GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

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

RE: License #: AS820383852
Investigation #: 2025A0101012
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) 456-0380.

Sincerely,

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 #:	2025A0101012
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/15/2025
Report Due Date:	03/16/2025
Licensee Name:	Genesee Manor, Inc.
Licensee Address:	30002 Saint Martins Livonia, MI 48152
Licensee Telephone #:	(131) 344-9689
Administrator:	Gary Ray
Licensee Designee:	Gary Ray
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:	11/04/2023
Expiration Date:	11/03/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has a two to one staffing pattern. When Resident A woke up on 01/02/2025, he had a bruise on his right eyelid. The staff assigned to Resident A on 01/01/2025, were unaware of the bruise.	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0101012
01/15/2025	Referral received from Adult Protective Services
01/15/2025	Office of Recipient Right referral made
01/15/2025	Special Investigation Initiated - Telephone Adult protective services worker Kya Lockett
01/15/2025	Contact - Telephone call made Resident A's guardian/mother
01/16/2025	Inspection Completed On-site Reviewed resident record Interviewed human resource representative Meghan William
03/12/2025	Inspection Completed On-site Reviewed staff Katara Jackson and Julian Watson employee files
03/14/2025	Contact- Telephone call made Designated person Michelle Ray
03/18/2025	Contact - Document Received Staff schedules Staff names and telephone numbers
03/18/2025	Contact – Telephone call made Ms. Jackson
02/18/2025	Contact – Telephone call made Mr. Watson
03/18/2025	Exit Conference

ALLEGATION: Resident A has a two to one staffing pattern. When Resident A woke up on 01/02/2025, he had a bruise on his right eyelid. The staff assigned to Resident A on 01/01/2025, were unaware of the bruise.

INVESTIGATION: On 01/15/2025, I spoke with Resident A's mother. She stated that she was aware of the bruise on Resident A's eyelid. Resident A's mother stated that the licensee took care of the situation and the staff that were responsible were no longer working at the group home.

On 01/16/2025, I reviewed Resident A's assessment plan. According to Resident A assessment plan Resident A is not able to verbally communicate full sentences or ideas. Furthermore, the assessment plan stated Resident requires two staff at all times.

On 01/16/2025, I interviewed the human resource representative for Genesee Manor Meghan Williams. Ms. Williams stated that the staff assigned to Resident A on 01/01/2025, were Katara Jackson and Julian Watson. Ms. Williams further stated that they were terminated, and she gave me a copy of their termination letter. Ms. Williams stated on 01/02/2025, Resident A woke up with a bruise on his right eyelid. Ms. William stated that Ms. Jackson and Mr. Watson were unaware of the bruise. Ms. Williams stated an internal investigation was conducted and management found out that Ms. Jackson was not with Resident A the entire day. Ms. Jackson was in the living room without Resident A. Ms. Williams further stated Mr. Watson was terminated for attendance and for violating the abuse and neglect policy. According to Ms. Williams Mr. Watson told management that on 01/01/2025, Resident A was trying to come out of his room, and he wouldn't let him, then he pushed Resident A back on his bed.

On 03/12/2025, I reviewed Ms. Jackson and Mr. Watson's employee files. All hiring practices were in compliance with licensing rules.

On 03/14/2025, I spoke with the Genesee Manor designated person Michelle Ray. Ms. Ray stated that Ms. Jackson and Mr. Watson were both terminated. Ms. Ray stated that Ms. Jackson was terminated because on 01/01/2025, the other staff on duty observed Ms. Jackson in the living room without Resident A. Ms. Ray further stated Mr. Watson pushed Resident A when he was attempting to stop Resident A from leaving his bedroom.

On 03/18/2025, I spoke with direct care staff Katara Jackson. Ms. Jackson stated "They are lying on me. I don't even work there anymore, and I don't want to talk about it anymore."

On 03/18/2025, I spoke with Julian Watson. Mr. Watson stated that the second staff assigned to Resident A was not present however she was on shift. According to Mr. Watson the second staff was assisting with an interview. Mr. Watson stated

Resident A “kept charging and attacking me.” I was trying to get him off of me and he fell backward. But the other staff stated they heard me push him down.”

On 03/18/2025, I conducted an exit conference with Ms. Ray. Ms. Ray agrees with my findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the preponderance of evidence the licensee did not provide the supervision and protection as defined in the act and as specified in Resident A’s written assessment plan. According to Resident A’s assessment plan two staff are assigned to him. According to Ms. Ray and Ms. Willams on 01/01/2025, Ms. Jackson was supposed to monitor Resident A at all times, however, she was observed in the living room without him.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.

	(iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R 400.14102(1)(m). (i) Any electrical shock device.
ANALYSIS:	Based upon the preponderance of evidence Mr. Watson used physical force to confine Resident A in his bedroom. According to Ms. Ray and Ms. Williams, Mr. Watson told them he would not let Resident A leave his bedroom and he pushed Resident A back on the bed.
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

03/19/2025
Date

Approved By:

03/19/2025

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Ardra Hunter
Area Manager

Date