GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 9, 2026

Lisa Bruder
Genesee Health System
1040 W Bristol Road
Flint, MI 48507

RE: License #: AM250418778
Investigation #: 2026A0576033
Genesee Health System BH Urgent Care

Dear Lisa Bruder:

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.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250418778
Investigation #:	2026A0576033
Complaint Receipt Date:	04/17/2026
Investigation Initiation Date:	04/17/2026
Report Due Date:	06/16/2026
Licensee Name:	Genesee Health System
Licensee Address:	1040 W Bristol Road, Flint, MI 48507
Licensee Telephone #:	(810) 496-5510
Administrator:	Lisa Bruder
Licensee Designee:	Lisa Bruder
Name of Facility:	Genesee Health System BH Urgent Care
Facility Address:	1040 W Bristol Road, Flint, MI 48507
Facility Telephone #:	(810) 496-5510
Original Issuance Date:	09/19/2025
License Status:	REGULAR
Effective Date:	03/19/2026
Expiration Date:	03/18/2028
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A attempted suicide using medications that staff had failed to remove at admission raising serious concerns about safety and medication handling.	Yes

III. METHODOLOGY

04/17/2026	Special Investigation Intake 2026A0576033
04/17/2026	Special Investigation Initiated - Telephone
05/29/2026	Inspection Completed On-site Interviewed Staff Brandon Gayari and Crisis Services Manager Tonya Outman
06/01/2026	Contact - Document Received Reviewed Incident Report (IR)
06/03/2026	Contact - Document Received Received email from Licensee Designee Lisa Bruder
06/08/2026	Contact - Telephone call made Sent message to RN Supervisor Sherrie Maxwell to return call
06/08/2026	Contact - Telephone call made Left message for Staff Jason Scales to return call
06/08/2026	Contact - Telephone call made Left message for Staff Terry Winn to return call
06/08/2026	Contact - Telephone call made Left message for Kim Redmon to return call
06/08/2026	APS Referral
06/09/2026	Contact - Telephone call made Left message for Staff Jason Scales to return call
06/09/2026	Contact - Telephone call made Left message for Staff Terry Winn to return call

06/09/2026	Contact - Telephone call made Left message for RN Supervisor Sherrie Maxwell to return call
06/09/2026	Contact - Telephone call made Interviewed Staff Kim Redmon
06/09/2026	Contact - Telephone call made Left message for Case Manager Carmen Clark to return call
06/09/2026	Contact - Telephone call received Interviewed Case Manager Carmen Clark
06/09/2026	Contact - Telephone call made Left message for Carmen Clark to return call
06/09/2026	Contact - Telephone call made Call to Licensee Designee Lisa Bruder
06/09/2026	Contact - Telephone call received Interviewed Case Manager Clark
06/09/2026	Contact - Telephone call made Interviewed Licensee Designee Lisa Bruder
06/09/2026	Exit Conference

ALLEGATION:

Resident A attempted suicide using medications that staff had failed to remove at admission raising serious concerns about safety and medication handling.

INVESTIGATION:

On May 29, 2026, I conducted an unannounced on-site inspection at Genesee Health System (GHS) Behavioral Health Urgent Care and interviewed Staff Bradon Gayari who reported he heard that a resident attempted to overdose however he was not working at the time.

On May 29, 2026, I interviewed Tanya Outman GHS Crisis Services Manager who reported she was not working at the facility at the time of the allegations however it was reported to her that Resident A had medications that were in a bag in her belongings when she arrived at the facility. Case Manager Carmen Clark was completing an inventory of Resident A's belongings when she first arrived, and Case Manager Clark did not look in Resident A's bag well. There were medications in an envelope in

Resident A's belongings along with miscellaneous papers. The envelope was not see-through, and the envelope was not labeled. There were pill bottles in the envelope, and the medications were not secured upon Resident A arriving at the facility. Manager Outman reported residents do not keep their medications with them and all resident medications are to be secured in the medication room. On April 17, 2026, Resident A ingested the medications and reported to staff that she took the pills. Resident A's vitals were taken, and she was transported to the hospital. It was unknown if Resident A was admitted to the hospital and she did not return to the facility.

On June 1, 2026, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) involving Resident A. The IR was dated April 17, 2026, and authored by Sherrie Maxwell Registered Nurse (RN). The IR documented that on April 17, 2026, at 6:30am, Resident A came out of her room and stated she took pills to kill herself. There were numerous pills found on the floor in Resident A's room. Staff notified supervisor and 911 was called. Nurse monitored Resident A's vitals until emergency personnel arrived and transported Resident A to the hospital.

On June 3, 2026, I received an email from Licensee Designee Lisa Bruder that Resident A arrived at GHS Behavior Health Urgent Care on April 3, 2026, and an inventory was completed. On April 17, 2026, at 6:30am Resident A attempted to overdose, and Resident A was transported to the hospital via ambulance.

On June 3, 2026, I reviewed Resident A's assessment plan which revealed Resident A is 27-year-old female and was admitted to the facility on April 3, 2026. Prior to arriving at the facility, Resident A was hospitalized for approximately 2 months due to attempting to overdose with 100 pills of diphenhydramine. Resident A was diagnosed with major depressive episode, single episode, unspecified.

On June 8, 2026, and June 9, 2026, I called Resident A. There was a message recording that stated, "the subscriber I dialed was not in service".

On June 8, 2026, I sent a text message to Sherrie Maxwell Registered Nurse (RN) Supervisor to return call. On June 9, 2026, I left a voice message asking Sherrie Maxwell to return call.

On June 8, 2026, and June 9, 2026, I left a message for Staff Jason Scales to return call.

On June 8, 2026, and June 9, 2026, I left a message for Staff Terry Winn to return call.

On June 8, 2026, I left a message for Staff Kim Redmon to return call. On June 9, 2026, I interviewed Staff Kim Redmon regarding the allegations. Staff Redmon reported she was coming to work on the morning of April 17, 2026, as things were happening. The police were arriving and Staff Redmon walked into the facility. Resident A had pills in her belongings and had thrown pills on her floor. Staff Redmon was not sure Resident A took any pills, and Resident A was making statements that she wanted to kill

herself. Other staff reported to Staff Redmon that Resident A was okay, and her vitals were monitored by the nurse.

On June 9, 2026, I left a message to Case Manager Carmen Clark, and she returned my call shortly thereafter. I began to discuss the allegations with Case Manager Clark, and she responded “don’t say that” in response to the allegation that she did not remove medications from Resident A’s belongings. Case Manager Clark reported that Resident A had pills on her person and Case Manager Clark is unable to search her body. Case Manager Clark stated, “I’m tired of this” and hung up the phone.

On June 9, 2026, I called Licensee Designee Lisa Bruder and advised her that I needed to complete an interview with Case Manager Carmen Clark. Licensee Designee Bruder advised she would have Case Manager Clark return my call.

On June 9, 2026, I received a call from Case Manager Carmen Clark and continued my interview. Case Manager Clark stated that she completed the inventory of Resident A’s belongings when she arrived at the facility and Case Manager Clark did not see any medications. No one told Case Manager Clark where the pills Resident A came from, and Case Manager Clark was not aware of any medications being in an envelope.

On June 9, 2026, I interviewed Licensee Designee Lisa Bruder who reported when Resident A arrived at the facility she had a discharge bag from the hospital. Resident A opened the bag, showed the contents to staff, and stated “this is just papers from the hospital”. Staff said “okay” and did look into the bag.

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:	It was alleged that Resident A attempted to overdose on medications that staff did not secure upon admission raising concerns for safety and supervision. Resident A began living at the facility on April 3, 2026, and Case Manager Carmen Clark inventoried her belongings. Staff Clark did not complete a thorough inventory of the belongings and was not aware that Resident A had medications in her bag. On April 17, 2026, Resident A reported to staff that she ingested medications in attempt to overdose and was transported to the

	hospital. According to Resident A's assessment plan, Resident A was recently discharged from the hospital due to attempting to overdose from medications. There is a preponderance of evidence to conclude that Resident A was not provided with adequate protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

One June 9, 2026, I conducted an exit conference with Licensee Designee Lisa Bruder and advised her of the findings of my investigation. I advised Licensee Designee Bruder I would be requesting a corrective action plan for the cited rule violation.

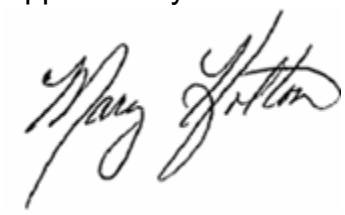
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan no change in the license status is recommended.

6/9/2026

Christina Garza Date
Licensing Consultant

Approved By:



6/9/2026

Mary E. Holton Date
Area Manager