GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

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

RE: License #: AS820383852
Investigation #: 2025A0101016
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,

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 #:	2025A0101016
Complaint Receipt Date:	02/20/2025
Investigation Initiation Date:	02/25/2025
Report Due Date:	04/21/2025
Licensee Name:	Genesee Manor, Inc.
Licensee Address:	30002 Saint Martins Livonia, MI 48152
Licensee Telephone #:	(131) 344-9689
Administrator:	Michele 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?
• Direct care staff Iyona Lee and Jumari Travis are not suitable. • Direct care staff are drinking and having sex in the workplace.	Yes No
Resident A and Resident B are being medically neglected.	No

III. METHODOLOGY

02/20/2025	Special Investigation Intake 2025A0101016
02/25/2025	Special Investigation Initiated - Telephone Former direct care staff Iyona Lee
03/12/2025	Inspection completed Interviewed Megan Williams the human resource administrator, Resident B Reviewed Residents A's and B's resident record Reviewed direct care staff Iyona Lee and Jumari Travis employee record.
03/18/2025	Contact telephone call made direct call staff Jumari Travis Left message
04/11/2025	Adult Protective Services & Office of Recipient Rights referrals
04/11/2025	Contact - Telephone call made Guardian A1 Case manager B1 Direct care staff Shantell Brown, Tyesha Willis, Kennesha McConico and Megan Williams the human resource administrator
04/15/2025	Exit Conference with the administrator/designated person Ms. Ray.

ALLEGATION: Direct care staff Iyona Lee and Jumari Travis are not suitable.

INVESTIGATION: On 02/25/2025, I spoke with former direct care staff Iyona Lee. Ms. Lee stated on 02/13/2025, she was arguing with direct care staff Jumari Travis.

Ms. Lee stated they were arguing about the Drake and Kendrick Lamar controversy. Ms. Lee stated the verbal confrontation became physical and she was terminated on the spot.

On 03/12/2025, I interviewed the human resource administrator Meghan Williams. Ms. Williams stated Ms. Lee and Mr. Travis were immediately terminated for "endangering" the residents. Ms. Williams stated they were fighting in the workplace.

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

On 03/18/2025, I called Mr. Travis. There was no answer, and I left a message for him to return my call. Mr. Travis did not return my call.

On 04/11/2025, I spoke with direct care staff Shantel Brown, Tyesha Willis, Kennesha McConico and Megan Williams the human resource administrator. They all stated staff are not drinking and having sex in the workplace.

On 04/15/2025, I conducted an exit interview with the administrator/designated person Ms. Ray. Ms. Ray agrees with my findings.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	Based upon the preponderance of evidence direct care staff Iyona Lee and Jumari Travis are not suitable to assure the welfare of the residents. On 02/25/2025, Ms. Lee described the verbal and physical altercation she had with Mr. Travis in the workplace. There is no evidence staff are drinking and having sex in the workplace. Ms. Williams stated Ms. Lee and Mr. Travis were fired for fighting in the workplace.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A and Resident B are being medically neglected.

INVESTIGATION: On 02/25/2025, I spoke with direct care staff Iyona Lee. Ms. Lee stated Resident A's bowels are always impacted and she is often dehydrated. Ms. Lee also stated Resident B has had an ongoing yeast infection.

On 03/12/2025, I interviewed the human resource administrator Meghan Williams. Ms. Williams stated Resident A was recently treated for impacted bowels and dehydration. Ms. Williams stated Resident A is susceptible to impacted bowels and dehydration and there is protocol in place to address these problems. Ms. Williams stated if Resident A has less than three bowel movements in a week staff is to seek medical attention. Ms. Williams further stated Resident B did have a yeast infection, however, it is not a reoccurring problem.

On 03/12/2025, I interviewed Resident B. Resident B acknowledged that she recently had a yeast infection, but it is not reoccurring.

On 03/18/2025, I reviewed Resident A's and Resident B's resident records. Resident A's resident record contained documentation that she was recently treated for impacted bowels and dehydration. And Resident B's file contained documentation that she was recently treated for a yeast infection. However, their resident record did not have documentation showing that Resident A and B were having these medical diagnoses on a reoccurring basis.

On 04/11/2025, I spoke with Resident A's guardian. Guardian A 1 stated Resident A was recently treated for constipation and dehydration. Guardian A1 stated these medical conditions are not related to Resident A's care needs not being met. Guardian A1 stated her daughter takes a lot of medication and she is wheelchair bound which are contributing factors to the constipation and dehydration.

On 04/11/2025, I spoke with Resident B's case manager Angela Buchanan. Ms. Buchanan stated she meets with Resident B monthly, and she is not aware of any

reoccurring yeast infection.

On 04/15/2025, I conducted an exit conference with Ms. Ray the administrator/designee person. Ms. Ray agrees with my findings.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon the preponderance of evidence Resident A's and B's personal needs are being attended to at all times. There are no reoccurring medical needs that are not being addressed. According to the human resource administrator Ms. Williams and Guardian A 1, Resident A is susceptible to impacted bowels and dehydration. Ms. Willian stated there is protocol in place to address these conditions. Furthermore, Guardian A1 stated Resident A was recently treated for constipation and dehydration. Guardian A1 stated the constipation and dehydration are not related to Resident A's care needs not being met. On 03/12/2025, I interviewed Resident B. Resident B acknowledged that she recently had a yeast infection, but it is not reoccurring. According to Resident B's case manager, Ms. Buchanan, she meets with Resident B monthly, and she is not aware of any reoccurring yeast infection. On 03/18/2025, I reviewed Resident A's and Resident B's resident records. Their records did not contain documentation indicating that the aforementioned medical conditions were reoccurring.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

04/22/2025

Edith Richardson — Date
Licensing Consultant

Approved By:

05/01/2025

Ardra Hunter — Date
Area Manager