



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2026

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

RE: License #: AS820383852
Investigation #: 2026A0101010
Genesee Manor 2

Dear Mr. 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone

immediately, please contact the local office at (313) 456-0439.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820383852
Investigation #:	2026A0101010
Complaint Receipt Date:	11/20/2025
Investigation Initiation Date:	11/21/2025
Report Due Date:	01/19/2026
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, Designee
Name of Facility:	Genesee Manor 2
Facility Address:	29825 Joy Road Westland, MI 48185
Facility Telephone #:	(313) 949-2501
Original Issuance Date:	05/04/2017
License Status:	REGULAR
Effective Date:	11/04/2025
Expiration Date:	11/03/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS
--	---

II. ALLEGATION(S)

	Violation Established?
Resident A requires two to one staffing at all times and, on 11/07/2025, he eloped.	Yes

III. METHODOLOGY

11/20/2025	Special Investigation Intake 2026A0101010
11/21/2025	Special Investigation Initiated - Telephone ORR
11/21/2025	APS Referral
12/03/2026	Inspection Completed On-site Interviewed direct care, staff Nicole Allen
12/30/2026	Contact – Documents received Direct care staff, Alana Whittaker and Riyana Tigner’s termination letter and the incident report
01/14/2024	Inspection Completed On-site Interviewed the home manager, Steven Price and spoke with the administrator/designated person Michele Ray
01/29/2026	Contact – Documents received Resident A’s treatment plan Direct care staff Alana Whittaker and Riyana Tigner employee records
01/29/2026	Contact – Telephone call made Guardian A1
02/12/2026	Contact – Telephone call made Ms. Ray and lead direct care worker Tykeshia Jordan
02/12/2026	Exit Conference Administrator/designated person Michele Ray

ALLEGATION: Resident A requires two to one staffing at all times and on 11/07/2025, he eloped.

INVESTIGATION: On 12/03/2025, I interviewed direct care staff, Nicole Allen. Ms. Allen stated that she was not working when Resident A eloped. Ms. Allen stated it happened over the weekend, and she did who was working.

On 12/30/2025, I spoke with the administrator/designated person Michele Ray. Ms. Ray stated the two direct care staff assigned to Resident A when he eloped were Alana Whittaker and Riyana Tigner. Ms. Ray stated it happened during shift change.

On 12/30/2025, I received and reviewed the incident report. According to the incident report on 11/07/2025, at 7:30 p.m. Resident A eloped from the home and was missing for 30 minutes.

On 01/14/2026, I interviewed the home manager, Steven Price, and we spoke with Ms. Ray on speaker phone. We discussed the seriousness of Resident A eloping when he does not have the wherewithal to move independently in the community, and this is not the first time Resident A did not receive his required level of supervision. **REPEAT VIOLATION Rule 400.671 (4) is the updated rule for R 400. 14303 (2) as promulgated 11/03/2025. Special Investigation Report #2025A0101012.**

On 01/29/2026, I reviewed Resident A's treatment plan. According to Resident A's treatment plan, Resident A is not able to communicate full sentences or ideas. The treatment plan also stated Resident A requires two staff at all times.

On 01/29/2026, I reviewed direct care staff Alana Whittaker and Riyana Tigner employee records. According to the employee records Ms. Whittaker and Ms. Tigner were trained and the licensee was in compliance with all licensing rules regarding hiring requirements.

On 12/30/2026, Ms. Ray sent me Ms. Whittaker and Ms. Tigner their termination letters. On 01/29/2026, I called Ms. Whittaker and Ms. Tigner. They did not return my calls.

On 01/29/2026, I spoke with Guardian A1. Guardian A1 is Resident A's mother. Guardian A1 stated Ms. Ray contacted her regarding discharging Resident A. Guardian A1 stated Ms. Ray is discharging Resident A because his level of supervision is being decreased from two staff to one. Guardian A1 stated she was not concerned about Resident A being discharged, she stated her issue is with Resident A's level of supervision being decreased following his recent elopement.

On 02/12/2026, I spoke with the lead direct care worker Tykeshia Jordan, who was also working when Resident A eloped on 11/07/2025. Ms. Jordan stated that the shift was ending and she was passing medications. Ms. Jordan stated she observed

one of Resident A's two to one staff sitting at the dining room table charting and the other staff was standing in the hallway near the bathroom close to his bedroom. Ms. Jordan stated that they received a call from another young lady that was previously employed at the group home. Ms. Jordan stated she informed them that Resident A was in the community. Ms. Jordan stated the former employee gave staff Resident A's location. Ms. Jordan stated when the group home staff arrived at Resident A's location he was with the police.

On 02/04/2026, I conducted an exit conference with the designated person Ms. Ray. Ms. Ray agreed with the findings. Ms. Ray stated Resident A was discharged on 01/31/2026.

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:	<p>The licensee did not provide the level of supervision as specified in Resident A's assessment/ treatment plan.</p> <p>According to the incident report on 11/07/2026, at 7:30 pm Resident A eloped from the home and was missing for 30 minutes. If Resident A had received his required level of supervision he would not have been able to elope.</p> <p>According to Ms. Jordan, the lead direct care staff on shift when Resident A eloped, his two to one staff were not providing the required level of supervision.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan I recommend the status of the license remains unchanged.



Edith Richardson
Licensing Consultant

02/18/2026

Date

Approved By:



02/19/2026

Ardra Hunter
Area Manager

Date