



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2026

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

RE: License #: AS630417946
Investigation #: 2026A0605017
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.
- 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,

Frodet Dawisha

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 #:	2026A0605017
Complaint Receipt Date:	04/07/2026
Investigation Initiation Date:	04/07/2026
Report Due Date:	06/06/2026
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:	1ST PROVISIONAL
Effective Date:	03/11/2026
Expiration Date:	09/10/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff member Juvonta Travis was found sleeping while supervising Resident A and leaving her unsupervised.	Yes
Missing staff initials on medication logs for multiple residents, indicating serious lapses in care and oversight.	Yes

III. METHODOLOGY

04/07/2026	Special Investigation Intake 2026A0605017
04/07/2026	Special Investigation Initiated - Telephone Discussed allegations with Detroit Wayne Office of Recipient Rights (DWORR) Tiffany Burgess
04/07/2026	Contact - Telephone call made Left message for DeVonier Murphy with Easterseals requesting a return call
04/07/2026	Contact - Telephone call received Discussed allegations with DeVonier Murphy with Easterseals
04/08/2026	Inspection Completed On-site Conducted unannounced on-site investigation
04/08/2026	Contact - Telephone call made Discussed allegations with shift lead and the home manager Left messages for shift leads and direct care staff
04/08/2026	Contact - Document Received Email from human resource Meghan Williams
04/08/2026	Contact - Document Sent Email to Meghan Williams
04/09/2026	Contact - Document Received Email from Meghan Williams
04/13/2026	Contact - Telephone call made Left messages for DCS and shift leads to return my call

04/13/2026	Contact - Telephone call received Discussed allegations with shift leads
04/13/2026	Contact – Telephone call made Followed up with Easterseals DeVonier Murphy
04/14/2026	Exit Conference Conducted with licensee designee Gary Ray and administrator Michele Ray with my findings.

ALLEGATION:

A staff member Juvonta Travis was found sleeping while supervising Resident A and leaving her unsupervised.

INVESTIGATION:

On 04/07/2026, intake #210170 was referred by Detroit-Wayne Integrated Health Network- Office of Recipient Rights (DWORR). Nat West Home 1 license was modified to a first provisional on 03/11/2026 due to quality-of-care violations.

On 04/07/2026, I initiated this special investigation by interviewing DWORR worker Tiffany Burgess regarding the allegations. Ms. Burgess is investigating these allegations. She stated to contacted DeVonier Murphy the assistant care coordinator with Easterseals who has direct knowledge of these allegations.

On 04/07/2026, I reviewed Resident A’s crisis plan that was completed by Easterseals on 07/14/2025. “One-on-one enhanced staffing was approved on 07/14/2025. Writer will monitor constructive use of one-on-one supervision and changes in sleep pattern at night. Will begin fading one-on-one to shared support starting during sleep hours upon zero evidence of insomnia or disruptive behavior during sleep hours for three consecutive months.”

On 04/07/2026, I received a return call from DeVonier Murphy regarding these allegations. Mr. Murphy conducted a scheduled visit at Nat West Home 1 around 8AM on 04/03/2026 when he observed a male direct care staff (DCS), later identified as Juvonta Travis sitting on a chair in the middle of the living room asleep. Also present was shift lead Shardinea Hamm. Mr. Murphy stated when he entered the home, Juvonta woke up and soon after, Juvonta told Shardinea he was going outside to smoke a cigarette. He was on his smoke break about 10 minutes. Resident A was sleeping in her bedroom. Resident A has enhanced staffing; one-on-one always even when she is sleeping; however, it is unclear how long Juvonta was sleeping and not supervising Resident A. While Mr. Murphy was at the home, Shardinea never addressed the issue

of Juvonta sleeping nor did she address the issue of Juvonta not supervising Resident A. Mr. Murphy stated that visits were increased by Easterseals to bi-weekly instead of monthly due to concerns at this home.

On 04/08/2026, I conducted an unannounced on-site investigation. Present were shift lead Shauna Minter and Resident B. Resident A and Resident C were at school, Visions Unlimited, during this visit. I observed Resident B in her bedroom sleeping. She was not interviewed during this visit. Shauna was not present on 04/03/2026 because she only works Mondays-Thursdays. She heard that DWORR told the provider, Michele Ray, that Resident A was without her one-on-one. Shauna stated that Resident A, Resident B, and Resident C each have a one-on-one. When all three residents are home, there must be three DCS per shift. Shauna explained that the one-on-one must be in direct sight/supervision of the resident even if the resident is sleeping in their bedroom. Shauna worked with DCS Juvonta Travis last year and he is "typically with his one-on-one with no incident." The shift lead for the weekend is Shardinea Hamm. There is one shift lead per shift, and their responsibilities include making sure DCS are doing what they are supposed to do during that shift. Shift lead, "supervises staff." Shauna stated that if she observed a DCS sleeping and not providing direct supervision to any of the residents, then she would "write them up for not following protocol," and "would address the issue with the staff." She is unsure what Shardinea did as she was not present.

On 04/08/2026, I interviewed home manager (HM) Steven Price regarding the allegations via telephone. Steven was not working on 04/03/2026; however, as soon as he found out about the incident with DCS Juvonta Travis, he was taken off the schedule and written up. Steven stated that all shift leads and DCS have reviewed Residents A, B, C individual plans of service (IPOS) and crisis plans; therefore, all staff are aware that they must have direct supervision with their resident when they are assigned one-on-one. Steven also stated that the shift lead, Shardinea also received a write up because she did not make sure Juvonta was doing what he was supposed to do during the shift. Steven reported this as an isolated incident with both Juvonta and Shardinea. On 04/08/2026, I interviewed shift lead Salena Baldwin regarding the allegations. Salena is the shift lead for second shift from 4PM-12AM. She has been working for this corporation for one year. She did not work on 04/03/2026, but she heard that DCS Juvonta was "caught sleeping," on his shift. Salena has worked with Juvonta and stated that he has never slept on his shift and always had direct supervision with his one-on-one.

On 04/06/2026, I received the April 2026 staff schedule confirming that DCS Juvonta Travis was working on 04/03/2026 along with shift lead Shardinea Hamm and DCS Ladonna Love. According to the schedule, Shardinea was assigned to Resident A, Ladonna was assigned to Resident B, and Juvonta was assigned to Resident C. However, that was not the case, and the schedule was not updated to reflect that Juvonta was assigned to Resident A, Shardinea was assigned to Resident B, and Ladonna was assigned to Resident C.

On 04/13/2026, I received a return call from shift lead Kayla Jones. Kayla works third shift from 12AM-8AM. She was not present on 04/03/2026 and has never worked with DCS Juvonta Travis. All staff are aware that a one-on-one means direct supervision of the residents and must always be in direct sight of the residents. Kayla stated if she had observed a DCS sleeping on their shift or not with their one-on-one resident, she would have addressed it immediately. Kayla would have advised the staff that they must be in direct contact with Resident A and wherever Resident A was, even if they are sleeping, the staff must either be in their bedroom or sitting at the door supervising them.

On 04/13/2026, I interviewed shift lead Shardinea Hamm regarding the allegations. She has been working with this corporation since May 2025. On 04/03/2026, Shardinea worked from 8AM-8PM with DCS Juvonta Travis. She was responsible for Resident B while Juvonta was responsible for Resident A. Shardinea was sitting outside of Resident B's bedroom supervising her. She observed Juvonta sitting in the living room on a chair facing the TV. She did not know he was sleeping until care coordinator assistant DeVonier Murphy from Easterseals brought it to her attention when he arrived at the home around 8AM. She did not address the issue that Juvonta was sleeping and stated, "it slipped my mind, I should have addressed it." Resident A was asleep in her bedroom. Shardinea stated that Juvonta would periodically check on Resident A to see if she was still sleeping which she was. She was not aware that staff must sit directly in the residents' bedroom or outside their bedroom when they're asleep. She stated, "I guarantee you that no staff member does that during any shift." If she had known, she would have advised Juvonta to sit in or outside Resident A's bedroom. Juvonta then asked her to take a break, which Shardinea agreed to because she stated, "we legally cannot deny breaks. We are allowed two 15-minute breaks." Shardinea asked, "Was Juvonta not allowed to have a break?" I advised her that the concern was he was already not providing direct supervision for Resident A for an unknown time and now he was outside taking a break for an additional 15 minutes. She stated, "yes that makes sense." Shardinea stated that Mr. Murphy also advised her that they were "short staffed," which she did not understand since there were three residents and three staff, one for each resident. I advised her that I would reach out to Mr. Murphy. She acknowledged.

On 04/13/2026, I received an email from HR Meghan Williams stating that since DCS Juvonta Travis was removed from the schedule and received disciplinary action, he has not been returning any of their calls too.

On 04/13/2026, I made several attempts to reach DCS Juvonta Travis, but his phone recording stated he is not accepting calls at this time.

On 04/13/2026, I followed up with Easterseals care coordinator assistant DeVonier Murphy. Mr. Murphy stated he did make that statement to Shardinea regarding being short one staff member because he is concerned about staff taking two 15-minute breaks which then leaves the residents without direct supervision because their enhanced one-on-one is on break. He is discussing this issue with Easterseals behavioralist, Talia Pruiett.

APPLICABLE RULE	
R 400.671	Resident care.
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	<p>Based on my investigation and information gathered, DCS Juvonta Travis did not meet the needs of Resident A in accordance with her crisis plan completed on 07/14/2025. On 04/03/2026, Juvonta was assigned as Resident A's one-on-one; however, he was observed by Easterseals care coordinator assistant around 8AM to be sleeping while sitting on a chair in the living room, leaving Resident A who was sleeping in her bedroom, without direct supervision. After Juvonta was observed sleeping in the chair, he then took a 15-minute smoke break outside, leaving Resident A again unsupervised without any staff who could relieve him while he was on break. According to Resident A's crisis plan, Resident A receives 24 hours of enhanced one-on-one staffing, including when Resident A is sleeping.</p> <p>Due to Residents A, B, and C each having enhanced one-on-one staff, there needs to be additional staff to provide coverage when staff are taking breaks.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Missing staff initials on medication logs for multiple residents, indicating serious lapses in care and oversight.

INVESTIGATION:

On 04/07/2026, I interviewed Easterseals care coordinator assistant DeVonier Murphy regarding the allegations. Mr. Murphy stated that he reviewed Resident A, Resident B, and Resident C April 2026 medication logs and found that on 04/03/2026 at 8AM, medications were administered to all three residents, but there was no initials on the medication log. Mr. Murphy asked Shardinea about the missing initials and Shardinea stated, "the midnight staff passed the meds this morning and forgot to initial the logs." Mr. Murphy stated that Resident B is on seizure medications and it is detrimental to her

wellbeing that she receives her seizure medication; therefore, staff's initials on the medication log confirms she received her medication.”

On 04/08/2026, I reviewed Resident A's, Resident B's, and Resident C's medications and medication logs with shift lead Shauna Minter. Shauna conducted a simulated medication pass correctly and followed all the rights of medication administration. However, I did find the following medication errors after reviewing the residents' medications and medication logs:

- Resident A, **Hydroxyzine HC Tab 50MG**: take one tablet by mouth three times daily 9AM, 12PM, 6PM Monday-Friday plus Saturday/Sunday package separately was not given at 9AM on 04/02/2026, 04/03/2026, at 6PM on 04/06/2026, but staff initialed the medication log.
- Resident A, **Olanzapine 10MG**: take one tablet by mouth every eight hours for increased behavior as needed was given on 04/07/2026, but the reason for this as needed medication was not recorded.
- Resident B, **Oxcarbazepine 600MG**: take two tablets by mouth twice daily was given at 8AM on 04/03/2026, but staff did not initial the medication log.
- Resident B, **Ibuprofen 600MG**: take one tablet by mouth every six hours as needed for pain was given on 04/02/2026, 04/04/2026, and 04/05/2026, but the reason for this as needed medication was not recorded.
- Resident B, **Aripiprazole 2MG**: take one tablet by mouth daily as needed for physical aggression behavior was given on 04/05/2026, but the reason for this as needed medication was not recorded.
- Resident C, **Fluocinonide 0.05% Solution**: apply to scalp twice daily for up to two weeks then two-three days a week as needed for maintenance was applied on 04/01/2026, 04/03/2026, 04/05/2026, and 04/07/2026, but the reason for this as needed medication was not recorded.

On 04/08/2026, I interviewed HM Steven Price regarding the allegations. Steven stated he was at Nat West Home 1 today because he just learned about these medication errors. Before I could complete my interview, the phone disconnected and I was unsuccessful in getting Steven back on the line. I left him a voice mail message to return my call.

On 04/08/2026, I interviewed shift lead Salena Baldwin regarding the allegations. Salena completed medication training. On 04/06/2026, she did not administer Resident A's Hydroxyzine because she stated, "I was confused with the pills because there is more than one blister pack and the blister packs were mixed in with my pile that I was going to pass. I saw the other blister pack already popped out so I thought I popped it and already passed it, but I made a mistake and didn't pass the medication." Shift lead Shauna Minter caught the mistake when she began her shift and reviewed the medications and informed Salena that she never passed Resident A's medication. Salena stated that she followed the five rights of medication administration but that she was "just confused," about this one medication. Salena stated that this was the second time she had a medication error. The first time was when she was still in training. Salena stated that shift lead Kayla Jones who also had the same issue of being

confused when administering Resident A’s Hydroxyzine. She stated, “something has to be done to stop this issue, and I feel that this medication, because it’s in two separate blister packs should be separated.”

On 04/13/2026, I interviewed shift lead Kayla Jones regarding the allegations. Kayla stated she made a mistake when she was administering medications to Resident A because she should have followed the rights to passing medications. Kayla was distracted with Resident B who was “having a moment,” and “overlooked,” the medication she was supposed to pass to Resident A and did not. Kayla was disciplined for this mistake and stated that she completed refresher medication training.

On 04/13/2026, I interviewed shift lead Shardinea Hamm regarding the allegations. Shardinea stated that shift lead Kayla Jones passed medications at 8AM on 04/03/2026. She was unaware that Kayla did not initial the medication logs. There is no protocol in place regarding two-person check on medications during shift changes. Shardinea has completed medication training and stated she always follows all the rights of medication administration when she passes medications to the residents.

On 04/14/2026, I conducted the exit conference via telephone with licensee designee Gary Ray and administrator Michele Ray with my findings. Mr. and Mrs. Ray have terminated DCS Juvonta Travis regarding sleeping on his shift and taking a 15-minute break, leaving Resident A unsupervised. They have also had both shift leads Kayla Jones and Salena Baldwin retake refresher medication training and will be submitting a corrective action plan. Both acknowledged that the license would remain unchanged.

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:	<p>During the on-site investigation on 04/08/2026, I reviewed Resident A’s medications and medication log and found the following error:</p> <ul style="list-style-type: none"> Resident A, Hydroxyzine HC Tab 50MG: take one tablet my mouth three times daily 9AM, 12PM, 6PM Monday-Friday plus Saturday/Sunday package separately was not given at 9AM on 04/02/2026, 04/03/2026, at 6PM on 04/06/2026, but staff initialed the medication log.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <p>(v) Initials of the individual who administered the medication at the time given.</p>
ANALYSIS:	<p>During the on-site investigation on 04/08/2026, I reviewed Resident A's and Resident B's medications and medication logs and found the following errors:</p> <ul style="list-style-type: none"> • Resident A, Hydroxyzine HC Tab 50MG: take one tablet my mouth three times daily 9AM, 12PM, 6PM Monday-Friday plus Saturday/Sunday package separately was not given at 9AM on 04/02/2026, 04/03/2026, at 6PM on 04/06/2026, but staff initialed the medication log. • Resident B, Oxcarbazepine 600MG: take two tablets by mouth twice daily was given at 8AM on 04/03/2026, but staff did not initial the medication log.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(c) Record the reason for each administration of medication that is prescribed on an as needed basis.</p>

ANALYSIS:	<p>During the on-site investigation on 04/08/2026, I reviewed Resident A's, Resident B's and Resident C's medications and medication logs and found the following errors:</p> <ul style="list-style-type: none"> • Resident A, Olanzapine 10MG: take one tablet by mouth every eight hours for increased behavior as needed was given on 04/07/2026, but the reason for this as needed medication was not recorded. • Resident B, Ibuprofen 600MG: take one tablet by mouth every six hours as needed for pain was given on 04/02/2026, 04/04/2026, and 04/05/2026, but the reason for this as needed medication was not recorded. • Resident B, Aripiprazole 2MG: take one tablet by mouth daily as needed for physical aggression behavior was given on 04/05/2026, but the reason for this as needed medication was not recorded. • Resident C, Fluocinonide 0.05% Solution: apply to scalp twice daily for up to two weeks then two-three days a week as needed for maintenance was applied on 04/01/2026, 04/03/2026, 04/05/2026, and 04/07/2026, but the reason for this as needed medication was not recorded.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Frodet Dawisha

04/14/2026

 Frodet Dawisha
 Licensing Consultant

 Date

Approved By:

Jay Caluverts

For

04/14/2026

 Denise Y. Nunn
 Area Manager

 Date

