible for scheduling staff and they were out on 01/08/2026, so both the day and afternoon shift were not fully staffed. During the afternoon shift, the two additional staff that were supposed to be working were pulled over by the police and arrested. It is unclear what the arrest was regarding. Therefore, HR was out and did not fill the shifts with additional staff.

On 01/27/2026, I contacted the principal with Vision's Unlimited regarding Resident A. On 01/08/2026, the principal was out of the building but was informed by the secretary and two different paraprofessionals about what happened. Resident A was dropped off at 9:30AM by HM Steven. According to the secretary and the two paraprofessionals, Steven said, "I tell her I will bring the tablet to her so I can get her in the car and to school." They believed Steven would return with the tablet, but an hour later, Resident A was getting disruptive asking for her tablet. She was incredibly upset and violent, turning chairs over. Around 11AM, the secretary called the group home advising them that they either had to bring the tablet or take Resident A home because she was disruptive. Steven brought the tablet to school hours later. Steven denied saying he was going to bring the tablet to school. The principal stated she had never informed the group home that Resident A could not bring her tablet to school. She told the group home that the school would not be responsible for the tablet if anything happened.

On 01/27/2026, I interviewed the secretary at Vision's Unlimited regarding the allegations. On 01/08/2026, HM Steven dropped Resident A off at school around 9:30AM. Steven said, "I used her iPad as a bribe to get her in the car and into school." The secretary told Steven he had an hour to bring the iPad to school. She got busy and it was 11:30AM and Steven had not returned with the iPad. Resident A was upset, disruptive, and violent. She was throwing chairs around in the classroom. She called the group home and spoke with Shauna who advised her that Steven usually bribes Resident A with her tablet to get her into the car and to school. Shauna advised the secretary that Steven had not returned to the group home, but that Shauna would call him. Steven arrived at school around 2PM, an hour before dismissal. There was no further incident once she received her tablet.

On 01/28/2026, I received an email from Wayne County Office of Recipient Rights (WCORR) Frank Lewis stating that he is investigating the allegations.

On 01/29/2026, I attempted a face-to-face with Resident A at Vision's Unlimited, but Resident A was not in school. The teacher was texted by the MGM stating that Resident A had a doctor's appointment this morning.

On 02/05/2026, I interviewed Resident A face-to-face at Vision's Unlimited. Resident A is tall and large in stature. She is verbal, but her communication skills are limited due to her disability. Resident A likes living at this group home. The staff are "really neat," but she does not like the "loud noises." She was unable to provide further details regarding the "loud noises." Many of her responses were "I don't know."

Note: There was insufficient support/information if any DCS or anyone inappropriately touched Resident A.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on my investigation and the information gathered, DCS during the afternoon shifts did not have the qualifications nor were they capable of appropriately handling emergency situations regarding Resident A. On 01/08/2026, during the afternoon shift 4PM-12AM, DCS Kennesha McConnico and Margaret Hilton were working when Resident A's behavior escalated after returning from school. Resident A was using racial slurs, hitting, and spitting at staff. Kennesha and Margaret reported that they were unable to deescalate the situation and Resident A locked herself in Resident B's bedroom, then climbed out of the bedroom window. Neither staff were capable of appropriately handling this situation due to both staff not following Resident A's crisis plan implemented by Easterseals on 12/03/2025 as the police were contacted and Resident A was arrested for domestic assault.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and

	competent in all of the following areas before performing assigned tasks independently: **(d) Personal care, supervision, and protection.**
ANALYSIS:	Based on my investigation and information gathered, DCS Kennesha McConnico and Margaret Hilton were not competent in providing supervision and protection to Resident A on 01/08/2026. Resident A's behavior escalated to hitting and spitting. However, when Margaret was asked what interventions were utilized from Resident A's behavioral plan, she stated, "we talk to her to calm her down. I don't know what's in her plan because I'm not her one-on-one."
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based on my investigation there was insufficient DCS to resident ratio on 01/08/2026. There were four residents residing at Nat West Home 1 on 01/08/2026; Resident A, Resident B, and Resident C, are one-on-one; therefore, when all four residents are home, there must be four DCS on shift. According to team leader Shauna Milton, there was only one DCS during the morning shift before Resident A and Resident C went to school and there were only two DCS during the afternoon shift. Therefore, there were insufficient DCS on duty during those shifts to provide for the supervision, personal care, and protection of all the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(3) Staff responsible for implementing a resident's assessment plan must be trained in the applicable behavior intervention techniques and onsite at the facility during each shift.
ANALYSIS:	Based on my investigation and review of Resident A's crisis plan implemented by Easterseals on 12/03/2025, DCS are not trained nor utilizing the intervention techniques specified in Resident A's assessment plan. DCS Kennesha McConnico and Margaret Hilton were unable to provide any specific statements that should be used with Resident A during a behavior. In addition, case coordinator Tai'Escia Gibson and behavioralist Talia Pruitt from Easterseals expressed concerns about DCS not competent in Resident A's crisis plan nor are they following the crisis plan due to the numerous incident reports they receive regarding Resident A's hospitalizations.
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 my investigation and information gathered, Resident A was not treated with dignity and respect by HM Steven Price nor was she protected or safe on 01/08/2026 when he bribed her to go to school by advising Resident A that if she went to school, he would bring her personal tablet to the school. Resident A agreed to go to school, and staff at Vision's Unlimited stated that they heard Steven tell Resident A he would bring her tablet, but Steven never returned. Resident A's behavior escalated at school, throwing chairs, yelling, and crying. The secretary contacted Nat West Home 1 and spoke with Shauna asking if Steven was returning to school with the tablet, but Shauna told the secretary that "Steven tells Resident A this so Resident A can go to school due to not having staffing for Resident A during the day shift." Several hours later, Steven returned to the school

	with the tablet and Resident A then calmed down with no further incidents at school.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B had a seizure; however, her seizure protocol was not followed, and it was unclear how long the seizure lasted, but staff administered Resident B's seizure medication.

INVESTIGATION:

On 01/27/2026, intake #209111 was created but dismissed as I will be addressing the allegations within this complaint. The complaint was referred by APS who will not be investigating and stated that on 01/17/2026, Resident B had a seizure and if the seizure lasts three minutes or more, then the seizure medication must be administered. It is unclear how long the seizure lasted.

On 01/28/2026, I emailed the administrator Michele Ray advising her that another complaint was received but it was regarding Resident B. I requested Resident B's seizure protocol, January medication log, and a picture of the seizure nasal spray medication. I received and reviewed the following documents:

- Resident B's seizure protocol specifically states the following, "They can give a dose of Nayzilam 5MG Nasal Spray if a seizure lasts more than three minutes or if she has more than three seizures in one hour."
- I reviewed the label on the Nayzilam 5MG Spray and it stated, "place one spray (5MG) into one nostril as needed for seizures (longer than three minutes or if more than three seizures/one hour max does two sprays/day)."
- I reviewed January 2026 medication log and on 01/17/2026, Nayzilam 5MG Spray was not administered; however, this seizure medication was administered by DCS Kiana Kid on 01/25/2026.

On 02/02/2026, I emailed Easterseals/MORC case coordinator Tai'Escia Gibson regarding Resident B's seizures and if she has an IR that stated the "time of the seizure." Ms. Gibson responded, stating that she was not informed of the time of the seizure but did receive the IR on 01/17/2026 that did not state the time. She addressed this concern with HM Steven during a recent meeting. Steven told Ms. Gibson that "all staff in the home are trained on her seizure protocol." Ms. Gibson stated, "I remain concerned about whether staff are following the protocol appropriately. In another IR I received, staff reported administering the emergency seizure medication at the two-minute mark, whereas the seizure protocol clearly specifies administration at three minutes." Ms. Gibson included IR dated 01/25/2026 which clearing stated that the seizure was timed and it was two minutes and the Team Lead administered the seizure medication. The two DCS on shift were Nadra Kidd and Kiana Kidd.

On 02/02/2026, I interviewed HM Steven regarding the allegations. Steven stated that Resident B's seizure protocol is if the seizure lasts longer than three minutes then staff must give the seizure medication. He stated, "all staff have been trained since Resident B's first seizure." On 01/17/2026, staff tried to call him, but he did not answer. He was told that Resident B went to the restroom, washed her hands, dropped to the floor, and had a seizure. The medication was not given as the seizure did not last longer than three minutes; however, the ambulance was called and Resident B was transferred to the hospital. On 01/25/2026, he was contacted by Nadra advising him that she was sitting next to Resident B when Resident B had a seizure. He was informed that Kianna administered the seizure medication to Resident B. Steven asked Nadra, "how long did the seizure last?" Nadra stated, two minutes and 45 seconds. Steven did not feel it was "an issue," that Kianna administered the medication even though Resident B's seizure protocol specifically stated, longer than three-minutes before the medication can be administered.

On 02/02/2026, I interviewed DCS Riyanna Tigner regarding these allegations. Riyanna has been working for this corporation since June 2025. She works the weekends from 8AM-8PM. Riyanna has reviewed Resident B's seizure protocol and stated that staff must time the seizure and if the seizure lasts more than three minutes or has three seizures within one hour, then the seizure medication is administered. On 01/17/2026, she was working this shift with Kiana Kidd, Nadra Kidd, and Lerise Clark. Riyanna stated that Lerise Clark was responsible for Resident B on 01/17/2026. At 1:25AM, Resident B was alone in the bathroom washing her hands after using the bathroom. Riyanna heard something, "hit the floor." Riyanna immediately ran into the bathroom and saw Resident B lying on the floor having a seizure. Lerise was sitting on the couch and not with Resident B in the bathroom. Riyanna immediately turned Resident B to her side and began timing the seizure. Lerise grabbed a spoon, Kianna called 911, while Nadra called HM Steven. The ambulance and police arrived and transported Resident B to the hospital. Riyanna stated the seizure medication was not administered as her seizure lasted between 2-2:30 minutes. On 01/25/2026, Riyanna was working with the same staff she worked with on 01/17/2026. However, Nadra Kidd was responsible for Resident B on this day. Resident B was in her bedroom while Nadra was sitting on the couch with Lerise. Resident B began having a seizure, so Riyanna again found her and put her on her side and timed the seizure. The seizure lasted two minutes but this time, Kianna Kid administered the seizure medication. According to Riyanna, medication is not administered during their shift, and she is not aware of any of the staff on this shift that have completed their medication training. Riyanna stated that Team Lead Shauna told Kianna that she "shouldn't have administered the seizure medication because the seizure was not longer than three-minutes."

On 02/02/2026, I contacted the AHM Shakita Lloyd regarding the allegations. Shakita stated she was also contacted on 01/17/2026, but she too did not answer and when she called staff back, staff advised her that they no longer needed her as they spoke with Meghan Williams, with HR. Shakita was told that Resident B went to the bathroom, washed her hands, fell to the floor and had a seizure. Lerise was responsible for

Resident B, but Shakita was told by Riyanna that Lerise was not with Resident B. Riyanna found Resident B, put her on her side and they called 911. Shakita does not know how long the seizure lasted and she does not know if the medication was administered but stated that the medication is only administered if the seizure lasts longer than three-minutes. Shakita did not know about Resident B's seizure on 01/25/2026 and stated this is the first time she is hearing about this.

On 02/02/2026, I interviewed Meghan Williams with HR regarding the allegations. On 01/17/2026, she was contacted by either Nadra or Kianna Kid regarding Resident B's seizure. She was informed that the ambulance was at the group home and going to take Resident B to the hospital. Lerise was supposed to be Resident B's one-to-one, but Lerise was not with Resident B in the bathroom when Resident B fell to the floor and had the seizure. Meghan was not told how long the seizure lasted on this day. She too did not know Resident B had another seizure on 01/25/2026 and this was the first she heard about the seizure.

On 02/02/2026, I interviewed team lead Shauna regarding the allegations. Shauna was not present during both seizures on 01/17/2026 or 01/25/2026 but stated that anytime Resident B has a seizure, according to her seizure protocol, seizure must be timed to determine if the seizure medication should be administered or not. If the seizure lasts longer than three minutes, then the medication should be administered but if it is less than three minutes, then the medication should not be administered. Also, Resident B is a one-to-one and that means that the staff responsible for Resident B must always be with Resident B, during sleeping and awake hours. Therefore, on 01/17/2026, staff should have been with Resident B when she was using the bathroom.

On 02/02/2026, I interviewed DCS Kianna Kidd regarding the allegations. Kianna has been with this corporation since 10/17/2025. She works 8AM-8PM on the weekends. Kianna stated she was never in-serviced on Resident B's seizure protocol when she began employment with this corporation; however, Kianna had personal experience with seizures she stated, "I know from personal experience I have to turn them on their side." On 01/17/2026, she worked with Riyanna, Nadra who is Kianna's mother, and Lerise. Lerise was Resident B's one-on-one, but when Resident B was in the bathroom around 1:25AM, Lerise was sitting on the couch. Riyanna and Nadra saw Resident B on the floor having a seizure. Riyanna put Resident B on her side and began timing the seizure. Nadra called Meghan Williams while Kianna was on the phone calling an ambulance. Kianna does not know what Lerise was doing at this time. Kianna stated she asked Meghan, "what to do, because she did not know what to do," and Meghan advised Kianna to provide the ambulance with Resident A's plan of service and provide them with information they needed, which Kianna did. After this incident, Kianna was in-serviced on Resident B's seizure protocol. She understood that if the seizure lasted longer than three minutes, then the seizure medication should be administered and if the seizure lasted less than three minutes, then the seizure medication should not be administered. On 01/25/2026, Kianna was working the shift with the same staff on 01/17/2026. Nadra was responsible for Resident B and sitting in the bedroom with Resident B. Resident B begun having a seizure and Nadra said, "she's seizing." Kianna

stated she went into the medication cabinet and grabbed the seizure nasal spray. Riyanna timed the seizure and it lasted two minutes and 45 seconds; however, Kianna still administered the medication, not following the seizure protocol. Kianna said she administered the medication because “Resident B was confused,” even though she “came out of the seizure.” Kianna stated she has not completed her medication training as she has only had “two nights of training.”

On 02/02/2026, I received an email from Michele Ray with the seizure protocol staff sign-in sheet training completed on 01/18/2026 with Lerise Clark, Kianna Kidd, Nadra Kidd and Riyanna Tigner. On 01/19/2026, Meghan Williams trained the 4PM-12AM shift on seizure protocol, Salena Baldwin, Kennesha McConnico, Margret Hilton, and Makayla Hawkins.

On 02/03/2026, I received an email from Michele Ray with Kianna Kid’s training, and she completed her medication administration training on 02/02/2026; therefore, Kianna was not properly trained on medication administration when she administered Resident B’s seizure medication on 01/25/2026.

On 02/04/2026, I interviewed DCS Nadra Kidd regarding the allegations via telephone. Nadra has been working for this corporation since June 2025. She too works 8AM-8PM Fridays-Sundays. On 01/17/2026, she was working with her daughter Kianna Kidd and DCS Lerise Clark and Riyanna Tigner when Resident B had a seizure around 1:25AM. Lerise was Resident B’s one-to-one staff. Resident B went to the bathroom and as she was washing her hands, Nadra stated, “I saw her fall and have a seizure. I said, “Resident B is having a seizure.” Riyanna was the first to get to Resident B and placed her on her side and began timing the seizure. Lerise grabbed a spoon, Nadra called Meghan Williams and Kianna called the ambulance. The ambulance arrived and took Resident B to the hospital. Lerise was sitting on the couch in the living room when Resident B was in the bathroom by herself. On 01/25/2026, Nadra worked with the same staff on 01/17/2026, but this time Nadra was responsible for Resident B. She was sitting in the bedroom with both Resident B and her sister Resident C when she saw Resident B having a seizure. She called out for help because Resident B was sliding off the bed. Kianna came into the bedroom to help but when Riyanna came into the bedroom, Kianna went to grab the seizure medication. Riyanna timed the seizure and Kianna stated, “If it hits three minutes, we have to call the ambulance.” Resident B came out of the seizure, and it was around two minutes; however, Kianna administered the seizure medication. Nadra stated, “I believe she gave the medication because Kianna thought Resident B wasn’t going to come out of it.” Nadra stated that the seizure protocol is that the medication should not be administered only if the seizure lasts longer than three minutes. She was trained on the seizure protocol after 01/17/2026.

On 02/05/2026, I interviewed Resident B’s mother regarding the allegations. Resident B moved into this group home in April 2025 and soon after her Resident B’s sister Resident C moved in too. They were the first residents placed in this group home when it was licensed. Both sisters have seizure protocols, but Resident C has not had a seizure for years; however, Resident B has. Resident B’s physician put the seizure

protocol in place in addition to prescribing the seizure medication. It was documented at the time of Resident B's admission and understood by HM Steven and the provider Mrs. Ray that all staff must be properly trained in following the seizure protocol and when to administer the seizure medication. On 12/30/2025, Resident B had a seizure while she was in her bed. There was a staff member (name unknown) in the room watching Resident C, but that staff did not respond to Resident B's seizure. Shauna found Resident B seizing underneath her blanket, putting her to her side, and timed the seizure. The seizure lasted four minutes so Shauna administered the medication. It is unclear why there were no staff with Resident B and why the staff in the bedroom did not assist Resident B.

On 01/17/2026, Resident B's mother received a telephone call from Farmington Resue Team saying, "we don't trust that Resident B is receiving care at this home." Resident B must have a one-on-one and her staff was not with her at 1:23AM when Resident B was in the bathroom alone, fell and had a seizure. Her seizure was unwitnessed. Staff reported to Resident B's mother that they "heard a thud," and then responded to Resident B who was on the floor having a seizure. Resident B was transported to the hospital. On 01/25/2026, Resident B's mother heard that the seizure lasted around one-minute, but that a staff member used the nasal spray medication not following the seizure protocol. She stated, "this home has a detailed protocol on what to do; lay her on her side, time the seizure, and if lasts longer than three-minutes to give the medication." Resident B's mother does not know why staff grab a "spoon," every time Resident B has a seizure because the seizure protocol does not state anything about a spoon. She stated that Resident B "tends to have seizures on the weekend," and she is concerned that the weekend staff are not trained on the seizure protocol. Resident B's mother stated other concerns she has with the staff is that she and Resident B's biological father have done "pop-up visits," and found no staff with either Resident B or Resident C when they are in their bedroom. There should be two DCS, one with Resident B and Resident C as both are supposed to have a one-on-one. She also reported concerns about the school Vision's Unlimited report to Resident C's mother that Resident C has arrived at school with poor hygiene. Resident C has Down Syndrome and requires more hands-on assistance. Resident C's mother has observed staff assist Resident C on the toilet because she had loose stools, but then staff would keep her on the toilet for over 30 minutes instead of wiping her and getting her up to avoid having to put her back on the toilet. She reported the poor hygiene to HM Steven whom the mother believes is overloaded due to the many homes he is responsible for.

On 02/05/2026, I received police records from Farmington Police Department regarding Resident B. On 06/02/2025, Resident B had a seizure, ambulance was contacted but not transported to hospital as Resident B came out of the seizure and Resident B's mother wanted her to remain at the group home. On 01/17/2026, Resident B had a seizure and the ambulance was called. Staff reported that the seizure was "unwitnessed." Resident B was transported to the hospital.

On 02/11/2026, I received a telephone call from Joy Mathias with WCORR regarding Resident B. She is investigating these allegations. I emailed her the documents

submitted to me by Michele Ray regarding Resident B. Ms. Mathias provided an updated number to DCS Lerise Clark.

On 02/11/2026, I left a voice mail message for DCS Lerise Clark requesting a return call but never received a call back.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, DCS Lerise Clark did not provide personal care, supervision, and protection as specified in Resident B's assessment plan on 01/17/2026 during the 8PM-8AM shift. Resident B is a one-on-one and Lerise was the DCS who was responsible for Resident B. Resident B got up out of bed, went to the bathroom, fell to the floor and had a seizure. Riyanna found Resident B on the floor, seizing, laying her on her side and timed the seizure. The ambulance was contacted and transported Resident B to the hospital. According to DCS Riyanna Tigner, Kiana Kidd, and Nadra Kidd who were present, stated that Lerise was sitting on the couch and not supervising Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and information gathered, Resident B's seizure medication Nayzilam 5MG Nasal Spray was not given as prescribed by DCS Kiana Kidd on 01/25/2026 during Resident B's seizure. According to the medication label, this medication is administered only if Resident B's seizure lasts more than three minutes or if she has three or more seizures within one hour. Resident B's seizure was timed, and it only lasted about two minutes and 30 seconds; however, Kiana administered the medication. Kiana did not follow the label instructions as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on my investigation and information gathered, DCS Kiana Kidd had not completed her medication administration training on 01/25/2026 when she administered Resident B's seizure medication Nayzilam 5MG Nasal Spray. Kiana stated she was in the process of completing her medication training but had not completed it when she administered Resident B's medication. Kiana completed her medication administration training on 02/02/2026.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

ADDITIONAL ALLEGATIONS:

INVESTIGATION:

On 02/12/2026, Kate the secretary with Vision's Unlimited stated that according to Resident C's teachers and paraprofessionals, Resident C has arrived at school several times with poor hygiene, "smelling bad." These concerns were brought to Resident C's mother's attention. She does not have dates to provide.

On 02/17/2026, I made a face-to-face visit at the group home and observed Resident A, Resident B, and Resident C. I was informed by team leader Shauna Minter that Resident D moved out of this group home yesterday morning but did not know where she moved to. DCS Jaylen McCullers and DCS Tierra Vance were also working this shift. Resident A was sleeping in her bed, and Resident B was playing on her tablet in her bedroom. Resident C was sitting on the couch in the front room. Resident C has Down Syndrome and is non-verbal therefore I was unable to interview her. I discussed the concerns that Resident C's mother brought to my attention regarding Resident C's hygiene. Resident C was dressed appropriately for the day and appeared to have good hygiene during this visit. Residents are showered twice a day every day. They are showered during the afternoon and midnight shifts. Therefore, when Resident C attends school in the morning, midnight shift is supposed to shower her and get her dressed before the morning shift arrives. There are progress notes for each resident, and the progress notes must be completed by staff who are showering the residents.

I reviewed Resident C's February 2026 progress notes, and it documented that Resident C was not showered on 02/11/2026, 02/12/2026, and 02/16/2026. Shauna also reported that each shift has a team lead that is responsible for DCS working that shift. The team lead is responsible for administering medications and ensuring that DCS are doing what they are supposed to do during the shift. Selena Baldwin is the team lead for the afternoon shifts and Kayla (last name unknown) is the team lead for the midnight shifts. Shauna stated that there were times when Resident C returned from school soiled. Shauna brought this to Resident C's mother's attention who addressed it with the school. Shauna arrives at her shift and observes all the residents dressed and both Resident A and Resident C ready for school. She has never observed Resident C with poor hygiene or Resident C "smelling bad." Shauna stated there are times when residents refuse showers, such as Resident A but after several attempts, Resident A takes a shower. However, if a resident refuses a shower, it must be documented on the progress notes by staff.

I interviewed DCS Jaylen McCullers. He stated he has been working for this corporation for one year. He fills in at this group home and stated that he has worked the midnight shifts with female staff who are responsible for showering the residents. He stated that showering was done when he worked. He reported no concerns with any of the residents' hygiene.

I interviewed DCS Tierra Vance. She stated she has worked for this corporation for about seven months. She only works day shift and stated that when she arrives at work, all the residents are already dressed including Resident C. She has never observed Resident C with poor hygiene nor has Resident C "smelled bad."

On 02/18/2026, I interviewed afternoon team lead Salena Baldwin via telephone regarding the allegations. Salena has worked for this corporation since June 2025. She works from 4PM-12AM. Residents are showered daily at 5:30PM during her shift. When residents are showered, staff must complete the progress notes logs documenting what was done which includes getting the residents dressed and groomed for the day.

Resident C gets showered daily, but there are times when Resident C refuses to shower, but after some redirection she agrees to a shower. Salena has never observed Resident C or any other resident with poor hygiene or smelled bad. Resident C's mother has never reported any concerns to her about Resident C's hygiene. Salena has heard from the day shift that Resident C has arrived at home from school soiled more than once. Salena stated it was her responsibility and the responsibility of HM Steven to review progress notes to ensure staff on her shift are recording showers and grooming. She reviewed progress notes for 02/11/2026, 02/12/2026, and 02/16/2026 and agreed that staff from her shift did not record showers, personal hygiene, or dressing for Resident C. She stated these were done but understands that staff must record what they did to show it was done.

On 02/18/2026, I interviewed midnight team lead Kayla Jones via telephone regarding the allegations. Kayla has worked for this corporation since August 2026. She works 12AM-8AM during the weekdays. Resident C gets up at 6:30AM because she goes to school. She is showered, groomed, and then dressed daily before school. Her hygiene is always taken care of by staff and there has never been a time when Resident C was sent to school "smelling bad, "or had "poor hygiene." Staff must record showering, grooming, and dressing in the progress notes daily. She too reviewed progress notes on 02/11/2026, 02/12/2026, and 02/16/2026 and acknowledged that staff did not record showering, grooming, and dressing for Resident C. She too stated that it is the responsibility of the team lead, which is her and HM Steven to review these progress notes to ensure staff are recording the information to confirm it was done.

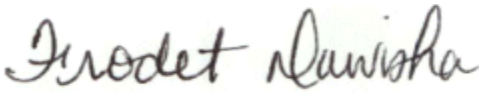
On 02/18/2026, I conducted the exit conference with administrator Michele Ray regarding my findings. Mrs. Ray stated that licensee designee Gary Ray was unavailable as he was on a conference call, but she will have him contact me to acknowledge my recommendation. I advised Mrs. Ray due to the severity of the quality-of-care violations, I would recommend the license be modified to a provisional license. Mrs. Ray stated that she agreed with my recommendation and that she and Mr. Ray would accept the provisional license. She will work with Mr. Ray on a corrective action plan regarding the violations once the report is received. I received a call from licensee designee Gary Ray and advised him of my findings and my recommendation. He acknowledged.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: **(a) Bathing or showering, or both.**

ANALYSIS:	Based on my investigation and information gathered, Resident C was not showered or bathed according to the home's policy that residents are to be showered twice daily. The school reported to Resident C's mother that Resident C has arrived at school "smelling bad." DCS at Nat West Home 1 stated that Resident C was being showered and that when she is showered, DCS must sign her progress note log showing it was done. I reviewed February 2026 progress logs and DCS did not sign the logs on 02/11/2026, 02/12/2026, nor on 02/16/2026. Therefore, even though staff reported that Resident C was being showered, the documentation did not support their reporting.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

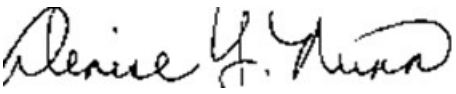
Contingent upon receiving an acceptable corrective action plan I recommend modification of the license to a 6-month provisional.



02/23/2026

Frodet Dawisha — Date
Licensing Consultant

Approved By:



02/24/2026

Denise Y. Nunn — Date
Area Manager